Training manual for surveillance of suicide and self-harm in communities via key informants

World Health Organization

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Foreword

Suicide is a global public health concern with far-reaching impacts on individuals, families, friends and communities. It is estimated that more than 700 000 people die by suicide globally each year, and for every suicide many more people deliberately harm themselves.

Critical to the prevention of suicide and self-harm are high-quality, comprehensive surveillance data. Surveillance data help to highlight the scale of the issue and provide valuable information - for instance on age, sex and methods of suicide and self-harm. This information is crucial in supporting decision-making for timely and effective evidence-based interventions. WHO's *LIVE LIFE implementation guide for suicide prevention in countries* and the WHO report *Preventing suicide: a global imperative* identify the improvement of data on suicide and self-harm as a key foundational pillar for suicide prevention.

To support the improvement of surveillance data, WHO has developed *Preventing suicide: a resource for suicide case registration* and a *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* in health-care settings. Although these are important resources for strengthening administrative data, large numbers of the people who self-harm or die by suicide remain hidden and unknown to official health and police services, yet they may be known to their communities. Furthermore, in some remote and hard-to-reach communities, particularly in low- and middle-income countries, official administrative records may be weak or absent. While strengthening the administrative systems should remain the key priority, there are opportunities to identify suicide and self-harm occurring within communities via key informants.

This training manual builds on the previous work on suicide case registration and surveillance of self-harm in health-care settings and is intended to be used in conjunction with these resources. An overview of surveillance of suicide and self-harm in communities via key informants is provided in the manual. The material outlined is primarily designed for training surveillance fieldworkers (e.g. health workers) who will collect data on suicide and self-harm from the community via key informants and official administrative records. The training is designed to equip fieldworkers with the skills to conduct interviews and accurately complete case registration forms. Additional instruction on quality assurance and data management is provided for supervisors.

Users of the manual are encouraged to adapt the training material to suit the cultural context and to match the resources available in their specific context. Importantly, capturing suicide and self-harm using both administrative and community sources can help to quantify comprehensively the size of the issue, identify vulnerable populations at risk and pinpoint emerging trends. This data will help inform the implementation of timely interventions that are appropriate in each context and thus contribute to an effective evidence-based suicide prevention strategy.

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Acknowledgements

01 Introduction

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Importance of surveillance

More than 700 000 people die by suicide every year. Suicide affects all age groups and is the fourth leading cause of death among individuals aged 15–29 years. Globally, according to the World Health Organization (WHO), 1.3% of all deaths in 2019 were suicides and 77% of these occurred in low- and middle-income countries (LMICs) (WHO, 2020a).

A core foundation of suicide prevention is the timely registration and regular monitoring of suicide and self-harm (WHO, 2014). Public health surveillance systems provide essential information on the numbers, rates and characteristics of health conditions. Timely surveillance data helps to identify populations at risk and can be used to assess the impact of clinical interventions and policy changes (WHO, 2021d). Furthermore, surveillance data can be used to show important progress towards reaching global targets, such as reducing the suicide rate by one third by 2030 as articulated in the United Nations Sustainable Development Goals (SDGs) and in the WHO Mental Health Action Plan (WHO, 2017, 2021a). However, there are considerable discrepancies in the quality of data on suicide and self-harm globally, with much of the high-quality evidence skewed towards high-income countries. The various methods of identifying cases of suicide and self-harm are described in further detail below.

Surveillance of suicide

A well-functioning system of civil registration and vital statistics (CRVS) is essential for monitoring mortality and causes of death (including suicide). When amalgamated with population statistics, CRVS systems provide crucial public health information needed to understand emerging health issues and the burden of health conditions (WHO, 2021d). CRVS systems rely on medical certification of cause of death, preferably using International Classification of Diseases (ICD) codes (WHO, 2021d). The quality of CRVS systems varies globally. Of the 183 WHO Member States for which estimates for suicide were made for the year 2019, 87 had vital registration data of good quality.[1] The 50 high-income countries with good vital registration data account for 98% of all estimated suicides in high-income countries, but the 37 LMICs with good vital registration data account for only 22% of all estimated suicides in LMICs (WHO, 2022a). Due to the lack of data, suicide rate estimates need to be modelled for the majority of remaining countries (mostly LMICs) which account for 61% of global suicides, and the extrapolation of subnational reports may not be accurate or reflect the national scenario (Vijayakumar & Phillips, 2016; WHO, 2020b). Even in countries which have CRVS systems, it is often difficult to separate suicide data from accidental deaths or homicides and the data may have insufficient details to be useful (WHO, 2011). WHO has formally recognized the need to strengthen CRVS systems globally, as articulated in the *WHO civil registration and vital statistics strategic implementation plan 2021-2025* (WHO, 2021d). Guidelines have also been developed by WHO and UNICEF to assist governments on how the health sector can best contribute to improving registration of vital events (WHO, 2021b).

In the absence of a well-functioning CRVS system and where medical certification is not possible, verbal autopsy may also be used to identify causes of death. Verbal autopsy involves retrospectively interviewing the primary caregiver (e.g. family member) using a structured questionnaire to ascertain the cause of death

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[1]"Good quality" refers to countries with a quality rating of 1 or 2 according to WHO's classification, as follows:

1 = multiple years of national death registration data with high completeness and quality of cause-of-death assignment are available;
2 = multiple years of moderate-quality death registration data are available. Data have low completeness and/or issues with cause-of-death assignment which possibly affect estimated deaths by cause and time trends.

(WHO, 2022c). WHO has developed a verbal autopsy instrument for routine use to assist standardization of data collection (WHO, 2022c). However, as with CRVS systems, stigma around suicide and the criminalization of suicidal behaviour in some countries may deter reporting and registration of cases.

Surveillance systems for self-harm presenting at hospitals

These challenges are further exacerbated for surveillance of suicide attempts and self-harm.[2] It is estimated that for every person who has died by suicide, there were as many as 20 others who self-harmed (WHO, 2014). Most people who self-harm do not go on to end their lives; however, previous self-harm is an important risk factor for suicide, at least in high-income countries (WHO, 2014). Consequently, timely monitoring of self-harm provides crucial information for identifying emerging trends and populations at risk that warrant attention and intervention. Identifying self-harm presentations at health facilities (usually hospitals) is a crucial method for understanding self-harm rates at population level (WHO, 2016). To this end, WHO released a *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* (particularly in health-care settings), which includes a training section and case vignettes (WHO, 2016).

Examples of dedicated surveillance systems for hospital-presenting self-harm are largely based in high-income countries (WHO, 2016). A National Self-Harm Registry has been operating in Ireland since 2002 (Griffin et al., 2018). A multi-centre study has also been established across England (Oxford, Manchester and Derby) where data are collected on self-harm presenting to five hospital emergency departments (Bergen, Hawton, Waters, Cooper & Kapur, 2010). Other examples of hospital presenting self-harm registers include Christchurch, New Zealand (Beautrais, Joyce & Mulder, 1994), Newcastle, Australia (limited to self-poisoning) and Victoria, Australia (Hiles et al., 2015; Robinson et al., 2020). Hospital-presenting self-harm registries are also emerging from LMICs, including in Kandy, Sri Lanka (Knipe et al., 2021), Karachi, Pakistan (WHO, 2021c), southern India (Krishna et al., 2021) and Jamaica (Ward et al., 2010). Further work is needed to scale up self-harm surveillance systems to the national level in countries across the world (Witt & Robinson, 2019; WHO, 2016). The WHO practice manual serves as a guide for supporting the establishment and maintenance of surveillance systems for hospital-presenting self-harm and suicide. This should continue to be a priority where existing systems are weak or absent.

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[2] Note: A "suicide attempt" is typically characterized as an act of self-injury or self-poisoning with the intent to die, whereas "self-harm" typically encompasses any act of self-injury or self-poisoning with or without suicidal intent. Suicidal intent can be difficult to ascertain, particularly in hospital emergency settings. For reasons of simplicity of language, the more inclusive term "self-harm" is used in this document.

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Community surveillance of self-harm via household surveys

While hospital registration systems are essential tools for surveillance, some episodes of self-harm are not captured in hospital data for various reasons. For instance, people may not seek medical attention for self-harm due to stigma, criminalization of suicidal behaviour, limited access to health facilities, and the use of methods of self-harm that do not require hospital presentation or intensive medical management or hospitalization. The extent to which these episodes of self-harm become known and/or are reported is often compared to an iceberg (Figure 1). What is visible above the surface of the water, represents only a small proportion of the people who self-harm or die by suicide. These are the people who present to health-care facilities or are identified by local police or medico-legal services. As such, a large proportion of people who self-harm or die by suicide remain hidden and unknown to health services although they may be known to their communities.

Self-reports of self-harm via household surveys of representative samples of the population are typically used to identify the prevalence of self-harm occurring in the population or in a community (Gillies et al., 2018; Knipe et al., 2018; WHO, 2016, 2022b). However, such measures are often resource- and time-intensive and are limited by the reference period of measurement (which could be only once or periodically every 5 or 10 years). Furthermore, in resource-limited settings it may not be feasible to conduct such large-scale surveys regularly.

Figure 1. Focus of community surveillance system

The extent of suicidal behaviour, fatal and non-fatal*

Focus of community surveillance system

Suicide
—
and
—
Self-harm captured by health, police and administrative authorities

Suicide and self-harm occurring in communities
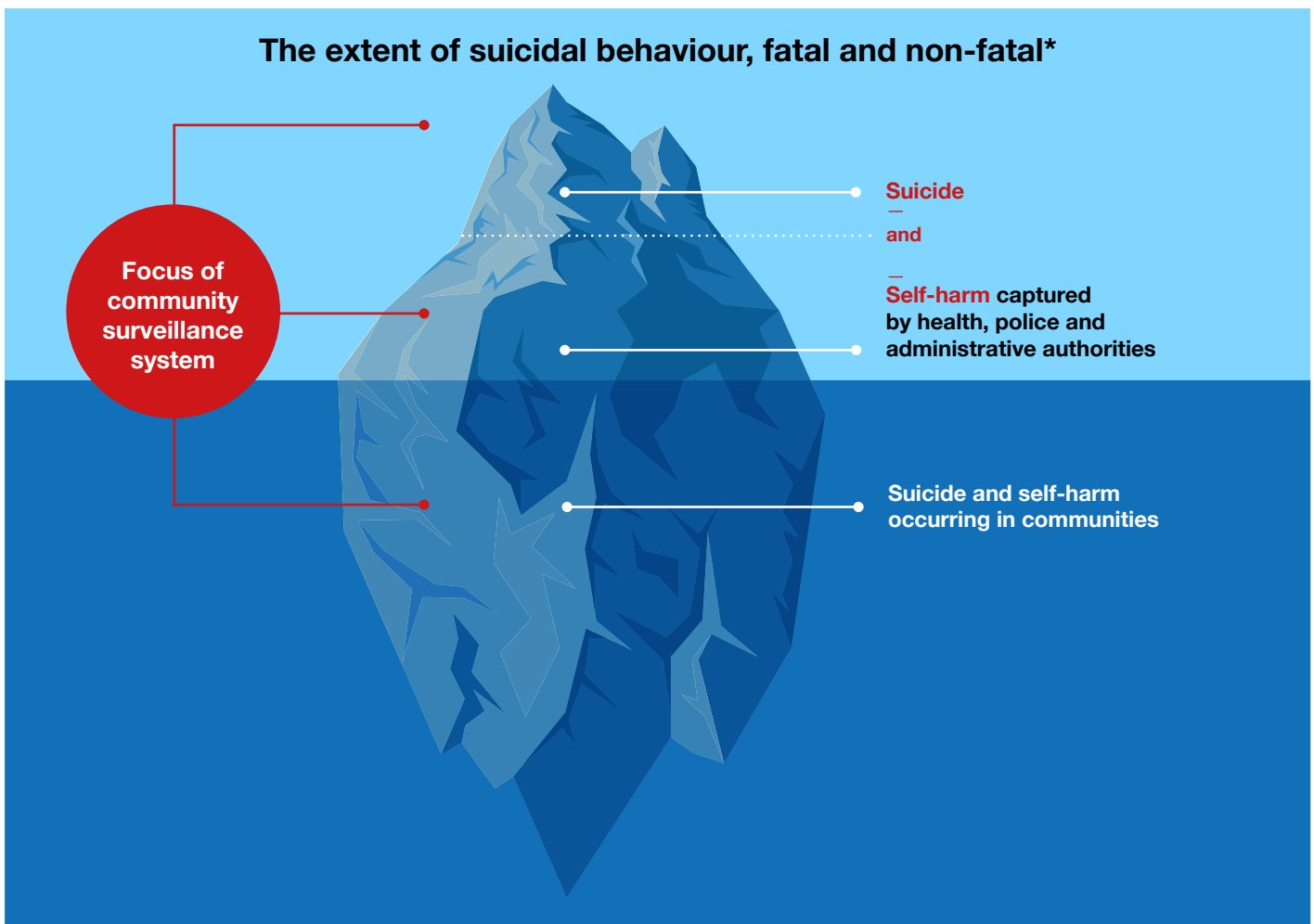
* Proportions illustrated in this diagram stem from international research findings; however, these proportions may vary between countries and regions. Adapted from *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm.* Geneva: World Health Organization; 2016.

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Community surveillance of suicide and self-harm via key informants

In response to these challenges, community surveillance systems have been proposed to capture and monitor suicide and self-harm, supplementing administrative records (Vijayakumar et al., 2020). These community systems typically rely on third-party community informants to report suicide deaths and episodes of self-harm that have occurred within the community (Cwik et al., 2014; Vijayakumar et al., 2020). This information is then corroborated with existing administrative records (e.g. hospital and police/forensic registration systems) to identify comprehensively the total number of suicides and cases of self-harm occurring within a given community (Cwik et al., 2014; Vijayakumar et al., 2020).

When to use a community surveillance system

Community surveillance systems are applicable for implementation in the following scenarios:

- when there is no suicide or self-harm registration at all (they can be a starting point for reflecting community engagement in suicide prevention);
- in isolated or hard-to-reach communities, in a specific geographical area or in a population deemed to be at high risk;
- where local hospital and police records exist but may be of poor quality (community-identified cases can be used in cross-validation to identify discordance in case ascertainment, thus serving as an opportunity to strengthen overall surveillance of suicide and self-harm both in the community and at national level);
- as an evaluation tool to assess the impact of local suicide prevention interventions in a community;
- as an intervention model to capture persons who have self-harmed but are not in contact with the health system and thus provide a crucial opportunity to intervene.

Due attention and diligence need to be given to adapting the approach to the cultural context and to settings where suicidal behaviours are criminalized.

Two community surveillance systems have been identified to date – one in Gujarat, India, (Vijayakumar et al., 2020) and one in Arizona, USA (Cwik et al., 2014). The community surveillance system trialled in Gujarat was initially developed to capture suicide and self-harm cases comprehensively and to evaluate the impact of interventions for suicide prevention implemented in communities (Vijayakumar et al., 2020). Alternatively, the community surveillance system led by the White Mountain Apache Tribe in Arizona was initially developed in response to a rise in youth suicides in the community and functions to identify all suicide deaths, self-harm and ideation in the community and to facilitate follow-up support (Cwik et al., 2014). Depending on the purpose (e.g. research-driven or intervention-driven) and/or size of the community, these two models can serve as examples and starting points for building a community surveillance system. Importantly, any community surveillance system that is adopted should be modified as necessary to suit the needs of the various communities to which it is applied.

This training manual is primarily based on a modified version of the community surveillance system trialled in Gujarat. An overview of the community surveillance system is described below. Further information on the White Mountain Apache model can be found in Annex 1.

The organizational chart of the proposed community surveillance system is shown in Figure 2.

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Figure 2. Organigram for the model of a community surveillance system (can be adapted depending on local context and resources)
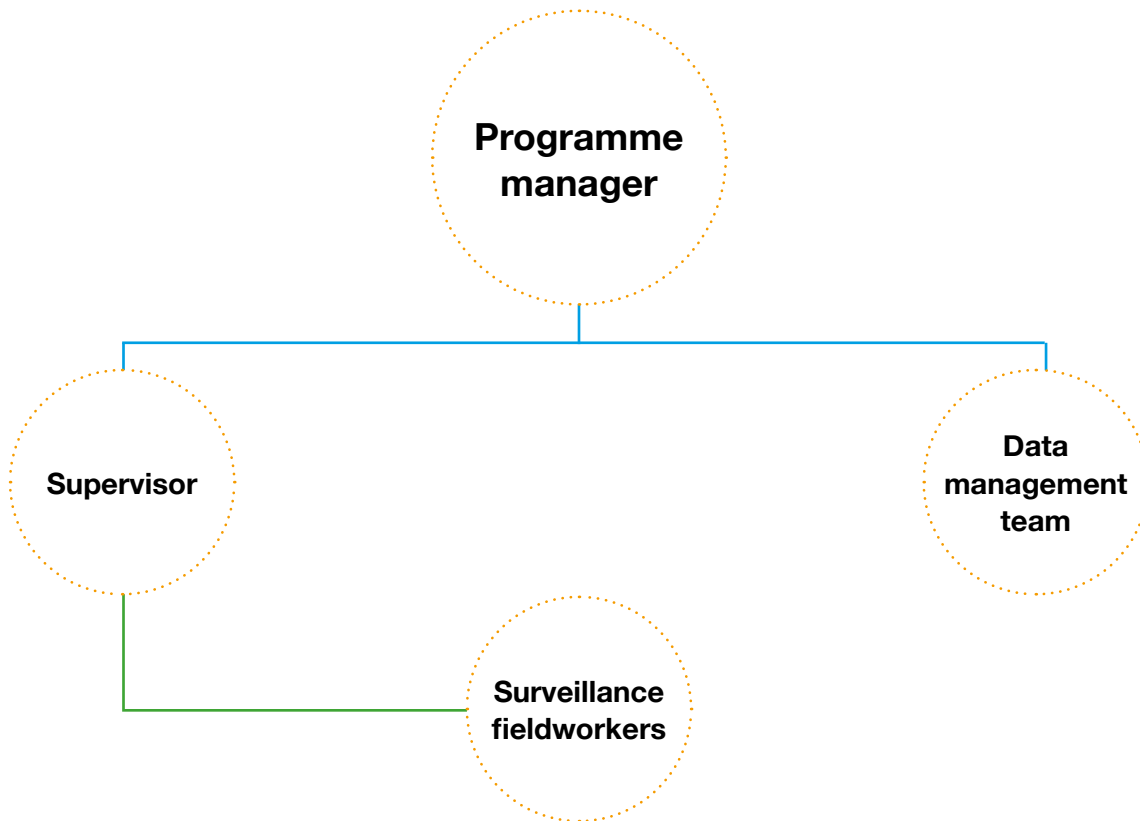
The programme manager manages the overall implementation and functioning of the community surveillance system and is responsible for recruitment, conducting training (as outlined in this manual) and supervision of all staff who report to the surveillance system. The programme manager is the focal person for contact with different parts of the health-care system and with the authorities working in collaboration with it. A programme manager can be someone with postgraduate qualification in public health or psychology, or a person with any social work background and with good expertise in training and project management.

The supervisor reports to the programme manager and is responsible for regular monitoring, support and supervision of the surveillance fieldworkers who collect the data. The supervisor is also responsible for data cleaning and cross-validation of multiple sources of data submitted. The supervisor will coordinate with local community key informants, health-care facilities and the police and legal/administrative authorities for securing permissions and for sustaining regular data collection. In coordination with the data management team, the supervisor ensures the quality and safety of the data collected through the community surveillance system. Supervisors can be graduates in public health or psychology, or with any social work background with good project and team management skills.

The data management team includes a data manager and a statistician who will coordinate with the supervisor for data management and analysis regularly. The team will mainly be responsible for ensuring the quality and security of the data collected through the community surveillance system.

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The surveillance fieldworkers can be graduates, preferably from the social workstream or even from allied courses with experience in community engagement. If feasible, fieldworker responsibilities may be incorporated into the role of existing community health workers to strengthen integration within the health system and to ensure sustainability. Advanced degrees are not a necessary requirement for this role. Fieldworkers should be able to read and write and be able to work closely within the community. Surveillance fieldworkers collect data from three key sources, namely:

- community key informants - residents of the community (e.g. village council head, school principal, shopkeeper, pharmacist, community priest, community health worker) with key insights into the geography, sociocultural context, and births and deaths occurring within the community;

- health-care facilities; and

- police and any legal/administrative authorities (e.g. medico-legal, forensic services).

Key informants are approached on a routine basis (e.g. monthly) via a semi-structured interview by surveillance fieldworkers to identify cases of suicide and self-harm occurring in the community. Data on suicides and self-harm are also routinely obtained from health facilities and police stations (e.g. every three months). Data are then matched across the three sources to identify unique episodes of self-harm and suicide.

The organigram (Figure 2) depicts the work distribution as proposed in this manual; however, this can be modified in accordance with the context and needs of a given community's surveillance system. For instance, data entry could be done by the data management team instead of by a fieldworker or, instead of the programme manager training all staff, s/he could train the supervisor who in turn trains the fieldworkers.

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Aim and scope of this training manual

The aim of this training manual is to equip fieldworkers and supervisors with the skills to collect and manage data on suicide and self-harm in the community via key informants, health-care facilities and police records. In doing so, the value and overall goal is to strengthen the surveillance of suicide and self-harm in communities, particularly in LMICs and hard-to-reach communities where CRVS systems are weak or absent. Information provided by comprehensive community surveillance systems will help to inform the design of suicide prevention programmes and national strategies, with better representation of the population. It will also help policy-makers to take decisions and make investments for suicide prevention on the basis of actual numbers.

This training manual is designed to be used in conjunction with existing WHO resources on suicide and self-harm case registration, including:

• *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* (WHO, 2016) and an associated e-learning course on *Suicide research and prevention e-learning;*[3] and:

• *Preventing suicide: a resource for suicide case registration* (WHO, 2011).

While the present training manual includes some guidance instructions, it does not address the implementation of a community surveillance system step-by-step. A more comprehensive guide on how to establish surveillance systems for suicide and self-harm is described in *Preventing suicide: a resource for suicide case registration* (WHO, 2011) and the *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* (WHO, 2016). The latter includes a step-by-step guide on how to inform and engage relevant stakeholders, how to set up surveillance systems (including the consideration of costs and potential funding sources), how to ensure confidentiality, how to analyse the data and evaluate the system, as well guidance on maintenance and sustainability over time – all of which are applicable to a community surveillance system. The training manual should be used in conjunction with these resources.

Importantly, community surveillance systems should not be substitutes for well-functioning CRVS and hospital surveillance systems. Instead, a community surveillance system may be considered as an adjunct that captures data on suicide and self-harm or creates momentum for a national CRVS and hospital-based system.

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[3]See: https://suicideresearchpreventionelearning.com/, accessed 2 September 2022.

Who is this training manual for?

This manual is intended for health professionals, data registration officers, researchers and statisticians working in communities, health institutions, nongovernmental organizations (NGOs), university departments and research institutes in settings where public health surveillance systems on suicide and self-harm are weak or absent.

The training material that is outlined in this manual is primarily intended for:

- surveillance fieldworkers (e.g. health workers or volunteers) who will collect data on suicide and self-harm from the community via key informants and official health and police records; and

- supervisors who will have oversight of data collection and data management.

Contents of the training manual

This manual provides instruction and guidance on training of surveillance fieldworkers and additional instruction for training supervisors on data management.

The training for fieldworkers encourages the use of trainee participation and active learning. This means that time should be allocated for discussions in both large and small groups to facilitate critical thinking, communication and listening skills, with role-plays to allow trainees to practise their skills and interpersonal interactions, as well as consolidation and reflection activities to ensure that learning has been successful.

All training should be adapted to suit the cultural context, including the use of language that is understandable and appropriate, so that all trainees can participate. General tips for those conducting the training are provided in Annex 2. The training discusses content that may be distressing for some trainees. All trainees are encouraged to raise any concerns with the programme manager or supervisor and/or seek support. Programme managers and supervisors should ensure that local support options are available for participants in the training.

An overview of the training schedule for fieldworkers, and additional training for supervisors, is provided below. Brief refresher training sessions could be considered every three months (for instance, to review interview skills or address challenges).

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Table 1. Training plan for surveillance fieldworkers and supervisors

Session	Name of the session	Suggested duration	Day
Session 1	Background on suicide and self-harm according to the local context Introduction to the community surveillance system and its objectives	15 minutes	**Day 1**
Session 2	Interview skills 2.1 Making the first contact 2.2 Introducing yourself 2.3 Building rapport 2.4 Active listening 2.5 Confidentiality and privacy 2.6 Informed consent	160 minutes	
Session 3 and 4	Data collection and support for individuals in distress	75 minutes	
Session 5	Planning a visit	30 minutes	**Day 2 (half-day)**
Session 6	Handling difficult situations	90 minutes	

Note that sufficient additional time should be allocated for breaks and meals.

Training plan for additional training for supervisors

Session	Name of the session	Suggested duration	Day
Session 7	Data management and matching	180 minutes	**Day 2 (half-day)**
Session 8	Quality assurance	60 minutes	
Session 9	Reporting and dissemination	20 minutes	

Note that sufficient additional time should be allocated for breaks and meals.

02 Training of surveillance fieldworkers

02 Training of surveillance fieldworkers

Session 1. Contextual information on suicide and self-harm and introducing the community surveillance system and its objectives

Before beginning, the trainer should orient the group regarding the purpose and expectations of the training, including the interactive style of learning that will be employed throughout (e.g. role-plays). This includes establishing group agreements, rules and safety information. Box 1 provides an example activity for establishing group agreements.

> **Box 1. Activity for establishing group agreements**
>
> In order to establish shared expectations within the group, make clear the shared norms for the training sessions and provide relevant safety information. Rules should be identified and agreed on by the group.
>
> These may include:
>
> - We are committed to attending all the sessions and arriving on time.
> - We will listen to each person when they are speaking and try to contribute to each session.
> - We will respect each other's opinions even when they are different from our own.
> - We will commit to maintaining confidentiality. Information discussed within the context of the training is not to be shared with anyone outside of the training.
> - We are aware of, and agree to utilize, support services should we feel distressed or in need.

The main objective of Session 1 is to provide contextual information on suicide and self-harm and to clarify why a community surveillance system is needed. Background information on suicide and self-harm should be tailored to the local context and should include, for instance, details on the sex-specific suicide rates, the sociodemographic profile of suicide and self-harm cases, and the main methods of suicide and self-harm. Examples of existing local surveillance systems should be described. The introduction to this manual provides a useful starting point, and trainers should be encouraged to describe the variation in quality of vital registration data both globally and within their local area, as well as the so-called "iceberg model" (Figure 1). The rationale for a community surveillance system should then be explained.

An introduction to the structure of community surveillance is also needed. This includes the organizational structure plus key roles and responsibilities. This is likely to vary according to the local context. The proposed organigram that is supplied in the Introduction (Figure 2) is an example of the organizational structure of a community surveillance system and can be adapted and modified as needed. A proposed workflow is illustrated in Figure 3, highlighting the various sources of data, routine data collection, and cross-validation of suicide deaths and self-harm episodes across different sources. This should be adapted to the local context.

Figure 3. Workflow of community surveillance of suicide and self-harm

KI = Key informant

SFW = Surveillance field worker

Suicide or self-harm occurs in community

Community member identified as key informant (KI) aware of suicide or self-harm

Cases of suicide or self-harm in health facility and/or police records

SFW interviews KIs (e.g. once a month) to identify cases and fills case report form

SFW visits health facility/ police station and fills case report form (e.g. every 3 months)

Case report forms submitted to supervisor and entered into key informant surveillance database

Case report forms submitted to supervisor and entered into health/ police record surveillance database

Data cleaning and matching of data from multiple key informants

Data cleaning and matching of data from health/police records with key informant data

Supervisor records unique events in surveillance database

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Session 2. Introducing yourself and using interview skills

The main objective of Session 2 is to learn and practise the necessary communication skills to liaise with stakeholders in different phases of the data collection. Given that there may be some variation across communities as to the background and education of surveillance fieldworkers, the following training suggestions aim to provide a baseline of skills. For some communities and fieldworkers the following information may be new and for others it may be a refresher of skills acquired in previous roles or during education. Communities are encouraged to adapt the training to their local context and needs.

2.1 Identifying key informants and making the first contact

Once the surveillance system is established in the community and the relevant permissions are obtained for the catchment area, surveillance fieldworkers and/or supervisors will need to identify key informants for the surveillance system before arranging appointments and meetings with the key informants for their area.

Key informants may be formal or informal community leaders - such as elders, religious leaders, private physicians, pharmacists, community health workers, teachers/school principals, sports coaches, prominent business holders, service providers, or any other informant who is culturally relevant within a community. It is important that relevant key informants are identified and that they adequately suit the diversity of the local context. There must be confidence that the system has sufficient breadth to identify community suicide or self-harm in young persons, older persons and other groups. It may be feasible for the network of communities and key informants to expand gradually over time.

Making first contact in the community can be challenging but is essential. The readiness of the key informants to volunteer information will largely depend on *how* you make the first contact and introduce yourself. A good place to start within a community may be an elected leader or similar person within the community. A person with a leading role within a community may act as an important community "gatekeeper" whose permission may be required before approaching other key informants in the community. It is important that a strong rationale is provided for the surveillance system and rapport is established between the surveillance team and relevant stakeholders. It is crucial that the community understands the purpose of the surveillance system and shares the vision for identifying suicide and self-harm within the community as an important cornerstone for future prevention efforts.

In some cases, the elected head may not be the sole decision-making authority. It is important to be aware of cultural, social and political power dynamics before beginning work in a community setting. Seeking collaboration and support from other key formal or informal stakeholders (e.g. those who have been living in the community for many years, those well known in the community) might help to influence acceptance for the surveillance system within the community in general.

2.2 Introducing yourself

An appropriate introduction is crucial because this is your first interaction with important key informants in the community or with relevant officials of the health facilities or police (Box 2).

• The purpose of introducing yourself is to help people become familiar with you and to answer any questions they may have about your visit.

• It is important to plan the timing of your introduction. It may be more appropriate in some situations to schedule the introduction in advance at a mutually suitable time and location. If you have approached the potential key informants in the middle of their day-to-day activities, it may be necessary to ask for some of their time while introducing yourself.

• The introduction must be short and precise. It may be particularly helpful to rehearse your introduction before the visit.

• The introduction should consist of details about who you are, where you are from and the purpose of your visit. Since you will be collecting data on a potentially sensitive and stigmatized issue, it is important to be careful with the language used in your introduction. In particular, use of terms such as "suicide" or "mental health issues" may be confrontational to some key informants and may evoke negative responses, depending on the context. Use terminology that is acceptable in the local context. The idea is to develop rapport, build trust and reduce stigma. Framing the introduction in terms of supporting people in distress may be less threatening.

• It may be useful/helpful to mention that you work in collaboration with the government, the health system or the local authority.

Box 2. Important points to remember when introducing yourself

- Begin by introducing yourself - who you are, where you are from (mentioning your place of origin may be helpful within a community context) and the purpose of your visit.

- Using terms such as "distress", "daily hassles/troubles" or "challenges in daily life" may be appropriate.

- If asked whether the project is funded by the government, mention if applicable that you are working in collaboration with the government, health system and/or local authority.

- Request time and participation at the end of your introduction.

Example: "(Insert locally appropriate greeting). My name is _____. I am from _____ and I work as a surveillance fieldworker on the community surveillance system, run in collaboration with the (government/health system/local authority). We work on issues related to mental health and improving access to care for persons who are distressed. I am here to introduce myself to you and get to know you better, as we would like to collaborate with you in collecting important data on the community. Before doing so, I feel it would be important for me to explain our work and for us to get to know each other well. Do you have some time?"

Exercise 1

Write your introduction (approx. 10 minutes)

Instructions:

Based on the points above, take 10 minutes to write an introduction that you can use as a surveillance fieldworker when meeting a key informant from the community.

At the end of the exercise, the trainer should ensure that each surveillance fieldworker and the supervisor have a standardized introduction to be used while approaching key informants.

Before going to the community, it is worthwhile to go through some points to remember (Box 3).

Box 3. Points to remember before entering a community

Before entering a community, ask yourself the following questions:

- Do I know where the community is located?
- Do I know how to get to the community?
- Am I going at the right time?
- Do I know who to approach? Is there anyone else I could approach?
- Has the person(s) been notified in advance?
- Am I well versed with my introduction? Do I have my identity card?
- Do I have the necessary documents with me? These documents include an identity card, official letter about the community surveillance system, informed consent forms, case registration forms, information leaflets.

Exercise 2

Role-play (approx. 15 minutes)

Scenario:

You have approached a community leader. Your task is to introduce yourself and explain the surveillance system in order to receive permission to gather data from key informants in the community.

Instructions:

For this role-play, two volunteers from among the participants are needed.

One participant will act as a community leader and the other will take the part of the surveillance fieldworker or supervisor. The community leader is encouraged to be sceptical of the community surveillance system and to ask questions about the details of the system and its implementation.

The surveillance fieldworker or supervisor will introduce her/himself and the surveillance system, and will respond to questions asked by the community leader.

The rest of the participants will take notes while observing their interaction. At the end of the role-play, discuss the interaction as a group and summarize the discussion outcome (e.g. what went well, what could have gone better).

2.3 Building rapport

It is important to build a sense of trust and understanding with the key informants by giving background information about the community surveillance system, a brief description of the topics concerned and the nature of questions to be asked (Box 4). It may be useful for surveillance fieldworkers to provide the case report form (CRF) to the key informants so they can become familiar with the types of questions that will be asked of them (Annex 3).

Box 4. Points to remember when building rapport

- It is important to speak openly with key informants and to reassure them by avoiding threatening descriptions of your work. Statements like "I am here to talk to you", "I'd like to hear more about the community and your work", and "I'd like to have a brief conversation with you" are less threatening than "I am here to interview you".

- If you have never been an interviewer, preparedness can help you tackle anxiety.

- In the process of explaining the background of the community surveillance system, do not make it sound like a technical or a medical procedure but rather a process in which information will be shared openly between the community key informant and the interviewer. All the data collected/shared during an interview is jointly reported by both the informant and interviewer. It is possible that the key informants have different aims and timelines than the interviewer. The purpose is also to align these aims and timelines, especially in the early phases.

- It is important to communicate why informants' participation is valuable for the surveillance system.

- Providing time and space to ask questions is essential.

2.4 Active listening

Active listening is an important interpersonal skill that is required for effective communication. It is also important for emphasizing empathy. Active listening involves both verbal and non-verbal communication.

Non-verbal communication

Appropriate non-verbal cues are an important part of communication. When interacting with key informants and collecting surveillance information from them it is important to be aware of your body language and how it affects your rapport with the key informant. By being mindful of the non-verbal cues they are using, surveillance fieldworkers can minimize any miscommunication or perception of judgement. Aspects of appropriate non-verbal communication differ across cultures and regions. Nevertheless, they may include:

- **Body posture:** slouching or leaning back can communicate lack of interest. An upright posture or leaning forward communicates interest.

- **Gestures and movements:** movement of the hands, looking at your watch, doodling with a pen, playing with or checking your mobile telephone, or looking around the room can communicate a lack of interest.

- **Eye contact:** maintaining eye contact is important. Blinking or looking elsewhere may be a hindrance in communication.

- **Facial expressions:** raising eyebrows or frowning may not be helpful. Nodding or maintaining a neutral facial expression may be helpful.

Verbal communication

Verbal communication is another essential component of effective communication. Remember to use appropriate and respectful language and terminology that are suited to the local context and the key informant. Active listening is an important skill for surveillance fieldworkers while conducting interviews (Box 5).

Box 5. Examples of points to consider for active listening

To help people feel that they have been heard, interviewers can use active listening skills. Active listening consists of the following:

- The interviewer makes affirming statements. For instance, the interviewer offers a statement that acknowledges that he or she has heard what the person has said (e.g. "I understand what you are saying" or "Yes, that is clear").

- The interviewer does not interrupt the person when they are speaking.

- The interviewer summarizes, in his or her own words, what the person has said (e.g. "So, you feel that these are the reasons why it happened") to gain clarity if needed and to demonstrate that the person has been understood.

The volume and tone of voice, as well as the speed with which the interviewer speaks, all affect how the questions will be received by the interviewee.

- For example, if the interviewer speaks quickly, the person being interviewed may feel anxious and rushed to respond, or the question may not be properly interpreted.

Equally, the volume of an interviewer's voice can affect a person's response to a question.

- For example, if the tone of voice is soft, then it will help a person to feel relaxed, but if the voice is loud then it may cause a person to feel intimidated and may discourage them from responding to the question

For both verbal and non-verbal communication, and to display active listening skills, it is essential that the skills are adapted to the preferences, expectations and customs of the local community.

02 Training of surveillance fieldworkers

Exercise 3

Two-stage role-play (approx. 15 minutes)

This role-play is designed to be conducted in two parts. In the first part, the person acting as the interviewer is instructed to "not listen". Participants are taught the skill of effective listening by demonstrating ineffective, inaccurate behaviour. This is an effective technique to help people remember "what not to do" while conducting the interview.

Scenario:

One person (Person 1) will play the role of a person in distress and will share their problem with another person (Person 2). This can be any problem that is currently being experienced, or it can be invented problem. It is advised to refrain from sharing serious problems (e.g. long-standing issues with no clear solution).

Instructions (Part 1):

Person 1 will share their problem with Person 2. Person 2 will play the role of an interviewer with poor listening and communication skills (e.g. checking their telephone while Person 1 is talking, laughing at inappropriate times). After five minutes the trainer will stop the interaction and the group can comment on what went wrong and how it could be improved.

Instructions (Part 2):

The interaction will resume, this time Person 2 will attempt to utilize good verbal and non-verbal communication skills suited to the local context, displaying empathy and actively listening to the concerns of Person 1. After five minutes the trainer will again stop the interaction and the group can comment on what went well and how it could be improved – and how it was different from the first interaction. It is important that all group members can share their views and experiences. If there is time the group may wish to practice in pairs.

2.5 Confidentiality and privacy

Confidentiality is important to ensure that the information given by participants is protected so that it can be accessed and identified only by those collecting the data. It is important to ensure that the information given by participants remains private, is not accessible to anyone and is not disseminated. Although identifiable personal information will be collected, it is important that only authorized personnel have access to the data and that the data are securely stored.

Confidentiality is important for building a trusting relationship with key informants, particularly in settings where suicidal behaviours are criminalized. Failure to ensure confidentiality could have far-reaching consequences. A breach of confidentiality not only breaks trust but can also threaten the safety and security of the person who has shared the information. It could affect relationships and prevent the interviewee from trusting the interviewer with any information in the future.

Exercise 4

Case scenarios on confidentiality (approx. 20 minutes). Note: Language should be adapted to suit the local context.

Instruction:

The following scenarios should be discussed in a group and group members should identify solutions. You may wish to discuss each scenario as a whole group or divide into smaller groups before reconvening in the larger group and sharing responses. It may also be helpful for the group to identify other possible situations where confidentiality will be tested in their community (e.g. where suicidal behaviours are criminalized).

Scenario 1:

You have approached a key informant for an interview. There are others in the room who wish to sit through the interview.

What will you do?

Possible response: Confidentiality is essential because of the exchange of sensitive information. The surveillance fieldworker needs to ensure that the informant, as well as others in the background, are informed about the principle of confidentiality. If they have questions about the project or the interview process, these could be addressed separately by the surveillance fieldworkers. However, the surveillance fieldworker needs to reiterate that the interview must be conducted in private because otherwise the informant may not be able to share information freely.

Continued>>

Exercise 4

Scenario 2:

Someone from the community approaches you, asking you about a recent interview you conducted with another key informant from the same community. They want to know the questions that were asked and the information that the person gave. They also want to know why they are not being interviewed and only a few specific people in the community are being contacted.

What will you do?

Possible response: The surveillance fieldworker could say: "I am bound by the principle of confidentiality and hence I cannot share information with you regarding an interview I conducted. I can give you information about the surveillance system and what we do." If a person has questions about why they are not being interviewed, the surveillance fieldworker could say: "In accordance with the design of the surveillance system, we have identified only a few stakeholders in the community. Hence, these individuals are being interviewed. However, if there are other individuals in the community who may also have this information, we may approach them as well."

AND/OR

One key informant asks you about the information another key informant gave you from the same community.

Possible response: "We are bound by confidentiality. We cannot give you the information that was shared with us by another informant. However, I am open to sharing details of the surveillance system and what we aim to do."

AND/OR

The key informant calls other people in their house/surroundings to answer interview questions.

Possible response: The surveillance fieldworker needs to ensure that only the key informant responds to the interview questions. Hence, privacy is necessary. If the interview is conducted in a space that is accessible to all, there are chances that there may be interference from others. The surveillance fieldworker could say: "In accordance with the protocol, we are expected to meet these key individuals in the community because they are likely to have the information we need. It is important for me to speak to the person concerned and gather her/his views about the questions I am asking."

Continued>>

AND/OR

The key informant is a young woman in her 20s. The informant and her family members are uncomfortable allowing her to sit in a private space with the male interviewer.

Possible response: This situation needs to be dealt with sensitively. Depending on the context, it may be more appropriate to assign a female surveillance fieldworker to conduct the interview. It is important to include the family members during the process of building rapport so that they feel as comfortable with your presence as the informant herself. It is also important to give the family members adequate information about the surveillance system in order to allay their fears. However, it is important to emphasize the principle of confidentiality. The interviewer could choose to sit in a space which is visible to all (e.g. under a tree). Even in such circumstances, privacy can be maintained in a non-threatening manner.

AND/OR

After the interview is over, others in the community mention that the information given by the informant is incorrect. They are trying to hide information.

Possible response: There are two levels of response to this situation:

1. The chances of hiding information or sharing incorrect information are high, especially when rapport has not been effectively established. A key informant who feels unable to trust you with her/his information is likely to hide information.

2. If you believe that you have developed a trusting relationship with the key informant, it is important to accept the information given by the informant at face value. At times, probing further and exploring the details of the information that is given may help you to understand if any details have inadvertently been missed out. Additionally, in the process of matching information, these details are likely to be corroborated through other findings.

Scenario 3:

You have come back home after a long day of conducting interviews and wish to share your experiences with your family members. They ask you about the details of the interviewees who you spoke to.

What will you do?

Possible response: Since we are bound by the principle of confidentiality, it would be advisable not to share details of the persons interviewed. You could share general information in a non-identifiable manner. However, if the interviews have had a significant impact, you could also discuss these experiences with your supervisor, in confidence.

Continued>>

Exercise 4

Scenario 4:

The key informant asks you whether the information will be shared with the police.

What will you do?

Possible response: The key informant is reminded of the principle of confidentiality. She/he is told that the information will not be shared with the police and their responses will be kept confidential.

Scenario 5:

Your informant is a police officer who asks you whether you have any information about a new case.

What will you do?

Possible response: The situation needs to be handled sensitively. The informant is reminded of the principle of confidentiality and that, in accordance with the project protocol, the information is to be kept confidential. Details about the community surveillance system could be shared with the police officer in order to allay fears. This needs to be kept in mind at the time of establishing rapport.

2.6 Informed consent

Seeking informed consent is an important part of the data collection process and involves two key components, namely:

- the right of key informants to refuse to participate in the surveillance process or to answer questions without repercussions (including the key informant stopping the data collection at any point without repercussions);

- the confidentiality of a key informant's participation and protection of their identity (as well as protection of the data they provide).

A consent form is usually a written record which documents that the key informant agrees to participate in the data collection process without any undue pressure. In some cases, verbal consent may be the preferred method. The purpose of engaging in a consent procedure is to ensure that the key informant understands what she/he has signed up to (Box 6). To ensure this, the following need to be clarified:

- the purpose of the community surveillance system;

- procedures involved in the community surveillance system with regard to the local context (including data protection and/or privacy);

- alternatives to participation;

- ensuring that the key informant is aware of all foreseeable risks and discomforts they may experience by taking part as a key informant (including not only physical injury but also possible psychological, social or economic harm, discomfort or inconvenience);

- benefits of the community surveillance system to society (and possibly to the informant);

- the amount of time the informant is expected to allocate to the role;

- the name of a key person who may be contacted for answers to questions or in the event of an illness, injury or emergency which would affect data collection;

- a statement indicating that participation is voluntary and that refusal to participate will not result in any consequences or loss of benefits that the key informant is otherwise entitled to receive;

- a statement regarding the key informant's right to confidentiality and the right to withdraw from the data collection at any time without any consequences.

Box 6. Points to remember for the consent procedure

The consent procedure includes the following:

- Each key informant is given an information sheet about the community surveillance system as well as a printed copy of the consent form. One signed copy can remain with the informant and one copy is retained by the surveillance fieldworker who later submits the consent form to the supervisor who in turn will submit it to the programme manager.

- A consent form should be signed only once by the informant at the beginning of their enrolment into the surveillance programme.

- If written consent is not possible (e.g. the key informant is illiterate), verbal consent can be obtained. The fieldworker should explain the contents of the information sheet and obtain a thumbprint to confirm verbal consent.

- All consent forms are to be stored securely.

- It is important to note that the informant has the right to refuse consent to participate. No informant can be forced or pressured to participate in data collection. In such a scenario, it would be important to respect the informant's choice and document their reasons for not giving consent.

Exercise 5

Case scenarios on consent (15 minutes)

Instructions:

The following scenarios should be discussed as a group and group members should identify solutions. You may wish to discuss each scenario with the whole group or divide into smaller groups before reconvening in the larger group and sharing responses. It may also be helpful for the group to identify other possible case scenarios for the local context. Following this exercise, the group should review the consent form.

Scenario 1:

The informant wishes to leave the interview halfway through the process.

What will you do?

Possible response: Consent involves not only the agreement to participate. It also includes the freedom to refuse, to leave the interview and not to answer questions without any repercussions. If the informant wishes to leave the interview process, there are underlying reasons for this. The informant has the freedom to leave; however, the surveillance fieldworker should probe the reasons for doing so and should document them. It should be clarified whether the informant may wish to participate again in the future.

Continued>>

Exercise 5

Scenario 2:

The informant is being coerced to participate in the surveillance system because there is pressure from the head of the community. You can gauge that they are not interested in talking to you.

What will you do?

Possible response: The interview process is transparent. There is a lot of emphasis on establishing rapport which helps in building a trusting relationship. Since the surveillance fieldworker is going to be in contact with the key informants over a period, it is important to invest time and effort in building a relationship with each of the key informants. This is important to ensure the quality of information. The informant has to choose whether or not to participate without any undue pressure. This should be clarified at the outset of the interview process. The surveillance fieldworker and the informant need to agree on key principles. It may also be useful for the community surveillance workers to revisit the purpose of the surveillance system with community heads in order to clarify its voluntary nature.

Scenario 3:

The informant refuses to give consent because s/he considers this a waste of their time, or because they are unable to understand how the interview will benefit community members, or they are worried about confidentiality or ask for compensation in return.

What will you do?

Possible response: As an important stakeholder in the process, it is the right of the informant to know all details of the process before the interview begins. Questions related to benefits/harm, worries about confidentiality, expectations of compensation, are indicative of inadequate information being given to informants. If surveillance fieldworkers have not spent time explaining the process, the reason for doing the data collection, and the expectations and benefits, the informants are likely to remain anxious and may eventually not participate in the interview process.

Session 3. Data collection

The objectives of Session 3 are to learn about: 1) open-ended and leading questions; and 2) the use of the case report form (CRF) (Annexes 3–4).

3.1 Asking questions

- After the initial rapport building, introduction and consent procedure, the interview process of asking questions about suicide or self-harm begins (Box 7). Information is recorded using questions in the CRF (Annex 3). All questions in the form must be asked of all key informants.

- The key informant must be reminded of confidentiality and privacy before any questions are asked.

- The interviewer must ensure that the process is flexible and flows naturally (to put the informant at ease). This is possible because the questions of the CRF (Annex 3) relate to basic demographics of the person who self-harmed or died by suicide and the circumstances around the event.

- Leading questions must be avoided.

Box 7. Points to remember before beginning the interview

Before beginning the interview, interviewers could ask themselves the following questions:

- Have I given adequate information about the community surveillance system, the process of conducting the interview and the nature of questions in a language that the participant understands?

- Have I received consent from the informant?

- Does the informant understand the nature of her/his participation?

- Is the setting private, non-threatening and comfortable?

- Do I have all the material I need?

- Have I revisited all the questions?

- Am I well-versed in the interview process?

Exercise 6

The difference between open-ended and leading questions (approx. 10 minutes)

Instructions:

The trainer will ask the group both a leading question and an open-ended question. The trainer can highlight the differences between a leading question and an open-ended question and can then describe why a leading question is problematic. Members of the group are encouraged to come up with their own examples. For instance:

"This training is good, isn't it?" (leading question).

"How is the training?" (open-ended question).

Leading questions are problematic because of the following:

- The answer to the question is presumed before the question is asked.
- There is an assumption about the person and their circumstances and thereby about the answers they will give.
- Leading questions prompt and encourage a desired response, while an interviewer should remain neutral and objective about a participant's responses.
- Leading questions imply that certain answers are better than others.
- Leading questions influence their responses and inhibit informants from giving their own response.
- Leading questions stem from the interviewer's concern to get "good information".

3.2 Inclusion criteria for self-harm

Eligible cases for self-harm need to meet the following inclusion criteria (see also (WHO, 2011, 2016):

- The act was self-inflicted.
- The act was carried out with the purpose of harming oneself - i.e. this was not an accident. However, this may or may not include the intent to die (or the intent to die may be transient, or the person may be ambivalent about death).
- This may or may not have been an impulsive act.
- All methods of intentional self-harm as per ICD-10 codes (Annex 5).
- A combination of methods may have been used (e.g. medication and self-cutting). If a person has used multiple methods of intentional self-harm, all methods should be recorded on the CRF.
- The act was non-fatal (i.e. the person is alive).

To identify cases of self-harm, the following line of questioning can be used (Figure 4).

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Figure 4. Line of questioning for identifying cases of self-harm
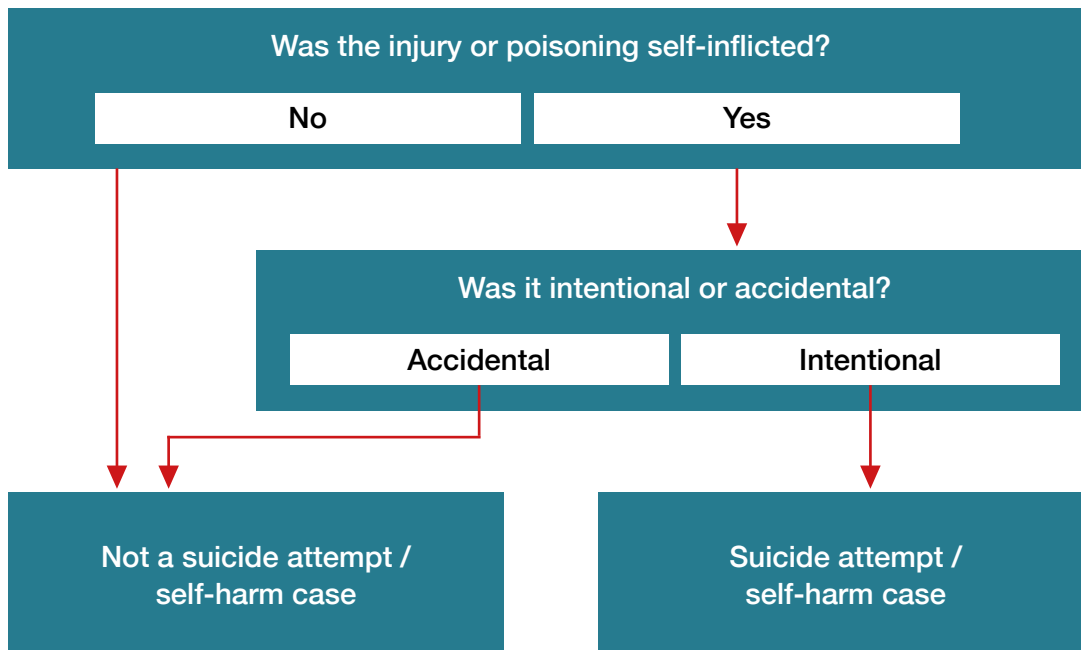
Source: WHO, 2016.

3.3 Inclusion criteria for suicide

In addition to the above criteria for self-harm, eligible cases for suicide must be fatal (i.e. the person died; see also Table 2). The NASH principles (natural, accidental, suicide, homicide) of mortality (Figure 5) can also guide when cases are being coded as suicides (WHO, 2011).

Table 2. Overview of inclusion criteria for suicide and self-harm

Criteria	Self-harm[a]	Suicide
Act was self-inflicted.	✓	✓
Act was carried out intentionally (i.e. it was not an accident) with the purpose of harming oneself. May or may not include the intent to die, or the intent to die was/is transient, or the individual was/is ambivalent about death/living.	✓	✓
Act may or may not have been impulsive.	✓	✓
Any method, or combination of methods, of intentional self-harm as per ICD-10 codes (Annex 5) was used.	✓	✓
Outcome of the act was …	Non-fatal	Fatal

[a] Given the difficulties in establishing the intent to die, all instances of self-harm should be recorded wherever possible. Some communities and individuals may prefer the term "suicide attempt" (WHO, 2016).

Figure 5. Distinguishing suicide deaths from natural, accidental and homicide deaths
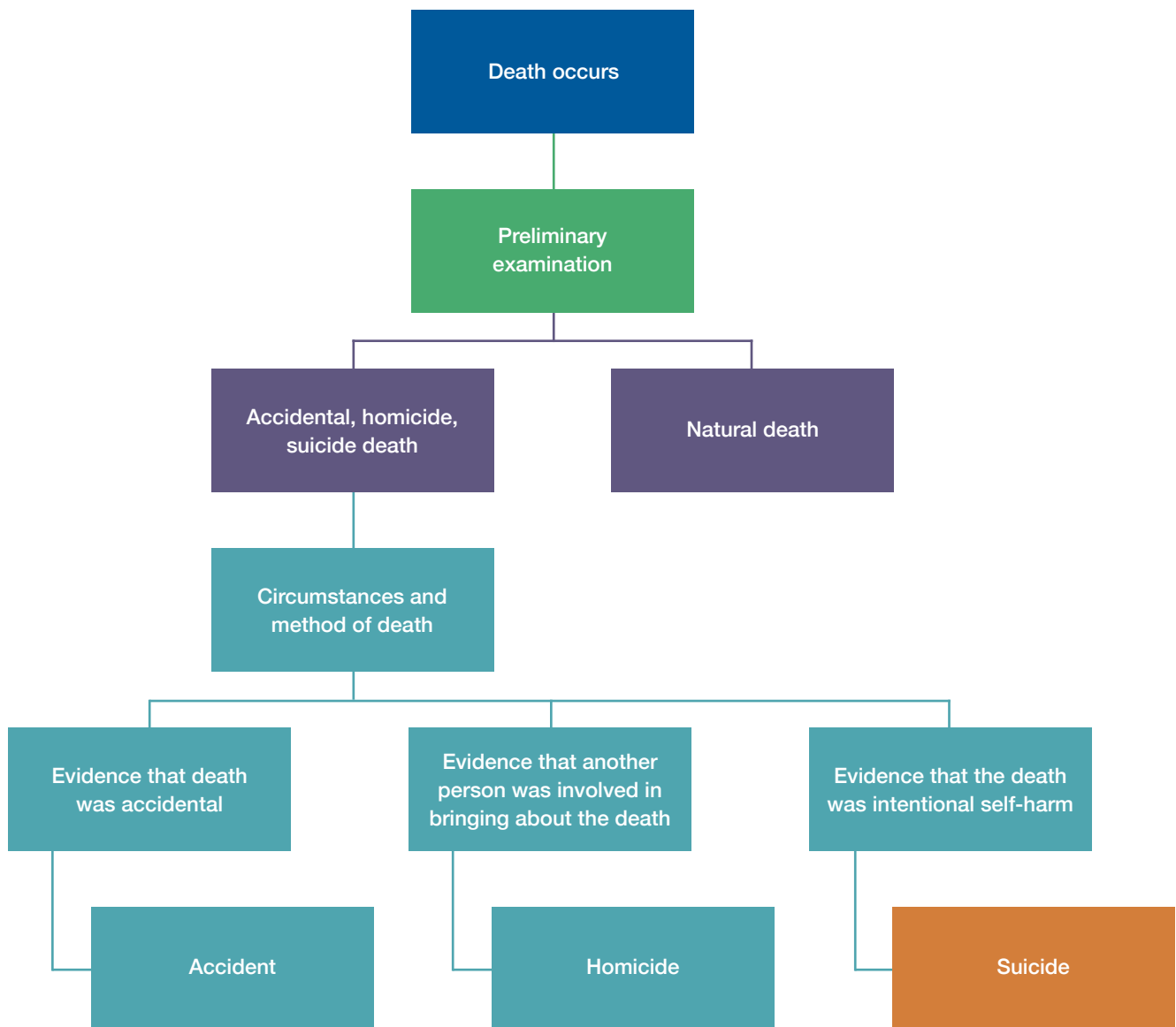
Source: WHO, 2016.

Some additional factors may help when coding a suicide, including a suicide note, communicating suicidal thoughts (Box 9), and also a history of mental illness or recent stressful life events (e.g. break-up from partner). Those factors may differ depending on the culture and the availability of suicide methods and their lethality.

Box 9. Additional factors to consider when coding a suicide

Factors to consider include:

- presence of a suicide note;
- previous episodes of self-harm;
- verbal communication of suicidality (threats, thoughts, plans);
- non-verbal acts such as making a will, stockpiling bills or acquiring a gun permit;
- history of mental health condition;
- recent stressful life events (e.g. breakup, separation, loss of employment);
- possible life-threatening illness or injury.

If in doubt whether an act was accidental or intentional, the general rule to follow is to treat it as intentional (non-accidental). If the doubt persists after matching, the decision will have to be made by the programme manager.

3.4 Exclusion criteria for suicide and self-harm

Cases fulfilling any of the following exclusion criteria are **not** considered a suicide or self-harm (see also WHO (2016):

•   accidental (i.e. by accident) overdose (e.g. alcohol, illicit drugs, prescription medicine);

•   accidental ingestion of a poisonous substance;

•   accidental injury (e.g. related to sports or work).

Exercise 10

Practice case examples

Instructions:

Read each of the following community case vignettes and discuss as a group how to record the case using the criteria above.

Case Vignette 1.

A key informant (religious leader in the community) advises that a 43-year-old man in the community was taken to hospital by his brother after ingesting paraquat (pesticide). The key informant was asked by the family to visit the man during his hospital stay last week. The family communicated to the key informant that the man had recently separated from his wife and that he communicated to his brother how pointless life seemed these days and there was no reason to live without his wife and to continue living in the family home. The key informant is unsure how much pesticide was ingested or whether any other substances or methods were used, but it is known that the man died in hospital.

Should this be recorded in the case report form (Yes/No) and, if yes, would this be a suicide or self-harm? (Response: Yes, it should be coded as a suicide).

Case Vignette 2.

An emergency department presentation is recorded in health-care notes reviewed by the surveillance fieldworker. The clinical notes state that a 17-year-old boy arrived at the emergency department with friends in the early afternoon on Saturday, with an injury to the left ankle after jumping from a bridge into the water where his friends were swimming below. The boy is recorded as relaxed and jovial with friends yet reporting substantial pain from the injury. The injury is recorded a suspected fracture.

Should this be recorded in the case report form (Yes/No) and, if yes, would this be a suicide or self-harm? (Response: No, it is an injury).

Continued>>

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Case Vignette 3.

An emergency department presentation is recorded in health-care notes reviewed by the surveillance fieldworker. The clinical notes state that a 28-year-old woman presented to the emergency department via ambulance at 02:30AM on Thursday morning. The woman presents as heavily intoxicated (with alcohol) and she reports taking an excessive amount of acetaminophen and that she felt there is no point to living because she is worthless. The woman called the ambulance herself and immediately attempted to clear the contents of her stomach. The woman has a diagnosis of major depressive disorder and a history of previous self-harm presentations.

Should this be recorded in the case report form (Yes/No) and, if yes, would this be a suicide or self-harm? (Response: Yes, it should be coded as self-harm).

Case Vignette 4.

Police records state that a 32-year-old woman was found deceased by her work colleague at 07:30AM on Monday morning. The work colleague normally meets the woman so they can travel to work together. The woman was found by the colleague hanging. There was a note found at the scene which was written by the deceased woman and addressed to her parents; it stated that she no longer wished to live, apologized for any distress caused, and wished her family well.

Should this be recorded in the case report form (Yes/No) and, if yes, would this be a suicide or self-harm? (Response: Yes, it should be coded as suicide).

3.5 Case report form

How to use the case report form (CRF) with key informants in the community

The following steps should be followed when asking questions of key informants in the community:

- On the basis of the interviews with key informants, surveillance fieldworkers will collect information on self-harm and suicide.

- The information collected is entered into the CRF (see Annex 3).

- The CRFs will include personally identifiable data on people from the community. Hence, it is necessary to ensure the safety and confidentiality of these forms and of the data collected.

- It is recommended that information should be collected electronically (e.g. via tablets) and stored in a password-protected digital database that is regularly backed up. If information is collected in paper form, the forms must be promptly and carefully handed over to the supervisor (e.g. within three days) and stored securely.

It is advised that the trainer should distribute copies of relevant sheets and should ask the group to go through the questions on the form and raise concerns or doubts and clarify any questions.

3.6 Data collection from health-care facilities

The following steps should be followed when collecting data from health-care facilities:

1. Before data collection can begin, supervisors may need to map all the primary health-care centres, community health-care centres, district-level public hospitals, private hospitals, and hospitals run by NGOs and trusts in or around the targeted communities. This can be done using official records or with the help of community-based health professionals or social workers, auxiliary nurses, midwives or similar professionals. Information on how suicide and self-harm are registered at health facilities (if at all) should be ascertained.

2. Once the system-level permissions from the appropriate local administrative authorities are obtained (support from the appropriate officer for mental health or other competent authorities can be sought for obtaining these permissions), supervisors should visit these health-care facilities in person, together with the surveillance fieldworkers, and should seek permission of the head of the institution for access to data.

3. If permission is granted, the surveillance fieldworker should visit these health facilities regularly (e.g. once every three months). If permission is denied, this should be documented. The responsibility for regular data collection from health-care facilities can be modified according to the local context (e.g. it can be organized online).

4. During each visit, the medico-legal register and postmortem record should be reviewed to document all the suicide and self-harm events in the preceding quarter. For data security reasons, these registers and records should not be printed, scanned electronically or photocopied and should not be removed from the health facility. The data should be recorded in the CRF for health-care facilities and police stations (Annex 4), preferably electronically, and should be processed further by the supervisor for data cleaning, matching and entry.

3.7 Data collection from police stations

The following steps should be followed when collecting data from police stations:

1. Before data collection can begin, supervisors may need to map all police stations and forensic services in or around the targeted communities. Information on how suicide and self-harm are registered (if at all) at these services should be ascertained.

2. Once the system-level permissions from the appropriate local law enforcement authorities are obtained, the supervisor will have to approach the offices of the relevant police station officials to obtain permission to collect data from the records maintained by the police.

3. If permission is granted, the surveillance fieldworker should visit these police stations regularly (e.g. once every three months). If permission is denied, this should be documented. The responsibility for regular data collection from police stations can be modified according to the local context.

4. During each visit, the police records should be reviewed in order to document all the suicide and self-harm events during the preceding quarter. For data security reasons, these records should not be printed, scanned electronically or photocopied and should not be removed from the police station. The data should be recorded in the CRF for health-care facilities and police stations (Annex 4), preferably electronically, and should be processed further by the supervisor for data cleaning, matching and entry.

Exercise 7

Role-play (15 minutes)

For this exercise, two volunteers are required. After the participants have looked through the CRFs, they are encouraged to practice using the form themselves.

The trainer asks one participant to be a staff member at the school (note that, according to the context, this could be any stakeholder) in the community and another to be a surveillance fieldworker. The school staff member is unwilling to give information about a recent suicide because the person (deceased) held an important social position or was from a high-income group or belonged to a privileged social class. Sharing information with an outsider can be threatening for the school staff member who is the only person who knows the actual cause of death.

The task of the surveillance fieldworker is to introduce himself or herself, establish rapport, seek consent and go through the CRF with the school staff member.

Note that, at the end of the exercise, the trainer should ask the other participants, who are observing the role-play, what they would have done differently in the same situation. The trainer should try to get different responses from the participants and productively summarize them by highlighting different individual styles.

Session 4: Supporting individuals in distress

Prior to engaging key informants in the community, it is important to ensure that there are adequate support systems in place to help people in distress. In resource-poor settings, formal mental health care services can be limited. Other forms of psychosocial support should also be explored (e.g. helplines, peer support groups, community organizations and social welfare organizations). Information on available support should be updated regularly. The main objective of Session 4 is to understand the importance of creating an information leaflet that includes information on sources of support (Annex 6) and distributing it to key informants and community leaders. This information leaflet needs to be tailored to the local context and community before it can be distributed to key informants and community members.

4.1 The need to provide support to individuals at risk

During the process of conducting interviews, you may come across, hear about, or identify persons who have recently engaged in self-harm. These could be persons at risk for further self-harm, who need help and support. Help should be provided to those who are at risk, especially those who have previously self-harmed, as this is an important risk factor for repeat self-harm and suicide.

It is important to ensure that all persons at risk receive adequate support. As part of the interview process, if a key informant expresses distress, the surveillance fieldworker should pause the interview, listen attentively and not pass judgement (avoid teaching, preaching or counselling). The surveillance fieldworker can provide copies of an information leaflet (containing information on available formal and informal mental health supports and other social welfare services in the area) to the key informant at the first meeting and at each interview. The key informant could then distribute a copy to a person needing help who they are aware of or could assist in disseminating the leaflets to the community more widely (e.g. by leaving copies in waiting rooms for people to collect of their own accord and according to their need). If helpful or necessary, the surveillance fieldworker can explain some parts of the leaflet to the key informant if there are any questions for clarification.

The draft information leaflet should be discussed and created within the group to ensure that it is tailored to the local context and is relevant to local needs.

Exercise 8

Creating and updating the information leaflet (10 minutes)

As a group, discuss the importance of the information leaflet and work together to compile a list of tailored resources and supports (including contact information and/or websites) that can be accessed by key informants and/or community members when experiencing distress and/or suicidal crisis. It may be that the programme manager or supervisor has already created a leaflet that can be discussed by the group and updated.

Session 5: Planning routine community visits

The main objective of Session 5 is to guide the process of planning community visits for data collection (Box 8).

5.1 Importance of planning visits and developing a plan for visits to communities

It is essential for the surveillance fieldworkers to plan their visits in order to ensure regularity. It may be useful to create a schedule to record the time and date of both planned and actual contact with each key informant. The schedule will need to suit both the key informant and the surveillance fieldworker. It is recommended that each key informant is contacted at least once each month and that this should follow the same schedule each time. This will be more or less time- and resource-intensive depending on how many communities and informants are covered by the surveillance fieldworker.

5.2 Developing a plan for visits to health-care facilities and police stations

The supervisors and fieldworkers are encouraged to keep a master list of all the primary health-care centres, community health-care centres, detention facilities, district-level public hospitals, private hospitals, psychiatric hospitals/centres, hospitals run by NGOs and trusts, and police stations (district-level/local substations) in or around the targeted communities which granted permission and participate in the community surveillance system. Visits to health-care facilities and police stations should be planned in the same way as the community visits; however, it is recommended they are visited only once every three months (unless a different schedule is more appropriate to the local context).

Box 8. Points to remember for community visits

- Communities or subcommunities (depending on size) will be allocated to each surveillance fieldworker.

- The data collection of the community surveillance system will begin once the appropriate permissions have been obtained and the key informants have provided their informed consent. Supervisors will guide surveillance fieldworkers in initiating the consent procedure from the key informants of the communities.

- Each community should be visited routinely (e.g. once per month depending on the context).

- During these visits, surveillance fieldworkers are expected to meet all the key informants of different categories - e.g. the head of the community, community religious leaders, private physicians, community health workers, school principal/teachers, staff at the crematorium or cemetery.

- Surveillance fieldworkers will also collect data regularly from health-care facilities (e.g. primary or community health-care centres, public or private hospitals) and from police stations (e.g. every three months). The surveillance fieldworker will need to consult the records maintained at these health-care facilities and police stations.

- Sometimes it may not be possible to obtain information from all key informants at the same time. In this case, it would be necessary for surveillance fieldworkers to make multiple visits to the same community within a month. Planning schedules will be crucial to ensure that one can meet all key informants in all communities.

Session 6: Handling difficult situations and questions

The main objective of Session 6 is to understand and learn how to handle difficult situations while interacting with the community.

6.1 Formulating answers and practising responses to frequently asked difficult questions

Exercise 9

Responding to difficult questions

Instructions:

Each of the following questions should be discussed as a group to identify collective solutions. The trainer should try to summarize the responses of the participants and include additional information if needed. Each of these scenarios can also be used for a role-play if this is preferred.

Examples of difficult questions that are frequently asked by the community are as follows:

• Who are you? Where have you come from?

For this question, it is important to give an effective introduction and form an effective rapport to allay the fears of community members.

• Why should we trust you with personal information?

A potential response could be: "You can be assured that your answers will be kept confidential. Your name will not be recorded on any document except the consent form; you will receive a copy of the same. The purpose of this data collection is not to focus on individuals and their personal information. The focus is to know the overall rates of suicide and self-harm in order to better support the community. This information will be available only to the staff of the community surveillance system and for research/evaluation purposes. Your personal information will not be shared with anyone and will be kept safely (e.g. password protected devices, within locked cabinets at the office). We have been trained to understand the importance of privacy and confidentiality. Therefore, please feel free to respond to the questions."

• Why are you asking for information from me? Why not from others?

A potential response to this question could be: "You are an important member of this community. You are probably one of the very few people in the community who would have the information we are asking for. Your opinion is very valuable to us as an important person in this community."

Continued>>

- Is there a risk in answering these questions? Will we lose our reputation?

A potential response could be: "Since your answers will be kept confidential, there is no risk of others getting to know the information you share with us. There is no risk of losing your reputation. We are simply conducting this interview to know more about how we can support people who are vulnerable and to ensure that suicide prevention services can reach persons in need. There is a possibility that you may be reminded of some past experiences which you do not wish to remember. If you feel overwhelmed during the interview process, you are free to leave the interview at any time without any implications or consequences. You can also refer to the information and resources for assistance that we provide."

- How does participating in this interview benefit me? Why should I bother?

A potential response could be: "Your answers are very valuable to us. This interview will help us to understand the extent of the problem within this area. It will help to advocate for making mental health services more accessible to those who are in need. In responding to the questions, you are helping us as well as the large community of individuals living with mental health issues and suicidal thoughts or who made a suicide attempt and are unable to access services to help them."

- The informant insists on making you talk directly to the affected person, insists that you refer the affected person to the hospital or police, or wants you to speak with the family.

A potential response could be: "We are here to gather data on suicides and self-harm. I understand that you may be aware of someone who may have self-harmed. However, adhering to the principle of confidentiality, it is difficult for me to speak directly with the person you have identified. It may be problematic for me to explain to that person how and from whom I received this information. It may also jeopardize your relationship and trust with this person."

"Having said that, it is important that help is provided to such a person. In this case, I would like to share this information leaflet. Since this information is generally available in the community, the person you refer to should not be made to feel that the pamphlet has been specifically made for them. If you are trusted by the person, you could also share the leaflet with them, assuring them that their details will not be shared with anyone else in the community. Alternatively, you may wish to place these leaflets somewhere in the community where everyone has free access to them."

- How do I support a person who needs immediate help?

A potential response could be: "If we become aware of a person who requires help and has expressed suicidal thoughts or plans or has self-harmed, this leaflet should be shared with them to show them how to access help. We will leave these information leaflets with you to be distributed generally to community members. If someone wishes to seek help, they can do so by referring to this leaflet."

- What should I do if the key informant is a family member of a person who has died by suicide or self-harmed?

Such a person should be treated as any other key informant. The surveillance fieldworker must emphasize the importance of confidentiality and the implications of not respecting it, especially for the person whose details are being shared. The information leaflet (provided at the end of each interview) can be given directly to the key informant who can choose to help the family member in distress accordingly.

03 Training for supervisors

03 Training for supervisors

The sessions in this chapter describe additional training for supervisors.

Session 7. Data management and matching cases

The objective of Session 7 is to standardize the process of matching. The different ways to approach data matching vary depending on the technical capacity and resources available (e.g. statistical software, Microsoft Excel, paper-based only). Ideally, persons with data management skills or trained statisticians will handle the data. The following is a guide only and can be modified according to the resources available.

7.1 General rules for data management and matching cases

- The CRFs should be submitted to the supervisors, preferably as electronic forms (based on Annex 3 and Annex 4), within three days of data collection. If the forms are not automatically linked to an electronic database, the information should be entered manually into separate key informant and health/police record surveillance databases respectively within three days of submission.

- The CRF data must be stored in a secure password-protected electronic database (e.g. Microsoft Excel) and should be managed by the data management team or supervisor (depending on local resources and data management skills).

- Using a logbook helps in keeping track of all the key informants who have been interviewed in a given month or who were not available (temporarily) or dropped out completely (including the reasons). It also helps in keeping track of new informants who are added (including their recruitment details). A logbook is also useful for keeping a record of the total number of CRFs submitted in a given month, as well as the total number of cases of suicide and self-harm. The supervisor updates the logbook within three working days of submission of the CRFs by the surveillance fieldworker. It is important that this information is kept confidential and is securely stored.

- Data should be reviewed, cleaned and matched no later than three working days after submission of CRFs by the surveillance fieldworker.

- At the time of matching, it should be possible to contact the surveillance fieldworker as it is important to clarify doubts when necessary.

- CRF data received from key informants should be stored in a separate database from CRF data received from health facilities and police stations.

- Two stages of matching are to be considered to derive unique events of suicide or self-harm, namely:
  - matching CRF data from multiple key informants; and
  - matching CRF data from key informants, health facilities and police records.

- To ensure accuracy in the matching process, both a software check and a manual check of duplicate cases should be conducted.

7.2 Matching CRF data from multiple key informants

• Assign identification codes. When data are stored in an electronic database, a personal identification number and an event number should be generated. Both are important, because the same person may have several acts of self-harm (repetition). This can be done using key information from the CRF (e.g. initials of legal first and last name [do not use nicknames], suicide or self-harm code, gender code, age, community identification number [ID] or health facility/police station ID, year of event, month and day – where the day, for instance, could be used to differentiate different events). This may be done manually in Microsoft Excel or by using a statistical software package.

• For example: John Smith, self-harm, male, age 33, community ID 021, incident occurred 9 May 2022 = JS2133021220509.

• The personal identification number can be used to identify duplicate reports about the same person by different key informants and a report of duplicates can be generated. Where duplicate reports about the same person are identified, the supervisor should assess the quality of the data from each key informant. Using information from multiple key informants, the supervisor should complete one new CRF that combines the information from the multiple key informants regarding one and the same person.

• If responses are varied from the key informants (e.g. the responses of informants related to the time of death vary from 09:00 to 19:00), the procedure should be as follows:

  1. Look for a majority. If most informants have given specific information, the majority needs to be considered and recorded by the supervisor in the new CRF.

  2. If there is an even number of conflicting responses (e.g. three informants mentioned 09:00 and three informants mentioned 19:00 as the time of death), responses from key informants with a closer relationship with the person should be considered more accurate and should take precedence. A close relationship would be defined by:
     • geographical proximity (i.e. the informant lives close by or was near the person when the act occurred);
     • relationship with the person (i.e. close familial relationship, working relationship, or relationship with regular contact);
     • source of information (i.e. first-, second- or third-hand [hearsay] information).
     If there is doubt, the programme manager should decide in consultation with the supervisor.

• Once a unique person is established and a new CRF completed, a unique identification number is entered in the database. This could be done, for instance, by adding a "U" (for "unique") to the person identification number which is then labelled "unique person identification number", or by adding a variable to the database which codes unique persons versus duplicate persons. Due attention needs to be given to repetition of self-harm, which means that not only is a unique person identification number assigned at this stage, but also a unique event number for which the code the day, for instance, could be used to differentiate between different events.

• If electronic data entry and storage are not feasible and a paper-based system is the only option, supervisors and surveillance fieldworkers should work together to review CRFs and identify cases of suicide and self-harm. Especially if the same case is reported by multiple informants, the surveillance fieldworker should help in matching the cases and in ascertaining the weightage to be given to each informant. Further information on matching using paper-based methods can be found in Annex 7.

7.3 Matching CRF data from key informants, health facilities and police records

• To ensure that valid suicide cases collected through key informants in the community (especially if a case has been reported by a single key informant), the data should be cross-validated with any official system that maintains records of suicide or self-harm (e.g. death registry, police records, health facility data).

• In the event of inadequate information or ambiguity during matching, the programme manager should be consulted.

• To match suicide and self-harm events from health/police records with key informant data, a new surveillance database should be generated which merges data from health and police records with key informant data. These data can be merged using the unique person identification number (which also allows identification of repetitions of self-harm by means of the date included in the code) with statistical software. Alternatively, if the use of a statistical software packages is not a viable option, manual searches of unique personal identification numbers can be conducted across both data sets to locate identical persons.

• If duplicates are detected, health facility and police data take precedence, given that these are considered officially recorded information and data from interviews with key informants in communities are considered as third-party information.

• For the final data set (after matching the data from multiple key informants and after matching with health facility and police records), unique personal identification numbers and unique event numbers can be replaced with completely random and de-identified codes (e.g. XY00FGS13568198). This would help to ensure confidentiality, as identifying information is used only for matching processes and is not stored in the same location as the final data set which is completely anonymized. A logbook of the anonymized codes with the corresponding identifiers should be kept in a separate secure database.

Session 8. Quality assurance

The objective of Session 8 is to learn about measures for quality assurance of data.

Quality refers to the standards that need to be maintained for the data gathered from informants. Quality assurance refers to the efforts, measures and procedures put in place to ensure the quality and accuracy of data being collected.

8.1 Refresher training

Refresher training is an important measure for revisiting concepts that have previously been learned, for ensuring continuity of good-quality work and for acquiring new skills. Meeting as a group can also minimize distress, ensure motivation and retention of staff members, and can provide an opportunity to share solutions to known challenges as well as success stories. The surveillance fieldworkers and supervisors should be trained by the programme manager on several topics during refresher trainings (Tables 3 and 4).

Table 3. Refresher training for surveillance fieldworkers

Topics	Based on the skills and knowledge gaps experienced by the surveillance fieldworkers, the following topics could be covered: • Interview skills • Qualities of a good data collector • Understanding stress and managing distress • Difficulties in the field and strategies to manage them.
Frequency	Once every 3 months
Duration	4 hours

Table 4. Additional refresher training for supervisors

Topics	Based on the skills and knowledge gaps experienced by the supervisors, the following topics could be covered: • Understanding stress and managing distress • Difficulties in the field and strategies to manage them.
Frequency	Once every 3 months
Duration	2 hours

8.2 Staff care

The well-being of staff is critical as it affects their ability to function in their role and to support affected populations (WHO, 2022d, 2022e). Surveillance fieldworkers and supervisors may experience distress as a result of:

- workload;
- travelling;
- monotonous work;
- listening to narratives of suicides and self-harm.

Proposed measures to prevent distress are as follows:

- *Clarity of roles and responsibilities at the time of recruitment:* The project staff must undergo a period of induction and orientation during which their roles and responsibilities are clarified so that they have a clear idea of what their work involves, the context in which they will work and the background of the project.

- *Management:* The management at each level should listen, empathize, respect, support, mentor and work with each other as a team. The management works towards setting realistic goals, work responsibilities and clear timelines at each level. Managers and supervisors should be available to meet with fieldworkers to debrief them about potentially stressful events that occur.

- *Communication:* For better management, it is important to have clear, open and consistent communication. The management should aim to create pathways of communication which keep the individuals' problems at the centre of the process. The method of problem-solving is collaborative in nature. Structures should be developed to enable consistent communication pathways between the project management, staff and volunteers in order to ensure adequate support.

- *Diverse responsibilities:* There is recognition of the diverse skills and capacities of the staff. The community surveillance system aims to recognize these skills and abilities so that roles and responsibilities can be assigned accordingly. The emphasis is on the quality of work rather than the quantity.

- *Recognition for work:* The efforts of the staff members will be recognized through small tokens of appreciation at regular intervals.

- *Meetings:* Regular individual and group debriefing sessions should be conducted not only to share challenges but also to encourage peer learning and support, recognize the work carried out by the surveillance fieldworkers and sustain motivation.

- *Psychosocial support:* Listening to narratives of suicide and self-harm can be deeply distressing. Staff are encouraged to access confidential mental health and psychosocial support. Tools and sources of support should be made available to all staff prior to training.

Proposed techniques to manage distress are as follows:

- sharing with peer network of fieldworkers;
- sharing concerns with someone close - such as a spouse, friend or family member – is important (and can be done without sharing details of the information gathered);
- maintaining a balance between work and leisure;
- taking a break from work for some time and spending time in recreation (which should be encouraged);
- doing regular exercise, using relaxation techniques and taking part in social activities;
- maintaining a regular and balanced diet and sleep patterns is important, as is avoiding negative ways of coping such as smoking, alcohol and substance misuse;
- if the stress cannot be managed, seeking professional help.

8.3 Field visits by the supervisor

When the supervisor visits individual surveillance fieldworkers, it is recommended to spend the entire day together in the field. The supervisor can provide feedback on the surveillance fieldworkers' performance on the basis of the expectations outlined for them. Field visits also help in observing other aspects of professional behaviour such as planning, coordination and the ability to manage uncertainties in the field. A field visit is not simply about observing the performance of the surveillance fieldworkers in the field, but is also about having an open discussion with them about the data they collect and the struggles and challenges in their work.

What to do during a field visit:

- The visit of the surveillance fieldworker should be documented and information shared with the data management team for feedback regarding the gaps and challenges in the field.
- On the evening before the visit at the latest, the surveillance fieldworker is informed about the visit by the supervisor.
- During the visit, the supervisor spends the entire day with the surveillance fieldworker and carefully observes her/his activities. The supervisor does not take over the tasks; however, the supervisor intervenes when an action could lead to potential harm (e.g. when incorrect information is given to the members of the community).

  The supervisor also observes the response of the community towards the community surveillance system and the surveillance fieldworker and takes notes during the visit.
- The supervisor sits with the surveillance fieldworker during a break to discuss the visit, share observations and gives feedback to the fieldworker about their work.
- It is expected that the feedback provided should be incorporated into the next set of interactions in the community.
- This is also an important opportunity for the supervisor and surveillance fieldworker to discuss challenges and to develop a plan to overcome them. The role of the supervisor is to support and mentor the surveillance fieldworker and not simply to highlight their shortcomings. Being a mentor also means giving assistance to bridge gaps and shortcomings.
- Before leaving, the supervisor shares some points for improvement and notes appreciation for the efforts of the surveillance fieldworker by highlighting the positive aspects of their work.

Each surveillance fieldworker should be visited by the supervisor regularly (e.g. twice per month). A surveillance fieldworker can also be visited as needed (e.g. if there is an emergency or there are doubts about the fieldworker's performance). Surveillance fieldworkers could also be contacted by supervisors by telephone if it is felt there is a need or in case of emergencies.

8.4 Spot checks for quality assurance

A spot check is different from a field visit because the supervisor makes an unannounced visit to the surveillance fieldworker.

- On the basis of the plan of the surveillance fieldworker for that day (which should be submitted to the supervisor every week), the supervisor arrives at the community directly and unannounced.

- A spot check could be planned to observe the quality of work of the surveillance fieldworker and/or the quality of the data being collected.

- If the quality of data is being checked, the supervisor could approach one or two key informants in the community and verify the data that have already been collected earlier by the fieldworker. This activity is distinct from a spot check but can be done during a spot check.

- A spot check could be done at any time of the day. However, the time of the spot check is not decided randomly. For instance, if there are doubts about a surveillance fieldworker spending the entire day in the field, a spot check could be conducted in the afternoon. If there are doubts about punctuality, a spot check could be conducted in the morning to observe the time at which the fieldwork is started.

- After reaching the field, the supervisor could call the surveillance fieldworker to announce her/his arrival. The supervisor needs to be aware which community should be covered on that day. Once informed, the supervisor can visit the surveillance fieldworker wherever they are within the community.

- Once a spot check is completed, the details need to be recorded.

Spot checks are carried out randomly (e.g. once a month).

8.5 Group meetings

Group meetings are essential for sharing learning and challenges. These meetings are led by the supervisors with the surveillance fieldworkers who report to them. The meetings can be used for learning a new skill or gathering more information on a specific topic. This helps to break the monotony of the fieldwork and allows the surveillance fieldworkers to take a step back, reflect and evaluate their work, the progress they have made, and the quality of the data being gathered.

Group meetings can be convened once every 4 months. Table 5 summarizes quality assurance activities and their scheduling.

Table 5. Summary of the quality assurance schedule

Activity	Method	Output	Time required (recommended)
Field visits	Face-to-face meetings in the field, need-based phone calls	Details of the visit are recorded.	All surveillance fieldworkers covered twice a month
Spot checks	Spot check in the field	Details of the visit are recorded (e.g. a summary of challenges, feedback, improvements required).	2-3 half days per month (once a month for each surveillance fieldworker)
Refresher training	Face-to-face sessions	Summary report prepared by the supervisor to be submitted to the programme manager.	4 hours - once in 3 months
Group meetings	Face-to-face sessions	Summary report of activities.	2-3 hours - once in 4 months

Documentation is an important aspect of quality assurance. The documentation provides evidence of the activities carried out, challenges faced, strategies discussed and the overall improvement over time.

Session 9. Reporting of surveillance outcomes and dissemination

Outcomes of surveillance systems of suicide and self-harm should be reported and disseminated to key stakeholders (e.g. policy-makers, NGOs, universities/research institutes, local hospital management, community organizations, and the community itself through local forums). A detailed explanation of statistical analysis and reporting is provided in WHO's *Practice manual for surveillance of suicide attempts and self-harm* (WHO, 2016). Readers are advised to consult this manual for further instructions on data analysis and reporting.

In brief, data should be processed and analysed quarterly at a minimum. Reports on numbers, trends and relevant comparisons should be made (e.g. by gender, age, ethnicity). The quarterly analysis of the data allows for summaries to be compiled and disseminated. Data can be disseminated in a variety of ways, including through quarterly and annual reports, evidence summaries and peer-reviewed publications. The dissemination of data can be utilized to inform government policy at local and national levels. The data serve a number of key objectives, such as informing stakeholders about specific trends in suicide and self-harm, describing priorities in terms of (emerging) high-risk groups, and drawing attention to frequently used and "new" methods of suicide and self-harm. These data can then also be used to inform planning, implementation and evaluation of suicide prevention interventions. For instance, if specific pesticides have been identified as a key means of suicide and self-harm, this information can provide impetus for regulatory action to ban such highly hazardous pesticides.

Annexes

Annex 1: Overview of White Mountain Apache (Celebrating Life) suicide surveillance and prevention system

In 2001, the White Mountain Apache Tribe agreed a tribal resolution that mandated all persons, departments and schools in the community to be responsible for reporting persons at risk for self-injurious behaviours. Information on suicidal or self-injurious behaviours – including suicidal ideation, non-suicidal self-injury, binge substance abuse, suicide attempt or suicide – can be reported by anyone in the community to the local mental health service (Cwik et al., 2016). Following this initial report, formal treatment services are offered by the community mental health service; simultaneously a Celebrating Life community mental health worker will follow up, in person, with the individual at risk to validate the initial report and support linkages and compliance with care. The Celebrating Life team then reviews the information that has been gathered and reaches a consensus on the coding of the event. Information is also routinely collected from local health services and police reports (for suicides) and corroborated with information gathered from community informants. All surveillance data are entered into a secure password-protected, online database.

Annex 2: General tips for the training

Training materials

It is suggested that the following training materials should be at hand for the training:

- slides (e.g. PowerPoint slides);

- the training manual;

- whiteboard with markers or blackboard with chalks;

- flipchart;

- blank sheets of paper and pen.

Training method

A participatory and active learning approach is used during the training. This requires using methods of active participation as follows:

- Discussions help develop critical thinking, communication and listening skills. They require no materials and can be conducted with small or large groups. Topics for discussion should generate debate with questions about "why" and "how". Discussions can be prompted by asking questions or by narrating an incident as an example.

- Role-play allows participants to express their viewpoints in their own words. It is important for participants to develop their own scripts for conducting interpersonal interactions and resolving problems. After the activity is completed, it is important to review it by encouraging discussion in which participants express their views.

- It is important to review activities, no matter which active learning method is used. Issues to explore include what you learned, what you did, why you did it, what you felt and how you think the others felt? This reflection helps participants to transfer their learning from an active learning method to real settings. After reviewing the activity, participants are ready to link their learning to their activities and practise new skills in real-life situations.

Conducting the training

• Programme managers train supervisors and surveillance fieldworkers. Depending on the setting, a model of training could be envisaged whereby the programme managers train supervisors who in turn train surveillance fieldworkers.

• The training must be in a language that allows participants to participate effectively in the training.

• The trainer, who would normally be the programme manager, should inform the participants in advance that some content may trigger emotions in some of them. In such a scenario, they should reach out to the trainer for help. Trainers should also provide to participants with an information leaflet (Annex 5) which lists resources for support and help.

• The trainer should establish some group agreements (e.g. restriction on the use of mobile telephones during the training).

• Use open-ended questions ("can you tell me about …") and do not encourage yes/no answers.

• Probe further and ask questions - for instance: "Can you elaborate on that?" "Can you explain where you are coming from?" "Can you share an example of what you mean?"

• Encourage participants to answer each other's questions rather than relying solely on the trainer. Encourage as much discussion as possible.

• Encourage each person to speak. If one person dominates the discussion, ask that person politely to hold back their comments. Others in the group can be asked to share their views.

• Summarize and paraphrase what participants say to make sure you understand them correctly.

• Be prepared for each training session. The trainer must do adequate preparation and reading.

• Since most of the training activities are group activities, sitting in a circle is helpful. The trainer should be at the same level as the participants.

• If you do not know an answer, frankly admit it. Tell the group you will find out and inform them the next time. Follow through with your promise.

Annex 3: Case report form for key informants

Note: Use a separate form for each reported case of suicide or self-harm. This form can be converted to an electronic form and linked to an electronic database to be exported, for example, in Microsoft Excel or CSV format. The form should be adapted to suit local contexts. Questions relevant to the local context can be added to provide additional insights.

Survey information	Response	
Village/community identification code (ID)	☐☐☐	
Village/community name		
Fieldworker ID		
Supervisor ID		
Date of interview		
Consent has been read and obtained	YES 1 NO 2 If NO, END THE INTERVIEW	
Key informant (tick one option only)	Head of the community	1
	Community religious leader	2
	Private physician	3
	Community health worker	4
	Nurse/midwife	5
	School principal/teacher	6
	Staff of crematorium/cemetery	7
	Other, please specify_____	8
Person identification number (generate after completion of form). Use: • Initials (legal first and last name) • Initials (first and last name) or first two letters of given name of person if only one name is provided • Suicide (1) or self-harm (2) code • Gender code (male = 1, female = 2, other = 3) • Age, or age range if specific age unknown (e.g. any age between 30 and 39 years is coded as 30) • Community ID • Year, month and day of incident (e.g. John Smith, self-harm, male, age 33, community ID 021, incident occurred 9 May 2022 = JS2133021220509	☐☐☐☐☐☐☐☐☐☐☐☐	
Event number	☐☐☐☐☐☐☐☐☐☐☐☐	

Case report information – related to the person who has died by suicide or has self-harmed		
Demographic information	**Response**	
Suicide or self-harm case?	Suicide	1
	Self-harm	2
Family name		
First name		
Gender	Male	1
	Female	2
	Other, please specify_____	3
Date of birth	☐☐ ☐☐ ☐☐☐☐ dd/mm/yyyy	
Age (years)	☐☐ If unsure, specify range: _____	
Religion (adapt to local context)	Buddhist	1
	Christian	2
	Hindu	3
	Islam	4
	Jewish	5
	No religion	6
	Other, specify_____	7
	Not known	88
Ethnicity (adapt to local context)	[Locally defined]	1
	[Locally defined]	2
	[…]	3
	Not known	88
Marital status	Never married	1
	Currently married	2
	Cohabiting/living with partner	3
	Separated	4
	Divorced and not remarried	5
	Widowed and not remarried	6
	Not known	88
Highest level of education completed (adapt to local context)	No formal schooling	1
	Less than primary school	2
	Primary school completed	3
	Secondary school completed	4
	High school completed	5
	College/University completed	6
	Postgraduate degree	7
	Not known	88
Employment status	Government employee	1
	Non-government employee	2
	Daily wage earner	3
	Self-employed	4
	Non-paid	5
	Student	6
	Homemaker	7
	Retired	8
	Unemployed (able to work)	9
	Unemployed (unable to work)	10
	Not known	88

Information on the incident of suicide or self-harm	Response		
Date of incident	☐☐ ☐☐ ☐☐☐☐ dd/mm/yyyy		
	If unsure, specify tentative date or range:		
	Not known	88	
Time of incident (24 hour clock)	If known, specify	☐☐ : ☐☐ hr : mins	
	If unsure, give tentative time	☐☐ : ☐☐ hr : mins	
	Not known	88	
Method according to ICD-10 codes (see Annex 5 for full list of methods) If the person used multiple methods, all methods should be recorded; for intentional self-poisoning (X60–X69), the name of the substance should be provided.	ICD-10 code	x ☐	
	If self-poisoning, specify substance	x ☐	
	Other, specify	x ☐	
	Not known	88	
Was the person under the influence of any substance (e.g. drugs/alcohol) when the incident occurred?	Yes, specify	1_____	
	No	2	
	Not known	88	
Did the person previously attempt suicide or self-harm?	Yes, specify number of attempts if known	1_____	
	No	2	
	Not known	88	
Did the person leave a suicide note?	Yes	1	
	No	2	
	Not known	88	
Location of incident (if known)			
Was the person taken to a health-care facility/professional?	Yes	1	
	No	2	
	Not known	88	
a. If yes, specify what for:	Outpatient medical treatment	1	
	Admission, specify number of days	2_____	
	Counselling	3	
	Not known	88	
b. If yes, specify the health-care facility/professional to which the person was referred:	Public hospital	1	
	Private hospital	2	
	Health facility run by NGO/trust	3	
	Community health facility	4	
	Other, specify	5_____	
	Not known	88	
c. If yes, outcome on discharge:	Survived self-harm	1	
	Referral to another critical care facility	2	
	Death	3	
	Other, specify	4_____	
	Not applicable, person was deceased on arrival	5	
	Not known	88	
Additional notes			

01 **Introduction**	02 **Training of surveillance fieldworkers**	03 **Training for supervisors**	Annexes

Annex 4: Case report form for health facilities and police stations

Note: This form can be converted to an electronic form and linked to an electronic database to be exported, for example, in Microsoft Excel or CSV format. The form should be adapted to suit local contexts. Questions relevant to the local context can be added to provide additional insights.

Data source information	Response		
Cluster/village/community identification code (ID)	☐☐☐		
Cluster/village/community name			
Fieldworker ID			
Supervisor ID			
Date of visit			
Data source and ID	Police station	1	☐☐☐
	Health facility	2	☐☐☐
Name of data source (health facility or police station)			
If health facility, specify	Primary/community health- care centre	1	
	Public hospital	2	
	Private hospital	3	
	Hospital run by NGO/trust	4	
	Other facility, specify	5_____	

ID*	Event number	Case	Name		Gender	Date of birth	Age	Date of incident	Method according to ICD-10 codes (see Annex 5 for full list of methods)	Additional notes
		Suicide = 1 Self-harm = 2	Family surname	First name	Male = 1 Female = 2 Other = 3	DD/MM/YYYY	Specify in years	DD/MM/YYYY	If the person used multiple methods, all methods should be recorded; for intentional self-poisoning (X60–X69), the name of the substance should be provided.	

*Personal identification number (generate after completion of form). Use:

- Initials (legal first and last name)
- Suicide (1) or self-harm (2) code
- Gender code (male = 1, female = 2, other = 3)
- Age, or age range if specific age unknown (e.g. any age between 30 and 39 years is coded as 30)

- Health-care facility/police station ID
- Year, month and day of incident
- Example: John Smith, self-harm, male, age 33, community ID 021, incident occurred 9 May 2022 = JS2133021220509

Annex 5: ICD-10 codes for intentional self-harm

X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics.

X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified.

X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified.

X63 Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system.

X64 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances.

X65 Intentional self-poisoning by and exposure to alcohol.

X66 Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours.

X67 Intentional self-poisoning by and exposure to other gases and vapours.

X68 Intentional self-poisoning by and exposure to pesticides.

X69 Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances.

X70 Intentional self-harm by hanging, strangulation and suffocation.

X71 Intentional self-harm by drowning and submersion.

X72 Intentional self-harm by handgun discharge.

X73 Intentional self-harm by rifle, shotgun and larger firearm discharge.

X74 Intentional self-harm by other and unspecified firearm discharge.

X75 Intentional self-harm by explosive material.

X76 Intentional self-harm by smoke, fire and flames.

X77 Intentional self-harm by steam, hot vapours and hot objects.

X78 Intentional self-harm by sharp object.

X79 Intentional self-harm by blunt object.

X80 Intentional self-harm by jumping from a high place.

X81 Intentional self-harm by jumping or lying before moving object.

X82 Intentional self-harm by crashing of motor vehicle.

X83 Intentional self-harm by other specified means.

X84 Intentional self-harm by unspecified means.

Annex 6: Sample information leaflet

The information leaflet provides details on locally available resources for crisis, mental health and welfare services.

Type of services	Name of authorities/ services	Contact details of authorities/ services	Address of authorities/ services	Working hours of authorities/ services
Crisis lines, including for suicide prevention				
Mental health-care services				
Social welfare services				
Child protection and welfare services				
Women's protection and welfare services				
Psychosocial support groups/ community peer support				
Postvention services				

Annex 7: Matching using paper-based methods

• Supervisors and surveillance fieldworkers collaborate in reviewing CRFs and identifying cases of suicide and self-harm (Table 8). Especially if the same case is reported by multiple informants, the surveillance fieldworker helps to match the case and to ascertain the weightage to be given to each informant.

Table 8. Illustration of data-matching to identify cases of suicide and self-harm

Data-matching example

Name of village 1	Key informants				
	1	2	3	4	5
Self-harm	a	?	a	a	?
Suicide	X	x	?	?	x

• If the informants are talking about the same person, the supervisor and surveillance fieldworker will be able to match "a" as one person who self-harmed in a given month. Only one de-identified ID of "a" will be entered into the database.

• In the same way, the supervisor and surveillance fieldworker will be able to match "x" as one person who died by suicide. Only one de-identified ID of "x" will be entered into the database.

• Matching is carried out by the supervisor in charge of the surveillance fieldworker who has collected the information about a specific case of death by suicide or self-harm. At the time of matching, it is important that the surveillance fieldworker is present to clarify doubts as necessary.

• All the information gathered by the surveillance fieldworker should have been entered in the CRF (Annex 3).

• If the responses of the informants vary (e.g. the responses related to the time of death vary from 09:00 to 19:00), the following steps should be taken:

  • Look for a majority. If most informants have given specific information, the majority needs to be considered.

  • In case there is an even number of responses (e.g. three informants mentioned 09:00 and three informants mentioned 19:00 as the time of death), the rule of familiarity applies. Familiarity means the following:

    • geographical proximity (i.e. the informant lives close by or was near the person when the act occurred);

    • relationship with the person (i.e. close familial relationship, working relationship, or relationship with regular contact);

    • source of information (i.e. first-, second- or third-hand [hearsay] information).

All these factors will affect the weightage given to the responses of the informants and will be considered when deciding which information should be recorded. If there is doubt, the programme manager will decide in consultation with the supervisor.

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Training manual for
surveillance of suicide
and self-harm in
communities via key
informants

World Health
Organization