Risk Factors, Patterns, and Prevalence of Suicide among Youth in Anywaa Zone,
Gambella Regional State

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ABBREVIATIONS AND/OR ACRONYMS

AIDS= Acquired Immune Disease Syndrome
CDC= Center for Disease Control
CIHI= Canada Institute for Health Information
DSH= Deliberate Self-Harm
FBO= Faith Based Organizations
FGD= Focus Group Discussion
GBD= Global Burden of Disease
DH= Health District
HIV= Human Immune Virus
ICD= International Classification of Disease
MHGAP= Mental Health Gap Action Programme
NGO= Non-Governmental Organizations
NY= No Year
SES= Socio-Economic Status
SPSS= Statistical Package for Social Science
VVDRS= Virginia Violent Death Reporting System
WHO= World Health Organizations
YRBSS= Youth Risk Behavior Surveillance Survey
ABSTRACT

As it has for decades, suicide remains one of the leading causes of injury and death worldwide. The objective of this study was to examine the risk factors, patterns and the prevalence of suicide and suicidal behavior and ideations among the youth in Anywaa zone of Gambella Regional State. The method of the study was both quantitative and qualitative. Descriptive statistics was used in data analysis to enable identifying the most common risk factors. The results on survey part revealed that chronic illness or long suffering with disease/HIV/Aids and other related diseases 64(60.4%), Poor relationship among family members/relationship problem 57(53.8%), unplanned married/early married/divorce 47(44.3%) and Unwanted pregnancy/unplanned pregnancy 47(44.3%), alcohol abuse and /or drugs abuse 43(40.5%), Physical/mental illness 35(33.1) and Preventing youngest from his/her lover or prevented one’s choice 32(30.2%) were ranked as the most common risk factors of suicide among the youth. The findings showed that risk factors for females were that of conflict in relationship among family members and between partners, getting a child with no real father, death of partner, divorce. And the risk factors responsible for youth males were “unplanned marriages, married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases. The results on patterns of suicide showed that hanging and drugs overdose or poisoning were the most commonly used by both males and females. Prevalence of suicide indicated that 347 individuals were found committed suicide from 2010-2016. Data showed that 188 were females and 164 males. The higher prevalence of suicide was among the females than males. The study also revealed that high prevalence of suicide was found in the age groups ranged from 26 to 30 years old. The findings for age and gender difference in the risk factors, patterns and prevalence of suicide showed that there was no a significant age differences in risk factors and patterns of suicide among youth, except age difference in prevalence was found. The result shows that there was a significant gender differences in prevalence of suicide among the youth. Findings on relationship between suicide and grade levels, marital status and family background of youth found that, there was a significant negative relationship between suicide and grade levels, marital status and family background.

KEY WORDS: Suicide, Risk factors, Patterns, Prevalence Youth, Anywaa youth, and Gambella youth,
CHAPTER ONE

1. Introduction

1.1 Background of the Study

Suicide as a major public health concern requires significant attention both from the public as well as the government. As a serious social problem, suicide prevention/control is not a simple task (Sanford & Hedegaard, 2008). Although many deaths related to other factors are preventable, suicide is always too often a low priority for both governments and policy-makers (WHO, 2014). Therefore, today’s institutions such as families, communities, governments and religious organizations need to have better knowledge of national, regional and local suicide risk factors and patterns that would improve the effort prevention in dealing with suicide cases (Cantor & Baume, 2006 & Nordentoft & Wandall-Holm, 2003).

By its nature, suicide is a complex phenomenon that involves biological (genetic), psychological, socio-economic, individual, and environmental risk factors (Chen, Wu, Yousuf, & Yip, 2012) & (Yip, 2009). Socio-political risk factors are also important in understanding the phenomenon of suicide (Durkheim, 1951). According to Sanford and Hedegaard (2008), suicide is an important public health problem and the most serious psychological problem. Suicide is always a cause of great distress to family, friends, and community and largely to the nation as well (Renberg, 1999).

Suicide is quite different from suicidal behavior in variety of ways. According to Durkheim (1951), suicide is a final task of behavior that is probably the end result of interactions of several different factors. It has defined as an act of intentionally terminating one’s own life, that is an individual carefully planned and killed her/himself (Nock,Borges, Bromet, Alonso, Angermeyer & Beautraiis, 2008). Another definition is as a death resulting from the intentional use of force against oneself (Nock et al. 2008 & Shneidman, 1985).

Suicidal behavior is a process from suicidal thoughts to completed action (Retterstol, 1993). This process is considered by some theorists to originate in childhood. Suicidal behavior is a range of behaviors that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself (Posner,Oquendo & Gould, 2007). However, there is a wide spectrum
of suicidal behavior, ranging from low-level suicide ideation (occasionally thinking about suicide) through to a deliberate action that actually results in death.

There is a great overlapping between the risk factors of suicide and suicidal behavior. There is act of deliberate self-harm and there is also a small risk of death in both of them respectively. This shows that deliberate self-harm, attempted suicide and completed suicide should be regarded as occurring on a continuum ranging from thoughts of suicide to completed suicide (Taylor, 1988).

According to Nock and Prinstein (2005); and Nock and Kessle (2006) suicidal behavior is classified more specifically into three categories: suicide ideation, which refers to thoughts of engaging in behavior intended to end one’s life; suicide plan, which refers to the formulation of a specific method through which one intends to die; and suicide attempt, which refers to engagement in potentially self-injurious behavior in which there is at least some intent to die. Attempted suicide is the term most often used to describe self-harm where there is apparently an intention to kill oneself but death does not occur. Taylor (1988) defines this type of suicidal behavior (suicide attempt) as any deliberate act of self-damage or potential self-damage, where the individual cannot be sure of survival.

Suicide behavior and patterns were greatly affected by variety of risk factors such as biological, psychological, socio-economic, individual, environmental, and demographic risk factors (Chen, Wu, Yousuf & Yip, 2012 & Yip, 2009). Furthermore, King and Merchant (2008); Steele and Doey (2007), Bridge (2006); Spirito and Esposito-Smythers (2006); and Evans, Hawton & Rodham (2004), suicide, suicidal behaviors and patterns of among the youth were more influenced by multiple and interacting risk factors that compressed of biological, psychological (depression, hopelessness), environmental (familial, interpersonal), social, individual (substance abuse, low grade, unemployment), and political (displacement, war) risk factors.

According to WHO (2008), the study conducted worldwide in 17 countries that included the regions of Africa, American, Asia and Pacific, Europe and Middle East has found the consistencies important evidence of the influence of risk factors on age differences and sex. Among the other risk factors, psychological risk factors such as mental disorders and mood disorders were identified as strong diagnostic risk factors across countries, particularly, on age
and sex. Females and youngest from (12-to-34 years), were mostly affected population in different countries, particularly by psychological and individual risk factors (WHO, 2008).

Globally, suicide has been reported to be accounted as the third leading cause of death among young people of 10-34 years of age. As to a nationally representative survey of youth conducted in 2011 found that youth are more vulnerable of suicide. In each year they seriously contemplated suicide, made a plan to commit suicide, attempted suicide at least once, and others received medical care for an injury sustained during a suicide attempt. So these troubling indications point to a serious problem for youth of today (Centers for Disease Control and Prevention, 2011).

Specifically, suicide was found as the third leading cause of death among persons aged 10-14 years, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons of 65 years and older (CDC, 2013).

According to Fuse (1997), throughout human history numerous theories have been advanced in an effort to explain or better understand how multi-risk factors were associated with suicide and why people were seeking to take their own lives. As to him, the theories were classified into three groups, biological, psychological and sociological (socio-economic and environmental). That means, this classification depend on how each risk factor was influenced/associated with suicide and its patterns.

King and Merchant (2008), Steele and Doey (2007); Spirito et al. (2006); and Evans et al. (2004), defined risk factors as those factors and social conditions that are associated with an elevated risk for suicide and suicidal behavior and also determined the patterns. As to Fuse (1997), the first theory is biological factor that comprise with certain physiological, biochemical or genetic factors putting an important influence on the emergence of suicide. According to the research findings, biological factors were found as a predisposing to suicide and have been shown up the general situation, pointing out the areas that have the most relevance to young suicidal behavior. These situations and areas are as follows, genetic predispositions, chemical imbalances, abnormal levels of neurotransmitters, neurological damage due to infections, and nutritional disorders (Fusé, 1997). In families with a heavy genetic loading for mood disorders
the suicide rate was higher (Mahon, Tobin, Cusack, Kelleher & Malone, 2006; South African Depression & Anxiety Group, 2006). Biological risk factor might work independently or in addition to the genetic transmission of mental disorders of the parents (National Youth Violence Prevention Resource Centre, 2006; South African Depression and Anxiety Group, 2006; & Brent, Agerbo & Oquedo, 2003).

The second theory is psychological and psychiatric, that is largely focuses on the states of mind, psyche, or feeling and beliefs about the world of individuals who commit or attempt suicide (Fusé 1997& Retterstol 1993).

The first important analysis of psychological insight into suicide was done by Sigmund Freud. Freud stated that, suicide represents aggression turned inward against an “introverted” object. In his description of suicide mentioned that, this retroflexed murder is either turned inward or used as an excuse for punishment, or self-directed death instincts, which he refers to as Thanatos. The famous psychologist Freud had identified three components of hostility suicide within individual. These are: a wish to kill, a wish to be killed, and a wish to die (Kaplan & Sadock, 1998).

Beck, Emery and Greenberg (1985) claimed that, hopelessness is an important psychological construct for understanding suicide. Then, mentioned that, hopelessness as a strong psychological construct can affect an individuals and lead to depression and in turn predicting suicide act. Wetzel, Margulies, Davis and Karam (1980), was also supported that, there is a significant linkage between hopelessness and suicide intent. Minkoff, Bergman, Beck and Beck (1973) compared hopelessness and depression and found that, the magnitude of suicidal intent was more highly correlated with hopelessness than with depression. However, as to Esposito, Margulies, Davis and Karam (2003), explained that to prevent suicide, properly handling of depression must to do first. Because, if depression was controlled, hopelessness would not result in suicide ideation. Generally, hopelessness has been suggested that, might place youth at risk for suicidal behavior only for a certain time, if care would not been given (Dori & Overholser, 1999).

The third Theory is socio-economic, which is very much focus on the significance role of the social environment, social relationships, social capital, economic and cultural factors in the etiology of suicide. Families with no smooth interaction and poor communication among its
members also associated with increased risk factors of suicidal behavior (Gould, Fisher, Parides, Flory & Shaffer, 1996). According to Joiner and Rudd (2000) multiple of stressful events have been known that served as a trigger for suicide. Interpersonal problems with family members or other intimates were understood as a typical stressor experienced by those who have made serious suicide attempts (Chen et al. 2012; & Bastia & Kar, 2009). Socio-economic also the risk factor that is closely related to suicide. Such risk factors include poverty, low-income, discrimination, unemployment, social capital, divorce and marriage (Runeson & Åsberg, 2003).

Furthermore, Durkheim (1951) asserted that when divorce happened it reduces family ties, well beings and resulted in suicide increases. Suicide depends on the lack of social integration, including family ties. Moreover, a number of empirical works have suggested that divorce have been found significantly associated with suicide, supporting the view of Durkheim (Rodríguez, 2005; Nuemayer, 2003; Brainerd, 2001). If this is so, then the tendency of increasing suicide rates is partly an outcome of rising divorce rates.

Social capital is factor of social relationship. According to Putnam (2000) if a person lives in a tightly knitted community with the members cooperating with each other, that person would expect the quality of life to be greater. But lack of social capital, which supposed to enhance community development, has a greater negative impact on peoples’ lives. On the other hand, poor human relationships and support in a workplace are more correlated with suicidal behaviors.

Since multiple risk factors are contributed to the selection of a suicide patterns, patterns of suicide can be understood from basic concepts such as the social acceptability of the method (culture and tradition) and its availability (opportunity) (Farmer, Rohde, Stack & Wasserman, 2005). Cantor et al. (2006) stated that, international or intercultural comparisons of suicide methods help increase understanding of the interplay between these two factors (suicide patterns and prevention strategies) and provide a basis for preventive strategies.

The scholars described that, to improve prevention efforts, better knowledge of national, regional and local suicide patterns is important, and better understanding of underlying mechanisms is also vital. According to national studies on suicide indicated that, suicidal behaviors and, in particular, the preferred suicide method varies among the countries.
As it was indicated by Brent et al. (2003), firearm was the most commonly used method in the United States but was also prevalent in Argentina, Switzerland and Uruguay, and only youngest males were used this method in Switzerland. Jumping from a height was also a method of suicide in urban societies such as Hong Kong SAR, Luxembourg and Malta and it play role in rural Latin American countries (El Salvador, Nicaragua and Peru), Asian countries (the Republic of Korea and Thailand) and also in Portugal. Poisoning with pesticides and poisoning with drugs was a major pattern, commonly among females in Canada, the Nordic countries and the United Kingdom (Weller, Kimball & Romney, 1990). In another study mentioned that, the role of pesticide suicide in Asian countries become the common one among youngest people (Eddleston, 2000). According to the writers, Charcoal burning becomes the emergence of a new method (pattern) of suicide in Hong Kong Special Administrative Region (SAR), China and urban Taiwan, China (Chan, Yip, Au & Lee, DT. 2005 & Liu, KY. Beautrais, Caine, Chan, Chao, Conwell, et al. 2007).

According to the medical records of patients with acute poisonings presented to the Gondar University hospital between July 2001 and June 2004 by Abulaand Wondmikun, was claimed that Poisoning with suicidal intention is becoming a most common method of suicide and a serious health problem among people of Ethiopia, particularly in adults. The usual material they use as a pattern to suicide is pesticides commonly used toxicants (Abula & Wondmikun, 2004).

As to Abdullahi and Bekry (1999), hanging and strangulation were the most commonly used methods of suicide in cities of Ethiopia. And also in many developing countries, particularly Africa and Asia, poisoning is the most commonly used means for people, especially young people to end their life in rural areas (Gunnell & Eddleston, 2003).

As the prevalence, Suicide is a huge in its cause of death but is more controllable health problem which causing even almost half of all violent deaths and resulting in one million fatalities per a year, as well as financial costs in billions of dollars (WHO, 2004). Worldwide, suicide represents 1.4% of the global burden of diseases.

According to the Youth Risk Behavior Survey, 13.8% of youth contemplated suicide in 2009, and 10.9% of youth reported having made a plan about how they would attempt suicide. Youth females were more exposed to attempt suicide than males, while the males are frequently four
times more likely to die from suicide (Child Trends, 2010). Differences of suicide prevalence also exist between racial and ethnic groups, as Native American/Alaskan Native and Hispanic youth experience the highest suicide rates (CDC, 2008).

American-Indian/Alaska Native youth have the highest prevalence of suicide across all age groups and males have the higher prevalence than females. European-American youth have the next highest prevalence. European-American prevalence is higher than that of African-American, Latino, and Asian-American/Pacific Islander youth. Although research suggests that Native American and Latino youth have the highest suicide-related fatalities (CDC, 2009), Latino female youth were more likely to attempt suicide than all other groups of youth (National Adolescent Health Information Center, 2006).

According to the study conducted among high school students in Addis Ababa, Ethiopia, by Kebede and Ketsela (1993) showed that the lifetime prevalence of suicide attempt among youth are in contrast of 14.3% to the 6.6% that found by the present study from the previous one. Of course this study was only limited to preparatory school youth who have good academic performance and predicted to join higher education might have contributed to the lower prevalence of suicide attempts in the present study. According to them, prevalence is more in females (9.0% than males (4.3%) and rural (7.2%) than urban. However, there was no significant difference by ages, living arrangement, family connectedness; religious affiliation and residence for actual suicide attempt (Derege & Tigist, 1993).

The study carried out of over 10,000 adults in Butajira shown that, a higher prevalence of mental distress and suicide attempt was found in those using alcohol and Chat. An increased prevalence of suicide attempts was also reported in adolescents in Addis Ababa who drank alcohol (Kebede & Kestela, 1993). Generally, In Ethiopia, the prevalence of suicide observed ranged from 3.24 to 11.64 per 100 000 inhabitants per year between 1981 and 1996 (Abdullahi & Bekry, 1999).

To see the impact of risk factors on suicide, suicidal behaviors, patterns and prevalence, several studies have been conducted in different countries of the world by different researchers. The majority of the studies were identified strong correlation of risk factors and suicidal behaviors across countries (World Bank, 2003). The studies indicated above have emphasized on different areas regarding the impact of risk factors on suicide, patterns and prevalence. Some of them were
focused to assess the influence of psychological risk factors, socio-economic risk factors, environmental risk factors, and individual factors on suicide and suicidal behaviors. Others were emphasized on age and sex as related risk factors of suicide and patterns. Some others were examined the prevalence of trends, in risk factors for suicidal behavior. Regarding the locations, most of the studies were conducted in Americas, Canada, Asia and the Pacific, Europe, Middle East countries, China, Colombia, Lebanon, Ukraine, Mexico and in some African countries such as, Nigeria, South Africa, Egypt, Cameroon, Uganda, Tanzania, and Ethiopia. According to Hjelmeland and Knizek (2011); and Hjelmeland and Knizek (2010) who was the famous in qualitative study stated that, only two qualitative studies on suicidal behavior have been conducted in Africa to date; one on suicide and the other on attempted suicide. Moreover, there was no qualitative study conducted in Ethiopia at large and Gambella regional state, particularly.

All these mentioned above can show that there is a knowledge gap of risk factors, patterns and prevalence of suicide in Gambella regional state, and encourage the student researcher to carry out this study in Gambella regional state, particularly in Anywaa zone.

1. 2. Statement of the Problem

Suicide is among the leading causes of death worldwide (WHO, 1996). In addition to that suicide, however, it has been a low priority for both government and policy-makers (WHO, 2014). Many countries around the world, particularly the less developed countries, including Ethiopia had paid low attention to suicide and suicidal behaviors (Vijayakumar et al., 2005).

Different studies were conducted worldwide, including Ethiopia about suicide. Some of these studies were focused to assess the influence of biological, psychological, socio-economic, environmental, and individual risk factors on suicide and suicidal behaviors. Others were emphasized on age and sex as related risk factors of suicide and patterns. Some others were examined the prevalence of trends, in risk factors for suicidal behavior. The majority of the studies were identified strong correlation of risk factors and suicidal behaviors across countries (World Bank, 2003).

Three studies were carried out in Ethiopia. The first, was among high school students in Addis Ababa (Kebede & Kestela, 1993), second was conducted over 10,000 adults in Butajira and the third one was the medical records of patients with acute poisonings presented to the Gondar
University teaching hospital (Abula & Wondmikun, 2004, & Derege & Tigist, 1993). All these were focused to examine the contribution of various risk factors on suicide, suicidal behaviors, and even to investigate the patterns and prevalence of suicide (Abdullahi & Bekry, 1999, Derege & Tigist, 1993 & Kebede & Kestela, 1993). Thus, the student researcher did not come across the study carried out in Gambella region. This can show that there is a knowledge gap of risk factors, patterns and prevalence of suicide in Gambella regional state that need to be study.

Although suicide, suicidal behavior, pattern and prevalence have been extensively studied in worldwide, including Ethiopia, they still remain as major problems to be solved in Gambella context. These studies were not addressed the problem regarding to Gambella regional state. In addition to this, majority of the studies conducted on suicide were based on quantitative method only, and qualitative method was not used in various studies, especially, those which were studied in African countries. That also another problem to be considered, thus, student researcher, felt interested to study this problem in Gambella regional state context to come up with finding that would be in line with scientific evidence. Student researcher was also motivated to incorporated qualitative method in the study together with quantitative one. The student researcher was again felt interested to study this problem to identify whether or not there will be a strong correlation between risk factors mentioned above and suicide or to see whether the finding of this research will match with the previous findings.

The study was focused to examine the influence/impact of risk factors (biological, psychological, socio-economic, and individual factors) on suicide, in relation to age and sex differences in Anywaa zone of Gambella regional state. The study seeks to describe and explain the risk factors, patterns and prevalence of suicide in youth population in Anywaa zone of Gambella regional state, where different cases of suicide have been recorded in recent years.

Therefore, to identify the prevalence and examine the risk factors and patterns of suicide and suicidal behaviors, the study was tried to answer the below research questions.

**RESEARCH QUESTIONS**

i. What are the risk factors causing suicide among youth in Anywaa zone?

ii. What is the pattern or method used by youth to commit suicide?
iii. What is the prevalence of suicide among the youth in Anywaa zone?

iv. Are there ages and gender difference in the risk factors, patterns and prevalence rate of suicide among the youth in Anywaa zone?

v. What is the relationship between suicide and grade level, marital status and family background of youth in the zone?

1. 3. Objectives of the Study

General Objective

The general objective of the study is to examine the risk factors, patterns and prevalence of suicide among youth in Anywaa zone.

Specific Objectives

The specific objectives of this study are as follows:

a. To examine the risk factors caused suicide among youth in Anywaa zone.

b. To analysis the patterns of suicide used by youth to commits and attempt suicide.

c. To identify the extent of suicide prevalence among the youth of Anywaa zone.

d. To investigate the role of sex and age differences in the risk factors, patterns and prevalence of suicide among Anywaa youths.

e. To explain the relationship between suicide and educational level, marital status and family background.

1. 4 Significance of the Study

This study seeks to add to the literature on case studies of suicide in Ethiopia. To date, the phenomenon of suicide in the region of Gambella has not been studied, and there is no any report documented concerning risk factors, patterns and prevalence among youth in Anywaa zone, particularly. Therefore, this study will be very much essential:

1. Help fill the gap in knowledge about suicide in Gambella, Ethiopia.
2. Help stakeholders including parents, peers, victims themselves and government and non-governmental concerned bodies to understand how to support suicide victims.

3. Help in the identification of major risk factors that cause extremely one ‘self-killing and injuring, and come as a ground for prevention.

4. Serve as a stepping stone for those who will be interested to conduct further study on suicide issue.

5. Provides the basis for solving-problem that the community encountered/faced for many decades.

1. 5. Scope and Limitation of the Study

The study was carried out to explore risk factors, patterns and prevalence of suicide associated with the onset of suicidal behavior in young people based on gender and age of 15 to 34 years old in Anywaa zone. It was focused on the contribution of risk factors that causes suicide among the youth in Anywaa zone. And also to see the extent to which prevalence of suicide has been so far among the youth, in that particular zone. The study was conducted in two woreda/districts of Anywaa zone, Gambella region. These are, Abobo and Gog, where high incidences of suicides have been recorded.

1. 6. Operational Definition of Key Terms

Suicide: - it is the act of ending one’s life through the means of hanging, poisoning, jumping from height place, shooting, and etc. it can be intentional oneself killing or accident.

Risk factors: - are the causals/influencers that determine the suicide problem to happen.

Pattern: - the means in which suicide processes follows from the initial of ideation to actual suicide.

Prevalence: - is the number of available cases (both the new and old) in a given year in a specific area.

Youth: - the young people who their ages ranged from adolescent to early adult stage. The people in the age of 15-to-34 years, who most of them still depending their lives on others, in term of shelters and food.
CHAPTER TWO

2. LITERATURE REVIEW

This chapter is dealing with the review of related literature that done on effect of suicide risk factors, patterns, and prevalence on Youth. In this chapter, definition of each term below was discussed. Suicide, Suicidal behavior, suicide attempt, and suicide ideation are defined under this chapter. The term youth was also defined under this chapter based on International, Africa, and Ethiopia contexts. Major risk factors that determine suicide and patterns that victims followed in the process of suicide and suicide attempt are also discussed.

2.1. Meaning of Suicide: Overviews

Suicide has many definitions and does not have one definition universally accepted. However it has defined, simply, as intentional self-inflicted death (Jacobs, Baldessarini, Conwell, & Horton, 2003) defined Suicide as a complex and multidimensional phenomenon stemming from the interaction of several factors. Suicide remains an important and major cause of death in various populations. Defined as “the conscious act of self-induced annihilation, best understood as multidimensional in a needful individual who defines an issue for which the suicide act is perceived as the best solution” (Scheidman, 1985). Suicide is not a random or pointless act; on the contrary it is a way out of a problem- solving Jacobs et al. (1998).

According to WHO (2013), the term suicide has no single explanation of why people died by suicide. However, many suicides happened impulsively and, in such circumstances, easy access to a means of suicide such as pesticides or firearms can make the difference as to whether a person lives or dies.

Consistent with the rules of sociological method, Durkheim (1897) began his work with a warning against what is commonly called suicide. Durkheim's first effort for the definition was followed common usage, according to which a "suicide" is any death which is the immediate or eventual result of a positive (shooting oneself) or negative (refusing to eat) and the act accomplished by the victim him/herself. Durkheim in his historical treatise on suicide coined the terms and defined it as anomy (an individual’s sensitive ideas to social progress), egoistic (an
individual’s certain personality), and altruistic (personality that should be sacrificed if the community required it) (Durkheim E, 1897).

Lisa Firestone (1987) defined suicide as like this. For the general population, suicide is often a silent tragedy. For the media, it is a treacherous taboo. For those who are in the mental health professions, it is a deeply disturbing occupational hazard and the most common psychiatric emergency people face.

Clinard and Meier (1975) also defined suicide as simply the destruction of oneself, self-killing or self-murder in the legal sense. Retterstol (1993) has been offered more detailed definitions: An act with a fatal outcome, that is deliberately initiated and performed by the deceased him- or herself, in the knowledge or expectation of its fatal outcome, the outcome being considered by the actor as instrumental in bringing about desired changes in consciousness and/or social conditions.

2. 2. Suicidal Behavior, Suicide Attempt, and Suicide Ideation

Suicidal behavior is defined as a range of behaviors that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself (Posner et al. 2007). Attempted suicide is the term most often used to describe self-harm where there is apparently an intention to kill oneself but death does not occur. Taylor (1988) has defined this type of suicidal behavior as any deliberate act of self-damage or potential self-damage, where the individual cannot be sure of survival.

According to Taylor (1988), whether or not a person really intended to die is sometimes unclear or ambiguous in both attempted and completed suicide situations, given that it is difficult to accurately determine a person’s intention after the event. For this reason, Taylor (1988) has tried to distinguish four types of behaviors related to suicide: 1) Suicide; the person intends to dies, and does so. 2) Attempted suicide; the person intends to die, but does not. 3) Suicidal gesture; the person has no real intention of dying, and does not. 4, Accident; the person does not intend to die, but does (Altergott, 1998, Cited by Stack, 2000).

A number of psychological theorists further explained suicidal behaviors (Menninger 1938; cited by Fusé, 1997) and suggested that, people who engaged in suicidal behavior often want to live
and die at the same time. Other meanings were that such people gambled and left it up to others to decide the outcome, they were not aware that they have such a suicidal intent, or they were acting passively (failing to stop themselves from dying) rather than actively (Clinard & Meier, 1975).

2. 3. Suicide among the Youth

Adolescence/youth is a period of multiple conflicts that resulted due to the developmental process, such as exploration and experimentation that needs adjustment to physical maturity, changing roles within families and with peers, and the emergence of a more independent lifestyle (Rockville, 1999). Compared to adults, youth show higher stress levels and have fewer coping resources. The stressful process of differentiation and identity consolidation can result in significant psychological distress, which later resulted in suicide. Studies show that at least one in five children and adolescents had died of suicide because of a mental health disorder (Rockville, 1999).

Suicide documented a monotonically increasing relationship between age and suicide. Such a relation has been observed repeatedly since the beginning of the nineteenth century, making it one of the most robust facts about suicide. Economic theory explained this relation naturally, that youth or young people have the most life to lose and also have the least information about what their life will be like (Hamermesh & Soss, 1974). Suicide is now the second or third leading cause of death for youths in the United States, Canada, Australia, New Zealand, and many countries of Western Europe. The youth suicide is become more and more an epidemic and attempted suicide is even more so. Take for instance, for every teenager who commits suicide (0.01 percent each year), four hundred teens report attempting suicide (4 percent per year), one hundred report requiring medical attention for a suicide attempt (1 percent per year), and thirty are hospitalized for a suicide attempt (0.3 percent per year). So, youth suicide rates become increased so much than suicide among adults and the elder people. Indeed, when Durkheim wrote, suicide was primarily an urban phenomenon, but today youth suicides are 15 percent more prevalent in rural areas than in urban areas (Durkheim, 1897).

Most people, including youth, who contemplate, attempt and/or die from suicide suffer from one or more psychopathologies. Mood disorders are the most common mental disorders reported as
associated (Groholt & Ekeberg, 2009 & Renaud, Berlim, McGirr, Tousignant & Turecki, 2008). Globally, suicide is the third leading cause of death among young people of 15-24 years of age, next to unintentional injury and homicide. According to Surgeon General’s call to action to prevent suicide (1999) more teenagers and youth people died of suicide in the US and other parts of the world than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung diseases combined. That show, suicide is extremely very high among the group of youth than other age groups.

A study conducted among preparatory school youth in Addis Ababa reported a lifetime prevalence of suicide attempt among youngest. A history of suicide among family members and friends, sexual activity, female gender and some depressive symptoms were found to be strong predictors of suicide attempt (Derege & Tigist, 1993).

Many of the basic risk factors for adolescent suicidality are well known. Among these, the most important are depression, exposure to suicide or history of suicide attempts by family members or friends, substance or alcohol abuse and having guns in the home (Kebede & Alem, 1999).

2.4. Theories on Youth Suicide

This part is reviewing the literatures that attempts to explain why suicide prevalence/rates vary over time and between different population groups and examines a selection of theories about why people commit suicide. The focus is mainly on biological, sociological (socio-cultural), psychological theories that seek to explain variations in suicide patterns over time and between different groups of people.

According to Durkheim (1897)’s study Le Suicide proposed that suicide is a symptom of an underlying inadequacy of social integration and social regulation. This interpretation paved the way for the development of more suicide theories. Based on Durkheim’s proposal and analysis of suicide, other theorists modified or elaborated on Durkheim’s concepts and suggested that disruptions to social status, social networks, social relationships or the economy could increase suicide levels. Specifically, theories of suicide are classified into three groups.

Biological theories: postulate that certain physiological, biochemical or genetic factors exert an important influence on suicide, sometimes in combination with environmental factors. For
instance, genetic predispositions, chemical imbalances, abnormal levels of neurotransmitters, neurological damage due to infections and nutritional disorders (Fusé, 1997).

Psychological and psychiatric theories: focus on the states of mind, psyche, or feeling and beliefs about the world of individuals who commit or attempt suicide. Often these theories give little prominence to the broader social relations or the socio-cultural context of suicidal behaviors. (Fusé, 1997).

Sociological theories: focus on the significance of the social environment, social relationships and other social, economic and cultural factors in the aetiology of suicide (Douglas, 1967, cited in Giddens 1971).

Theories of youth suicide in explaining youth-suicide attempts and completions are also categorizes according to two basic facts. The first fact is that people have variable feelings, which everyone has high and low feelings. For youths, the variability of emotions/feeling is particularly great. The second fact is that youths do not have financial resources that they can use to influence others or they can solve their own problems. Youths are still at the point in life where their consumption exceeds their net income. These two facts suggest a number of different explanations for youth suicide (Hamermesh & Soss, 1974).

According Hamermesh and Soss (1974), explanations for youth suicide are grouped as alternative explanations into four theories. The first explanation is the strategic suicide theory; youths attempt suicide is to signal others that they are unhappy or to punish others for their unhappiness. In this theory, suicide attempts are not primarily designed to result in death. Rather, they are a way for youths to influence others in nonfinancial ways. The second theory is the depression theory, at various points, youths become sufficiently unhappy that they “rationally” take their life. The third theory is the contagion theory, it is really an extension of the first two theories, suggesting that a “social multiplier” may amplify the effects of stressors leading to depression or may amplify the effects of factors leading to suicidal signaling as a method of conflict resolution among youth. The fourth theory has less to do with events that produce suicide thoughts and more to do with the ability to carry out suicide plans. We term this the instrumentality theory, when youths become particularly unhappy; they commit suicide if the
means to do so is readily available. Thus, youths with access to guns will, for the same level of unhappiness, have higher suicide rates than youths without access to guns.

Another theory of suicide developed by Hamermesh and Soss (1974) is the Rational Suicide Theory; this theory is the most conventional one. According rational suicide theory suicide is 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. The rational-suicide theory was developed as a way of explaining why suicide seemed to increase monotonically with age (Hamermesh and Soss, 1974).

2. 5. Risk Factors of Suicide

Risk factors have been defined as those factors and social conditions that are associated with an elevated risk for suicide and suicidal behavior. According to the recent reviews of the empirical literature confirmed that, there are a number of factors that have been linked to suicide and suicidal behaviors among youth (King & Merchant, 2008, Steele & Doey, 2007, & Spirito & Esposito-Smythers, 2006 & Evans et al. 2004). These numbers of factors are: biological, psychological, individual, socio-economic and environmental factors.

According to WHO (2014), biological, Social, psychological, individual, and cultural and other risk factors can interact to lead a person to suicidal behavior. Additional to that, risk factors associated with suicidal behavior and ideation includes biological, environmental, psychological, socio-economic and individual risk factors (Mazza, 2006).

2. 5. 1. Biological Risk Factors

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2010) stated that, biological risk factors which are associated with suicidal behaviors among youth include gender, ethnicity, and family history. Although female adolescents report higher rates of depression, anxiety, suicidal thoughts, ideations, and suicide attempts, males are four times more likely to die because of suicide. Biological risk factors affect the behavior and lead in suicide attempt or suicide complete, when; abnormalities in the serotonergic system are associated with suicidal behaviors. Pfeffer, McBride, Anderson, Kakuma, Fensterheim and Khait (1998), low levels of serotonin identified among those who attempted suicide were predictive of
future completion of suicide. Other data by Kohli, Young & Conwell (2010), suggested that, an abnormal in neurotrophin system can contributes to happening of suicide. According to Zayas, Cabassa, Lester & Fortuna (2005), gender is accounted as the potential risk factor suicide action among the youth. However, African-American male youth have shown an increased rate high suicide among themselves compared to African-American female youth early in the decades ago. 

Ethnicity can also play a role in suicide risk among the youth. Study shown that youth between the ages of 15 and 34 who were identified themselves as a Native of American or Alaskan Natives were seen have a high rate of suicide 2.4 times than the national average, and suicide is become the second leading cause of death among them (Centers for Disease Control and Prevention, National Center for Injury Prevention & Control, 2010). In 2011, the study composed with a nationally representative sample of high school students indicated that, Hispanic adolescents were reported attempting suicide more often than African-American and White students, 13.5% versus 8.8% and 7.9%, respectively (Centers for Disease Control & Prevention, 2011).

Some researchers also points to genetic factors to explain the link between parental characteristics and youth suicide. According to Fergusson and Lynskey (1995), parental psychopathology namely, depression and substance abuse have possibility to be transmitted to the offerings. And the youth from the families with psychopathology experience are more likely to be affected. Families with the history of suicidal behaviors are also a gate way to their children (Gould et al. 1996).

2. 5. 2. Environmental Risk Factors

According to Stein et al. (1998), stressful life events are usually occurs before a suicide attempt for adolescents. Environmental risk factors appeared in the form of relationship breakups or family and romantic conflicts, parental divorce, death of a loved one, military deployment of a parent, academic failure, the presence of legal/disciplinary problems, and physical/sexual child abuse are events often cited as occurring prior to a suicide attempt (Kidd, Henrich, Brookmeyer, Davidson, King, & Shahar, 2006 & Mazza, 2000). Although these situations mentioned in the above are experienced by most young people at some conditions, research suggested that many
of these negative life stressors in combination with a psychiatric disorder can greatly contribute to suicide risk and behaviors (Sofronoff, Dalgleish & Kosky, 2005).

Researchers stated that, adolescents or youths who attempted suicide can describe their families as stressful, unsupportive, highly conflicted, and emotionally distant (Kohlberg, Peña & Zayas, 2010). Whereas the adolescents or youths who are more connected and supported by their families have a lower risk of engaging in suicidal behaviors (Kidd et al. 2006).

Peer relationships and school environment also a major risk factor and play a major role in young men suicide. According to human development stage, during adolescence period, the primary attachment shifts or change from parental figures to peers (Reed, Bell & Edwards, 2011). This shows that relationships can have a great effect on youths in a different ways. If the individual adolescents or youths have poor social skills, low self-concept and social self-concept, and feeling rejected or isolated by peers, that can serve as a risk factor for them. Several family factors are associated with an increased likelihood of youth suicide: According to King, O'Mara, Hayward and Cunningham (2009), poor family relationships and obligation to the family have great influence in the youth suicide.

Finally, recent studies have started to look for investigating the impact of technology on young peoples’ suicide risk. So the researchers identified that, it has long been recognized that media coverage on suicide can lead to suicide clusters that means it has great impact on youth suicide with an excess number of suicides or attempts than would be expected in a particular community at a particular time (Gould, Greenberg, Velting & Shaffer, 2003). Addition to that, the internet can also play a big role by providing youth with plenty of information about how to commit suicide successfully and may even encourage youth to commit suicide (Alao, Soderberg, Pohl, & Alao, 2006).

2.5.3. Psychological Risk Factors

Mental health problems and psychiatric disorders are known to be a risk factor for suicidal behavior among adolescents. As to Koutek, Kocourkova, Hladikova and Hrdlicka (2009), depression has been singled out as the most prevalent condition. They stated that, the intensity of a person’s suicidal intent is associated with a history of depression and anxiety and current stress from a mental disorder. Although many mental disorders increase the odds of suicide ideation,
disorders characterized by anxiety and poor impulse-control increase the odds of actual suicide attempts (Kwoy & Shek, 2009). According to Groves, Stanley and Sher (2007) indicated that, female youths are more under the influence of alcohol and affective disorder than male youth affected. Substance abuse was also found as a significant risk factor, especially for older adolescent male victims (Shaffer et al., 1996) and when co-occurring with an affective disorder (Gould & Kramer, 2001).

Psychological factors researchers have been trying to examine what the specific constructs that may explain exactly why psychiatric disorders are associated with suicidal behavior. According to researchers, several psychological risk factors including the presence of hopelessness, impulsiveness, and high emotional reactivity are the typical psychiatric disorder leading young people to suicide. Research also has supported that, adolescents who engage in suicidal behaviors tend to behave more aggressively and impulsively, lack positive coping and problem solving skills, feel less supported by family and friends, and have a general feeling of hopelessness (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Thus, each of these elements of psychological factors has potential to increase psychological distress in the behavior of people and lead a person to seek escape via suicide (Williams & Pollock, 2000).

2.5.4 Socio-economic risk Factors

Fergusson et al. (2000) stated that, parental low socioeconomic status (SES), poverty and educational under achievement of parents were most common risk for offspring’s suicidal behavior. Socio-economic factors can be understood in the areas with greater level of socio-economic disadvantage and would have higher suicide rates. As to the studies, poverty and deprivation are linked to suicide risk at an ecological (area) Unemployment is linked to elevated risk of suicide. Occupational social class and suicide and deliberate self-harm (DSH) are inversely linked: the lower the social class, the higher the risk of suicidal behavior (Agerbo, 2005; Sheikh, 2000).

2.5.5 Individual Risk Factors

According to the explanation given about suicidal behavior regarding the individual resources, lack of education, poverty, substance abuse (alcohol or drug abuse), severe somatic disease, mental illness, ongoing or previous psychiatric treatment, homeless, prisoners, institutionalized
persons, and long-term unemployment were considered as the potential contributors in both suicide completion and attempt (Fazel et al., 2008, Qin et al., 2006; Brønnum-Hansen et al., 2005; Agerbo, 2003; Nordentoft & Wandall-Holm, 2003; Christoffersen et al., 2003; Stenager & Stenager, 2000).

For teenagers school problems (failed a grade, suspended from school, dropped out of school, neither work nor school/college) was found to be a significant risk factor for youth suicidal behavior (Gould et al., 1996).

**Theoretical framework**

According to Beautrais et al. (2000)’s model, the empirical literature on suicide and suicidal behavior risk factors were drawn from a broad range of disciplines, from genetics/biological, to socio-economic and demographic, family characteristic and childhood experience and individual, that is widely accepted that suicide and suicidal behavior have a multi-factorial etiology and therefore an interdisciplinary theoretical framework is required to help understand the phenomenon. The framework covers both independent variables which include biological, socio-economic, family characteristic, childhood experience and individual factors and dependent variables such as suicide and suicide attempt.
Fig 2.1: The Proposed Theoretical Framework

**Independent Variable**

**Risk Factors**

**Dependent variables**

**Suicide and Suicidal Behaviors**

**Biological Factors**
- Gender/male or female
- Family history

**Socio-economic factors**
- Low-income
- Poverty
- unemployment

**Individual factors**
- Lack of education
- Substance abuses
- Mental illness
- unemployment

**Environmental factors**
- Interpersonal relationship
- Media influence

**Psychological factors**
- Mental disorder or Depression
- Previous psychiatric care
- Substance abuse

**Suicide & Suicide attempt**
2. 6. Patterns of Suicide

2. 6. 1. International suicide patterns

The data about patterns/method/means of suicide were derived from the WHO mortality database (Ajdacic et al. 2008). Though the WHO mortality database provides the most comprehensive source of mortality data collected in a standard way, data from many countries were incomplete and some of the countries did not report anything. So the ICD-10 (International Classification of Diseases) tried to encode data that covered only certain parts of the world countries. According to the knowledge in the above, it should be noted that ICD-9 encoded data in the WHO database did not exactly differentiated between/among the countries suicide methods (Pearson-Nelson et al., 2004).

Patterns of suicide was stated earlier by the English-speaking Western countries, across all age groups, and putted that according to their studies, males shown consistently higher completed suicide rates than females, whereas females, by contrast, have shown higher rates of suicide ideation and attempted suicide (Canetto & Sakinofsky, 1998). To them Pattern has been defined as a particular way in which something is done, organized, or happens. The pattern was begun to emerge from the analysis of the accident data. Many suicidal behavior patterns have been identified in difference studies.

According to Stack (2000) gender roles were considered to exert a major influence on suicidal behavior. Stack (2000) males largely use more lethal forms of suicide found that even when females use the same methods as males they tend to be less successful at completing suicide. On the other hand, in the developing countries where female rates of completed suicide exceed those of males, more females tend to use highly lethal methods, such as agricultural poisons; for examples, rural females in Beijing, Mainland China (Yip et al., 2000) and Western Samoa and Fiji. Canetto and Safinofsky (1998) were argued that the socialization patterns accounted for much of the differences in males and females suicide outcomes and that people were tended to adopt self-destructive behaviors conforming to their cultural gender scripts. As to the example, females (women) in their lives may choose to use a less lethal suicide method than men because of the view of society that, it is less appropriate for females to kill themselves (Canetto & Safinofsky, 1998). The researchers also suggested that high alcoholism among males in the
United States may be possibly mean for males’ alternative to attempting suicide (Canetto & Safinofsky, 1998).

Stengel (1964, cited by Lester 1997) suggested that, the higher incidence of suicide attempts among females may stem from their being more inclined than men to use suicide threats and suicide attempts to manipulate their personal relationships. Stengel expanding on his hypothesis that, females’ flirtations with death may be their way of attempting to bring about a change to their immediate environment, or an alternative means of expressing aggression (Lester, 1997).

According to the report of Virginia Violent Death Reporting System (VVDRS) from 2003-2008 known as Commonwealth of Virginia (2011) indicated that, traditional statistical reports of fatal suicide methods do not reflect methods used by subpopulations. A report on suicide in Virginia would note that 57% of suicides were used by firearm. This statistic describes suicides overall, but obscures method choices made by many subpopulations. Firearm were used in 57% of all suicides largely because most Virginia suicide victims were White males (66%) and most of these White males (64%) committed suicide by using firearm. The proportions of persons who are not White males and use a firearm were 42% (Commonwealth of Virginia, 2011).

The report stated also that, the influence of demographic traits on method choice revealed the difference use of suicide methods within and between subpopulations, and provided useful information for understanding how different types of people committed suicide (Commonwealth of Virginia, 2011). Suicide methods vary within and between subpopulations and among the countries in terms of race, gender, age, culture and birthplace (U.S. born or foreign-born).

According to the report, the most commonly used suicide method was a firearm with (57%), next was hanging or suffocation with the (19%), and followed by poison with (18%). The majority of suicide victims (94%) were choses to commit suicide by using either a firearm, hanging/suffocation, or poison (Commonwealth of Virginia, 2011). The others methods which were commonly used among the suicide victims, particularly, young people (youth) are: falling from height, using sharp instrument, drowning, fire/burning, motor vehicles, and intentional neglect.

Based on race, age and nationality, whites and Blacks chose firearms with similar frequency. Blacks always favored hanging/suffocation more often than Whites, while Whites chose poison
more often than Blacks. Asians were distinguished from other races by selecting hanging/suffocation most often, and at almost twice the frequency of firearms than others. Age appears to impact method choice for all persons and for certain subpopulations (Commonwealth of Virginia, 2011).

2.6. 2. Patterns of Suicide in Africa

The main purpose of working hard to know about the patterns of suicide is to give clear understanding and effort for prevention based on reports of methods of suicide that were first compiled worldwide based on WHO mortality data, that African countries were incomplete in their reports of suicide deaths. So the all data reported, were directly submitted to a correspondence analysis to identify typical configurations across countries (Ajdacic et al., 2008).

In developing countries, especially African countries, poisoning is the most commonly used means for people to end their life in rural areas (Gunnell & Eddleston, 2007). Based on the data received for very few countries of Africa that patterns/methods of suicide indicated as to Gunnell and Eddleston (2007) in the study conducted in Cameroon, ingesting toxic agricultural chemicals was the most common method of suicide (n = 36; 76.6%), followed by hanging (n = 8; 17%) and ingesting non-agricultural toxic chemicals the women who committed suicide all were claimed as used poisonous agricultural chemicals (Gunnell & Eddleston, 2007). In Cameroon, Toxic agricultural chemicals were the means most often used by suicide completers, mostly by females. Therefore, access to toxic products should be restricted, as research findings indicated that suicide could be prevented if access to lethal means is restricted or denied (Dzamalala et al., 2005; Brigham, 2003 & WHO, 2000).

Another means in Cameroon was pesticide. According to Gunnell and Eddleston (2007), many people used the pesticide to commit suicide because they know it is very poisonous and easy means to die. Person who used pesticide would be quickly without suffered compared to other means like hanging which the person suffers before death (Gunnell & Eddleston, 2007). That means, methods of suicide are depending on the accessibility and their process to death which is very minimal of suffering.

Some methods of suicide frequently used in other countries, such as gun deaths or drowning were not identified in Cameroon. Only the Cases of drowning have been registered in Guidiguis
HD (Health District) during the rainy season, but cannot necessarily be considered suicide as many rivers do not have bridges, especially in rural areas death (Gunnell & Eddleston, 2007).

In South Africa, the patterns of suicide that are most commonly used by the victims are hanging, next to poisoning, followed by firearms, pesticides, fall from height, and drowning. Hanging was higher among males with (68.7) than females with (41%), firearm for males (12.6) than females (9.2). Females were higher in using poisoning with (27.7) than male with (6.6), females higher in pesticides (12.6) than males (3.6), drowning and falling were high in females (0.8 and 0.8) respectively than males with (0.0 & 0.2) (Ajdacic et al., 2008).

According to Ethiopia context, hanging and strangulation were the most commonly used methods of suicide (70%), particularly in urban Ethiopia (Abdullahi Bekry, 1999).

2.7. Prevalence/Rates of Suicide

According to the definition of prevalence, it was defined as the number of completed suicides in a given demographic, usually expressed as the number of suicides per 100,000 population (Segen's Medical Dictionary, 2012).

2.7.1. International Suicide Prevalence/Rates

Since its foundation in 1948, the World Health organization (WHO) has been in collaboration with the state members for obtaining the deaths from all causes, including death of suicide. As result a WHO tried to maintain a data bank of mortality according to the data provided by its state members. Then, the actual number of deaths in each demographic have been categorized and transformed into rates. Mortality associated with suicide is the part of data bank (WHO, 1999). According to World health Organization’s report, estimated that, the year 2020 based on the current trends, approximately 1.53 million people will die of suicide, and 10-20 times more people will attempt suicide worldwide. This shown that, as an average one person death in every 20 second and one attempt suicide in every 1-2 second globally (WHO, 1999).

As the report stated, suicide rates of men and women worldwide are consistently quite different in most places, as the rates are categorized according to age levels. World Health Organization (1999) in its report mentioned that, the highest suicide rate for both males and females were found in Europe, more particularly in Eastern Europe, among the countries that have similar
historical background and socioeconomic characteristics. These countries of Eastern Europe are as follows: Estonia, Latvia, Lithuania, and to lesser extent Finland, Hungary, and the Russian Federation. High rate of suicide have been also found in the countries that are different in the relationship of these characteristics which are in Eastern Europe. The countries like, Sri Lanka and Cuba. Specifically, when data separated by WHO by regions, the highest rates of suicide in each region with the exclusion of Europe, was found in island countries, such as Cuba, Japan, Mauritius an Sri Lanka. Also according to the WHO regional distribution, the lowest prevalence/rates of suicide as a whole were found in the Eastern Mediterranean region which composes with the countries that are more experience in Islamic tradition. That was also true to central Asian republic that was formerly integrated into Soviet Union (WHO, 1999).

According to figures, global suicide prevalence has been increased approximately 49% of suicide prevalence/rates in males and 33% in females that were observed between the year of 1950 and 1995 (Philips et al., 2002).

Prevalence of suicide has indicated as, an American fellow dies by suicide within in every 12.95 minutes, and those who attempted suicide were estimated as one million. Among American Indians/Alaska Natives aged 10 to 34 years, suicide was accounted as the second leading cause of death. That resulted, suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 become (19.5 per 100,000) and was 1.5 times higher than the national average for that age group (12.9 per 100,000). That show the prevalence of suicide among American Indian/Alaska was extremely very high (CDC, 2013).

The percentages of people aged 18 or above having suicidal thoughts previously in America were 2.9% among blacks, 3.3% among Asians, 3.6% among Hispanics, 4.1% among whites, 4.6% among Native Hawaiians /Other Pacific Islanders, 4.8% among American Indians/Alaska Natives, and 7.9% among people who were boned by two different people or intermarriage (Substance Abuse and Mental Health Services Administration, Results from the National Survey on Drug Use and Health Mental Findings, 2013).

The study conducted in America among Hispanic students in grades 9-12, revealed that, the prevalence of having seriously considered attempting suicide (18.9%), having made a plan about how they would attempt suicide (15.7%), having attempted suicide (11.3%), and having made a
suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention (4.1%) was consistently higher than white and black students (Kann et al., 2014).

The prevalence/rates of suicide in Australia was explained by Australian Bureau of Statistics (2011) that, in every year, around 2,000 Australians die by suicide, that resulted in affecting families, friends, workplaces and communities. As the following reports indicated that, Suicide rates in Australia appeared to have declined slightly over the last decades, from 2,320 people died and attempted suicide in 2002 to 2,273 people died and attempted suicide in 2011. However, Males accounted for around 76% of deaths by suicide in 2011. Suicide accounted for 27.8% of all deaths amongst young men aged 15 to 24. Suicide rates are fairly similar for females of all ages in Australia, The age-specific suicide rates for males show significant Variations between age groups, with the highest being in the 85 years and over age group (32.1 per 100,000) and the lowest in the 15-19 years age group (10.4 per 100,000) (Australian Bureau of Statistics, 2011).

According to Canada in 2009 alone, there were approximately 238,000 people died in Canada, from this figures 3,890 people were attributed to suicides death. This was resulted in a suicide rate of 11.5 deaths per 100,000 people. During the year of 2009, a total number of 2,989 males were committed suicide (17.9 deaths per 100,000) compared to 901 females (5.3 deaths per 100,000). As these data show, males were three times more likely to commit suicide than females (WHO, 2012).

Deaths by suicide, it should be noted, reflect only a small percentage of suicide attempts. It was estimated that for every completed suicide there were many 20 attempts (WHO, 2012). According to the findings, although males were more likely to die from suicide, females were three to four times more likely to attempt suicide (Mustard et al., 2010 & Langlois & Morrison, 2002). Additional to that, females were likely hospitalized for attempted suicide 1.5 times more frequently than males (Canadian Institute for Health Information, 2011).

According to CIHI (2011), The prevalence differences may become due to the fact that females tend to use less fatal methods, such as poisoning which is the most common cause of self-harm hospital admission, whereas males tend to use more violent methods such as hanging and firearms than females (Canadian Institute for Health Information, 2011).
According to WHO (2011) the table 2.1, below indicated that Suicide rates or prevalence by country. Suicide rates (number of deaths by suicide per 100,000) for males and females from selected countries around the world.

Table 2.1: Suicide rates for males and Females from Selected Countries around the World

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahamas</td>
<td>2005</td>
<td>1.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Greece</td>
<td>2009</td>
<td>6.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Israeli</td>
<td>2007</td>
<td>7.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Italy</td>
<td>2007</td>
<td>10.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Italy</td>
<td>2009</td>
<td>10.9</td>
<td>3.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2009</td>
<td>10.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Australia</td>
<td>2011</td>
<td>15.2</td>
<td>4.7</td>
</tr>
<tr>
<td>India</td>
<td>2009</td>
<td>13.0</td>
<td>7.8</td>
</tr>
<tr>
<td>Untied State of American</td>
<td>2005</td>
<td>17.7</td>
<td>4.5</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2007</td>
<td>18.1</td>
<td>5.5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2007</td>
<td>24.8</td>
<td>11.4</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>2006</td>
<td>53.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>2009</td>
<td>39.9</td>
<td>22.1</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2009</td>
<td>61.3</td>
<td>10.4</td>
</tr>
</tbody>
</table>

2.7.2. Prevalence of Suicide in Africa

According to the vast land and the population of the continent, Africa is accounted as the world’s first largest and second most populous continent, with a population of over one billion people across its regions. The Africa continent is diversified, comprising rural, semirural and urban areas, a difference range of religions, ethnic groups, values and cultures and several regions affected by constant wars, political and economic instabilities exist within. World Health Organization Report of 2004, regardless of high overall death rates caused by different factors, prevalence/rates of suicide in Africa have been thought to be very low (Wasserman & Wasserman, 2009). However, little is actually known about the incidence and patterns of suicide across the continent.

The overall annual report of suicide incidence rate of Africa countries conducted in 1990 and was estimated to be 3.2 per 100,000. So the figure was compared with an estimate of 49,558 people who had committed suicides and their median incidence rate was (4.8 per 100,000), this information then was derived from the recent GBD (Global Burden of Disease) study which was carried out in 2010 (Lozano et al., 2013). Prevalence/rates of suicide based on the estimation for specific countries of Africa, there were big variation from the GBD results that estimated for South Africa was (higher), Zimbabwe (lower), Uganda (lower), Malawi (lower) and Tanzania (lower).

There were few studies that examined suicide in Africa by Ajdacic-Gross et al. (2008) and Reza et al. (2001), and the ones that exist were mostly conducted in urban areas (Vijayakumar et al., 2005; Gunnell & Eddleston, 2003; Dong & Simon, 2001 & Reza et al., 2001). In Addis Ababa, Ethiopia, the average suicide rate was estimated at 7.8 suicides per 100 000 inhabitants over a 15-year period (Abdullahi Bekry, 1999).

In the multiple publications from many studies, several data of African countries were available including, five for South Africa which their mean annual estimates was ranged from (10.9 to 32.5 per 100,000 population) (Garrib et al., 2011; Burrows & Laflamme, 2006 & Meel & Leenaars, 2005) and two for Egypt that mean annual estimated was (0.7 and 2.2 per 100,000 population) (Abdel et al., 2011 & Gad et al., 2009), Senegal mean annual estimated was (0.7 and 3.7 per 100,000 population) (Soumah et al., 2013 & Guyavarch et al., 2010), Uganda mean
annual estimated (1.0 and 15.8 per 100,000 population) (Kinyanda et al., 2012 & Kinyanda et al., 2009) and the United Republic of Tanzania their mean annual estimated (2.3 and 3.2 per 100,000 population) (Mgaya et al., 2008 & Ndosi et al., 2004). In addition, WHO had reported the death rates of both South Africa and Egypt that were obtained from available data, claimed that both countries their rates were considered lower than in the publication which South Africa was (0.9 vs. 17.2 per 100,000) (Burrows & Laflamme, 2006), and Egypt was (0.1 vs. 0.7) (Abdel et al., 2011).

According to other studies conducted in South Africa and Egypt by Garrib et al. (2007); Meel and Leenaars (2005) and Gad et al. (2009) reported similarly high rates in both countries that can show WHO data were likely to be rejected.

According to sex difference in prevalence of suicide, 13 countries data revealed that higher rates were found in males with most reporting a male to female ratio of at least 3:1. As to the evidence for sex differences in suicide attempts it was little clear. According to the data that were available from the studies of 11 countries, which among them five studies were reported a clear female predominance (Johnson et al., 2008; Joe et al., 2008; Agoub et al., 2006; Chibanda et al., 2002 & Ndosi), whereas three studies found a clear male predominance (Adinkrah, 2011; & Kinyanda et al., 2004) and three of them reported similar rates for both males and females (Gureje et al., 2007; Dzamalala et al., 2006 & Ikealumba & Couper, 2006).

Age-specific rates were available from WHO report for five countries that show, the lowest rates were generally found in those under the age of 25 with few suicides reported in children less than 15 years (≤0.5 per 100,000). In Egypt, there was little variability in age-specific rates for that indicated as follows (0.0-0.2 per 100,000). Suicide prevalence in the Seychelles were increased with age below 55 years, after which there were no reported suicides. In Mauritius and Zimbabwe, rates were highest amongst older adults aged 55 above. Rates of suicide in South Africa were highest in people aged 15–54 and those over 75 years old (Country reports and charts, NY).
2. 8. Suicide in Ethiopia: Risk Factors, Pattern and Prevalence

2. 8. 1. Risk Factors

The most common risk factors of suicide in Ethiopia are the result of psychological disorder, social and the effect of environment factors. According to the study conducted by Solomon Shiferaw, Mesganaw Fantahun, and Abeba Bekele (2006) in Dessie town, north east Ethiopia, reported that, the history of suicide among family members and friends, particularly the young people, is caused by sexual activity, female gender and some depressive symptoms as strong predictors of suicide attempt. Their finding is in accordance with most findings regarding adolescent suicide attempt (Resnick, Bearman, & Blum, 1997).

2.8.2. Patterns of Suicide in Ethiopia

The pattern of suicide in Ethiopia that are commonly used by the victims, according to the findings from different researchers, hanging was mentioned as the most common method used in many other communities based on Ethiopian studies such as those were conducted in Butajira and Addis Ababa. Next, poisoning was identified as the second most common method of suicide that was accounted of (19.8%) this evidence was consistent with other Ethiopian studies (Kebede & Alem, 1999; Alem et al. 1999 & Kebede & Ketela, 1993).

2.8.3. Prevalence of Suicide in Ethiopia

According to Ethiopia MH GAP working group (2010) (FMOH), Ethiopia is really striving and working to have valuable information about the burden of mental illness and substance abuse within the country. Prevalence and incidence of the major general mental illness and substance abuse disorders existing in the country, and also their impact on people in term of suicide attempts and completed suicide have been summarized. And findings mentioned that, mental illness which always is likely resulted in suicide is not just considered as a west’s luxury, rather, its levels are similar with one of our country.

The report was indicated that, in Ethiopia, neuropsychiatric disorders were estimated to contribute to 5.8% of the global burden of disease (WHO, 2008). According to source of study mentioned that, suicide rates were found higher in those who were suffered from psychiatric than the whole population of the worldwide (WHO, 2004). In Ethiopia mental illnesses/disorder were
contributed to 12.45% of the burden of disease. This show that mental disorders, which have much possibility to suicide, are much more common in Ethiopia as like other diseases that are also regarded as major health problems in the country (Alem, 2001).

The prevalence of suicide in Ethiopia stated in this way: Suicidal ideation was 64.8% (307/474) and attempted suicide was 19.2% (91/474). The other studies which were community based studies in other parts of Ethiopia have come up with different results from what are in the above and showed lower values as compared to that result. For example, a study conducted in Addis Ababa, the capital city of Ethiopia among adult population indicated that, suicidal ideation was 2.7%, and suicidal attempt was 0.9% (Alem et al. 1999). The study in Butajira (Southern Ethiopia) also conducted among adult population was showed that, Suicidal attempt at Butajira adult population was 3.2% (Alem et al. 1999). Another study on high school students at Addis Ababa demonstrated a life time risk of suicidal attempt 14.3% (Kebede & Ketela, 1993). So the higher prevalence of suicidal attempt and ideation that was found, the studies were most likely due to the fact that the studies were conducted in a psychiatric population where high risk individuals were evaluated as compared to community based studies at Addis Ababa and Butajira stated above.

Prevalence of suicide in sex distribution among suicidal ideation was nearly equal representing male to female ratio of one (Female/Male=155/153). Females were more represented on suicidal attempt with a ratio of 1.3/1 (Female/Male=52/39) (Alem et al. 1999 & Kebede & Ketela, 1993).

Table 2.2: Prevalence and Impact of suicide selected out from the Priority Illnesses in Ethiopia

<table>
<thead>
<tr>
<th>Suicide completed</th>
<th>7.7/100000/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide attempted</td>
<td>3.2/100000/year</td>
</tr>
</tbody>
</table>

Source: Ethiopia mhGAP working group 2010 (FMOH)

Note: This did not indicate the prevalence of suicide base on sex and age, rather is just a general that was selected out from others priority illness that are available the country.
2.9. Summary and Implications

Suicide is a complex and multidimensional phenomenon stemming from the interaction of several factors. Suicide remains an important and major cause of death in various populations (Scheidman, 1985). Meanwhile, suicidal behavior is defined as a range of behaviors that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself (Posner et al. 2007).

Suicide among the youth was explained by Economic theory that youth or young people have the most life to lose and also have the least information about what their life will be like (Hamermesh & Soss 1974). Suicide is now the second or third leading cause of death for youths worldwide.

Theories of suicide are as follows: biological, sociological (socio-cultural), psychological theories. Some of suicide theories are categorized on two basic facts, such as, the fact that people have different feelings, which everyone has high and low feelings. The second fact is that youths do not have financial resources that they can use to influence others or they can solve their own problems. Other theories are strategic suicide theory; depression theory, contagion theory, instrumentality theory, and rational-suicide theory (Hamermesh & Soss 1974). Therefore, risk factors commonly influencing suicide and suicidal behavior are biological, psychological, environmental, socio-economic, individual and demographic.

Pattern has been defined as a particular way in which something is done, organized, or happens. Most commonly used method was a firearm with (57%), followed by hanging or suffocation with the (19%), next by poison with (18%). The majority of suicide victims (94%) were choses to commit suicide by using either a firearm, hanging/suffocation, or poison (Commonwealth of Virginia, 2011). The others methods which are commonly used among the suicide victims, particularly, young people (youth) are: falling from height, using sharp instrument, drowning, fire/burning, motor vehicles, and intentional neglect.

Prevalence was defined as the number of completed suicides in a given demographic, usually expressed as the number of suicides 100,000 population (Segen's Medical Dictionary, 2012). Suicide rates of men and women worldwide are consistently quite different in most places, as the rates are categorized according to age levels. World Health Organization (1999) in its
The report mentioned that, the highest suicide rate for both males and females were found in Europe, more particularly in Eastern Europe, among the countries that have similar historical background and socioeconomic characteristics.

The suicidal behavior in youth has many implications. Effects of youth suicide go beyond the deceased, impacting those who survive their death–their parents, friends, peers and communities. Suicide is understandably a tragic event and it elicits strong emotional responses. The relationship between academic problems and suicidal behavior has the negative effect on youth academic. Youth with poor reading ability were more likely to experience suicidal ideation or attempt and to drop out of school than youth with typical reading ability (Daniel, Walsh, Goldston, Amold, Reboussin, & Wood, 2006).
CHAPTER TTREE

3. Methods

3.1. Research Design

The design employed in this study was mixed method approach. The methods were both qualitative and quantitative approaches, as it would help to describe and interpret the experience of participants since the study was to collect both quantitative and qualitative data. According to Creswell and Clark (2011), the mixed approach would enable the researcher for collecting, analyzing, and “mixing” both quantitative and qualitative methods in a single study to understand a research problem. The basic assumptions for using both quantitative and qualitative methods in combination, first was to provides a better understanding of the research problem and questions than used one approach (Creswell, 2011). Second, Mixed approach is a good design to use if the researcher seeks to build on the strengths of both quantitative and qualitative data (Miles & Huberman, 1994). Third, it enables to counteract the weaknesses in both qualitative and quantitative research. When one combines, quantitative and qualitative data, “researcher would have a very powerful knowledge of how to deal with problem”.

Student researcher felt motivated to use mixed method approach for this study due to the above assumptions in order to address the research problem and fill the gap that would suppose emerge from one approach. As writers mentioned, the mixed approach is conducted when one type of research (qualitative or quantitative) is not enough to address the research problem or answer the research questions (Greene & Caracelli, 1997). So the student researcher was highly convinced and felt interested to use this approach due to the vital information and reasons in the above.

Since the employed approach for this study was mixed method which consisted of quantitative and qualitative method, the preferable designs that have carried the student researcher in the process of collecting quantitative and qualitative data, respectively, were both survey and in-depth interview designs, focus group discussions and document analysis. Survey design has been used for collecting quantitative data. Survey design as a procedure in quantitative research, has been used as a means for gathering data in the form of questionnaires to describe the attitudes, opinions, behaviors and experience of participants towards suicide and its risk factors and to
explain the prevalence. Quantitative and numbered data have been collected through survey design by using questionnaires.

In-depth interviews design has been applied in this study as a research design of study to collect qualitative data. The reason of using in-depth interview was because of its effectiveness in giving a chance to the participant to explain out her/his insight. In addition, an in-depth interview was used for its important to offer an opportunity to participants to express themselves and share their precious experience in conversation process. In-depth interview has been in the form of interview to fill the gap appeared in survey or questionnaires. Therefore, due to the above advantages it was encouraged the practitioner student to employ in-depth interview as a design of study.

3.2. Study Site

Description of Region

Gambella Peoples’ Region state is one of the nine regions in Ethiopia. Gambella is located to the west of the country. The region borders with Oromia to the North and East; Southern Nations, Nationalities and Peoples State (SNNPS) and South Sudan to the West. Gambella is situated between the Baro and Akobo Rivers with its western part including the Baro salient. It is mentioned that the region covers 34,063 km². According to 2007 census, the total population of Gambella is 306,916 of which 159,679 are men and 147,237 are women. From the total population 25.37% live in urban. The estimated density of the region is 9.57 people per km square. Although Gamella is a small state in term of its population size, its culture is unique since there are variations from tribe to tribe. Hence the Gambella culture could be categorized as a diverse due to different ethnic groups found in the region. The economics of Gambella people depend on agriculture. Socio-economic activities of the population living in Gambella region are subsistence farmers, some of them living on crops and others on cattle.

Study took place in Abobo and Gog woreda/districts, respectively, Anywaa zone of Gambella National Regional State. Anywaa zone has five woreda/districts. The two woreda/districts of Abobo and Gog were selected because they have largest number of suicide cases. Within two woreda/districts, Abobo and Gog, four kebele/villages were selected; two in each woreda which
where the sites of the study. The selected kebele/villages were the most affected areas of suicide cases among others.

3. 3. Population

The main target populations of this study were the youth in Anywaa zone who were in the age from 15 - 34 years old. These youth were the students in Abobo and pinyudo preparatory schools and others youth who attempted suicide and relatives of the suicide victims.

3. 4. Samples and Sampling Procedure

A sample size of the study was 138 participants selected from four kebele/villages, two preparatory schools in two woreda/districts and two police stations in the respective woreda. This sample size of 138 participants was drawn from four groups. The four groups were as follows, youth in preparatory schools, suicide survivors/attempters, parents/relatives of suicide victims, others youth who were not schooling and two police officers. Sample of 106 students were selected and made to complete the questionnaires. 5 (five) parents/relatives of suicide victims and 6 (six) suicide survivors/attempter from two woreda, which is equal to eleven participants were also selected for interview. 19 youth were been selected for the focus group discussions (FGD). And 2 (two) police officers were contacted for document reviews, one in each woreda police office. So, the sample size of the study was 138 participants.

For sampling procedure, site of the study was purposely selected. Probability random sampling technique was used to select participants for focus group discussions and to fill questionnaires. And in order to get people who would be the best help in understanding phenomenon, snowball technique was carried out for the selection of suicide attempters/survivors and the parents/relatives of the victims.

Quantitative data were collected by using questionnaires in English language form. For qualitative data interview, focus group discussions and document analysis were used as a means to collect data. Interview and focus group discussion were carried out with purposely selected participants to explain some of the central issues from interviews using a semi structured discussion guide. Discussions have been locations segregated and divided according to woreda/districts (Abobo and Gog). The number of participants in each group was ranged from 9-
10 individuals. The focus group discussions was centered on risk factors and patterns of suicide that affecting youth lives, and tried to discuss their attitude towards suicide.

3. 5. Data Collection Tools/Measures

As the study was composed of both qualitative and quantitative data, the data were gathered through the use of questionnaires, interview, FGD and document reviews. The questionnaires were plot tested before the actual survey conducted. Questionnaires and documents analysis were been used for quantitative data, whereas interviews, focus group discussions and documents analysis were used for qualitative data.

3. 5.1. Questionnaires

The questionnaires were developed by student researcher to be filled by youth who were students in preparatory schools. There were three parts of questionnaires. First part was personal data/demographic information, second part was questions of risk factors in the first table on ranking the basic risk factors from 1 as the first most common risk factor to 5 as the fifth or least common risk factor. Which 1= stand for the first most common. 2= the second most common 3= the third most common; 4= the fourth most common; and 5= the fifth or least most common risk factors of suicide among the youth in Anywaa zone of Gambella region. So, based on the rank the participants given for each item, the risk factors were labeled to the first most common to the fifth or less most common risk factor of suicide. And the third part was about the questions on suicidal behavior and ideations in the form of two dichotomies in tables, which can be only answered by yes or No.

The Questionnaires were consisted of 15 items in ranks form and 12 in two dichotomies form, which were equal to 27 items of the survey part. The researcher interested to use questionnaires for quantitative data in order to collect large amounts of information at a low cost per respondents. According to Fraenkel and Wallen (2000), questionnaires are used at a time when factual information was so much needed. Moreover, questionnaires could be used for more detail information and could be easily and quick to analyze.
Therefore, the questionnaires were only prepared to collect quantitative data. The qualitative data were gathered through other instruments like interview, focus group discussions and document reviews.

3. 5. 2. Interviews

To collect qualitative data, student researcher prepared interview guide to gather data from suicide attempters (survivors), and families of suicide victims through snowball techniques. In order to obtain useful and reliable information about the patterns and risk factors of suicide, the unstructured interviews were carried on. It was already proved by the writers that, people are likely to be more interested to talk (converse) than writing (Best & Khan, 2006).

To fill the gap in questionnaire items as a means of quantitative data collection, interview was required to use. This technique helps the researcher to have rich information by probing beyond the answer. The interview has three parts/sections. The parts of interview are (I) personal data, (II) interview for the families of suicide victims, (III) Interview for the suicide survivors.

3. 5. 3. Focus Group Discussions (FGD)

Focus group discussions were conducted with youth to discuss their experiences about suicide’s risk factors and patterns. This method of data collection due here helping the researcher by going to the field-into the real world of participants and getting close enough to them and circumstances where to capture what is happening and the real problem. According to Patton (2002), this method makes possible description and understanding of both externally observable behaviors and internal states. This means that the researcher must get to know the subjects of the study in ways that permit the "use of all of one's senses and capacities, including the capacity to experience affect no less than cognition" (Patton, 2002). The discussions were divided into two groups based on the locations which each group was ranged from 9-10 members.

3. 5. 4. Document Review

Documentation review was also conducted for data collection from police office of crime investigator in two woreda/districts. The documents were reviewed to see recorded information about the suicide and how the pattern (methods) of suicide prior committed by the victims look likes. The intention of the researcher was to reviewed what the police officers were recorded
about the factors (causes), pattern (Methods) and prevalence (existing of old and new cases) of suicide. This technique was used both in qualitative and quantitative data.

The researcher used the documents analysis in order to supplement participants’ survey made questionnaires distribution, interviews and focus group discussions. So, the documents were gathered and analyzed that become helps in the course of everyday events or specifically for the research at hand. According to Berelon (1952), the use of documents often entails a specializes analytic approach called content analysis. He also stated that the raw materials for document analysis may be in the form of communication, usually written materials (textbooks, and pictures). Therefore, student researcher went and reviewed the recorded information and pictures of the suicide victims.

3.6 Pilot Study

In order to evaluate the reliability and validity of instruments, researcher has pilot tested the questions before distributing the questionnaires for actual data to the sample of the study. This was to ensure that the participants in the sample are capable of completing the survey and they can understand the questions. Since the sample size of survey part was 106, the student researcher developed 10 items out of 27 items and selected 10 individuals for pilot test. To ensure that if there was a change in pilot test. Fortunately, based on the feedback from individuals who completed pilot test, the instruments were identified with no any modified or change. That means there was a consistence in instruments and validation was also correctly.

3.7 Method of Data Analysis

Data analysis was done separately, since the data were gathered in the form of numbers (quantitative) and words (qualitative). Therefore, quantitative data collected through questionnaires were classified and arranged into tabulation based on their variables. Since the main objective for this research findings was to identify the most common risk factors to the least common one by ranking these risk factors according to the response of the respondents. The analysis was done by using descriptive Statistical Analysis, through Statistical Package for the Social Science (SPSS) Software version 20. And then, the frequency distribution and percentage of each risk factor was calculated and computed. Then, the first most common to the fifth/less
most common risk factor was labeled depending on high and low number of responses by the respondents.

Qualitative data collected through interview, focus group and document review were analyzed by following the common steps in qualitative data, that the researcher to prepared and organized the data for analysis, engaged in an initial exploration of the data through the process of coding, using the codes to develop a more general picture of the data- that means by describing and themes, then representing the finding through narrative and visuals ways.

3.8. Ethical Consideration

In this sensitive study, ethical consideration is very vital to be followed. Initially permission was taken from Anywaa zone administration and then woreda/district administrations were also asked. To contact the police office for document review, two woreda administrations allowed the researcher to meet with the police officers. For youth students, the head of education based in woreda/districts were requested and allowed the researcher to meet with school directors. The students were briefed about the objectives of this research before the distribution of questionnaires. And they were informed with the regard of confidentiality. To reach the attempters and parents/relatives of suicide victims, kebele/village leaders were asked for permission. Attempters and parents/relatives of victims were informed about the purpose of the study and how the interview would be going before started actual interviews. In general, ethical procedures were followed in the course of data collection. All participants were communicated about the study in order to obtain their verbal consent before administering questionnaires, interview, focus group discussions and documents analysis. Participants were informed about the study to ensure that it was for the academic purpose only. Participants were communicated that they have full right to discontinued or refused to participate in the study and informed them there was no deception. They were also informed that after this study the result will be communicated to you. After gained approval from zonal, woreda and kebele administrators and willingness of participants, the data were collected by administering the questionnaire, and conducted interviews, focus group discussions and documents analysis.
CHAPTER FOUR

4. Results

This chapter is concerning with the analysis of the data collected through questionnaires, in-depth interview, focus group discussions and document analysis. The main purpose of the study was to examine and investigate the risk factors, patterns and prevalence of suicide among youth in Anywaa zone. In this study five major risk factors (Biological, environmental, psychological, socio-economic, and individual) were assessed to see the very common one in the suicide. Patterns of suicide such as firearm, hanging, poisoning, drowning, jumping from high place and using sharp instruments were addressed in this study. To assess the patterns of suicide, in-depth interview, focus group discussions and document review were carried out, to understand the specific pattern that many youth killed themselves through. Prevalence of suicide among the youngest in Anywaa zone was also assessed by collected secondary data or recorded documents in police stations. This study also assessed the relationship between suicide and educational level, marital status and family background of the suicide victims. Since similar issues were presented to different respondents, the triangulation was used as for the purpose of holistic understanding.
4.1. Demographic Characteristics of Participants

Table 4.1: The Demographic Characteristics of Participants by Sex, Age, Marital Status and Educational Level

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>68</td>
<td>64.2</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>38</td>
<td>35.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>106</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-17</td>
<td></td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>18-20</td>
<td></td>
<td>59</td>
<td>55.7</td>
</tr>
<tr>
<td>21-25</td>
<td></td>
<td>33</td>
<td>31.1</td>
</tr>
<tr>
<td>26-30</td>
<td></td>
<td>16</td>
<td>15.1</td>
</tr>
<tr>
<td>31-34</td>
<td></td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>106</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td>41</td>
<td>38.7</td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td>64</td>
<td>60.4</td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td>1</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>106</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 11th</td>
<td></td>
<td>37</td>
<td>34.9</td>
</tr>
<tr>
<td>Grade 12th</td>
<td></td>
<td>69</td>
<td>65.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>106</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.1 above show that (n=68, 64.2%) of the respondents were males, while the (n=38, 35.8%) of them were females. This shows that the majority of this study’s participants were males. Regarding the age of the respondents, data show that the majority (n=59, 55.7%) of the respondents were found within the age ranged from 18 - 20 years old, followed by (n=33, 31.1%) people in the age ranged from 21 - 25, next by (n=16, 15.1%) age group from 26-to-30. The least number of respondents were found in the age ranged from 15 -17 (n=4, .3.8%) and 31-to-34 (n=4, 3.8%), respectively. This may imply that most of the respondents were the youth within the age from 18 - 25 years old. As table shows marital status in the above, majority (n=64, 60.4%) of respondents were single, (n=41, 38.7%) were married, and only (n=1, .9%) respondent was divorced. That show many youth in Anywaa zone were single and divorce case was rare. Concerning educational level of the participants, the data shows that, majority (n=69, 65.1%) of youth were grade 12th students and the remaining (n=37, 34.9%) were grade 11th students. That means majority of the participants were grade 12 students.
Table 4.2. Demographic Characteristics of the Attempters by Sex, Age, Educational level, Marital Status, Family Background, Year of Attempt and Patterns

<table>
<thead>
<tr>
<th>Interviewees/attempters</th>
<th>Sex</th>
<th>Age</th>
<th>Grade Level</th>
<th>Marital status</th>
<th>Family background</th>
<th>Year of attempt</th>
<th>Patterns of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interviewee/attempter</td>
<td>F</td>
<td>28</td>
<td>Grade 8th</td>
<td>married</td>
<td>Farmer</td>
<td>2015</td>
<td>Hanging</td>
</tr>
<tr>
<td>2nd interviewee/attempter</td>
<td>F</td>
<td>20</td>
<td>Grade 10th</td>
<td>married</td>
<td>police &amp; farmer</td>
<td>2015</td>
<td>drug overdose or poisoning</td>
</tr>
<tr>
<td>3rd interviewee/attempter</td>
<td>F</td>
<td>21</td>
<td>Grade 8th</td>
<td>married</td>
<td>Farmer</td>
<td>2014</td>
<td>Hanging</td>
</tr>
<tr>
<td>4th interviewee/attempter</td>
<td>M</td>
<td>25</td>
<td>Grade 9th</td>
<td>married</td>
<td>Farmer</td>
<td>2013</td>
<td>Hanging</td>
</tr>
<tr>
<td>5th interviewee/attempter</td>
<td>F</td>
<td>20</td>
<td>Grade 7th</td>
<td>single</td>
<td>Farmer</td>
<td>2016</td>
<td>drug overdose or poisoning</td>
</tr>
<tr>
<td>6th interviewee/attempter</td>
<td>M</td>
<td>28</td>
<td>Certificate</td>
<td>married</td>
<td>Farmer</td>
<td>2011</td>
<td>Hanging</td>
</tr>
</tbody>
</table>

As the table show demographic information of interviewees/suicide attempters indicated that, the majority of the youth who attempted suicide were females. From six suicide attempters who were interviewed four of them were youth females and only two were males. The ages of interviewees were found in the age groups ranged from 20 -28 years old. As to the data there was no any attempter found in the age below 20 years. As a conclusion, Gambella youth of Anywaa zone in the age groups ranged from 20 - 28 were more vulnerable individuals of suicide attempts.

Regarding grade levels, majority of attempters were found in primary seven (7th) to grade ten (10th), except only one who was found with certificate holder (10+1). In other word five out of six (5 of 6) attempters were in grade 7-10th. It means that, people who ended their educations in grade 10th and below would be likely to be affected by suicide case than others who had better levels of education and suicide attempt found to be very high among them.

According to the marital status in table 4.2 above majority of suicide attempters were married. Among the six attempters only one person found single/unmarried and the remaining five were all married. That can be concluded that married had great negative impact on people and had strong relationship with suicide attempt.

Coming to family background of the youth attempters/interviewees, data show that most of both parents were farmers and uneducated people. Only one father of one attempter was working as a
police man and completed grade seven (primary 7th). This indicated that suicide attempt was higher among the youth who their parents had no level of education and those who their parents were farmers. The more both parents lack an educational level and farmers, the greater the suicide attempt among their children. That can be concluded, family background has strong relationship with suicidal behaviors, especially when both father and mother were uneducated and farmer as well.

According to the data in the table 4.2 above show that among six attempters, two were attempted suicide in 2015 and the remaining four were attempted in 2011, 2013, 2014 and 2016 one in a year. This implies that 2015 was a year which more youth were attempted suicide. In another way, year of 2015 was found as the years which the prevalence of suicide attempt increased.

**Table 4.3: Demographic Characteristics of the Suicide’s Victims by Relationship, Sex, Age, Educational level, Marital Status Family Background, Years of committed Suicide and Patterns**

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Relationship</th>
<th>Sex</th>
<th>Age</th>
<th>Grade level</th>
<th>Marital status</th>
<th>Family background</th>
<th>Year of suicide</th>
<th>Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interviewee</td>
<td>Brother</td>
<td>M</td>
<td>24</td>
<td>10th +3</td>
<td>Married</td>
<td>Farmer</td>
<td>2014</td>
<td>hanging</td>
</tr>
<tr>
<td>2nd interviewee</td>
<td>Daughter</td>
<td>F</td>
<td>30</td>
<td>Grade 6th</td>
<td>Married</td>
<td>Farmer</td>
<td>2013</td>
<td>hanging</td>
</tr>
<tr>
<td>3rd interviewee</td>
<td>Son</td>
<td>M</td>
<td>25</td>
<td>Grade 9th</td>
<td>Married</td>
<td>Farmer</td>
<td>2014</td>
<td>hanging</td>
</tr>
<tr>
<td>4th interviewee</td>
<td>Daughter</td>
<td>F</td>
<td>20</td>
<td>Grade 10th</td>
<td>Single</td>
<td>Farmer</td>
<td>2015</td>
<td>hanging</td>
</tr>
<tr>
<td>5th interviewee</td>
<td>Sister</td>
<td>F</td>
<td>22</td>
<td>Grade 7th</td>
<td>Married</td>
<td>Farmer</td>
<td>2013</td>
<td>hanging</td>
</tr>
</tbody>
</table>

These demographic data in table 4.3 above were the victims’ data gathered from their families/relatives during interview. The relatives of suicide victims were interviewed about how suicide happened to their youngest people. So what you see above in the table, are representing the suicide victims or the demographic information of victims not the families/relatives, except relationship in the second column of table at the left.

As the relationship indicates in the table above, among the interviewees three of them were mothers of suicide victims/those who died by suicide. And the remaining two were brother and
sister of the victims. Data in the table 4.3 above show the sex of suicide victims that, three victims were females and two of them were males. This shows there was a little difference between males and females in the relation to suicide.

Regarding age, data indicated that, all suicide victims were found in age groups ranged from 20 - 30 years old. And there was no victim found in age below 20 years. That show youth in age groups ranged from 20 -30 years were most vulnerable individuals of suicide than others youth in age below 20 and above 30 years. This means that there was age difference in suicide among the youth.

Grade levels of suicide’s victims as was reported by their relatives and observed in the above table 4. 3 majorities of them were found in primary six (6th) up to grade ten (10th). Only one victim found in the level of diploma (10+3). It indicates that, there was a negative correlation between low level of education and suicide. This lead to the conclusion that people with low level of education were very much exposed to suicide than those with high level of education, such as diploma, bachelor degree, master degree, PhD, and so forth.

As marital status indicated, majority of suicide victims were married. From five victims, only one person was found single/unmarried and the rest were married. This means that, married had strong relationship with suicide. Conclusion was, youth of Gambella region, particularly of Anywaa zone who have been married were died more by suicide than those who were single/unmarried.

As the data show, all the victims’ family backgrounds were farmers and uneducated people. This show that family background, particularly when both parents were farmers and uneducated have negative association with suicide. This imply that since the majority of parents in Gambella region were farmers and uneducated, their youngest sons and daughters would be more affected by suicide.

Concerning the years of suicide, two suicide victims were found committed suicide in 2015. And others three were committed in the year of 2013, 2014 and 2016, respectively.
4.2. Risk Factors of Suicide among Youth in Anywaa Zone

Below table 4.4, is presenting the ranking of risk factors depended on the frequencies with their correspondent percentage given by the respondents. The goal of ranking suicide’s risk factors is to identify factors that may increase or decrease level of suicide action and attempt among the youth. So that, to be able to estimate an overall influence of each risks factor. In this table the first most common to fifth most common risk factors would be identified according the frequency and percentage of the respondents. The more frequency and percentages of the respondents’ responses on a particular rank the more that particular factor in that particular rank wound be counted as the first most common risk factor of suicide among the youth. And the least frequencies and percentages on a particular rank would also termed the less common risk factor.
Table 4.4: Ranking given on Risk factors based on number and percentage of responses by the respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Rank</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fre(%)</td>
<td>Fre(%)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Fre(%)</td>
<td>Fre(%)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Fre(%)</td>
<td>Fre(%)</td>
</tr>
<tr>
<td>Biological Risk Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of suicide</td>
<td>16(15.1)</td>
<td>9(8.5)</td>
</tr>
<tr>
<td>Chronic illness or long suffering with disease/HIV/Aids and other related diseases</td>
<td>64(60.4)</td>
<td>17(16.0)</td>
</tr>
<tr>
<td>Physical/mental illness</td>
<td>35(33.1)</td>
<td>17(16.0)</td>
</tr>
<tr>
<td></td>
<td>21(19.8)</td>
<td>17(16.0)</td>
</tr>
<tr>
<td>Environmental Risk Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing youngest from his/her lover or prevented one’s choice</td>
<td>32(30.2)</td>
<td>23(21.7)</td>
</tr>
<tr>
<td>Poor relationship among family members/relationship problem</td>
<td>57(53.8)</td>
<td>15(14.2)</td>
</tr>
<tr>
<td>unplanned married/early married/divorce</td>
<td>47(44.3)</td>
<td>34(32.0)</td>
</tr>
<tr>
<td></td>
<td>9(8.5)</td>
<td>13(12.3)</td>
</tr>
<tr>
<td>Psychological Risk Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression or remembering the past bad events, like death of beloved ones</td>
<td>26(24.5)</td>
<td>42(39.6)</td>
</tr>
<tr>
<td>Lack of problem-solving skills</td>
<td>28(26.5)</td>
<td>29(27.4)</td>
</tr>
<tr>
<td>Failing to fulfill an expectation and hopeless</td>
<td>8(7.5)</td>
<td>16(15.1)</td>
</tr>
<tr>
<td></td>
<td>22(20.8)</td>
<td>30(28.3)</td>
</tr>
<tr>
<td>Socio-economic Risk Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment/being jobless</td>
<td>15(14.2)</td>
<td>22(20.8)</td>
</tr>
<tr>
<td>Lower socioeconomic status including income/not affords to buy new fashion</td>
<td>9(8.5)</td>
<td>30(28.3)</td>
</tr>
<tr>
<td></td>
<td>29(27.4)</td>
<td>23(21.7)</td>
</tr>
<tr>
<td>Individual Risk Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self-esteem, felt so sad or hopeless</td>
<td>20(18.8)</td>
<td>30(28.3)</td>
</tr>
<tr>
<td>Unwanted pregnancy/unplanned pregnancy</td>
<td>47(44.3)</td>
<td>24(22.6)</td>
</tr>
<tr>
<td>Alcohol abuse and /or drugs abuse</td>
<td>43(40.5)</td>
<td>15(14.2)</td>
</tr>
<tr>
<td>Academic failure/lack of pass mark</td>
<td>6(5.7)</td>
<td>8(7.5)</td>
</tr>
<tr>
<td></td>
<td>22(20.8)</td>
<td>32(30.2)</td>
</tr>
</tbody>
</table>

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To indicate the first most common, the second most common, the third most common, the fourth most common and fifth most common which is the less common risk factors of suicide among the youth of Anywaa zone, Gambella region, frequencies and percentages of all the basic risk factors were computed. From the Table 4.4 above the basic risk factors labeled in rank one with more frequency as the first most common risk factors were those of chronic illness or long suffering with disease/HIV/Aids and other related diseases 64(60.4%), followed by Poor relationship among family members/relationship problem 57(53.8%), next by unplanned married/early married/divorce 47(44.3%) and Unwanted pregnancy/unplanned pregnancy 47(44.3%), respectively and again followed by alcohol abuse and /or drugs abuse 43(40.5%). As it observed under rank one in table 4.4 above the lower frequencies were that of Physical/mental illness 35(33.1) and Preventing youngest from his/her lover or prevented one’s choice 32(30.2%). The second most common risk factors were Depression or remembering the past bad events, like death of beloved one 42(39.6%), next Lower socioeconomic status including income/not affords to buy new fashion 30(28.3%) and Lack of problem-solving skills 29(27.4%). The risk factors labeled in rank three to be termed the third most common risk factors were unemployment/being jobless 31(29.2%) and low self-esteem, felt so sad or hopeless 31(29.2%), respectively. Regarding Failing to fulfill an expectation and hopeless as in the above table, was ranked as the fourth and fifth common risk factors with frequencies of 30(28.3%) and 30(28.3%), respectively. The fifth most common risk factors were that of Family history of suicide 34(32.1%) and academic failure/lack of pass mark 38(35.6%). Based on this one can be conclude that the first most common risks factors were chronic illness or long suffering with disease/HIV/Aids and other related diseases, poor relationship among family members/relationship problem, unplanned married/early married/divorce and Unwanted pregnancy/unplanned pregnant, alcohol abuse and /or drugs abuse, Physical/mental illness and Preventing youngest from his/her lover or prevented one’s choice.

To understand what exactly the risk factors of suicide action and suicidal behavior, qualitative data were incorporated in this study so that the participants would be communicated out their insights. This was done in order to fill the gap in data of survey about the risk factors of suicide as in the above table 4.4. Data collected through qualitative approach such as interviews, focus group discussions and documents analysis were presented here below.
Risk factors of suicide and suicide attempt by both suicide attempters and suicide victims’ relatives/interviewees

The interviewer wants to know major and specific risk factors leading the youth to self-harm and what condition pressured them to try to kill themselves. The interviewees were told to be free and express what they known about the causes of their attempt of suicide. This item was addressed.

Why you tried to do kill yourself (causes)? For attempters. And why he/she committed suicide? (Causes) for families/relatives of victims

4.2.1. Major and sub-themes of the Risk Factors Emerged from the Response of Respondents

Under this section the responses in the in-depth interviews and FGD were examined and the central themes mentioned by the informants were identified and categorized into the following seven (7) major themes that represented the participants’ knowledge and experience about the risk factors of suicide. These are: conflicts between partners/among family members, problems related to marriage, death of partner and divorce, uses of substance abuse (alcohol, marijuana, chat, etc.) and chronic illness/HIV/Aids and other related diseases.

Below are seven major themes emerged from the data were analyzed in sub-themes and were observed if they described similarly point with that in the survey part.
As it is observed in table 4. 6 conflicts in relationship were analyzed into two sub-themes which majority of the informants mentioned in their responses.

4.2.1.1.Conflicts in Relationship

As it was mentioned by most participants in both interviews and focus group discussions that many youth were committee and attempted suicide as a results of unhealthy conflicts between partners or among the family members. For instance, take look at the quotes of the participants below.

This young female has narrated the reason of her suicide attempt in such a way:

“I tried to kill myself because I scared about my mother and elder brother for what they did by standing upon me due to early marriage of my youngest sister, since she was got pregnancy. They blame me; I was the one who encouraged my
youngest sister to be pregnancy. I felt feared of what other people might think of me. I attempted suicide because; I scared about my sister how she will deliver, since her age is low. Then, I decided to eliminate myself in order to avoid the problem”. (Interview 1)

Another young female respondent stated as follows:

“The problem was, my husband made me anger when he married another wife without my knowledge while I’m pregnancy and he stopped his relationship with me and even didn’t come to visit me. Due to this case, I seriously anger with him and involved in routine conflict with ourselves. Then, I concluded that, he made this problem because of his new marriage, and then I decided either to make an abortion or killed myself”. (Interview 2)

Likewise third young lady made her explanation as this way:

“The cause of my attempt to suicide was the conflict between me and my elder sister. She was insulted me just without knowing any reason and for this reason I was felt not happy and then decided to die”. (Interview 3)

He also responded to the above item as like this:

“The cause of my suicide attempt come as a result of sadness feeling, depression, hopelessness, and stress due to interpersonal conflicts. I have been in conflict with my relatives (parents, sisters, brothers and my wife) for long period of time for many reasons such as being married without job, family instability, and significant family conflict. As all these contributed, I came up with an idea to eliminate myself in order to escape such problems, unfortunately it was not succeeded. This was the quote by one interviewee/attempter, said. “If it would be possible, I would to review my age back to the age of below 20 years in order to maintain my life as new because of this burden without an income per month”. (Interview 6)

Sister of the suicide victim expressed the root cause of her sister’s death:
“The cause was come after the conflict with her mother due to misbehavior she practiced. My mother insulted her that, she has no value in the future, not good and useless”. (Interview 11)

Adding to the above quotes by the participants, conflicts in relationship were described as the potential root cause of committed and attempted suicide among the youth. As mentioned above, the youth are very sensitive to the negative words towards themselves. They usually become hopeless by referring their parents or partner words to themselves &formed negative self-perception. The youth also are people who most the times lack problem-solving skills. According to Anywaa culture, when a person reaches in the adolescence/youth stage he/she would be respected by his/her parents or any member of the family not be simple insulted. And partners are also aware by respecting themselves for this sensitive condition. Based on the above points, it can be concluded that, young people in Anywaa zone were regularly committed and attempted suicide due to the conflicts. Suicide them is always to punish others or solution for the problem.

4.2. 1. 2. Problems in marriage

The second risk factor that the participants mentioned during interviews and focus group discussions was problems related to marriage. Below are the quotes of respondents, how they were reflected to the question.

The young man tried to communicate out the cause of his suicide attempt as like this:

“I got married a girl I loved her so much and my parents refused to pay the dowries to my in-law or the parents/relatives of girl. “From there I felt unhappy with my parents and myself as well and involved in conflict with them that led me not to think positively for anything else, and then I tried to avoid myself from this world”. (Interview 4)

Another respondent added that the reason of suicide was this:

“My brother was killed himself due to the problem raised from marriage. While he was already married his first wife, he again married the second wife which he failed to pay the dowries after her. And then, the parents of the girl felt angrily toward him and beaten him badly”. (Interview 7)
One of the participants who were the sister of victim made remark as follows:

“The cause of suicide was, my brother got married a girl while he and parents failed to pay the needed materials (dowries) which were necessary for marriage and he was seriously beaten by the parents/relatives of the girl. Then, he escaped away to gold mine to search for money. He again got married a second girl in the place he escaped to and failed also to pay dowries for that girl’s relatives/parents and also beaten there and escaped back to the original place. When he reached back the relatives of the first girl caught him and beaten him again until got problem in his ear and felt abnormal. Finally, he committed suicide”. (Interview 9)

During the interviews most of the themes emerged from participants’ responses were unplanned marriage; unwanted pregnancy and failure to pay dowries. According to the respondents, problems related to marriage were mentioned as the root of suicide. As to culture, if the daughter married, the boy with his parents would pay the materials or dowries in form of beads (dimuy), cows and money as price of marriage to the parents of a married girl. If someone married and failed to provide these materials (dowries) serious action would be taken on him by beaten and sometimes together with his parents (either father or mother) would be also beaten by the parents/relatives of girl. This came most of the times when young men married two to three wives without dowries to be pay after those wives. As a result, the young men would have decided of eliminated themselves through means of suicide in order to avoid that painful situation. Young females, especially when they noticed that there is pregnancy without plan, they would struggle for the ways to remove the fetus through the mean of abortion which indeed likely to kill themselves because they might use drugs overdose.
4.2.1. 3. Psychological and Physical Illness

Under this sub section, participants reported the reasons of suicide as they didn’t know exactly. As a professional their points were analyzed as the psychological and physical factors that caused suicide to young people. Below are their quotes.

The woman who was the mother of the victim said:

“She has been stayed long period of time without communicated with anyone, isolated from people, even if she was asked to say something about her problem, she didn’t said anything. Up to now I didn’t understand what was causes the death of my daughter. This was what the interviewee said; the death of my daughter came as an accident thing to me”. (Interview 8)

The father of the victim mentioned as follows:

“The suicide happened when she was slightly felt sick after she came from fishing and immediately found hanging in the house. According to the explanation of father said that. Death might result from devil spirit he obtained from the fish. She was claimed feeling of headache and talked unconsciously”. (Interview 10)

According to the two participants of this study in their explanations above, mentioned the signs of psychological problem/mental illness and physical illness as the causes of the suicide of their children. There was no specific point they indicated during conversations. But, from the explanation of respondents psychological problems were identified as the major cause of these two victims. Since one of the victims was claimed feeling of headache, showed isolated behavior and talked unconsciously and another one was unable to talk, the cause was concluded as resulted from both psychological and biological factors.

4. 2. 1. 4. Lack of Income

In contrary to the above, there was a respondent who reported that, the cause of her suicide attempt suicide was because her family usually didn’t provided her with what she requested due to the real status of family.
“I was attempted suicide because of my family (father, mother and elder brother and sisters) didn’t care of me. They didn’t buy for me anything new, like fashion clothes while my age mates were wearing very good and I used to felt shame when I’m among my age mates. Whenever I talked to them to buy something for me, nobody understood me and then, I concluded that nobody like me anymore and nobody feel the way I do, so better off dead. Off course, the socio-economic status of my family was very low but at least, they would try their best level a bit for me to felt like a member of family”. (Interview 5)

According to the quotes of participant in the above, youth of Anywaa zone are in risk of suicide since the majority of populations are found in lower economic level. As a result, one may conclude that, low income of family has a great contribution to youth’s suicide.

**Characteristics of Focused Group Discussion that Conducted With Two Separate Groups**

Focus groups discussion was incorporated in the study since it provides insights into how people think and provide a deeper understanding of the phenomena being studied. As a method to gain more in-depth information it was also used to supplement questionnaire surveys and informant interviews.

Two focus group discussions were carried out among purposely selected youth to explain some of the information by using a semi structured discussion guide. Discussions were locations segregated and divided according to their distances (Abobo and Gog woreda/districts).

Discussion was conducted with 19 youth (one group of 10 participants and another with $9 = 19$ participants). These two groups were of mixed gender (approximately 60% males and 40% females). Participants in two groups were selected from heterogeneous age groups ranged from 15-to-34 years. Another discussion was also conducted with two police officers; one from each woreda asked them about the causes of suicide among the youth in zone.

**What do you think were the causes of suicide among the youth (factors)?**

This question above was forwarded for discussion so that the participants might shares their knowledge and experiences about risk factors led young people to harm themselves. According to focus group discussions (FGD) members, they have shared the vital information related to the
risk factors of youth suicide. According to them, risk factors affected young people were categorized into two ways based on sex differences. As they mentioned, there were some risk factors common to the youth females only and some males alone. That shows suicide’s risk factors were affected youngest based on the sex differences. For more detail are in discussion section or chapter five.

4.3. Patterns/Methods of Suicide

Patterns were required in order to know the most suicide patterns/methods that the youngest were tried to attempted and completed suicide through. Suicide attempters, relatives of the victims and participants of focus group discussions were been asked to share their knowledge and experiences about the patterns/methods of suicide. In that way researcher would able to identify and analyze the most common patterns of suicide among the youth of Anywaa zone of Gmabella regional state. This question below was addressed to the suicide attempters and relatives of suicide victims/interviewees.

In what way have you tried to kill yourself? Did you have access to lethal means?

This question was designed to explore the patterns/methods of suicide and also to identify an accessibility of lethal means. So that Interviewer would be able to analyze and interpreting those patterns communicated by the interviewees. Below are the quotes/responses by attempters/interviewees and suicide victims’ relatives:

Responses of the Suicide Attempters/Interviewees

First interviewee explained as below:

“At the moment I have small amount of money and then, I went to the pharmacy to buy medicines with the intention to either to remove the fetus or killed myself. So, after I bought the medicines, I swallowed them in overdoes, then I become unconscious and admitted in health center for four days”. She used drug overdose or poisoning to kill herself”. (Interview 1)

The second young man interviewee made the explanation in this way:
“Yes, there was access to means. The way I tried to kill myself, there was a piece of cover sheet of my small baby, and then I tried to hang with it in my own house without any body known”. (Interview 2)

Another young made it like this:

“I searched for a rope around our compound and got, then hang myself in the house while someone watched at me from outside, then came to rescue from hanging”. (Interview 3)

In similar, this respondent expressed the method of attempted suicide as follows:

“There was no means but I went to the bush and got rope from wild tree then hanging myself. The mean I tried to kill myself was hanging from tree”. (Interview 4)

The young lady clearly explained how she tried to kill herself in the same way how the first interviewee was followed:

“Yes, I pretended myself as I’ was sick and went to clinic and buy medicines and I swallowed in more number in order to kill me”. (Interview 5)

Another respondent made a remark as follows:

“There was no lethal means at the moment but since I already decided to kill myself, I walked out to the forest and prepared a rope from tree and then I climbed up on big tree and hanging there. So the rope was not enough strong it cut off, then I felled down without knowing myself. After a while I came again in my conscious mind with paralyzed body and come home slowly”. (Interview 6)

Responses of the parents/Relatives of the Suicide Victims

Since the relatives were most people closest to those who were victims (died), this interview item was designed for them to be addressed so that they may explain out the real methods which the victims were committed suicide through.
How did he/she do it? (Method)

This relative said as below

“Without distinguished any sign of suicide from him, was simple went to the forest and found a rope there and then hanged. We were been informed after he already died in the forest and we got sucked by the information. (Interview 7)

Another relative said, she killed herself as:

“The means was hanging. She was hanged herself in her own house with nobody known”. (Interview 8)

Another victim’s relative explained the method as follows:

“He intended again to escape the area, while he was on his way, made decision of killing himself to escape all such problems and hanged with rope on tree in the bush far away from home with almost 10 kilometers”. (Interview 9)

Relative said that.

“She was hanging on the tree, out of home”. (Interview 10)

The last relative mentioned that.

“The means she committed suicide was hanging on the tree in the bush”. (Interview 11)

Patterns/methods of suicide action and attempt shared by focus group discussions participants.

The participants were urged to discuss and share the methods of committing and attempting suicide which they have known so far.

How did the victims have made it (suicide)? (Patterns/methods)

According to focus group discussions’ members two methods were mentioned. Hanging and drug overdose or poisoning.
“Previously, before Federal government, when there was availability of guns and lack of accessibility of clinics and pharmacies, most of the males were used to attempted or committed suicide through the means of firearms (gunshot). And females were committed/attempted suicide using traditional medicines, since that time there was lack of accessibility of modern drugs and limited of clinics and health centers”. (FGD)

“Nowadays, youth females attempted suicide or committed suicide through two means, such as using of hanging and drugs overdose or poisoning, whereas males used only hanging because there is no means to get firearms”. (FGD)

“Females when they are planning to attempt/committed suicide, they will search for money first in order to go to the clinics to buy medications, or they pretended themselves to be sick and be given money to buy medications. After that, swallow those medicines at one time with intention to kill themselves or make an abortion”. (FGD)

As the quotes from all groups indicated above hanging and drugs overdose or poisoning were observed as the two major patterns of committed and attempted suicide among the youth in Anywaa zone. Majority of the respondents mentioned that hanging was the most common pattern of suicide. According to the information gathered during interviews with both suicide attempters and suicide victims’ relatives reported that young people were attempted and completed suicide through the means of hanging and drug overdose or poisoning. From six attempters/survivors, four of them were tried to kill themselves through hanging and two were tried by taking drug overdose or poisoning. All five suicide victims were committed suicide through hanging. The two attempters who tried to kill themselves through the mean of taken drug overdose or poisoning all of them were youth females. For more information try to refer the table 4. 2 and table 4. 3 above.

In addition, the participants in two separate focus group discussions were clearly explained the methods/patterns of suicide by referring the previous years before federal democratic government of our country Ethiopia. The participants mentioned that up to the downfall of deruge regime, males were attempted and committed suicide through the mean of firearms and
females used the traditional medicines for suicide completion and attempts. This was because of accessibility of guns and lack of modern drugs (medicines). For this time, all the participants mentioned that hanging and drugs overdose or poisoning were an access lethal means of both suicide attempt and success. It was also found in the documents from police that, all the individuals who committed and attempted suicide from 2010 to 2016 April were used through hanging and drug overdose. This implies that hanging was the most common pattern for both youth males and females to take their lives, whereas drug overdose or poisoning was the most common patterns for the youth females only. As the informants indicated, one may concluded that all youth who attempted and committed suicide in Anywaa zone were used through hanging and drugs overdose or poisoning, especially hanging ones. In other word, hanging and drugs overdose or poisoning were the major patterns of suicide action and suicide attempt among the youth of Anywwa zone, Gambella regional state.

4.4. Prevalence of Suicide among the Youth

Youth females were more likely to attempt suicide than males. This also implies that the high prevalence of suicide attempt was found among the youth females, whereas youth males had low prevalence of suicide attempt. That means, prevalence of suicide attempt was very high among the youth who were in the age range of 20-to-28 years old.
<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
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<td>65</td>
<td>61.3</td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>41</td>
<td>38.7</td>
</tr>
<tr>
<td>My family would be better off without me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
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<tr>
<td>No</td>
<td>106</td>
<td>38</td>
<td>35.8</td>
</tr>
<tr>
<td>Next time ‘ll take enough pills to do the job right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>56</td>
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</tr>
<tr>
<td>No</td>
<td>106</td>
<td>50</td>
<td>47.2</td>
</tr>
<tr>
<td>I won’t be around to deals with that</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>64</td>
<td>58.5</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>44</td>
<td>41.5</td>
</tr>
<tr>
<td>You ‘ll be sorry when I’m gone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>76</td>
<td>71.7</td>
</tr>
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<td>No</td>
<td>106</td>
<td>30</td>
<td>28.3</td>
</tr>
<tr>
<td>I won’t be in your way much longer</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>61</td>
<td>57.5</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>45</td>
<td>42.5</td>
</tr>
<tr>
<td>I just can’t deal with everything- life’s too hard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>63</td>
<td>59.4</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>43</td>
<td>40.6</td>
</tr>
<tr>
<td>Nobody understand me-nobody feel the way I do</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>74</td>
<td>69.8</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>32</td>
<td>30.2</td>
</tr>
<tr>
<td>There is nothing I can do to make it better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>61</td>
<td>57.5</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>45</td>
<td>42.5</td>
</tr>
<tr>
<td>I’d be better off dead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>66</td>
<td>62.3</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>40</td>
<td>37.7</td>
</tr>
<tr>
<td>I feel like there is no way out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>68</td>
<td>64.2</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>38</td>
<td>35.8</td>
</tr>
<tr>
<td>Signs of planning a suicide such as obtaining a weapon or writing a suicide note</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>106</td>
<td>48</td>
<td>45.3</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>58</td>
<td>54.7</td>
</tr>
</tbody>
</table>

Table 4.6, above presenting the prevalence of suicidal behaviors and ideations. As in the table above, 65 (61.3%) of youth reported that they heard some people said “life isn’t worth living” and 41 (38.7%) said they didn’t heard anyone said “life isn’t worth living”. 68 (64.2%) said yes
they have heard people said “my family would be better off without me” and 38 (35.8%) said no they haven’t heard someone said “my family would be better off without me”. Majority 56 (52.8%) of respondent reported that, they have heard some people claimed that “next time will take enough pills to do the job right” and 50 (47.2%) of them said No. 64 (58.5%) of youth showed that, they have come across many people said, “I won’t be around to deals with that” and 44 (41.5%) of the youth said they haven’t heard anyone said that. Majority 76 (71.7%) of participants indicated that they have heard many youth said “You’ll be sorry when I’m gone” and only 30 (28.3%) of participants indicated no they haven’t heard anyone claimed that “You’ll be sorry when I’m gone”. Respondents of 61 (57.5%) reported that they had come around some people talked that “I won’t be in your way much longer” and 45 (42.5%) of the respondents reported they didn’t heard someone talked of that. Data show that 63 (59.4%) youth have heard some people said “I just can’t deal with everything- life’s too hard” and 43 (40.6%) of them haven’t heard someone claimed of that statement. As to the table majority 74 (69.8%) of youth mentioned that they have heard many people expressed their feelings that “Nobody understand me-nobody feel the way I do” and only 32 (30.2%) of them reported that they didn’t anyone said the feeling like that. 61 (57.5%) of youth reported that, they have heard some people, said “There is nothing I can do to make it better” and 45 (42.5%) of them said they didn’t heard anyone said “There is nothing I can do to make it better”. The data in the table above show that majority 66(62.3%) of respondents reported they have heard some people talking of wish to die by said “I’d be better off dead” and 40 (37.7%) of them reported that they haven’t heard someone talking of wish to died. 68 (64.2%) of youth said they have heard many youth claimed that “I feel like there is no way out” and 38 (35.8%) of them show that the haven’t heard anyone claimed that “I feel like there is no way out”. This showed that there was a very high prevalence of suicidal behavior and ideations among the youth of Anywaa zone who their ages ranged from15-to-34 years. High prevalence of suicidal ideations and behaviors were also found as the very potential risk factor of completed suicide among the youth. This means, suicidal ideations and behaviors were considered to be risk factors that may increase risk of suicide.

Regarding, if they have seen someone with the Signs of planning a suicide such as obtaining a weapon or writing a suicide note, majority 58 (54.7%) of youth reported that they haven’t seen someone with “Signs of planning a suicide such as obtaining a weapon or writing a suicide note” and 48 (43.3%) of them reported that they have seen some people having “Signs of planning a
suicide such as obtaining a weapon or writing a suicide note”. That show majority of youth in Anywaa zone were extremely aware of not be observed by others to have signs of planning such as obtaining a weapon or writing a suicide note. They used, to hidden their behaviors not to be recognized by others that they have a suicidal behaviors and ideations.
The table 4. 7 below is presenting the rates/prevalence of suicide deaths from 2010-2016

**Table 4. 7: Suicide Rates/prevalence by Sex, Age group and Year, Abobo and Gog, 2010-2016**

<table>
<thead>
<tr>
<th>Woreda/districts</th>
<th>Sex</th>
<th>Age</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>15-18</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19-25</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>26(7.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26-30</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>2</td>
<td>40(11.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31-34</td>
<td>-</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>14(4.0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>80(23.1)</td>
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<tr>
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<td>Female</td>
<td>15-18</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>1</td>
<td>-</td>
<td>1(0.3)</td>
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<td></td>
<td></td>
<td>19-25</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>6</td>
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<td>31-34</td>
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<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
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<td></td>
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<td>98(28.4)</td>
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<td><strong>Total of Abobo</strong></td>
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<td>23(6.6)</td>
<td>26(7.5)</td>
<td>28(8.1)</td>
<td>36(10.4)</td>
<td>44(12.7)</td>
<td>11(3.2)</td>
<td>178(51.3)</td>
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<tr>
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<td>-</td>
<td>-</td>
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<td>-</td>
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<td>3</td>
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<tr>
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<td>16(4.6)</td>
<td>27(7.8)</td>
<td>25(7.2)</td>
<td>31(8.9)</td>
<td>45(13.0)</td>
<td>14(4.0)</td>
<td>169(48.7)</td>
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<td>Females total of both woreda</td>
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<tr>
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<td>Total Cumulative from both woreda/districts</td>
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<td>21(6.1)</td>
<td>39(11.2)</td>
<td>53(15.3)</td>
<td>53(15.3)</td>
<td>67(19.3)</td>
<td>89(25.6)</td>
<td>25(7.2)</td>
<td>347(100.0)</td>
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</table>
Documents review was conducted to look for the rates/prevalence of suicide among the youth in term of location, sex, age and year. As the table above indicates, the recorded number of young people who were committed suicide during six (6) years and quarter were 347 individuals. The number of people died of suicide in Abobo woreda/district were 178(51.3) and victims of Gog woreda/district were 169(48.7). That shows there was relatively high suicide prevalence in Abobo woreda than Gog. Meaning youth in Abobo woreda were little bit more vulnerable of suicide incidence than youth in Gog woreda. During these years, a total of 188 females were committed suicide (54.2 deaths per 100,000) compared to 159 males (44.8 deaths per 100.0). As the data show, one may conclude that females were more likely to commit suicide than males.

In 2010, there were 21(6.1) individuals died by suicide in Anywaa zone. During 2011, 39(11.2) people were died. In the year 2012 and 2013, 53(15.3) and 53(15.3) youth were died, respectively. In 2014, 67(19.3) were died. In the time of 2015, 89 youth were committed suicide that resulted in a suicide rate of 25.3 deaths per 100,000 people. And from January to April 2016, 25(7.2) young people were death of suicide. This show that the number of people died in 2016, were only quarter of the year. And if it was from the whole year, this year would be the highest of suicide rate/prevalence. This can be concluded that the suicide rate/prevalence of 2015 was the highest of all years. Another conclusion was that, there was an increase of suicide rates/prevalence from year to year. During six years and quarter period, 168 (48.4) individuals aged from 26 - 30 years old were committed suicide. Followed by 125(36.0) people in the age groups ranged from 19 -25 years. People in 31 - 34 years were found in moderate of suicide rate/prevalence with number of 53(15.3 deaths per 100.0). Only1 (.3) person died during six years and quarter in age of 15 to 18 years. This implies that there was low suicide prevalence among the young people in age groups of 15 to 18 years. Therefore, suicide rate/prevalence was relatively among age groups of 26 - 30 years old, next by 19 - 25 years old. In another word, suicide incidence was more frequent among youngest people in age from 26 - 30, followed by 19 -25 years old. This shows that there was an age difference in prevalence of suicide among the youth of Anywaa zone. This means that the older age’s people have lower suicide incidence compared to youngest one.
Regarding gender, the data show that 188 (54.2) youth females and 159 (45.8) males were died in the period of six and quarter years. In similar way, suicide rates/prevalence was higher among females than in males.

As the table 4.2 & 4.3 indicated, prevalence of suicide was relatively higher in youth females than males one. According to data in the two table above, among eleven subjects (both suicide attempters and victims), seven were females and four males. This show, the number of youth female was higher in both suicide attempt and completed than youth males.

4.5. Sex and Ages Difference in the Risk Factors, Patterns and Prevalence of Suicide among the Youth

Table 4.8: Risk Factors and Methods/Patients of Suicide by Sex, Abobo and Gog, 2010-2016 documents

<table>
<thead>
<tr>
<th>Sex</th>
<th>Risk Factor</th>
<th>Method/Paternal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Married many wives, drugs abuse, &amp; HIV/Aids Cases and other related diseases</td>
<td>Hanging</td>
</tr>
<tr>
<td>Females</td>
<td>Conflicts, getting a child with no real father and unwanted pregnancy. Death of partner and divorce</td>
<td>Hanging and drugs overdose or poisoning</td>
</tr>
</tbody>
</table>

Source: police documents

Table 5.8, above is presenting the sex differences in risk factors and methods/patterns of suicide among the youth in Anywaa zone. These risk factors observed in the above table were collected from both interviewees, documents from police offices and participants of focus group discussions. Participants of focus group discussions were asked with below question.

What do you think were the causes of suicide among the youth (factors)?

This question above was forwarded for discussion so that the participants might shares their knowledge and experiences about risk factors led young people to harm themselves and committed suicide.
4.5.1. Sex and Age Differences in Risk Factors

The focus group discussions (FGD) participants, have shared the vital information related to the risk factors of youth suicide. According to them, risk factors affected young people were categorized into two ways based on sex differences. As they mentioned, there were some risk factors common to the youth females only and some males alone. Below are the quotes of FGD respondents:

**The most common risk factors for youth females:**

“Conflict in relationship (boy/girlfriend), getting a child with no real father, death of partner, divorce, misunderstanding among family members (husband, parents, brothers & sisters), preventing young from boyfriend”. (FGD)

The young females, since they fear of being lonely, fear lack of support and fear of holding children alone after the death of partner and divorce, they usually attempted and committed suicide as the solution to escape the conditions.

**The most common risk factors for youth males:**

“Unplanned marriages or married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases”. Police officers stated that youth females were died by suicide due to the getting a child with no real father and unwanted pregnancy and males were died of suicide as a results of married many wives, the use of too much drugs abuse and case of HIV/Aids. (FGD)

During focus group discussions, majority of the participants mentioned that risk factors most common for youth males were these of unplanned marriages, married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases. These factors were found as the major risk factors among the youth’s suicide incidences in the zone. Youth males, after involved into unplanned marriage and failed paid dowries and beaded seriously, they would conclude to die as a solution of escaping problem. Majority of male youth of suicide because their thinking abilities were dominated by drugs. Since of many youth feared stigma, when they noticed that, they already positive with HIV/Aids, automatically leading to
suicide as a reason not be shamed. That shows many of youth males in Anywaa zone were highly exposed to the use of substance abuses and chronic illness/HIV/Aids and other related diseases that resulted to committed and attempted suicide.

According to the data of interviews and focus group discussions reported that there was no a significant age difference in risk factors of suicide among the youth in Anywaa zone.

4.5.2. Sex and Age Difference in Patterns/Methods

As the table above and informants mentioned, two methods were observed in regard to sex difference. Data shows that, hanging was the commonly used method/pattern of suicide in both males and females, while drugs overdose or poisoning was found as the pattern of suicide among youth females only. These imply that, hanging and drug overdose or poisoning was the patterns existed as the means for youth’s suicide in Anywaa zone. And there was no age difference found in the patterns.

4.5.3. Sex and Age Difference in Prevalence of Suicide

Prevalence of suicide and suicidal behaviors and ideations among the youth in Anywaa zone was presented in Table 4. 6 & 4.7. A table 4.6 was presented the prevalence of suicidal behaviors and ideations. Data in Table 4. 6 showed that there was a very high prevalence of suicidal behavior and ideations among the youth of Anywaa zone who their ages ranged from15 -34 years.

As observed in table 4. 7 above, prevalence of suicide in gender differences show that, youth females were more frequently affected by suicide than males. Prevalence of suicide was also assessed during focus group discussions. This item was addressed to the participants.

Who do you think are most vulnerable of completed suicide and attempted suicide between males and females?

On this question, a lot of controversies were observed among the participants and after several times of argument they have come to common understanding that:

“Youth females are the most vulnerable of both completed suicide and suicide attempt. But youth males are not much vulnerable of both completed suicide and
attempt. Youth male when he already planned to kill himself, he exactly will do it and succeeded”.

According to the participants, majority reported that males have low cases of suicide attempt than females. Because males have potential to plan well and look for the lethal means which is very powerful for hanging, whereas females don’t have such characteristics, they just use to hang themselves with piece of their clothes which is easily to cut off soon”. As for suicide completion, females were also the leading. That show prevalence of suicide was higher in females than the males among youth of Anywaa zone.

In the case of age differences, prevalence of suicide was found very high among the youth at the age groups ranged from 26 - 30 years old. The second age group with more frequent of suicide were age ranged from 19 - 25 years. According to the data in table 4. 7 above youth in the age groups ranged from 31 - 34 years old have moderate suicide prevalence. And it was observed that the suicide rates/prevalence among young people in age groups of 15 - 18 was lower than any age groups mentioned above. This show that there was age differences in prevalence of suicide among Anywaa zone youth.
CHAPTER FIVE

5. Discussions

As it was mentioned earlier, the purpose of this study was to examine the risk factors, patterns and prevalence of suicide among youth in Anywaa. In this chapter results are discussed in light of previous research findings on youth suicide.

Based on ranking given as table 4.4 in chapter four presented, results showed that the most first common risk factors of suicide among the youth of Anywaa zone, Gambella region, were chronic illness or long suffering with disease/HIV/AIDS and other related diseases 64(60.4%), followed by Poor relationship among family members/relationship problem 57(53.8%), next by unplanned/early married/divorce 47(44.3%) and Unwanted pregnancy/unplanned pregnancy 47(44.3%), respectively and again followed by alcohol abuse and/or drugs abuse 43(40.5%), and then by Physical/mental illness 35(33.1) and Preventing youngest from his/her lover or prevented one’s choice 32(30.2%).

In addition to that, results from interviews and focus discussion revealed that unhealthy conflict among family members and between partners, problems related to marriage (many wives, unwanted pregnancy and unplanned marriage), death of partner and divorce, chronic illness/HIV/ AIDS and other related diseases were also found as the most common risk factors of suicide among the youth. However, the studies conducted by Tsuang, Fleming and Simpson (1998) suggested that chronic illness or illness severity might increase the possibility of completed suicide and suicide attempt. And other studies mentioned that chronic illness or illness severity was being an indicator of risk for suicide (Hoyer, Mortensen, Olesen, 2000, & Brown, Beck, Steer &, Grisham, 2000). While several studies have shown that people with HIV and AIDS are at high risk for suicide, the data on the extent of that risk vary. Durkheim (1951) asserted that when divorce happened it reduces family ties, well beings and resulted in suicide increases. In addition, young people who attempted suicide describe their families as stressful, unsupportive, highly conflicted, and emotionally distant (Kuhlberg et al., 2010). Evidence from several previous findings revealed that alcoholism was associated with an increased risk for suicide, with suicide mortality rates for alcoholics that are approximately six times of those of the general population (Inskip, Harris & Barraclough, 1998 & Harris & Barraclough, 1997).
Murphy (2000), in fact, abuse of substances including alcohol may be the second most frequent psychiatric precursor to suicide. Although suicide rates among alcoholics was higher in Europe and older literature indicated that a lifetime risk for suicide was in the 11%–15% range, recent literature suggests that the lifetime risk of suicide among alcoholics in the United States is as low as 3.4% (Murphy & Wetzel, 1990). In addition, psychological autopsy studies indicated that alcohol abuse or dependence was present in 25%–50% of those who died by suicide (Lonnqvist, 1993). The studies suggested that physical illnesses are also a source of social and/or psychological stress, which in turn augments risk. Physical illnesses such as hepatitis C or sexually transmitted diseases may signal an increased likelihood of impulsive behaviors that may in turn be associated with greater risk for suicidal behaviors. According to clinical cohort and record linkage studies clearly indicated that, medical illness was associated with increased likelihood of suicide (Harris & Barraclough, 1997). From all the above discussions, one can understand and concluded that young people in Anywaa zone of Gambella regional state were too much committed suicide due to the availabilities/accessibilities of the above mentioned risk factors.

According to the data in table 4.4 explained that second most common risk factors were those “Depression or remembering the past bad events, like death of beloved one 42(39.6%), next Lower socioeconomic status including income/not affords to buy new fashion 30(28.3%) and Lack of problem-solving skills 29(27.4%)”. Moreover, participants of two interviews and focus group discussions reported that hopelessness and depression resulted from psychological problem/physical illness, lack of income (socio-economic problem), were suicide’s risk factors which led the attempters and successors. This recent study comes out with the same finding to the previous findings. According to Cavanagh, Carson and Sharpe (2003), depression was the most common illness among those who die from suicide, with approximately 60% suffering from this condition. Other researchers contemplated their ideas about lower socio-economic status including income and stated that, parental low socioeconomic status (SES), poverty and educational under achievement were most risk factors for offspring’s suicidal behavior (Fergusson et al., 2000; Beautrais et al., 1998, Gould et al., 1996; Fergusson, 1995; Bucca and Fele, 1994; Andrews and Lewinsohn, 1992 and Dubow et al., 1989). As to the studies, poverty and deprivation were linked to suicide risk at an ecological (area) Unemployment was linked to elevated risk of suicide. Occupational social class and suicide and deliberate self-harm (DSH)
were inversely linked: the lower the social class, the higher the risk of suicidal behavior (Agerbo, 2005 & Sheikh, 2000).

The third most common risk factors were “Unemployment/being jobless and low self-esteem, felt so sad or hopeless”. As to the previous researchers, high baseline levels of hopelessness have been found associated with an increased likelihood of suicidal behaviors (Young, Fogg, Scheftner, Fawcett, Akiskal & Maser, 1996). Other studies found that hopelessness also contributed to an increased likelihood of suicidal ideation and suicide attempts, as well as an increased level of suicidal intent (Uncapher, Gallagher-Thompson, Osgood & Bongar, 1998).

According to table 4.4 above in chapter four, “Failing to fulfill an expectation and hopeless and Academic failure/lack of pass mark”, were ranked as the fourth and fifth most common risk factors; respectively. The previous studies are also supporting that, people with a negative expectation for the future to being devoid of hope and despairing for the future may like to expose risk of suicide. In general, individual with high levels of hopelessness have an increased risk for future suicide (Brown et al., 2000). Hopelessness is well established as a psychological dimension that is associated with increased suicide risk (Brown et al., 2000).

Regarding “Family history of suicide and academic failure/lack of pass mark” as data showed in chapter four under results, were been found as the less or fifth most common risk factors compared to other risk factors. In other word family history of suicide had found with low effect on suicide of Gambella youth, particularly of Anywaa zone. This finding becomes contradicted with the findings of previous studies. According to previous research findings of Tsai, Kuo, Chen and Lee (2002) and Wunderlich, Bronisch, Wittchen and Carter (2001) reported that, an individual with a history of suicide among relatives, the risk of suicidal behaviors is increased, apparently through genetic as well as environmental effects. Accordingly, an increased relative risk for suicide or suicide attempts in close relatives of suicidal subjects has been demonstrated repeatedly. Overall, it appears that the risk of suicidal behaviors among family members of suicidal individuals is about 4.5 times that observed in relatives of nonsuicidal subjects (Tureck, 2001). Furthermore, this increase in the risk of suicidal behaviors among family members seems, at least in part, to be independent of genetic contributions from comorbid psychiatric diagnoses (Fu, Heath, Bucholz, Nelson, Glowinski, Goldberg, Lyons, Tsuang, Jacob, True & Eisen, 2002).
As it was learnt from both quantitative and qualitative data, the risk factors responsible for youth suicide attempt and complete were work interdependence. Majority of interviewees explained that their action to suicide attempt was resulted from the contribution of many factors. This implies that for suicide completion and attempt two to three or many risk factors were interacted. According to Health in Canada (1994) revealed that no single determinant, including mental illness, is enough on its own to cause a suicide. Rather, suicide typically results from the interaction of many factors, for example: mental illness, marital breakdown, financial hardship, deteriorating physical health, a major loss, or a lack of social support. Beautrais (2000) presented that a multi-factorial, multi-level model of the risk factors and life processes were combined together and led to suicidal behaviors and suicide among young people. According to her proposes genetic/biological factors, social/demographic factors, family characteristics/childhood experiences, and personality traits/cognitive styles, all interact with one another to directly influence people’s vulnerability to suicide and suicidal behavior. According to the empirical evidence stated that, when individual factors interact with environmental factors negatively, this interaction would result into psychiatric morbidity, which in turn influence suicide action and suicidal behavior (Beautrais, 2000). Another, Research suggested that many of the negative life stressors from environmental factors in combination with a psychiatric disorder can greatly contribute to suicide risk and behaviors (Sofronoff et al., 2005). The data collected on suicidal behaviors and ideations showed that, high prevalence of suicidal ideations and behaviors were also found as the very potential risk factor of completed suicide among the youth. This means, suicidal ideations and behaviors were considered to be risk factors that may increase risk of suicide among the youth in Anywaa zone. According to studies conducted by Kuo, Gallo and Tien (2001) and Moscicki (1997), reiterated that, individual with suicidal ideations and behaviors were likely to die soon by suicide. According to the Anywaa community, based on the conversation in different occasions with different people, death of suicide is always blamed on the victims. As a researcher, the conclusion was that, this blaming was resulted from lack of awareness of whole community. That means any suicide action and attempt among the youth in Anywaa zone, of Gambella regional state, was resulted from the interactions of many different risk factors.

The young females, since they fear of being lonely, fear lack of support and fear of holding children alone after the death of partner and divorce, they usually attempted and committed
suicide as the solution to escape the conditions. The studies showed that, relationship conflict (e.g. separation), discord or loss (e.g. death of a partner) can cause grief and situational psychological stress, and are all associated with increased risk of suicide (Kposowa, 2003). According to Global and regional estimates of violence against women (2013) and Garcia-Moreno et al., (2006), intimate partner violence was associated with an increase in suicide attempts and suicide risk. Globally, 35% of women have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner. That can be concluded that females were mostly died of suicide due to unhealthy conflicts, death of partner and divorce, resulted from lack of problem-solving.

During focus group discussions, majority of the participants mentioned that risk factors most common for youth males were these of unplanned marriages, married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases. These factors were found as the major risk factors among the youth’s suicide incidences in the zone. Youth males, after involved into unplanned marriage and failed paid dowries and beaded seriously, they would conclude to die as a solution of escaping problem. Majority of male youth of suicide because their thinking abilities were dominated by drugs. Since of many youth feared stigma, when they noticed that, they already positive with HIV/Aids, automatically leading to suicide as a reason not be shamed. That shows many of youth males in Anywaa zone were highly exposed to the use of substance abuses and chronic illness/HIV/Aids and other related diseases that resulted to committed and attempted suicide. Many researchers explained in their studies that, alcohol was present in men twice as often as in women (Ohberg, Vuori, Ojanpera & Lonngvist, 1996). According to the researchers alcohol as a factor of suicide may act as precipitants or, conversely, alcohol use disorders may have a deteriorating effect on the lives of alcoholics and culminate in suicide. In addition researcher further stressed that, in terms of gender, alcoholic men were more likely to die by suicide, but female alcoholics appear to have a greater standardized mortality due to suicide than men (Harris & Barraclough, 1997). The researchers also suggested that high alcoholism among males in the United States may be possibly mean for males’ alternative to attempting suicide (Canetto & Safinofsky, 1998). Substance use disorders were particularly found common among male adolescents and young adults who died by suicide (Rich, Motooka, Fowler &Young, 1988). In fact, it had been suggested that the spread of substance abuse may have contributed to the two- to fourfold
increase in youth males suicide since 1970 (Murphy, 2000). Based on this, it can be concluded that there was a significant gender differences in risk factors of suicide among the youth of Anywaa zone, Gambella regional state. As the data from interviewees (both suicide attempters & relatives of suicide victims), focus group discussions and documents analysis indicated, there was no age difference found in risk factors of suicide among the youth. This means, there was no age differences in risk factors of suicide among the youth in Anywaa zone, Gambella region.

As the informants mentioned, hanging and drug overdose or poisoning were identified as patterns/methods of suicide among the youth of Anywaa zone, Gambella region. Majority of participants affirmed that hanging was the most common pattern of suicide for both suicide attempted and completed among other patterns, such as firearm, falling from height and drown. This implies that, hanging and drug overdose or poisoning was the patterns existed as the means for youth’s suicide in Anywaa zone. This current study finding come as matching (the same) with some of the previous studies’ findings and differs with others. According to the Commonwealth of Virginia (2011) explained that suicide patterns/methods vary within and between subpopulations and among the countries in terms of race, gender, age, culture and birthplace. Commonwealth of Virginia (2011) reported that, the most commonly used of suicide patterns/method among the young people of Virginia was a firearm with (57%), next was hanging or suffocation with the (19%), and followed by poison with (18%). According to the report of Viegina, the majority of suicide victims (94%) were choses to commit suicide by using either a firearm, hanging/suffocation, or poison (Commonwealth of Virginia, 2011). Another finding showed that, in developing countries, especially African countries, poisoning was the most commonly used means for people to end their life in rural areas (Gunnell & Eddleston, 2007). The report of research studied in South Africa revealed that, the patterns of suicide that were most commonly used by the victims were hanging, next to poisoning, followed by firearms, pesticides, fall from height, and drowning. The conclusion was that young people of Anywaa zone were committed and attempted suicide through the means of hanging and drugs overdose or poisoning. Or in another way, the most commonly used patterns/methods of completed and attempted suicide among the youth of Anywaa zone of Gambella regional state were hanging and drugs overdose or poisoning.
Two methods were observed in regard to sex difference. Data shows that, hanging was the commonly used method/pattern of suicide in both males and females, while drugs overdose or poisoning was found as the pattern of suicide among youth females only. Based on the study conducted in Cameroon, the data received from very few countries of Africa indicated that ingesting toxic agricultural chemicals was the most common method of suicide \((n = 36; 76.6\%)\), followed by hanging \((n = 8; 17\%)\) and ingesting non-agricultural toxic chemicals the women who committed suicide all were claimed as used poisonous agricultural chemicals (Gunnell & Eddleston, 2007). According to Moscicki (2001) showed that males were most likely to commit suicide by hanging \((46\%)\) while females most often died by poisoning \((42\%)\), and Males \((20\%)\) were far more likely to use firearms than females \((3\%)\). In Cameroon, Toxic agricultural chemicals were the means most often used by suicide completers, mostly by females (Gunnell & Eddleston, 2007). More females tend to use highly lethal methods, such as agricultural poisons; for examples, rural females in Beijing, Mainland China (Yip et al., 2000) and Western Samoa and Fiji (Booth, 1999). Poisoning with pesticides and poisoning with drugs was a major pattern, commonly among females in Canada, the Nordic countries and the United Kingdom (Weller, Kimball & Romney, 1990). According to the findings, hanging was found as higher among males with \((68.7\%)\) than females with \((41\%)\), firearm for males \((12.6\%)\) than females \((9.2\%)\). Females were higher in using poisoning with \((27.7\%)\) than male with \((6.6\%)\), females higher in pesticides \((12.6\%)\) than males \((3.6\%)\), drowning and falling were high in females \((0.8\) and \(0.8\%)\) respectively than males with \((0.0 \ & 0.2\%)\) (Ajdacic et al., 2008). According to the study conducted in our own country Ethiopia context, hanging and strangulation were the most commonly used methods of suicide \((70\%)\), particularly in urban Ethiopia for both males and females (Abdullahi & Bekry, 1999). This can be concluded that there was a gender difference in patterns/methods of suicide among the youth of Anywaa zone, Gambella regional state. There was no age difference found in patterns/methods of suicide among the youth in Anywaa zone, Gambella region.

Data in Table 4.6 showed that there was a very high prevalence of suicidal behavior and ideations among the youth of Anywaa zone who their ages ranged from 15-to-34 years. Kuo, Gallo and Tien (2001) and Moscicki (1997) stated that, Suicidal ideation and behaviors were more frequent in younger age groups than in later life. The researchers again reiterated that, individual with suicidal ideations and behaviors were likely to die soon by suicide. Regarding, if
they have seen someone with the Signs of planning a suicide such as obtaining a weapon or writing a suicide note, majority 58 (54.7%) of youth reported that they haven’t seen someone with “Signs of planning a suicide such as obtaining a weapon or writing a suicide note” and 48 (43.3%) of them reported that they have seen some people having “Signs of planning a suicide such as obtaining a weapon or writing a suicide note”. That show majority of youth in Anywaa zone were very aware of not being observed by others to have signs of planning such as obtaining a weapon or writing a suicide note. They used, to hidden their behaviors not to be recognized by others that they have a suicidal behaviors and ideations. According to the researchers, individuals with suicidal ideations and behaviors would often deny such ideas even when asked directly (Busch, Fawcett & Jacobs, 2003). This can be concluded that the youngest people in Anywaa zone were in high risk of suicide suicidal behaviors and ideations.

Prevalence of suicide in gender differences show that, youth females were more frequently affected by suicide than males. Prevalence of suicide was also assessed during focus group discussions. This item was addressed to the participants. According to the participants, majority reported that males have low cases of suicide attempt than females. As for suicide completion, females were also the leading. That show prevalence of suicide was higher in females than the males among youth of Anywaa zone. This study’s finding matched with one of the previous study and also differs with others. Take look to the prior studies. The study conducted in China revealed that the suicide rate/prevalence for women was 25% higher than that for men 18% (Phillips et al., 2002). Data on sex differences in the incidence of suicide are available for 13 countries. All these studies were reported that higher rates of suicide were in males with most reporting a male to female ratio of at least 3:1 (Johnson et al., 2008). So, the conclusion was that, there was a significant gender differences in suicide prevalence among the youth of Anywaa zone.

In the case of age differences, prevalence of suicide was found very high among the youth at the age groups ranged from 26 - 30 years old. The second age group with more frequent of suicide were age ranged from 19 - 25 years. According to the data in table 4. 7 above youth in the age groups ranged from 31 - 34 years old have moderate suicide prevalence. And it was observed that the suicide rates/prevalence among young people in age groups of 15 - 18 was lower than any age groups mentioned above. This show that there was age differences in prevalence of
suicide among Anywaa zone youth. Kuo et al., (2001), found a progressive decrease in the annual incidences suicide with increasing age. Researchers Duberstein et al., (1999) explained that people are less likely to report suicide and suicidal ideation as the age increased. In addition to that, Beutrais (2001); Gould and Kramer (2001), Cantor and Neulinger (2000), Pfeffer (1997), and Diekstra et al., (1995) indicated that, Suicide among young people aged 16 and under is relatively rare. That how this study finding wider it inconsistence with many pervious findings. As the studies revealed, age-specific rates were available from WHO (2004) for five countries that stated, lowest rates were generally found in those under the age of 25 with few suicides reported in children under 15 years (≤0.5 per 100,000). Suicide rates in the Seychelles increased with age until 55 years, after which there were no reported suicides. In Mauritius and Zimbabwe, rates were highest amongst older adults (aged 55+). Rates in South Africa were highest in those 15–54 and those over 75. In the United Republic of Tanzania rates were highest amongst those aged 45–59 years (5.7 per 100,000) followed by those aged 30–44 years (4.0 per 100,000) (Mgaya, Outwater & Kinabo, 2008). From the above one may conclude that there were age differences in prevalence of suicide among the youth in Anywaa zone.
Summary of Suicide Prevalence by Sex and Age, Abobo and Gog, 2010-2016

Figure 5.1: Number of suicides by Sex, Abobo and Gog, 2010-2016

The fig. 5.1 above shows that, 188 youth females and 159 males were died of suicide during six years and quarter with the total number of 347 youth. This implies that, there was a sex difference in prevalence of suicide among the youth.
Figure 5.2: Age-specific rate of suicide, Abobo and Gog, 2010-2016

Age Groups

According to the age groups in the Chart above, individuals in 26-to-30 years were identified as the groups with highest prevalence of suicide compared to other age groups, followed by the youth in 19- to 25 years. As it indicates, 168 youth of age groups ranged from 26-to-30 years were died of suicide since 2010 until, April 2016. Prevalence of suicide among people in age ranged from 31- to 34 years was moderate, since their figure is 53 as the chart shows. This study found that prevalence was very low in the youth of ages from 15- to 18 years old. According to this study, prevalence of suicide was decreased among the young people at the age below 18 and above 30 years.
Figure 5.3: Pictures of succeeded suicide gathered during documents analysis in Abobo and Gog woreda/districts.

Fig 5.3: picture of suicide victims from police documents

These pictures in above were collected during documents review from the two police stations which can indicates both prevalence and most commonly used patterns of suicide among the youth in Anywaa zone. In another way, these were collected to be evidences and indication that suicide incidence was really very high and existed in the area. As part of analysis, these pictures/images would help the readers to witness the method how youth were died by suicide in the zone. Based on the pictures above, researcher concluded that there was high prevalence of suicide among the youth and the most common pattern used by youth to kill themselves was hanging. That means, hanging was found as number one mean of suicide among the youth in Anywaa zone, Gambella region.
5. 1. The relationship between suicide and Educational Level, Marital Status and Family Background of Youth in Anywaa Zone.

The table 5. 1 below is presenting the biography of both suicide attempters and the suicide victims by level of education, marital status and family backgrounds.

**Table 5. 1: Characteristics of Suicide Attempters and Victims by Level of Education, Marital Status and Family Background**

<table>
<thead>
<tr>
<th>Attempters</th>
<th>Grade Level</th>
<th>Marital status</th>
<th>Family background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interviewee/attempter</td>
<td>Grade 8th</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>2nd interviewee/attempter</td>
<td>Grade 10th</td>
<td>Married</td>
<td>Police man</td>
</tr>
<tr>
<td>3rd interviewee/attempter</td>
<td>Grade 8th</td>
<td>Married</td>
<td>Farmers &amp; Uneducated</td>
</tr>
<tr>
<td>4th interviewee/attempter</td>
<td>Grade 9th</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>5th interviewee/attempter</td>
<td>Grade 7th</td>
<td>Single</td>
<td>Farmer &amp; uneducated</td>
</tr>
<tr>
<td>6th interviewee/attempter</td>
<td>Certificate</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Victims</th>
<th>Grade Level</th>
<th>Marital status</th>
<th>Family background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interviewee</td>
<td>Diploma (10+3)</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>2nd interviewee</td>
<td>Grade 6th</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>3rd interviewee</td>
<td>Grade 9th</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>4th interviewee</td>
<td>Grade 10th</td>
<td>Single</td>
<td>Farmers &amp; uneducated</td>
</tr>
<tr>
<td>5th interviewee</td>
<td>Grade 7th</td>
<td>Married</td>
<td>Farmers &amp; uneducated</td>
</tr>
</tbody>
</table>

As the data in table 5.1 shows above, regarding grade levels, majority of the suicide attempters and victims were found at primary six-to-grade 10th, except two individual one with certificate of 10+1 and another one with diploma (10+3). In other words, majority of suicide attempters and victims ended their education in grade six to 10th. That means, there was a negative relationship between low level of education and suicide. Based on the Youth Risk Behavior Surveillance Survey (YRBSS), reported that suicide attempt and completion had appeared higher in lower levels of education and to decreased from grade 9 (10.1%) to 12 (6.1%) (Suicide Prevention Resource Center, 2004). This lead to the conclusion that people with low level of education were
very much exposed to suicide than those with high level of education, such as diploma, bachelor degree, master degree, PhD, and so forth.

Regarding marital status, majority of the suicide attempters and victims were married. Only one attempter and suicide victim who were not married among them. This implies that, people who have been married were frequently committed and attempted suicide unlike the single, divorced and widower individuals in Anywaa zone, Gambella region. Conclusion was that, there was a negative relationship between suicide and marital status, particularly married. The finding of this study become inconsistence with the findings of the previous studies which claimed that, for both men and women, married people were the least likely group to commit suicide. Single (never married) people were the most likely, at a higher rate of suicide, followed by widowed and divorced. According to researcher, single men were much more likely to die from suicide than those who were married. Among women, widows had highest rates of suicide. The researcher again stressed that, the social support and companionship provided by marriage may be important conditions that help decrease the probability of suicide (Kposowa, 2000).

Concerning family background, table 5.1 above indicated that, only one suicide attempter who her father was a police man and completed grade seven (7th). According to the data in table, all suicide victims and majority of attempters’ family background were farmers and uneducated. This shows that, youth who their family background were farmers and uneducated have high probability to exposed to suicide incidences than others. This can be concluded that there was a negative strong relationship between suicide and family background among the youth of Anywaa zone, since the majority parents were farmers and uneducated people. Due to this suicide become frequently among the youngest in the area.
CHAPTER SIX

6. SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter concerned with the summary, conclusion and recommendations of the study. This part of the study is divided into subparts such as, first subpart is the summary of the major findings, the second subpart of the chapter is the conclusion made by the student researcher and the third subpart is about the recommendations made by the researcher.

6.1. Summary

The main purpose of this research was to examine the risk factors, patterns and prevalence of suicide among youth in Anywaa of Gambella regional state. The risk factors and prevalence were measured by using questionnaires and informant interview, focus group discussions and documents analysis. Patterns of completed suicide and/or attempted were measured through interview, focus group discussions and documents analysis. Risk factors were ranked as the most common to the least most common factor according to the labeling given to each risk factor by the respondents. The research was guided by the following basic research questions:

1. What are the risk factors causing suicide among youth in Anywaa zone?

2. What is the pattern or method used by youth to commit suicide?

3. What is the prevalence of suicide among the youth in Anywaa zone?

4. Are there ages and gender difference in the risk factors, patterns and prevalence rate of suicide among the youth in Anywaa zone?

5. What is the relationship between suicide and grade level, marital status and family background of youth in zone?

The data of this study were collected through quantitative and qualitative approaches. Surveys were used to collect some of basic risk factors and prevalence of suicidal behaviors and ideations among the youth in Anywaa zone from youth students in two preparatory schools (Abobo and Gog) with sample size of 106 youth students. Interview with six (6) suicide attempters and five (5) families/relatives of suicide victims was conducted as a part of collected qualitative data
through snowball technique to obtain more additional risk factors and patterns/methods of suicide that the victims and attempters were carried on. Two focus group discussions were carried out in two separate times with the groups of 19 youth as again to understand and gathered exactly the most common risk factors that would specifically affecting females and males and also to identify the major patterns/methods of suicide among youth. Lastly but not the least, documents review from two police stations was attended so that the recorded information were analyzed as for both quantitative and qualitative data. The documents review was mainly concerned for the number of people who were died of suicide from 2010 to 2016, years of committed suicide, sex and age of the victims and the pictures of the victims. 347 individuals were discovered died of suicide in the year from 2010 to 2016 April. The analysis was done using descriptive statistics, through Statistical Package for the Social Science (SPSS) Software version 20. And then, the frequency distribution of each variable was calculated as well as the percentages.

**Major Findings**

Based on the data analyzed the following major findings were drawn:

1. The results of demographic data showed that the majority of the respondents (n=68, 64.2%) were males and (n= 38, 35.8%) were females. The results on respondents’ ages, data showed that many (n=59, 55.7%) were found in the age groups ranged from 18 - 20 years old, followed by the participants (n=33, 31.1%) in the ages ranged from 21 - 25 years old. Regarding the marital status, majority (n=64, 60.4%) of participants were single. The results on level of education shows that, majority (n=69, 65.1%) of youth were grade12th students. That means majority of the participants were of grade 12 students.

2. The results of demographic characteristics of the suicide attempters and suicide’s victims, indicated that from six suicide attempters and five suicide victims, seven (7) of them were females and four were males. That show youth females were more likely to committed and attempted suicide than males. Results on the age showed that, all the six suicide attempters and five completed suicide victims were found in the ages ranged from 20 - 30 years old. Data showed that there was no any completed suicide victim and
attempter found in the age below 20 and above 30 years old. That can be concluded that youth in age groups ranged from 20 - 30 were more vulnerable individuals of completed suicide and attempts. Results on marital status of attempters and victims show that the majority of suicide attempters and victims were married. Among the six attempters and five completed suicide victims, only two of them found been single/unmarried and the remaining nine (9) were all married. That can be concluded that married had great negative impact on people and had strong relationship with completed suicide/attempt. Regarding educational levels, nine (9) out of eleven (9 of 11) attempters and completed suicide victims were in grade 6 - 10th, except two who were found with certificate holder (10+1) and diploma holder (10+3). This implies that, people who ended their educations in grade 10th and below would be likely to be affected by suicide case and suicide attempt than people with better levels of education. Results on family background show that majority of both parents were farmers and uneducated people. This indicated that completed suicide and attempt were higher among the youth who their parents had no level of education and farmers.

3. The results on frequency distribution on each variable and the percentages showed that the basic risk factors labeled in rank one with more frequency as the first most common risk factors were those of chronic illness or long suffering with disease/HIV/Aids and other related diseases 64(60.4%), Poor relationship among family members/relationship problem 57(53.8%), unplanned married/early married/divorce 47(44.3%) and Unwanted pregnancy/unplanned pregnancy 47(44.3%), alcohol abuse and/or drugs abuse 43(40.5%), Physical/mental illness 35(33.1) and Preventing youngest from his/her lover or prevented one’s choice 32(30.2%). The Depression or remembering the past bad events, like death of beloved one 42(39.6%), Lower socioeconomic status including income/not affords to buy new fashion 30(28.3%) and Lack of problem-solving skills 29(27.4%) were identified as the second most common risk factors of suicide among the youth of Anywaa zone, Gambella region. The third most common risk factors were that of unemployment/being jobless 31 (29.2%) and low self-esteem, felt so sad or hopeless 31(29.2%), respectively. Regarding Failing to fulfill an expectation and hopeless was ranked as the fourth and fifth common risk factors of suicide with 30 (28.3%) and 30(28.3%), respectively. The results on Family history of suicide 34(32.1%) and
academic failure/lack of pass mark 38(35.6%) showed that, these factors were found as the fifth most common risk factors of suicide among the youth. That show chronic illness or long suffering with disease/HIV/Aids and other related diseases, poor relationship among family members/relationship problem, unplanned married/early married/divorce and Unwanted pregnancy/unplanned pregnant, alcohol abuse and/or drugs abuse were confirmed as the first most common risk factors when compared to others. Lack of awareness from the whole community was identified as a great risk factor for suicide. Prevalence of suicidal behaviors and ideation was also considered as the potential risk factor of suicide among the youth in Anywaa zone, Gmbella region.

4. The results on patterns of suicide attempt and completed suicide revealed that hanging and drugs overdose or poisoning were the most commonly used patterns by the youth in Anywaa zone. This show that the increased use of hanging and drugs overdose or poisoning as a suicide methods in Anywaa zone of Gambella region were related to an increase in the overall suicide rate.

5. The suicidal behaviors and ideations were high among the youngest people in Anywaa zone, which also considered to be a risk factor of suicide among the youth.

6. The findings on prevalence of suicide indicated that 347 individuals were found committed suicide from 2010 to 2016 April. Data showed that from 347 victims 188 were females and 164 males. The number of people died of suicide in Abobo woreda/district were 178(51.3) and victims of Gog woreda/district were 169(48.7). Prevalence of suicide was higher among youth in Abobo than Gog woreda. The year 2015 was found as the year with highest suicide prevalence followed by the year 2014. And prevalence was increased from year to year forwards. Based on this 347 figure, one can be concluded that there was very high prevalence of suicide among the youth of Anywaa zone of Gambella regional atate.

7. The findings for age and gender differences in risk factors, patterns and prevalence/rate of suicide, showed that, there were some risk factors common to the youth females only and some for males alone. The most common risk factors for youth females: Conflict in relationship (boyfriend), getting a child with no real father, death of partner, divorce,
misunderstanding among family members (husband, parents, brothers & sisters), preventing young from boyfriend, feelings of negligent, and lack of income which she cannot afford to buy what she like, such as fashion”. The most common risk factors for youth males: “Unplanned marriages or married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases”. That can be concluded, there was a significance gender differences in risk factors of suicide among the youth of Anywaa zone. As the data showed, there was no age difference found in risk factors of suicide among the youth.

According to the patterns of suicide attempt and completed suicide revealed that hanging was the most commonly used pattern by both males and females. And drugs overdose or poisoning was found only among the females. This implies that gender difference was only found in the use of drugs overdose or poisoning. Results reported that, there was no age difference identified in patterns of suicide.

As the findings showed, high prevalence of suicide in the case of age differences was found very high among the youth at the age groups ranged from 26 - 30 years old. The second age group with more frequent of suicide were age ranged from 19 - 25 years. Youth in the age groups ranged from 31 - 34 years old have moderate suicide prevalence. And it was observed that the suicide rates/prevalence among young people in age groups of 15 - 18 was lower than any age groups mentioned above. This show that there was age differences in prevalence of suicide among Anywaa zone youth. Regarding gender difference in prevalence of suicide among the youth, it was found that, prevalence was higher among the females than males. That showed, there were sex differences in prevalence of suicide among the youth of Anywaa zone.

8. The results on relationship between suicide and grade level, marital status and family background of youth indicated that, majority of the suicide attempters and victims were found at primary six-to-grade 10th, except two individuals, one with certificate of 10+1 and another one with diploma (10+3). In other words, majority of suicide attempters and victims ended their education in grade six to 10th. That means, there was a negative relationship between low level of education and suicide. Regarding marital status, majority of the suicide attempters and victims were married. Only one attempter and
suicide victim who were not married. This implies that, people who have been married were frequently committed and attempted suicide unlike the single, divorced and widower individuals in Anywaa zone. Conclusion was that, there was a negative relationship between suicide and marital status, particularly married. This study found that, all suicide victims and majority of attempters’ family background were farmers and uneducated. This shows that, youth who their family background were farmers and uneducated have high probability to exposed to suicide incidences than others. This can be concluded that there was a negative strong relationship between suicide and family background among the youth of Anywaa zone, since the majority of the parents were farmers and uneducated people.

6.2. Conclusions

Based on the major findings in the above this study drawn the following conclusions below:

From nowadays deadly events, suicide is accounted as one of the leading causes of death among young people (Centers for Disease Control and Prevention, 2011). Many findings from different researchers suggest that suicide is an important public health issue in worldwide and African countries as well, with reported figures highly likely to underestimate the true incidence (WHO, 2008). With the contribution of various factors in each year youth/young people are seriously contemplated suicide, made a plan to commit suicide, attempted suicide, and others received medical care for an injury sustained during a suicide attempt ((Jacobs, Baldessarini, Conwell, & Horton, 2003). So these troubling indications point to a serious problem for youth of today. In conclusion, the study found that the availability risk factors including environmental risk factors (Preventing youngest from his/her lover or prevented one’s choice, Poor relationship among family members/relationship problem and unplanned married/early married/divorce), biological risk factors (Family history of suicide, Chronic illness or long suffering with disease/HIV/Aids and other related diseases, Physical/mental illness and death of partner), Psychological risk factors (Depression or remembering the past bad events, like death of beloved one, Lack of problem-solving skills and Failing to fulfill an expectation and hopeless), Socio-economic risk factors (Unemployment/being jobless and Lower socioeconomic status including income/not affords to buy new fashion), and Individual risk factors (Low self-esteem, felt so sad or hopeless, Unwanted pregnancy/unplanned pregnancy, Alcohol abuse and /or drugs abuse and Academic
failure/lack of pass mark) are high among the groups of youth. These risk factors are further indicated to predict suicide completion and suicide attempt. However, those of chronic illness or long suffering with disease/HIV/Aids and other related diseases, Poor relationship among family members/relationship problem, unplanned married/early married/divorce and Unwanted pregnancy/unplanned pregnancy, alcohol abuse and/or drugs abuse, Physical/mental illness and Preventing youngest from his/her lover or prevented one’s choice were identified as the first most common and frequently used risk factors of suicide among the youth of Anywaa zone. From the findings it was concluded that the youth in Anywaa zone were most commonly and frequently affected by these risk factors mentioned above. The findings concluded again that youth females were frequently died of suicide and attempted suicide due to unhealthy relationships or “conflict in relationship, getting a child with no real father, death of partner, divorce, misunderstanding among family members (husband, parents, brothers & sisters), preventing young from boyfriend, feelings of negligent, and lack of income which she cannot afford to buy what she like, such as fashion”. Whereas youth males were committed and attempted suicide as a results of “Unplanned marriages or married many wives, substance abuse (alcohol, marijuana, chat, etc.), chronic illness/HIV/Aids and other related diseases”. These multiple factors perhaps were interactional in nature that may render youth vulnerable to suicide action and suicidal behaviors.

The present findings concluded that the increased use of hanging and drugs overdose or poisoning as a methods of suicide among the youth in Anywaa zone of Gambella region were related to an increase in the overall of risk factors and suicide rate. Limiting access to lethal methods of suicide (e.g. hanging and drugs overdose or poisoning) is an effective strategy for reducing suicide by these particular methods.

As the prevalence indicated, this study concluded that there was a high prevalence of suicide and suicidal behavior in a community, particularly among the youth in 15 - 34 years old. Suicide and suicidal behavior were shown to be common problems in Anywaa zone, Gambella region, and no attention was paid to it. Youth females were found as the most suicide vulnerable individuals than male. Concerning age difference in prevalence of suicide among the youth of Anywaa, it was concluded that, prevalence was highest in the age groups from 26 - 30 years and prevalence was found very low among the youth in age groups from 15 -18 years. As the finding indicated
the high prevalence of suicide among the youth no one feel wonder or surprise about these huge number of death. This is comes as a result of lack of awareness from the whole community.

Finally, this concluded that, the burden of completed suicide and suicidal behavior in Anywaa zone of Gambella regional state was underscored the need for suicide prevention as a regional priority.

**6.3. Recommendations**

Based on the conclusions the student researcher of this study comment the following recommendations

1. Identification of risk factors is critical to prevent suicide actions and suicidal behavior in all groups of the population within their diverse settings. So, more psycho-social and health practitioners need to be trained in Gambella region, particularly in Anywaa zone to be deals with helping the population.

2. Since multiple risk factors of suicide were frequently influenced the youth in Anywaa zone, the researcher recommend that governmental and non-governmental partners in the region working with and/or for youth affairs would better support the following initiatives by creating awareness to reduce risk factors; promote protective factors; focus on early detection of new trends in suicidal behavior; promote public awareness of suicidal behavior, its causes and possibilities for prevention; and increase support available to individuals, families and communities affected by suicide and suicidal behavior incidences.

3. The zonal government in collaboration with regional government would be better to take suicide prevention as a regional priority together with other deadly events. So that, such a strategy should be implemented in a coordinated and strategic manner within an interdisciplinary context, and any suicide prevention efforts need to take as serious.

4. Government, Non-Governmental Organizations (NGO’s) and Faith Based Organizations (FBO’s) have moral obligations to create a climate where-in human life is celebrated and valued at all times. So those organizations based in Gambella region, mainly those which are working in Anywaa zone woreda/districts need to address social attitudes by
promoting and increasing knowledge about the risk factors and methods of suicide and suicidal behavior to reduce numerous deaths of this incidence. Targeting specific groups are important, such as, children, young people, the elderly, parents, government officials and victims of violence.

5. Mental health programming need be to formed so that Public education initiatives that are responsive to the very most common risk factors that endanger the lives of young people and that enhance recognition and understanding of the indicators of suicidal behavior and ideations before the action would be carried on.

6. It would be important for healthcare providers and counselors to establish Programs that target and incorporate the prevention or moderation of alcohol use, reducing feelings of depression, hopelessness, perceived stress and that also useful for the early identification, treatment and stress management in youth.

7. Adolescent/youth programs need to specifically focus, so that peer-helping it would be carried out among them.

8. The findings showed that majority of youth females and males were committed and attempted suicide due to the unhealthy conflict in the relationships and unplanned marriage. So the traditional systems of social support need to be revisited and developing activities that are appropriate and responsive to the social and cultural needs of the groups or populations.

9. As the feedbacks from different people during conversations indicated that, always suicide deaths can be blamed on the victims. That mean the one who committed or attempted suicide from the context of Anywaa community are the mistaken and be blamed, though he/she died. So, in this case awareness creation need to be given to the community to understand that, suicide is resulted from different factors, which need help/support from the surrounding.

10. Future studies also need to study suicide cases in comparison with others deadly diseases and investigate the position of suicide death among the youth in Ethiopian context.
References


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Appendix
Appendix A: Questionnaires for Youth

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Questionnaires to be filled by youth

The questionnaires are designed to be administered to youth in order to obtain useful information related to the topic of study. The main purpose of the questionnaires is to investigate and gather the information on the risk factors of suicide that affects young people in Anywaa zone, particularly, in Abobo and Gog woreda/districts within selective kebele/villages and two preparatory schools. Therefore, you are kindly requested to concentrate in answering the questions. The information you give will be used to improve understanding the risk factors of suicide for young people. Please your participation on the given questions is the base of good outcomes of this study. So your experience and rich information is highly needed.

Note:

A. Do not write your name on the questionnaire.

B. Completing the survey is voluntary

C. The answers you give will be kept privately and used for research purpose only

D. No one will know what you write. Answer the questions based on what you really know.

E. If you are not comfortable by answering a question, just leave it blank

Thank you very much for your cooperation!

Part I: Personal Data/Demographic information

1. Sex: Male □ Female □

2. Age: --------------
3. **Marital Status:** married □ Single □ Divorced □

4. **Education Level:** Grade 11<sup>th</sup> □ Grade 12<sup>th</sup> □

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**Part II: Questions on suicide Risk Factors**

**Instruction:** You are expected to read carefully 15 items of risk factors according to their causes of suicide among the youth in Anywaa zone of Gambella region. The rankings are consisting of five levels which you can agree and labeled the risk factors you thought is the first most common risk factor of suicide. You are expected to indicate by writing 1 as the first most common risk factors, 2 as the second most common risk factor, ………………..and 5 as the fifth or least most common risk factor.

| The five rankings are 1= first most common; 2= second most common; 3= third most common; 4= fourth most common; and 5= fifth or least most common risk factor. |

---

**Which factor is most commonly and least commonly cause suicide among the youth in Gambella region?**

<table>
<thead>
<tr>
<th>s/n</th>
<th>Risk Factors</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Depression or remembering the past bad events, like death of beloved one</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lack of problem-solving skills</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Preventing youngest from his/her lover or prevented one’s choice</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unemployment/being jobless</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Low self-esteem, felt so sad or hopeless</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Poor relationship among family member/relationship problem</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Family history of suicide</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Unwanted pregnancy/unplanned pregnancy</td>
<td></td>
</tr>
</tbody>
</table>
Part III: Questions on suicidal behavior and ideation

The items in the table below are based on the suicidal behavior and ideation questions, which are designated in two dichotomies (Yes/No). You are expected to indicate your answer by writing tick (√), under Yes or No for each statement. If your answer is yes put tick (√) under yes and if your answer is No put tick (√) under No.

<table>
<thead>
<tr>
<th>No</th>
<th>Have you heard/seen someone said?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life isn’t worth living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>My family would be better off without me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Next time I'll take enough pills to do the job right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I won't be around to deal with that</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>You'll be sorry when I’m gone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I won't be in your way much longer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I just can't deal with everything-life's too hard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Nobody understands me--nobody feels the way I do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>There's nothing I can do to make it better</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I'd be better off dead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I feel like there is no way out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Signs of planning a suicide such as obtaining a weapon or writing a suicide note</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Interview Items for Suicide Attempters & Parents of Suicide Victims

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Interview guide for the families/relatives of suicide victims and Attempters/survivors.

The interview is design to be administered to families of suicide victims and survivors of suicide in order to obtain useful information related to the topic of study. The main purpose of the interview is to investigate and gather the information on the risk factors, patterns and prevalence of suicide that affects young people in Anywaa zone, particularly, in Abobo and Gog woreda/districts within selective kebele/villages and two preparatory schools. Therefore, participants are kindly requested to give their times. The information you give will be used to improve understanding the risk factors, patterns and prevalence of suicide. Please your participation on the given questions is the base of good outcomes of this study. So, please your experience and rich information is highly needed.

Part I: Personal data

5. **Sex:** Male □ Female □

6. **Age:** -----------------------

7. **Marital Status:** married □ Single □ Divorced □

8. **Educational level:** Grade 1-4<sup>th</sup> □ grade 5-8<sup>th</sup> □ grade 9-10<sup>th</sup> □ grade 11-12<sup>th</sup> □ diploma-degree □ master degree-PhD □

9. **Family background:** -------------------------------
II: Interview for the survivors of suicide

1. During the past months, have you ever made an attempt to take your own life? Or did you thought of suicide?

2. Yes □ No □

3. When did you do it? (time)

4. What was the cause you tried to kill yourself?

5. In what way have you tried to kill yourself? Did you have access to any lethal means? Yes/no?

6. What is that mean?

III: Interview for the families of suicide victims

1. Have you a son, daughter or relative who have committed or attempted suicide some years, months or days ago? Yes □ No □

2. Was a male or female?

3. When did it happened (time)?

4. Why he/she committed/attempted suicide? The cause?

5. How did he/she do it? The method?

6. Did you ever understood or distinguished the signs of killing before he/she did that?
Appendix C: Questions for FGD with Youth

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Focus Group Discussion Guide

The focus group discussion guide is designed to be administered to youth in order to obtain useful information related to the topic of study. The main purpose of FGD is to discuss and gather the information on the risk factors, patterns and prevalence of suicide that affects young people in Anywaa zone, particularly, in Abobo and Gog woreda/districts within selective kebele/villages. Therefore, participants are kindly requested to give their times. The information you give will be used to improve understanding the risk factors, patterns and prevalence of suicide. Please your participation on the given questions is the base of good outcomes of this study. So, please your experience and rich information is highly needed.

Focus Group Discussion with youth

1. Any of your friends tried to kill her/him?

2. How often have you seen a person died of suicide? (Prevalence of suicide attempt)

3. Who do you think are most vulnerable of suicide between male and female?

4. What do you think was the causes of suicide? (Factors)

5. How did the victims have made it? (Methods/patterns)

6. Do you think suicide has something to do with age difference, grade level and family background?
Appendix D: Items for document Analysis in polices

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Document Analysis checklist

The document analysis checklist was prepared to review the documents available in the office of police crime investigator and of two woreda/districts in order to obtain useful information related to the topic of study. The main purpose of document analysis is to analysis the recorded information on the risk factors, patterns and prevalence of suicide that affects young people in Anywaa zone, particularly, in Abobo and Gog woreda/districts.

Document Analysis from police crime investigation offices and Health Centers

1. Recorded number of people who completed suicide and attempters
2. The years of suicide
3. Sex and age of the victims
4. The reasons/why suicide/causes
5. How did they made/ ways they committed suicide
6. The rate in each year
7. Pictures of both succeeded suicide and attempters