JOURNAL OF PAKISTAN PSYCHIATRIC SOCIETY
(Reviewed Manuscript - Version of Record to Follow)

COMMENTARY:
SUICIDE AS A REFLECTION OF STRUCTURAL INEQUALITY AND LIVED EXPERIENCES OF DISTRESS IN RURAL AND URBAN SINDH, PAKISTAN.

Riaz Ahmed,[1] Nida Shoaib,[2] Jalil Ahmed,[3] Muhammad Naeem.[4]

[1-4]Department of Public Health, Shaheed Zulfikar Ali Bhutto Institute of Science and Technology (SZABIST) University, Karachi, Pakistan.

CORRESPONDENCE: DR NIDA SHOAIB **EMAIL:** drnidashoaib@gmail.com

Submitted: June 12, 2026
Accepted: September 30, 2026

ABSTRACT
Suicide is a major public health and social issue in Pakistan, especially in Sindh province, yet it is neglected. Despite the rising trend in the region, it remains veiled by stigmatisation, under-reporting, and the ineffective response of institutions. This commentary examines the sociological aspects of suicide in the Sindh region in the absence of mental health infrastructure and state-mediated prevention. It considers how structural inequality, gender norms and legal frameworks shape vulnerability and responses. The discussion recommends evidence-based and culturally sensitive policy change within the provincial health systems of Pakistan through the sociological lens of health and disease.

KEYWORDS
Gender Equity; Pakistan; Psychological Distress; Social Determinants of Health; Social Stigma; Suicide.

INTRODUCTION

Suicide remains a significant and under-addressed public health and social concern in Pakistan, especially in Sindh province. These cases are often under-reported due to stigma, fear of legal consequences and ineffective reporting mechanisms. The determinants of suicide are multifaceted, including psychological, sociocultural, and economic domains. The sociological lens of health and disease provides a prism through which the phenomenon of suicide can be examined, including social inequalities, cultural constraints and structural imbalances on health outcomes.[1]

In Sindh, suicide is prevalent in regions characterised by poverty, unemployment, gender discrimination, domestic violence, and debt bondage, which are structural factors that undermine wellbeing. Provincial police statistics indicate that 1,287 suicides occurred between January 2014 and June 2019, of which 586 were female, with the highest prevalence (702cases) among those aged 21-40 years.[2] Tharparkar, Mirpurkhas, and Umerkot have been identified as high-burden districts.[2,3] Tharparkar reported 79 suicides in 2020, including 48 women.[3] Most cases are attributed to poverty, breakdown of romantic relationships, forced marriages, dowry conflicts, domestic violence, and debt-induced distress. Although clear sociological trends exist, suicide has been under-reported because of stigma, fear of police prosecution, as well as religious taboos.[4]

The contemporary discussions for suicides are centered on the following three areas:

1. **Under-reporting and criminalisation:** Suicide is a legally sensitive issue, and the 2026 restoration of Section 325 has renewed fear of prosecution, further encouraging families to conceal cases.[1]
2. **Individual and structural causes:** As much as psychiatric views focus on mental illness, sociological views focus on deprivation and inequality.
3. **Gender paradox:** Men die by suicide more often across the world, but in Sindh, the levels are very high among women because of the patriarchal limitations.[1,3]

DISCUSSION

The phenomena of suicide in Sindh should be reframed as a socially created psychosocial health crisis. Structural deprivation, joblessness, social and environmental pressures coupled with patriarchal values and ineffective health care systems contribute to suicidal tendencies in the province.[4] According to recent reports, the number of suicides in Tharparkar and Mirpurkhas has been increasing, especially among women.[1-3] A review confirmed that the suicide burden has a disproportionate impact on Pakistani youth aged 15-40 years, and frequently linked to social isolation and financial distress.[5] A 2023 demographic study also attributed suicides in Sindh to family conflict, debts and spousal abuse.6 In Tharparkar, about 50% of suicides occurred among individuals aged 15 to 25 years because of poverty and unsuccessful relationships.[4]

SOCIOLOGICAL THEORIES LENS AND REFLECTION

The conceptualisation of suicide in Sindh, therefore, dictates that the gap between public health, sociology, and health systems approaches is narrowed to unveil its structural and cultural contexts.

Functionalism of Durkheim: Through a functionalist perspective, suicide is a sign of disorganisation in society. Economic transformations, migration and family fragmentation of Sindh undermine communal ties and create anomic situations, which increase vulnerability.

Conflict Theory: This identifies the causes of chronic despair as gendered subordination, feudal control and class inequality. Lower caste women and the Hindu minorities are further marginalised, and some perceive suicide as an escape from the system.

Symbolic Interactionism Theory: It interprets suicide as culturally defined by honour and shame. In the Sindhi conservative environment, mental distress is stigmatised and emotional suffering tends to be hidden. The disclosure is inhibited and the silence reinforced by labelling and social judgment.[7]

POLICY AND ETHICAL IMPLICATIONS

The presence of psychiatric disorders such as depression is the major driver for suicide, which is a purely clinical framing that masks the structural factors of distress. A sociological approach to health and disease lays less emphasis on individual psychopathology and highlights social inequality. Historically, policy and ethics in this area have been shaped by the criminalisation of suicide under Section 325 of the Pakistan Penal Code. This law has made it harder to recognise suicide as a reflection of social inequality, and led families to conceal cases due to fear of arrest, leading to under-reporting.

The Sindh Mental Health Act 2013 reformed psychiatric care by moving the focus from incarceration towards care and addressing root causes at policy level.[9] The Criminal Laws Amendment Act 2022 removed Section 325, decriminalising attempted suicide and redirecting efforts towards rehabilitation.[10] This reform had shifted the focus towards identifying the social crisis and mapping high risks zones such as Tharparkar, which has continuously reported numerous cases despite its smaller population, proving suicide as a social mirror of socioeconomic deprivation. In May 2026, the Federal Shariat Court reversed the amendment on religious grounds and restored Section 325.[10] As a result, suicide attempt survivors in Pakistan once again face criminal liability, which is likely to reinforce concealment, delay help-seeking, and weaken the health system's ability to identify suicidal behaviour.[11]

Even though the mental healthcare institutions in Sindh are operational, they function in a fragmented, satellite manner without a state-level suicide prevention strategy at primary, secondary and tertiary levels. Additionally, substandard data monitoring, under-reporting and unreliable record keeping pose a major problem for targeted interventions, and need a standardised surveillance system.[1,6]

CONCLUSION

Suicide is a multifaceted phenomenon, interlinked with poverty, gender imbalance, patriarchy and policy-level neglect. It is not only centered on an individual's life events but a reflection of systemic social failures. Structural vulnerabilities, such as lack of economic security, gendered oppression, and feeble mental health infrastructure, interact with cultural stigma to create high risk, especially in women and youth in marginalised areas. Addressing suicide necessitates its reframing as a social justice and public health issue. The interventions must combine accessible mental health support, legal response to gender-based violence, community education and socioeconomic assistance. Sustainable prevention shall depend on a change in the social conditions, reduction of inequality and restoration of dignity. Thus, enabling communities to provide the cohesion, strength, and care needed to safeguard vulnerable groups. In Sindh, where stigma and structural disadvantage intersect, recording suicides has not been enough. The conditions that produce them are the unfinished task and require addressal.

Policy Recommendations

1. Integration of mental health in primary healthcare and training community workers with suicide prevention and referral skills.
2. Establishment of provincial suicide surveillance units to ensure standardised reporting, as mandated by the Sindh Mental Health Authority (SMHA).
3. Advocacy for the repeal of Section 325 through legislative or constitutional mechanisms.
4. Women empowerment through education, legal protection, and financial inclusion for reduction in gender-based vulnerability.
5. Organisation of anti-stigma campaigns in collaboration with the media and religious leaders.
6. Promotion of psychological autopsy studies, longitudinal research and interdisciplinary partnerships to develop culturally sensitive prevention models.

Ethics Statement

Not applicable

Consent Statement
Not applicable

CONFLICT OF INTEREST
None

FUNDING
None

Acknowledgements
The authors thank the researchers whose work informed this commentary.

REFERENCES

1. Khan MM, Naqvi H, Thaver D, Prince M. Epidemiology of suicide in Pakistan: determining rates in six cities. Arch Suicide Res. 2008;12(2):155-160. doi:10.1080/13811110701857517
2. Ali I. 586 women among 1,287 committed suicide during five years in Sindh: study. Dawn [Internet]. 2020 Feb 17 [cited 2026 June 01]. Available from: https://www.dawn.com/news/1534949
3. Sindh Mental Health Authority. Report on Psychological Autopsy (Tharparkar). Karachi: SMHA; 2021. Available from: https://smha.sindh.gov.pk/files/SMHA/Report%20on%20Psychological%20Autopsy%20%28Tharparker%29-%20Final.pdf
4. Tunio S, Shoukat G, Khan MA. Sociological analysis of suicide among female: a study of Nangarparkar, District Tharparker, Sindh. Liberal Arts and Social Sciences International Journal (LASSIJ). 2019;3(2):106–114. doi:10.47264/idea.lassij/3.2.13.
5. Shekhani SS, Perveen S, Hashmi DE, Akbar K, Bachani S, Khan MM. Suicide and deliberate self-harm in Pakistan: a scoping review. BMC Psychiatry. 2018;18(1):44. Published 2018 Feb 12. doi:10.1186/s12888-017-1586-6
6. Mahesar RA, Chandio DA, Latif M, Abbas S, Shabbir T. Demography and risk factors of suicide deaths in Pakistan: A twelve-month content analysis study. Asian J Psychiatr. 2023;80:103364. doi:10.1016/j.ajp.2022.103364
7. Mueller AS, Abrutyn S, Pescosolido B, Diefendorf S. The Social Roots of Suicide: Theorizing How the External Social World Matters to Suicide and Suicide Prevention. Front Psychol. 2021 Mar 31;12:621569. doi: 10.3389/fpsyg.2021.621569.
8. Sindh Mental Health Act 2013. Karachi: Government of Sindh; 2013.
9. Criminal Laws (Amendment) Act 2022. Gazette of Pakistan, Extraordinary. Islamabad: National Assembly Secretariat; 2022.
10. Asad M. Shariat Court reverses move to decriminalise death by suicide - newspaper - dawn.com [Internet]. Dawn; 2026 [cited 2026 June 01]. Available from: https://www.dawn.com/news/2001396

AUTHOR(S) CONTRIBUTION/UNDERTAKING FORM

Sr. #	Author(s) Name	Affiliation	Contribution
1	Riaz Ahmed	Department of Public Health, SZABIST University, Karachi, Pakistan.	Conceptualisation, study design & overall guidance
2	Nida Shoaib	Department of Public Health, SZABIST University, Karachi, Pakistan.	Drafting manuscript and technical guidance
3	Jalil Ahmed	Department of Public Health, SZABIST University, Karachi, Pakistan.	Literature review, final draft refinement
4	Muhammad Naeem	Department of Public Health, SZABIST University, Karachi, Pakistan.	Literature review, final draft refinement