Editorial

Suicide Prevention in Pakistan: an impossible challenge?

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Abstract

In recent years, incidences of suicide appear to have increased in Pakistan and suicide has become a major public health problem. From available evidence it appears that most suicides occur in young people (single men and married women) under the age of 30 years. Hanging, use of insecticides and firearms are the most common methods and interpersonal relationship problems and domestic issues as the most common reasons for suicide. Mental illness is rarely mentioned. Lack of resources, poorly established primary and mental health services and weak political processes make suicide prevention a formidable challenge in Pakistan. Public and mental health professionals need to work with government and non-governmental organizations to take up this challenge.

Pakistan is a South Asian developing country with a population of approximately 162 million. with 97% being Muslims. Suicide is a condemned act in Islam. Traditionally, suicide numbers were low but in recent years, they have shown an increase and suicide has become a major public health problem in Pakistan.[1]

There are no official statistics on suicide from Pakistan. Suicide deaths are not included in the national annual mortality statistics. National rates are neither known nor reported to the World Health Organization (WHO).[2]

Under Pakistani law (based on tenet of Islam) both suicide and deliberate self-harm (DSH) are illegal acts, punishable with a jail term and financial penalty.[3] All suicide cases must be taken to one of the government hospitals, designated as medico-legal centres (MLC). In DSH cases many people avoid going to these centres for fear of harassment by the police and stigma. Instead they seek treatment from private hospitals that neither diagnose suicide nor report them to police. Incidences of suicide and DSH are therefore, grossly underestimated in Pakistan.[4]

Information on suicide in Pakistan comes from a number of sources including newspapers, reports of non-governmental organizations (NGOs), voluntary and human rights organizations and police departments of different cities.[5] Further information is available from hospital based studies, e.g. on acute intentional poisoning[6], deliberate-self harm[7] and autopsies carried out by Forensic Medicine departments.[8,9]

These studies show that suicide cuts across all ethnic, provincial and rural/urban boundaries. In one study suicide was reported from at least 35 cities and towns (and their surrounding villages) of Pakistan.[10] Suicide has been reported from most major cities of Pakistan including Karachi[8,11,12], Larkana[13], Lahore[14], Multan[15], Bahawalpur[16], Faisalabad[17], Rawalpindi[18] and Peshawar.[9] Suicide has also been reported from the remote Ghizer District, in the Northern Areas of Pakistan.[19]

While official rates of suicide are lacking, it has been possible to calculate rates of suicide in at least six different cities of Pakistan.[20] Crude rates vary from a low of 0.43/100,000 per year (average for 1991-2000) in Peshawar to a high of 2.86/100,000 for Rawalpindi (in 2006), with other cities falling in between: Karachi, 2.1/100,000 (1995-2001); Lahore, 1.08/100,000 (1993-95); Faisalabad, 1.12/100,000 (1998-2001) and Larkana, 2.6/100,000 (2003-2004).[20]

Gender- specific rates show that for men, highest rates are 5.2/100,000 in Rawalpindi , while for women the highest rates are 1.7/100,000 in Larkana. The highest age- and gender-specific rates for men and women are in the age group 20-40 years: 7.03/100,000 and 3.81/100,000 in Larkana respectively.[20] Recently, a non-governmental organisation reported 5,800 suicides in nine months (January to September) of 2006.[21]

A review of relevant studies that listed methods used shows that poisoning and hanging to be the two most common methods, followed by firearms, drowning, self-immolation and jumping from a height.[1,9,11,13,14,19] Use of medications for suicide featured in only a small minority of cases.

As far as suicide prevention is concerned, this requires a multi-sectoral approach. Almost 34% of Pakistani population suffer from common mental disorders[22], and depression is implicated in more than 90% of suicides.[23] This needs to be addressed at the community level. Ideally mental health and suicide prevention programmes should be integrated within the primary health care (PHC) system. Unfortunately, in Pakistan public funded PHC system is largely ineffective. Hence training PHC staff to screen for

suicidal patients would be impractical. Perhaps the solution lies in low cost community mental health programs, involving mental health care workers and lay counselors. Suicide prevention as part of the programme would be more effective then.

It is estimated for every suicide there are at least 10-20 DSH acts.[2] Based on current figures, there would be in excess of 100,000 DSH acts in Pakistan annually. A previous history of DSH is one of the strongest predictors of future suicide. Along with medical management of DSH, the underlying psychological issues should be addressed as well. Every DSH subject, no matter how innocuous the act may appear, should receive a psychiatric assessment. Training emergency room personnel can contribute significantly to suicide prevention.

The `criminalization' of DSH has lead to a stigma, avoidance of health seeking help and lack of involvement of professionals and limitations in developing innovative programs for suicide prevention. There is an urgent need to review and repeal the law regarding DSH and suicide in Pakistan so that people who need psychological help can do so without fear of being persecuted by the police. The new Mental Health Ordinance, 2001 that superseded the Lunacy Act of 1912 has been a step forward and provides for a psychiatric assessment of survivors of suicide attempt. Section 49 of the Ordinance pertains to suicide and DSH and states: 'A person who attempts suicide shall be assessed by an approved psychiatrist and if found to be suffering from a mental disorder shall be treated appropriately under the provisions of this Ordinance'. However it does not go far enough to categorically decriminalize DSH.

In Pakistan the three most common methods are hanging, ingestion of insecticides and firearms. While hanging is difficult to control, restricting availability of latter two can potentially prevent 50% of suicides. Public education campaigns to promote safe storage of insecticides are needed.

Crisis intervention centers and suicide prevention telephone hotlines play an important role in helping suicidal people, as shown in neighboring Sri Lanka.[25] There is a need to establish such services in Pakistan.

To reduce the incidence of suicide in young people school- based interventions, as recommended by WHO's Suicide Prevention Strategies should be initiated . These include crisis management, self-esteem enhancement, development of social skills and healthy decision making.

There appears to be a strong association between poor socio-economic conditions and suicide in Pakistan.[14] Government must implement social policies that are just, equitable and fair that address the problems of the common man. Resource allocation for mental health is abysmally low and squandered away by corruption and mismanagement. There is need for increased spending on mental health as well as proper utilization of available resources.

Mortality statistics on suicides should be collected through a standard system of registration, recording and diagnosis of suicides, at all town/city, district and provincial levels. Information obtained can be used for epidemiological-analytical, intra-country and cross national studies. A mandatory reporting of suicide mortality statistics to the WHO would improve data collection and surveillance on suicide.

In summary, the traditional low rates of suicide and the protective influence of Islam appears to have undergone a radical change in Pakistan and suicide has become a major public health problem. There is need for collaboration between government, non-governmental organisations and public and mental health professionals to take up this challenge.

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