Ecological Perspectives on Suicide
Desk Review and Training Report
Taluka Hospital Kandiaro
District Noushero Feroze Sindh

Sindh Mental Health Authority

بِسۡمِ ٱللَّهِ ٱلرَّحۡمَٰنِ ٱلرَّحِيمِ

مِنْ أَجْلِ ذَٰلِكَ كَتَبْنَا عَلَىٰ بَنِي إِسْرَائِيلَ أَنَّهُۥ مَن قَتَلَ نَفْسًۢا بِغَيْرِ نَفْسٍ أَوْ فَسَادٍ فِى ٱلْأَرْضِ فَكَأَنَّمَا قَتَلَ ٱلنَّاسَ جَمِيعًا ۖ وَمَنْ أَحْيَاهَا فَكَأَنَّمَآ أَحْيَا ٱلنَّاسَ جَمِيعًا

Surah Al-Ma’idah (5:32)

ترجمہ

اسی وجہ سے ہم نے بنی اسرائیل پر یہ حکم لکھ دیا کہ جس نے کسی ایک جان کو بغیر کسی جان کے بدلے یا زمین میں فساد پھیلانے کے بغیر قتل کیا تو گویا اس نے تمام انسانوں کو قتل کیا، اور جس نے کسی ایک جان کو بچایا تو گویا اس نے تمام انسانوں کو بچایا۔

Message

Suicide is a serious and growing public health concern in Sindh. It is not caused by a single factor but is the result of multiple pressures—mental health conditions, economic hardship, family conflicts, social isolation, and limited access to care. These challenges are present across many districts, but they often remain hidden due to stigma and lack of awareness.

This report, focusing on Tehsil Kandiaro, is an important step toward understanding suicide through the ecological model. It helps us see how individual, family, community, and societal factors are connected. Such understanding is essential if we want to design practical and effective solutions.

I strongly appreciate the efforts of the district administration and district health department, especially the leadership shown by Assistant Commissioners and local officials. Their initiative to highlight the issue of suicide and to seek solutions within available resources is commendable. This reflects a positive shift toward recognizing mental health as a priority at the grassroots level.

At the community level, there is a strong need to promote self-help approaches. Families, teachers, community leaders, and healthcare workers can play a vital role in early identification of individuals at risk. Simple actions listening without judgment, providing emotional support, and guiding individuals toward available services can save lives. Strengthening awareness and building trust within communities are key steps forward.

At the same time, we must recognize the gaps in our system. There is a clear shortage of trained mental health professionals across Sindh. Addressing this gap requires focused efforts, including the hiring and placement of mental healthcare workers, especially at primary and secondary healthcare levels. Building the capacity of existing healthcare staff through training is equally important.

I also encourage academic institutions and researchers to take a more active role in studying suicide through the ecological model. There is a need for local evidence that not only identifies risk factors but also highlights practical, low-cost solutions that can be implemented within existing resources.

The Sindh Mental Health Authority remains committed to working with government departments, academia, and communities to strengthen mental health services and prevent suicide. Together, through awareness, collaboration, and practical action, we can protect lives and build healthier communities.

Karimkhuwaja

Senator Dr. Karim Ahmed Khuwaja
Chairperson Sindh Mental Health Authority

Foreword

Suicide is not only an individual tragedy; it reflects deeper social, economic, and psychological challenges within our communities. In many parts of Sindh, including Tehsil Kandiaro, the issue remains under-discussed and poorly understood. This report, “Understanding of Suicide: Under Ecological Model through Desk Review”, is an effort to bring clarity, evidence, and direction to this critical public health concern.

The ecological model helps us understand suicide at multiple levels including; individual, family, community, and societal. By using a desk review approach, this report gathers available evidence and connects it with local realities. It highlights how factors such as mental health conditions, poverty, social pressures, and limited access to services contribute to suicidal behaviour.
This document is not just an academic exercise; it is a practical guide. It aims to support policymakers, healthcare providers, and local administration in designing effective interventions.

Special attention has been given to the need for early identification of individuals at risk and the establishment of a clear referral mechanism.

I hope this report will serve as a foundation for informed action and encourage collaborative efforts to prevent suicide and promote mental well-being in Sindh Province.

Talpuralimurad

Talpur Ali Murad
Social Development Practitioner and Researcher

ACKNOWLEDGEMENT

The Sindh Mental Health Authority acknowledges the valuable contributions of individuals and institutions who supported the awareness and training session to understand suicide.

We are especially thankful to the district administration for their proactive role. We extend our sincere appreciation to Mr. Muhammad Arsalan, (DC Noshero Feroze) Raza Shar (AC Mehrabpur) and Noor ul Huda (AC Kandiaro) for their commitment to addressing mental health issues at the community level.

Their initiative to approach SMHA and request awareness and training sessions for healthcare workers reflects strong leadership and concern for public well-being.

We also recognize the efforts of healthcare professionals who are at the frontline of identifying and supporting individuals with suicidal thoughts. Their role is critical in ensuring early detection and timely referral.

Special thanks to Taluka Headquarter Hospital and all stakeholders who contributed directly or indirectly to this awareness session and healthcare workers training. Their support has made it possible to develop a meaningful and action-oriented event.

ZafarShah

Dr. Syed Zafar Mehdi Shah
Secretary Sindh Mental Health Authority

MASTER TRAINER PROFILE

Prof. Dr. Chunilal is a highly respected psychiatrist and academic leader, currently serving as the Head of the Department of Psychiatry at Jinnah Postgraduate Medical Centre (JPMC), Karachi. He has extensive experience in clinical psychiatry, teaching, and mental health system strengthening.

With years of service in both public health and medical education, Dr. Chunilal has played a key role in promoting mental health awareness and improving psychiatric care services in Sindh. His work focuses on early diagnosis, community-based interventions, and capacity building of healthcare professionals.

As a Master Trainer, Dr. Chunilal has trained numerous doctors, nurses, and healthcare workers on the identification and management of mental health conditions, including suicide risk assessment. His training approach is practical, evidence-based, and tailored to local needs.

In this initiative, his guidance is instrumental in strengthening the capacity of healthcare workers in Tehsil Kandiaro, district Nosheroferoze. His expertise supports the development of effective referral mechanisms and enhances the ability of frontline staff to respond to individuals with suicidal thoughts in a timely and compassionate manner.

Chunilal

Professor (Psych) Dr. Chunilal
Head of Psychiatry Department, JPMC

ACRONYMS

BHU – Basic Health Unit
Primary rural health facility providing frontline healthcare services.

CBT – Cognitive Behavioural Therapy
Evidence-based therapy targeting hopelessness and negative thinking patterns.

DALY – Disability-Adjusted Life Years
Measure of overall disease burden combining death and disability.

DHQ – District Headquarter Hospital
Main district hospital with specialist services including psychiatry (where available).

DSM-5 – Diagnostic and Statistical Manual
Manual Mental Disorders (5th Edition) Standard psychiatric classification used for diagnosing mental disorders linked to suicide risk.

GHE – Global Health Estimates
WHO statistical system used for global mortality and suicide data.

ICD-11 – International Classification of Diseases (11th Revision)
WHO diagnostic coding system for mental and behavioral disorders, including suicide classification.

IMV – Integrated Motivational–Volitional Model
O'Connor's framework explaining progression from defeat → ideation → suicidal action.

IPTS – Interpersonal Theory of Suicide
Joiner's model: suicide risk arises from thwarted belongingness + perceived burdensomeness + capability.

LMICs – Low- and Middle-Income Countries
Countries with limited resources where most global suicides occur (~73%).

MHPSS – Mental Health and Psychosocial Support
Integrated interventions addressing psychological and social dimensions of distress.

PHC – Primary Health Care
First-level healthcare system for early identification and referral of mental health cases.

RHC – Rural Health Centre
Intermediate primary care facility between BHU and THQ for rural populations.

SDG – Sustainable Development Goals
UN targets; SDG 3.4 aims to reduce premature mortality from NCDs and mental health issues including suicide.

SMHA – Sindh Mental Health Authority
Provincial body overseeing mental health governance and services in Sindh.

THQ – Tehsil Headquarter Hospital
Secondary care facility at sub-district level providing basic inpatient and outpatient services.

WHO – World Health Organization
Global UN health agency providing suicide estimates, guidelines, and prevention frameworks.

YLD – Years Lived with Disability
Years lived with reduced quality of life due to mental health conditions.

YLL – Years of Life Lost
Years lost due to premature death from suicide.

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Executive Summary

Suicide is a complex, multi-dimensional phenomenon shaped by the interaction of sociological structures and individual psychological processes. Classical theory, particularly the work of Émile Durkheim, established that suicide cannot be understood in isolation from society. Durkheim identified four types, including; egoistic, altruistic, anomic, and fatalistic arising from imbalances in social integration and regulation. His central insight, that suicide is a "social fact," remains foundational: weak social bonds, rapid societal change, or excessive control can all increase vulnerability.

Contemporary suicidology complements this perspective by examining internal psychological mechanisms. Edwin S. Shneidman emphasized "psychache," or intolerable psychological pain, as the immediate driver of suicidal behaviour. Thomas Joiner's Interpersonal Theory highlights the combined effect of thwarted belongingness, perceived burdensomeness, and acquired capability. Cognitive models developed by Aaron T. Beck link hopelessness and negative thinking patterns to suicide risk, while Roy F. Baumeister conceptualized suicide as an escape from distressing self-awareness. More recent frameworks, including the Integrated Motivational Volitional model and the Three-Step Theory, integrate these ideas into phased pathways from distress to action. Together, these theories underscore that suicide emerges when psychological pain, social disconnection, and enabling conditions converge.

An ecological model provides a comprehensive lens to synthesize these insights. At the individual level, factors such as mental illness, substance use, prior attempts, and chronic stress increase risk. Interpersonal dynamics family conflict, violence, neglect, and social isolation further compound vulnerability. At the community level, poverty, limited access to healthcare, and social disorganization create environments where support systems are weak. At the societal level, stigma, cultural norms, economic instability, and access to lethal means significantly shape both risk and reporting. Protective factors resilience, social support, coping skills, and accessible care operate across all these levels and are critical for prevention.

Globally, suicide remains a major public health challenge. According to the World Health Organization, approximately 727,000 people died by suicide in 2021, with it ranking among the leading causes of death for young people aged 15–29. Notably, nearly three-quarters of these deaths occur in low- and middle-income countries, reflecting disparities in healthcare access, socioeconomic conditions, and prevention systems. Common methods vary by context but frequently include pesticide poisoning, hanging, and firearms (gun shot), highlighting the importance of means restriction in prevention strategies.

In Pakistan, the burden of suicide is likely underestimated due to underreporting, stigma, and its historical criminalization. Available estimates suggest a rate comparable to the global average, with a disproportionate impact on young people and males. Evidence from media and hospital-based studies indicates that domestic conflict, financial stress, and relationship issues are common triggers, while poisoning often involving pesticides remains a predominant method. Within Sindh, Naushahro Feroze reflects a moderate but important share of suicide burden, contributing about 4% of reported cases. Although not among the highest-incidence districts, its relative position within its division highlights localized ecological risks, particularly at interpersonal and community levels. This underscores the need for strengthening primary mental healthcare, community awareness, and early referral mechanisms in such mid-burden districts to prevent escalation and address hidden, underreported cases.

Despite growing recognition of suicide as a public health priority, systemic gaps in Sindh province's mental health infrastructure limit effective prevention. There is a critical shortage of trained mental health professionals, particularly psychiatrists, psychologists, and psychiatric nurses, especially in rural and underserved districts. Secondary care facilities Tehsil Headquarters (THQs) and District Headquarters (DHQs) often lack functional psychiatry wards, trained staff, and essential psychotropic medications. At the primary healthcare level, providers typically have limited capacity to prescribe and manage mental health conditions, resulting in missed opportunities for early intervention.

Addressing these gaps requires a coordinated, multi-level response aligned with the ecological model.

Strengthening Human Resources for Mental Health

A structured plan is needed to expand the mental health workforce through recruitment, task-shifting, and incentives for rural deployment. Integrating psychiatrist, psychologists and counsellors into district health systems can significantly improve access to care.

Establishing Functional Psychiatry Units at DHQs and THQs

Basic psychiatry wards with trained staff, referral mechanisms, and essential medicines should be institutionalized at secondary care levels. This will enable timely management of high-risk individuals.

Capacity Building of Primary Healthcare Providers

Doctors, nurses, and Lady Health Workers should be trained in early identification of depression, anxiety, substance use, and suicidal ideation using simple screening tools. Embedding mental health into primary care can substantially increase detection and early support.

Strengthening Referral Pathways

Clear, standardized referral systems from community to primary care, and onward to secondary and tertiary facilities must be developed and practiced. This includes crisis response protocols and linkage with helplines where available.

Community Awareness and Gatekeeper Training

Regular awareness sessions at community, school, and workplace levels can reduce stigma and promote help-seeking behaviour. Training teachers, community leaders, and frontline workers as "gatekeepers/caretakers" enables early recognition of warning signs and timely referral.

Means Restriction and Policy Measures

Regulating access to highly hazardous pesticides, promoting safe storage, and responsible media reporting can significantly reduce suicide rates, as evidenced globally.

Data Systems and Research

Improved surveillance systems, including integration of suicide reporting into health information systems, are essential for evidence-based planning. Collaboration with academic institutions can support research on local risk patterns within the ecological framework.

In conclusion, suicide prevention requires moving beyond fragmented approaches toward an integrated, ecological strategy that addresses both individual vulnerabilities and structural determinants. Bridging gaps in mental health services particularly human resources, facility readiness, and primary care capacity combined with community engagement and policy reforms, can substantially reduce suicide risk. The convergence of sociological and

psychological theories provides not only a deeper understanding of suicide but also a clear direction for multi-sectoral, context-sensitive interventions in Pakistan and similar settings.

Suicide: Theory, Epidemiology, and Context

Suicide is best understood as a multi-layered phenomenon in which individual vulnerability interacts with relational, community, and societal conditions. A desk review of classical and contemporary theories, combined with global and Pakistani evidence, shows that no single factor explains suicidal behaviour; rather, it emerges when pressures across the ecological system converge without adequate protective support.

Theoretical Foundations within an Ecological Perspective

The earliest systematic explanation comes from Émile Durkheim, who conceptualized suicide as a product of social structure rather than merely individual pathology. His four types, including; egoistic, altruistic, anomic, and fatalistic map directly onto ecological levels. Egoistic suicide reflects weak interpersonal and community integration; altruistic suicide reflects excessive social control; anomic suicide arises from societal instability and breakdown of norms; and fatalistic suicide stems from oppressive regulation. Durkheim's contribution remains critical because it situates suicide within community and societal dynamics, emphasizing that strengthening social cohesion and stability is inherently preventive.

Psychological theories later deepened understanding at the individual level. Sigmund Freud introduced the idea of suicide as inward-directed aggression rooted in unresolved grief and internal conflict. Building on this, Edwin S. Shneidman proposed that unbearable psychological pain "psychache" is the immediate driver of suicide, framing suicidal behaviour as a response to intolerable emotional suffering rather than a desire for death itself. This perspective highlights the need for empathetic, person-centred interventions.

Cognitive approaches led by Aaron T. Beck identified hopelessness and distorted thinking as central risk factors, suggesting that individuals who perceive no positive future are more likely to consider suicide. Roy F. Baumeister further argued that suicide can function as an escape from painful self-awareness, where individuals seek relief from perceived failure and self-criticism. These models collectively emphasize interventions that reduce psychological distress, restore hope, and improve coping mechanisms.

Interpersonal and integrative models extend this understanding across ecological layers. Thomas Joiner's Interpersonal Theory explains that suicide risk intensifies when individuals feel disconnected (thwarted belongingness), perceive themselves as a burden, and develop the capability to enact self-harm. This framework bridges individual and interpersonal domains, highlighting modifiable social conditions. Empirical work by Kelly A. Van Orden validated these constructs and strengthened their application in prevention.

At the community level, Harriet I. Kushner and Cynthia C. Sterk revisited Durkheim's ideas through the lens of social capital, demonstrating that weakened trust and cohesion within communities elevate suicide risk. This reinforces the importance of collective environments in shaping individual outcomes.

More recent models integrate multiple stages and pathways. The Three-Step Theory by E. David Klonsky explains that suicide emerges when pain and hopelessness outweigh connectedness, followed by the development of capability. Similarly, the Integrated Motivational–Volitional model by Rory C. O'Connor and Olivia J. Kirtley conceptualizes suicide as a progression from feelings of defeat and entrapment to ideation and then action, emphasizing intervention at each phase. The Fluid Vulnerability perspective, associated with scholars like Craig J. Bryan, further highlights that suicide risk fluctuates over time and can be buffered by timely support and coping strategies.
Across all these theories, a clear convergence emerges that suicide is not a sudden act but the endpoint of interacting risks across ecological levels, and prevention must therefore be equally multi-layered.

Ecological Model of Suicide Risk

The ecological framework organizes suicide risk into four interrelated levels.

Individual Level

Mental health conditions (depression, substance use, psychosis), prior attempts, trauma, chronic illness, and impulsivity significantly increase vulnerability. Psychological theories psychache, hopelessness, and escape primarily operate at this level. Effective responses include clinical treatment, counselling, and development of coping and emotional regulation skills.

Interpersonal Level

Family conflict, domestic violence, social isolation, bereavement, and relationship breakdowns are critical drivers. Interpersonal theories highlight that lack of belonging and perceived burden amplify risk. Strengthening family systems, peer networks, and social support mechanisms is essential.

Community Level

Poverty, unemployment, weak social cohesion, and limited access to healthcare create environments where risk accumulates. Sociological perspectives emphasize that disconnected or marginalized communities experience higher suicide rates. Community-based mental health programs, economic support initiatives, and engagement of local gatekeepers (teachers, religious leaders, community workers) are key preventive strategies.

Societal Level

Cultural stigma, legal barriers, media portrayal, gender norms, and access to lethal means shape both behaviour and reporting. Societal interventions include anti-stigma campaigns, responsible media guidelines, and regulation of high-risk means such as pesticides and firearms.
This ecological structure demonstrates that each theory aligns with one or more levels, and effective prevention must simultaneously address all four.

Global and National Evidence

According to the World Health Organization, approximately 727,000 people died by suicide globally in 2021, with an age-standardized rate of about 9.1 per 100,000. Suicide is among the leading causes of death for young people aged 15–29, and nearly 73% of cases occur in low- and middle-income countries. Methods vary by context, with pesticide poisoning, hanging, and firearms being most common, underscoring the importance of means restriction.
In Pakistan, the true burden remains uncertain due to underreporting and stigma. Estimates suggest rates close to the global average, with approximately 19,000 deaths annually in recent years. Evidence indicates that young individuals and males are disproportionately affected,

although some regions particularly in Sindh show higher female vulnerability. Common triggers include domestic conflict, financial hardship, and relationship issues, while poisoning (often pesticides) and hanging are the predominant methods.

Sindh province illustrates important sub-national variation. Data from regional mapping exercises (2016–2020) indicate district-level disparities, with areas such as Naushahro Feroze presents a moderate but consistent suicide burden within Sindh, accounting for approximately 31 reported cases (around 4%) of total registered suicides during 2016–2020. While it does not rank among the highest-burden districts such as Tharparkar, Badin, or Dadu, its position within the Shaheed Benazirabad divisional cluster indicates a notable intra-divisional contribution. Compared to other districts in the same division, Naushahro Feroze reflects a mid-to-upper range pattern, suggesting localized vulnerability rather than extreme crisis. From an ecological perspective, this pattern is likely driven by interpersonal stressors (domestic conflict, relationship issues) and community-level pressures (semi-rural economy, limited access to mental health services), rather than the severe structural deprivation seen in high-burden districts. At the societal level, underreporting due to stigma and legal sensitivities further obscures the true magnitude, indicating that the actual burden may be higher. Overall, Naushahro Feroze represents a transitional risk setting, where strengthening primary healthcare capacity, early identification, and referral systems could significantly reduce suicide risk.

Synthesis: Linking Theory, Evidence, and Prevention

When integrated, theoretical models and empirical data point toward a unified understanding the suicide risk escalates when psychological distress is combined with social disconnection, economic hardship, and limited access to care. Each theoretical contribution aligns with a prevention domain.

- Social theories emphasize strengthening community cohesion and stability.
- Psychological models highlight reducing emotional pain, hopelessness, and maladaptive thinking.
- Interpersonal frameworks focus on rebuilding belonging and reducing perceived burden.
- Integrated models stress early identification and interruption of the pathway from ideation to action.
- This alignment translates directly into ecological prevention strategies clinical care at the individual level, family and peer support at the interpersonal level, community engagement and service delivery at the local level, and policy reforms at the societal level.
- **Systemic Challenges and Priority Actions**
- The shortage of trained mental health professionals, absence of functional psychiatry units in many District and Tehsil Headquarters Hospitals, and limited capacity at the primary healthcare level constrain effective response and to address these gaps, priority actions include.

- **Expanding Mental Health Human Resources**
- Recruitment, training, and retention of psychiatrists, psychologists, and counsellors, with incentives for rural deployment.
- **Establishing Psychiatry Services at DHQ and THQ Levels**
- Functional units with essential medicines and trained staff to ensure decentralized care.
- **Capacity Building in Primary Healthcare**
- Training frontline providers to identify early signs of depression, anxiety, and suicidal ideation using simple screening tools.
- **Strengthening Referral Pathways**
- Clear and practiced systems linking community, primary, and secondary care, ensuring timely management of high-risk individuals.
- **Community Awareness and Gatekeeper Training**
- Engaging teachers, community leaders, and health workers to recognize warning signs and facilitate early intervention.
- **Means Restriction and Policy Measures**
- Regulation of hazardous pesticides and promotion of safe media reporting practices.
- **Improved Data and Research Systems**
- Strengthening surveillance and encouraging academic collaboration to generate local evidence, particularly in high-burden districts.

Conclusion

A comprehensive understanding of suicide requires integrating sociological, psychological, and public health perspectives within an ecological model. Theories from Durkheim to contemporary scholars collectively demonstrate that suicide is not solely an individual act but the outcome of interacting vulnerabilities across multiple levels. Global and Pakistani evidence further confirms that social context, economic conditions, and health system capacity critically shape risk patterns.

Effective prevention, therefore, must be multi-sectoral and system-oriented combining mental health service expansion, community strengthening, and policy action. Addressing current gaps in human resources, service availability, and early detection mechanisms is essential to reducing suicide burden, particularly in underserved regions such as Sindh.

Awareness Session and Capacity-Building Training on Suicide Prevention within an Ecological Framework

Venue: THQ Kandiaro
District: Naushahro Feroze
Date: Monday, 2 March 2026
Facilitator: Professor Dr. Chunnilal Head of Psychiatry Department, JPMC
Participants: 50–75 primary healthcare providers (Medical Officers, LHVs, Nurses, Paramedics, District Health Staff)

Background and Strategic Alignment

This training was conducted as part of the broader desk review on suicide under an ecological model, which highlights that suicide is the outcome of interacting individual, interpersonal, community, and societal factors. In Naushahro Feroze, where the suicide burden is moderate but persistent, the absence of specialized mental health services at primary and secondary levels creates a critical gap in early identification and response.

Aligned with theoretical insights—from Émile Durkheim's emphasis on social integration to Thomas Joiner's interpersonal risk constructs—the session translated these frameworks into practical, field-level interventions. The training recognized primary healthcare providers as key gatekeepers in interrupting the pathway from suicidal ideation to attempt, particularly in resource-limited settings.

Objectives of the Training

The session aimed to operationalize the ecological model into actionable practices by

- Strengthening early identification of suicide risk at primary healthcare level
- Building skills for basic psychosocial support (psychological first aid)
- Establishing functional referral pathways within district health systems
- Enhancing understanding of multi-level risk factors and protective mechanisms
- Promoting community awareness and stigma reduction through frontline workers

Training Methodology

The session was delivered through an interactive and application-oriented approach, ensuring alignment with real-world constraints of district healthcare systems with contextualized global evidence into local practice using.

- Case-based discussions reflecting Sindh-specific socio-cultural dynamics
- Role plays on managing patients with suicidal ideation
- Group exercises on identifying ecological risk factors
- Practical demonstrations of communication and referral techniques
- This approach ensured that theoretical concepts were directly linked to service delivery realities at THQ level.

Key Learning Areas Aligned with Ecological Model

Early Identification (Individual & Interpersonal Levels) Participants were trained to identify early warning signs rooted in psychological and relational distress, including:

- Expressions of hopelessness, worthlessness, or emotional pain (psychache)

- Social withdrawal and reduced connectedness
- Family conflict, relationship stress, or recent loss
- History of prior attempts or mental health conditions

First-Line Management (Individual Level Intervention)
In line with evidence from psychological models, participants were trained in low-resource, high-impact interventions, including;

- Empathetic listening and non-judgmental engagement
- Validating emotional pain and reducing immediate distress
- Ensuring patient safety and minimizing access to harmful means
- Engaging family or caregivers to strengthen support systems

This aligns with the understanding that timely psychosocial support can interrupt progression from ideation to action, as highlighted in models such as the IMV and Three-Step Theory.

Referral Pathways (Community & Health System Level)
A major focus was on strengthening structured referral systems, recognizing gaps in mental health service availability. Participants were oriented to:

- Identify high-risk cases requiring urgent escalation
- Refer patients from THQ to DHQ or tertiary facilities, including Jinnah Postgraduate Medical Centre
- Maintain documentation and ensure follow-up continuity
- Coordinate with district health authorities for case management
- The training reinforced that effective referral is a critical bridge between identification and treatment, especially where specialist services are limited.

Role of Primary Healthcare (Community Level Prevention)
The session emphasized that primary healthcare providers are central to suicide prevention by:

- Acting as frontline identifiers of risk
- Delivering brief psychosocial interventions
- Facilitating referrals and follow-up care
- Leading community awareness and stigma reduction efforts
- Participants were encouraged to integrate mental health screening into routine clinical practice, even in high patient-load environments.

Outcomes and Reflections of Awareness Session and Training
The session resulted in improved understanding among participants of suicide as a preventable, multi-level public health issue rather than an isolated clinical event. Key outcomes included;

- Enhanced ability to recognize early signs of suicidal ideation
- Increased confidence in providing initial psychosocial support
- Better clarity on referral mechanisms within district systems
- Recognition of the importance of community engagement and awareness
- Participants acknowledged that suicidal cases are often underreported and under-managed, and that this training fills a critical capacity gap.

This training at THQ Kandiaro demonstrates how theoretical and epidemiological insights from the ecological model can be translated into **practical, field-level interventions**. By equipping frontline healthcare providers in Naushahro Feroze with skills for early identification, basic management, and referral, the initiative addresses a critical gap in the suicide prevention continuum.

Sustained investment in **human resource development, service integration, and community engagement** will be essential to ensure that such efforts lead to measurable reductions in suicide risk and improved mental health outcomes at the district level.

Pictorial Gallery


SUICIDE PREVENTION
District Administration Naushahro Feroze


SUICIDE PREVENTION
CAPACITY BUILDING WORKSHOP
FOR MEDICAL PROFESSIONALS ON
SUICIDE PREVENTION IN YOUTH
سیمینار
Presented With the Support of


CAPACITY BUILDING WORKSHO
FOR MEDICAL PROFESSIONALS ON
SUICIDE PREVENTION IN YOUTH
نوجوانن ۾ وڌندڙ خودڪشين
جو رجحان، سبب ۽ حل جو موضوع تي
سيمينار
Presented With the Support
Town Co ittee
SUICIDE
Naushahro Feroze


Chief Guest
Senator Dr Karim Ahmed
Khawaja

Key Takeaways

Major Psychological Theories of Suicide

Theory / Model	Key Contributors & Year	Main Concepts	Prevention Focus
Social Integration (Egoistic)	Durkheim (1897)	Low integration of individual in society	Build social support networks, community engagement
Anomie / Regulation	Durkheim (1897)	Normlessness after social change	Economic and social policies to reduce turmoil
Social Capital	Kushner & Sterk (2005)	Community trust and cohesion	Strengthen community bonds, public trust
Psychache (Pain)	Shneidman (1987)	Intolerable mental pain	Counselling to alleviate emotional pain; social support
Hopelessness / Cognitive	Beck (1975/2008)	Negative beliefs and hopelessness	Cognitive therapy; positive framing, building hope
Escape from Self	Baumeister (1990)	Suicide as self-directed aggression	Self-esteem interventions, addressing self-hatred
Interpersonal Theory	Joiner (2005); Van Orden (2010)	Thwarted belongingness; perceived burdensomeness; acquired capability	Social connectedness programs; reducing access to lethal means
Three-Step Theory (3ST)	Klonsky & May (2021)	Pain + hopelessness → ideation; plus, connectedness/capability for attempt	Early screening for hopelessness; crisis support to increase hope
Motivational-Volitional (IMV)	O'Connor (2018)	Defeat/entrapment → ideation → action	Gatekeeper training; immediate crisis intervention
Fluid Vulnerability	Rudd (2000); Bryan (2020)	Fluctuating risk, cumulative stress	Longitudinal follow-up; coping skills training

Selected Reports and Studies on Suicide (Global and Pakistan)

Study / Report	Context	Data Years / Type	Key Findings
WHO (2025) – Suicide 2021 Estimates	Global	2021; GHE data	727,000 suicides (9.1/100k); 73% in LMICs; 3rd cause of death (ages 15–29).
WHO (2021) – Suicide worldwide 2019 (Global Health Estimates)	Global	2019; GHE data	~773,000 suicides (9.5/100k); highlights reduction targets.
CDC (2024) – Suicide Risk Factors	USA (public health)	Review data (2024)	Lists multi-level risk/protective factors at individual, relationship, community, and societal levels.
WHO EMRO (2023) – Situation Analysis in Eastern Mediterranean	Region (incl. Pakistan)	2000–2019; estimates	~41,700 annual suicides in EMR (74% male); Pakistan had most deaths (largest share), followed by Iran, Egypt.
Naveed et al. (2023) – Patterns in Pakistan	Pakistan	2019–2020; media reports	2295 suicides reported; 61.9% male (M:F=1.6:1); majority <30 years; most common method poison ingestion; main triggers domestic conflict, financial and relationship problems.
Asad et al. (2022) – Karachi Study Protocol	Karachi, Pakistan	2017–2021; hospital records	Notes paucity of national data on suicide in Pakistan (historically criminalized); aims to document patterns in medico-legal cases.
WHO (2024) – World Health Statistics	Global	Annual report	Tracks SDG indicator for suicide (SDG 3.4.2), reporting on trends and country progress.
O'Connor (2011) – IMV Model	Theoretical (global)	Conceptual model	Elaborates how societal stressors can trigger defeat leading to entrapment and suicidal ideation.
Joiner (2005) – Why People Die by Suicide	Theoretical (global)	Book (psychiatric)	Formulates IPTS with examples from research and case studies.
Shneidman (1996) – The Suicidal Mind	Theoretical (global)	Book (psychology)	Emphasizes psychache and suicide as a plea for understanding.
World Bank WDI (2016)	Pakistan 2016		Suicide mortality: 3.00/100k (female), 2.70/100k (male). (Crude rates from WHO data.)
Mapping of Registered Suicide Cases in Sindh Report (2016–20)	Sindh Province	SMHA Report 2021	767 total cases (2016–20); Tharparkar highest (79 in 2020, 61% female). Other districts also vary (undisclosed).
The News (June 2021)	Naushahro Feroze, Sindh	News Report June 2021	Report of a 10th-grade boy's suicide by hanging; domestic issues cited. Indicates youth vulnerability and method.

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