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# Female Suicide in Ghizer: Policy Gaps and Prevention Strategies — Way Forward

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**Abstract**

Female suicide in Ghizer District, Gilgit-Baltistan, has become a critical public health and human rights concern, reflecting a complex interplay of social, cultural, and economic determinants. Despite recurring incidents, policy responses remain fragmented, with significant gaps in data collection, prevention, and intervention. This study analyzes secondary sources, media reports, and stakeholder perspectives to identify systemic weaknesses, including the absence of a coordinated suicide surveillance mechanism, inadequate community-based mental health services, weak referral pathways between schools, healthcare facilities, and law enforcement, and insufficient protection measures for women facing gender-based violence. Contributing factors such as stigma, restrictive gender norms, geographic isolation, and lack of digital access further impede help seeking. To address these challenges, the paper proposes an integrated, multi-level prevention framework: establishing a district-level suicide monitoring unit with confidential, gender-sensitive reporting; incorporating routine mental health screening into primary and maternal health services; introducing school- and community-based life skills education and gatekeeper training for teachers, health workers, and community leaders; expanding safe shelters, legal aid, and one-stop gender-based violence support centers; enforcing responsible media guidelines; and limiting access to common means of self-harm. Tele-mental health platforms, 24/7 helplines, and peer-support networks are recommended to overcome barriers of distance and privacy. The way forward emphasizes cross-sectoral coordination among health, education, police, and social welfare departments, sustainable

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financing, culturally sensitive awareness campaigns, and rigorous monitoring, with the ultimate goal of reducing female suicide rates and ensuring the safety and wellbeing of women in Ghizer.

**Keywords:** Ghizer; Gilgit-Baltistan; Female suicide; Policy gaps; Prevention strategies

**Introduction**

Suicide is a pressing global public health concern, with women in vulnerable and marginalized communities often at heightened risk due to cultural, social, and economic constraints. In Pakistan, suicide rates are underreported because of legal, religious, and social stigma, yet emerging evidence suggests that female suicide is alarmingly prevalent in specific regions such as Ghizer district of Gilgit-Baltistan (Shah et al., 2020). Ghizer has witnessed unusually high incidences of female suicides over the last two decades, earning grim recognition as a "suicide-prone" area in Pakistan (Ali & Kiani, 2019). This pattern reflects deeper systemic issues, including entrenched gender inequality, rigid cultural norms, domestic violence, and limited access to mental health services.

Despite the growing concern, there is a lack of comprehensive policy frameworks addressing female suicide prevention in Pakistan. Existing interventions remain fragmented, reactive, and often restricted to crisis responses rather than preventive approaches (WHO, 2021). In the context of Ghizer, where young women face intersecting vulnerabilities such as restricted mobility, lack of psychosocial support, and economic dependency, the absence of effective policies exacerbates the crisis (Sadia & Zubair, 2017). Moreover, the silence surrounding mental health issues due to societal stigma prevents affected women from seeking timely help, leaving suicide as a tragic outcome of unresolved distress.

Addressing this crisis requires a multi-dimensional policy response. Evidence-based prevention strategies must focus on strengthening mental health services, empowering women through education and economic opportunities, engaging community and religious leaders, and integrating suicide prevention into primary healthcare systems (Patel et al., 2018; WHO, 2021). By examining the policy gaps and proposing context-specific strategies, this study aims to contribute to the

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discourse on preventing female suicides in Ghizer and to highlight a way forward that ensures both immediate and long-term interventions. The Ghizer district in Gilgit-Baltistan has long drawn national attention for unusually high rates of female suicide compared with other parts of Pakistan. The earliest systematic assessment (2000–2004) recorded 49 female suicides and estimated an annual crude rate of 14.89 per 100,000 women overall and 61.07 per 100,000 among females aged 15–24—levels far above contemporaneous estimates from elsewhere in the country (Khan et al., 2009). These findings have been repeatedly cited in subsequent public-health analyses and maternal-mental-health reviews as indicative of a localized crisis requiring targeted policy responses (Anjum et al., 2020).

More recent media-compiled datasets and scholarly work suggest that Ghizer continues to account for a disproportionate share of suicides within Gilgit-Baltistan. A 2022 national daily, summarizing civil-society and administrative records, reported that nearly two-thirds (≈65%) of documented suicides in the region occurred in Ghizer, with depression and domestic stressors frequently cited as proximal contributors (Dawn, November 14, 2022). Although official tallies for 2023 showed a province-wide decline (42 cases; 15 female), the burden remains significant and patterns appear episodic, underscoring the need for sustained, district-level prevention rather than ad hoc responses (The News, January 24, 2024; Ahmed, 2024).

Evidence from Ghizer points to structural drivers—stigma and under-reporting, limited psychosocial services outside tertiary centers, constrained help-seeking for young women, and fragmented coordination across health, education, police, and community institutions (Anjum et al., 2020). Addressing these gaps requires a locally anchored, multisector strategy: strengthen primary-care detection and referral pathways; embed school- and college-based life-skills and crisis-response protocols; collaborate with community and faith leaders to reduce stigma and harmful norms; and establish reliable surveillance with standardized cause-of-death ascertainment.

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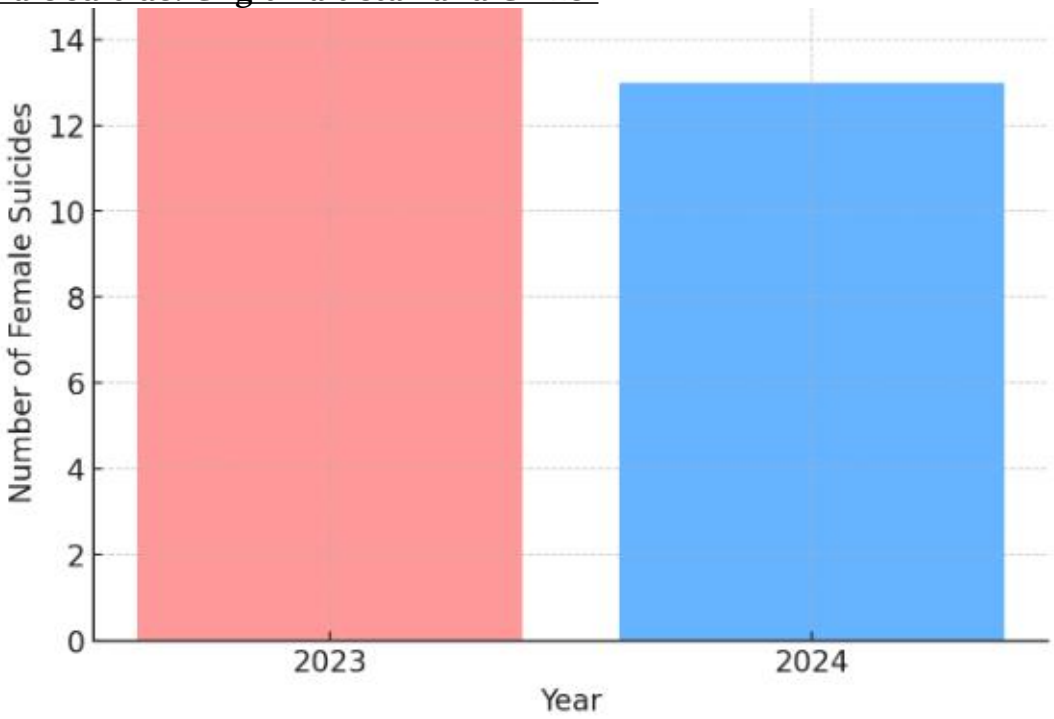
**Female suicide: Gilgit-Baltistan and Ghizer**




**Sources: Hum English. (2024, July 2). *Ghizer leads as G-B rocked by 46 suicides in 2024*.** Retrieved from https://humenglish.com/pakistan/ghizer-leads-as-g-b-rocked-by-46-suicides-in-2024/

**Policy Gaps**

Despite repeated recognition of Ghizer as a suicide-prone district, Pakistan still lacks a comprehensive policy framework dedicated to suicide prevention. The gaps are multi-layered and reflect systemic weaknesses across health, governance, and community institutions.

- **Absence of a National Suicide Prevention Policy**

  Pakistan does not have a national suicide prevention policy or an integrated mental health strategy. Suicide remains criminalized under the Pakistan Penal Code, discouraging families from reporting cases and preventing individuals from

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seeking timely help (Khan, 2012; Khan et al., 2021). This legal vacuum perpetuates underreporting, misclassification of deaths, and neglect in public health planning.

- **Weak Mental Health Infrastructure**

  Ghizer, like much of Gilgit-Baltistan, suffers from a shortage of trained psychiatrists, psychologists, and social workers. Primary healthcare units lack capacity for early detection of depression, anxiety, and suicidal ideation. Mental health services are almost absent outside tertiary centers in Gilgit city, leaving rural women with little to no access to counseling or referral systems (Anjum et al., 2020; Ahmed, 2024).

- **Limited Gender-Sensitive Interventions**

  Most interventions in Pakistan's health system are not tailored to women's psychosocial needs. In Ghizer, where female suicides are disproportionately high among young women, there are no gender-responsive programs addressing domestic violence, early marriage, mobility restrictions, or educational stressors. This gap reinforces vulnerabilities and isolates women at risk (Sadia & Zubair, 2017).

- **Fragmented Institutional Coordination**

  There is little coordination among police, education departments, local government, and healthcare providers in Ghizer. Case management is often reactive—focusing on investigation after a suicide rather than prevention. The absence of inter-sectoral referral mechanisms limits opportunities for early intervention (Anjum et al., 2020).

- **Lack of Reliable Data and Surveillance**

  There is no systematic surveillance or suicide registry in Gilgit-Baltistan. Most data come from media reports, NGO compilations, or small-scale academic studies, resulting in inconsistencies and underestimation (Dawn, 2022; Khan et al., 2009). The lack of reliable data hampers evidence-based policymaking and obscures the true scale of the crisis in Ghizer.

- **Stigma and Silence Around Mental Health**

  Deep-rooted stigma, religious sensitivities, and community silence discourage

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open discussion of mental health and suicide. This cultural barrier prevents women from seeking help and stops communities from advocating for reforms (WHO, 2021). Policy frameworks have yet to meaningfully engage religious and community leaders to reduce stigma.

**Prevention Strategies — Far Forward**

Tackling the high rate of female suicides in Ghizer requires a multi-layered, context-sensitive approach that bridges health, education, community, and policy domains. International evidence shows that integrated, community-driven interventions are more effective than isolated, top-down programs (Patel et al., 2018; WHO, 2021). Based on the structural vulnerabilities identified in Ghizer, the following prevention strategies are proposed:

- **Decriminalization and Policy Reform**

  Suicide remains criminalized in Pakistan, discouraging help seeking and underreporting. Decriminalizing suicide attempts and developing a national suicide prevention strategy aligned with WHO guidelines is a necessary first step (Khan et al., 2021). This would provide a legal foundation for evidence-based prevention programs in Ghizer.

- **Strengthening Mental Health Services in Primary Care**

  Integrating mental health into primary healthcare is vital, given the scarcity of specialized services in Gilgit-Baltistan. Training primary-care staff, Lady Health Workers, and community health volunteers to recognize and manage depression and suicidal ideation could help create an early warning system (Anjum et al., 2020). Tele psychiatry programs can also bridge the service gap in remote valleys.

- **School- and College-Based Interventions**

  Young women in Ghizer, particularly students, represent a high-risk group (Khan et al., 2009). Introducing life-skills education, peer-support groups, and crisis counseling in schools and colleges can provide safe spaces for early identification of distress. Teachers should be trained as gatekeepers to detect warning signs and refer students to appropriate services.

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 8 (August) (2025)

- **Gender-Sensitive Community Empowerment Programs**

  Since many suicides are linked to domestic violence, family pressure, and restricted autonomy, prevention must include empowerment of women through vocational training, financial inclusion programs, and safe shelters for those experiencing abuse (Sadia & Zubair, 2017; Saeed et al., 2024). Gender-sensitive policies should address social determinants such as early marriage and lack of mobility.

- **Engaging Religious and Community Leaders**

  In a socially conservative context like Ghizer, community and faith leaders can play a critical role in destigmatizing mental health, legitimizing counseling, and promoting resilience. Awareness campaigns led by trusted figures can reduce silence around suicide and encourage families to seek support before crises escalate (Anjum et al., 2020).

- **Establishing a Suicide Surveillance and Research System**

  Currently, data on suicides in Ghizer are fragmented and inconsistent. Creating a district-level suicide registry, coordinated across health, police, and education departments, will ensure accurate data collection for planning interventions. Partnerships with universities can help produce community-specific research on risk factors.

- **Crisis Helplines and Immediate Support Mechanisms**

  Developing 24/7 crisis helplines in local languages, linked to referral networks, would provide accessible and confidential support for women in distress. Mobile-based mental health apps could also be introduced for youth, providing psychoeducation and immediate coping strategies.

### Key Policy Gaps and Their Consequences

Despite multiple initiatives at the provincial and federal levels to promote women's rights and strengthen mental health services, implementation in Ghizer has been weak and fragmented. The first major gap lies in the absence of mental health infrastructure. There are no dedicated psychiatric facilities or trained psychologists available at the district level, leaving vulnerable women without professional care. In many cases, suicide prevention is left to untrained family

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members or religious figures, who may not have the expertise to handle mental health crises.

Second, there is a policy silence around female suicide as an issue specific to Gilgit-Baltistan. National health and social policies often generalize suicide prevention under broader health frameworks, without recognizing the unique socio-cultural and geographical dynamics of Ghizer. This means that the region's specific challenges—such as early marriages, domestic violence, cultural taboos, and social isolation—are not addressed in policy design.

Third, data gaps remain a major challenge. Reliable suicide statistics are difficult to access, as many cases go unreported due to stigma, fear of legal consequences, and cultural shame. This underreporting prevents policymakers from recognizing the true scale of the problem and developing targeted interventions. Without accurate data, prevention strategies risk being generic and ineffective.

Finally, there is a lack of coordination between state institutions, civil society organizations, and local community leaders. While some NGOs have raised awareness about mental health, their efforts are often localized and unstained due to resource limitations. The absence of an integrated approach perpetuates fragmented responses, which fail to provide women with consistent and reliable support systems.

## Conclusion

The rising trend of female suicides in Ghizer reflects a grave social and policy crisis that demands urgent and coordinated intervention. Structural inequalities, lack of mental health services, socio-cultural pressures, and weak institutional frameworks continue to exacerbate women's vulnerability. Despite policy commitments at the national level, gaps in implementation, resource allocation, and awareness campaigns leave communities without adequate support systems. Addressing this challenge requires a multi-pronged approach: strengthening mental health infrastructure, promoting gender-sensitive policies, ensuring community participation, and empowering women through education and economic opportunities. Moreover, religious and cultural leaders, local governance structures, and civil society must be engaged to destigmatize mental

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health issues and foster an environment of empathy and resilience. Without comprehensive and inclusive policy reforms, female suicides will remain a silent tragedy in Ghizer. The way forward lies in translating policy frameworks into actionable strategies that prioritize prevention, protection, and empowerment transforming Ghizer into a region where women's lives are safeguarded and valued.

Female suicide in Ghizer has emerged as a deeply concerning socio-psychological and policy challenge that reflects not only the vulnerabilities of women in peripheral regions but also the shortcomings of the state's institutional response. The increasing number of suicides among young women, many of them in their most productive years, represents both a humanitarian tragedy and a developmental obstacle for the region. Unlike other forms of mortality, suicides carry profound social stigma, silence, and denial within families and communities. This silence perpetuates a cycle where women's voices, struggles, and mental health needs remain invisible to policymakers. The urgency of the issue cannot be overstated: each suicide is not only the loss of a life but also the collapse of a social support system and a stark reminder of policy failure.

The Ghizer case underscores how geography, patriarchy, poverty, and institutional neglect intersect to shape women has lived realities. Being a remote district in Gilgit-Baltistan, Ghizer suffers from underdeveloped health infrastructure, limited educational opportunities, and a lack of platforms for women to express their concerns. The isolation of the district compounds the invisibility of the problem at the national level. Therefore, any effective way forward requires recognizing suicide not as an individual failure but as a systemic issue rooted in structural inequalities.

Female suicide in Ghizer is not only a health crisis but also a test of Pakistan's commitment to gender justice, human rights, and inclusive development. If left unaddressed, it will continue to rob communities of young, productive women whose potential contributions to society are immeasurable. However, if tackled through a coordinated, multi-layered, and empathetic approach, Ghizer can become a model for suicide prevention in other marginalized regions of Pakistan.

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www.thedssr.com

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DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 8 (August) (2025)

The way forward requires a paradigm shift: from viewing suicide as an individual act of weakness to recognizing it as a symptom of systemic neglect. Policymakers must translate frameworks into practice, civil society must sustain awareness and advocacy, and communities must cultivate compassion and support. By addressing policy gaps, investing in women's empowerment, and destigmatizing mental health, the tragedy of female suicide in Ghizer can be transformed into an opportunity for reform and resilience.

Ultimately, the goal is to ensure that no woman in Ghizer feels that ending her life is the only way out. Instead, through comprehensive reforms and community solidarity, every woman should be able to envision a future of dignity, opportunity, and hope.

*Suggestions for Future*

**Strengthen Mental Health Infrastructure**

- Establish district-level counseling and psychiatric units in Ghizer with trained professionals.
- Introduce mobile mental health clinics for remote valleys where women cannot travel easily.
- Train local health workers, teachers, and community leaders in basic mental health first aid.

**Promote Awareness and DE stigmatization**

- Launch community-based awareness campaigns to normalize discussions on mental health and suicide prevention.
- Engage religious scholars and local elders to deliver messages that reduce stigma and encourage empathy.
- Introduce mental health education into school and college curricula, focusing on resilience and coping strategies.

**Women's Empowerment through Education and Employment**

- Expand vocational training and microfinance programs tailored for young women.
- Provide scholarships and incentives for girls' education in Ghizer.
- Encourage public–private partnerships to create safe and dignified employment opportunities for women.

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www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 8 (August) (2025)

**Strengthen Legal and Social Protection Systems**

- Enforce laws against domestic violence, forced marriages, and harassment, ensuring women's protection.
- Establish helplines and safe shelters for women in crisis.
- Train police and judiciary personnel in gender sensitivity and suicide prevention.

**Community-Based Prevention Networks**

- Form village-level support groups for women, led by trained volunteers and social workers.
- Encourage peer-counseling programs in schools and colleges.
- Promote family counseling initiatives to address conflicts at the household level.

**Integrate Suicide Prevention into National and Provincial Policies**

- Mainstream suicide prevention into health, education, and gender policies rather than treating it in isolation.
- Allocate dedicated budgetary resources for mental health in Gilgit-Baltistan.
- Ensure monitoring and accountability mechanisms to bridge the gap between policy design and implementation.

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ISSN Online: 3007-3154
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ISSN Print: 3007-3146




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