WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
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Suicide is Preventable– Part III

This is the third and last of a series of three articles on Suicide Prevention.

Selective preventive strategies

Interventions for vulnerable groups

People who have experienced physical or psychological trauma, undergone sexual abuse, faced conflict or disasters are considered as a vulnerable group. These events have a destructive influence on an individual's social well being, health, housing, employment and financial security. Therefore, it is important to support them to secure these aspects along with helping them to cope with the stress adoptively. Adaptive coping mechanisms include goal setting, self esteem enhancement, setting priorities in life and working towards them, getting a healthy diet and adequate exercise, anger management etc. It is advised to preserve existing social ties and relationships of the affected individuals as much as possible as expressing their insecurities and concerns to a familiar person is more convenient for them. Further more, victims are more likely to seek help from and respond to the opinions of a familiar person than a stranger.

Indigenous people, refugees and migrants undergo acculturation stress as a result of changes that they undergo when they come into contact with a different culture. Acculturation stress is a risk factor for suicide. Improving social support within the family and the new community, improving socio economic status, improving self esteem, enhancing adaptive coping skills, encouraging to learn the new language and customs to get integrated with the new culture are effective to reduce this stress and prevent suicides.

Suicide rates are high among prisoners as well. Improving mental health of prisoners is important to reduce suicide rates among them. Meditation programmes, sports encounters and aesthetic activities are helpful in this context. All prisoners should be screened for the risk of attempting suicide and high risk individuals should not be placed in isolated accommodation. Measures taken to prevent alcohol and substance abuse among prisoners also help to reduce suicide rates.

The concept of " Gate keepers" once put into action is effective in preventing suicide in vulnerable groups. A Gate keeper refers to a person who is in the position to identify whether someone may be contemplating suicide. Primary, mental and emergency health care providers, school teachers, community leaders, police officers, social workers, spiritual and religious leaders are potential gate keepers. Training of gate keepers provide opportunity to start interventions in vulnerable groups as studies have shown that nearly half of women who show suicidal behaviour have seen a health care provider in the preceding four weeks. Gate keeper training consists of improving knowledge, attitudes and skills to identify individuals at risk, determine the level of risk and refer at risk individuals for appropriate treatment.

Contents	*Page*

Indicated preventive strategies

People who have attempted suicide before, have a particular risk for attempting again. Comprehensive psychological assessment of them by a qualified health care personnel is essential to determine the level of risk as mild to severe, to determine contributory factors, to find protective factors, to identify associated other mental disorders like depression, substance abuse etc. This will guide towards a management plan in order to prevent another attempt. Management plan includes psychological counselling, preventing access to means of suicide, medical management of depression and substance abuse and socio economical support.

People who have been recently discharged from hospitals after treatment for attempted suicide need proper follow up as they can feel isolated due to lack of social support. Frequent follow ups can be arranged in the form of exchanging postcards, telephone conversations or brief in person visits. They help to determine how the individual is coping with life in his/ her usual surrounding and to plan further management.

Challenges and obstacles

Even today, most countries have not recognized preventing suicide as a health care priority which has become a challenge to implement laws and regulations and formulate national level preventive strategies. People who truly need help are reluctant to seek support due to the stigma surrounding suicides and related mental health problems like depression. Due to the same reason, these aspects are not openly discussed in the community. Therefore, it is important to raise community awareness regarding this in order to strengthen preventive activities.

Apart from this, misconceptions and myths are commonly encountered in the society regarding suicides. One such misconception is that " people who talk about suicide do not mean to do so". However, people who talk about suicide do so as a way of seeking help. Therefore, considering this as a serious matter and helping them can prevent suicides. "Most suicides happen suddenly without a warning sign" is another misconception. Majority of suicides have been preceded by warning signs. Therefore, identifying these warning signs is all it takes to save a life. Many think that " someone who is suicidal is determined to die". Well, according to the evidence, suicidal people are mostly ambivalent about living or dying. Therefore, access to emotional support at the right time can prevent suicide. Some perceive talking about suicide as a bad idea and can be interpreted as an encouragement. On the contrary, openly talking about the suicidal ideation will allow to find other adaptive solutions for the problem. On the other hand, a person who is once suicidal does not remain suicidal forever. Suicidal behavior is often short term and situation specific. Therefore, appropriate interventions applied at the correct time can prevent suicides.

Sources

Suicide in Immigrants: An Overview available at http://file.scirp.org/pdf/OJMP_2013070515400068.pdf

Preventing suicide, A global imperative, WHO) available at *http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf*

Compiled by Dr. S.A.I.K. Sudasinghe of the Epidemiology Unit

Table 1 : **Water Quality Surveillance**
Number of microbiological water samples August 2016

District	MOH areas	No: Expected *	No: Received
Colombo	15	90	82
Gampaha	15	90	NR
Kalutara	12	72	NR
Kalutara NIHS	2	12	NR
Kandy	23	138	NR
Matale	13	78	NR
Nuwara Eliya	13	78	NR
Galle	20	120	NR
Matara	17	102	10
Hambantota	12	72	52
Jaffna	12	72	71
Kilinochchi	4	24	29
Manner	5	30	0
Vavuniya	4	24	26
Mullatvu	5	30	NR
Batticaloa	14	84	60
Ampara	7	42	0
Trincomalee	11	66	25
Kurunegala	29	174	101
Puttalam	13	78	NR
Anuradhapura	19	114	NR
Polonnaruwa	7	42	19
Badulla	16	96	123
Moneragala	11	66	77
Rathnapura	18	108	55
Kegalle	11	66	NR
Kalmunai	13	78	NR

* No of samples expected (6 / MOH area / Month)
NR = Return not received *

Table 1: Selected notifiable diseases reported by Medical Officers of Health 10th – 16th Sep 2016 (38th Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmani-asis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	137	13059	3	132	0	10	0	49	0	33	17	223	0	7	2	37	0	0	2	351	0	46	0	0	81	94
Gampaha	28	5349	1	116	0	13	1	23	1	32	3	262	0	14	0	32	0	1	4	323	0	37	0	7	33	80
Kalutara	35	2777	0	82	0	8	0	29	0	29	1	356	0	7	1	24	0	0	4	216	1	70	0	0	64	86
Kandy	56	3332	0	132	1	16	1	20	0	33	1	103	1	80	0	44	0	0	11	180	0	34	1	9	96	100
Matale	1	804	0	49	0	1	0	11	0	4	0	76	0	19	1	16	0	1	0	28	1	51	0	17	54	92
NuwaraEliya	5	348	5	85	0	2	2	51	0	36	4	51	0	62	1	34	0	0	9	118	2	35	0	0	92	92
Galle	17	1712	0	116	0	8	0	7	0	8	1	212	2	96	0	9	0	0	2	238	0	33	0	3	65	85
Hambantota	7	638	2	54	0	1	1	4	0	57	1	92	3	56	2	80	0	0	7	188	0	14	8	259	83	92
Matara	18	979	1	102	0	13	0	7	0	38	6	153	2	44	0	29	0	0	3	149	1	20	0	162	100	100
Jaffna	12	1753	8	220	1	6	3	74	0	54	0	12	1	580	0	8	0	0	1	145	3	50	0	1	100	100
Kilinochchi	0	68	0	35	0	0	0	35	0	9	0	13	0	24	0	0	0	0	0	10	0	10	0	0	75	75
Mannar	0	108	0	26	0	4	2	22	0	9	0	9	0	38	0	0	0	0	0	7	1	2	0	0	60	80
Vavuniya	2	212	1	13	1	4	1	82	2	33	1	13	0	10	0	6	0	0	1	26	0	10	0	6	75	100
Mullaitivu	0	150	0	24	0	2	0	17	0	40	0	24	0	6	0	2	0	1	0	20	0	7	0	5	60	100
Batticaloa	5	442	2	242	0	3	0	41	0	91	3	41	1	6	1	11	0	0	2	84	1	13	0	1	64	100
Ampara	0	206	0	44	0	2	0	0	0	21	0	26	0	0	0	9	0	0	0	132	0	4	0	5	0	71
Trincomalee	2	349	0	50	0	2	0	11	0	24	0	28	0	24	0	33	0	1	0	129	0	11	0	5	42	92
Kurunegala	22	2045	2	252	0	11	0	3	0	13	1	129	0	36	1	20	0	2	4	271	1	48	3	80	72	97
Puttalam	1	896	1	73	0	4	0	6	0	0	0	37	0	61	0	2	0	1	2	73	2	48	0	4	64	86
Anuradhapura	11	568	0	75	0	3	0	6	0	26	2	248	0	25	0	15	0	0	0	194	0	36	8	196	79	100
Polonnaruwa	3	379	0	31	0	4	1	12	0	13	0	85	0	2	0	3	0	0	2	100	0	14	0	102	71	100
Badulla	20	666	2	103	0	13	0	8	0	25	1	110	7	95	2	106	0	0	2	192	2	164	0	3	76	94
Monaragala	10	337	2	69	0	1	0	3	1	11	0	154	3	108	1	118	0	2	1	60	1	19	0	33	91	91
Ratnapura	17	2413	2	291	0	29	0	25	0	23	2	436	0	32	10	143	0	0	6	178	1	122	0	1	56	89
Kegalle	8	1164	0	69	0	18	0	31	0	52	1	152	0	24	0	22	0	0	4	261	0	44	0	2	64	100
Kalmune	0	419	0	81	0	3	0	5	0	43	0	17	0	0	0	3	0	4	0	77	1	20	0	0	46	92
SRILANKA	417	41173	32	2566	3	181	12	582	4	757	45	3062	20	1456	22	806	0	13	67	3750	18	962	20	901	70	93

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 16th September, 2016 Total number of reporting units 339 Number of reporting units data provided for the current week: 306 C**-Completeness

A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

10th – 16th Sep 2016 (38th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2016	Number of cases during same week in 2015	Total number of cases to date in 2016	Total number of cases to date in 2015	Difference between the number of cases to date in 2016 & 2015
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	01	00	00	00	00	00	00	01	00	52	54	-4.7%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	00	00	00	01	00	00	00	00	01	04	293	283	+3.5%
Measles	00	01	00	00	00	00	00	00	00	01	34	324	2195	-85.2%
Rubella	00	00	00	00	00	00	00	00	01	01	00	08	08	0%
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	08	14	-43.1%
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	15	07	+114.2%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	04	52	68	-23.5%
Tuberculosis	61	07	06	08	23	06	03	05	21	140	201	6906	7257	-4.8%

Key to Table 1 & 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.

RDHS Divisions: CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS** =Congenital Rubella Syndrome

AFP and all clinically confirmed Vaccine Preventable Diseases except Tuberculosis and Mumps should be investigated by the MOH

Influenza Surveillance in Sentinel Hospitals - ILI & SARI

Month	Human					Animal		
	No Received	ILI	SARI	Infl A	Infl B	Pooled samples	Serum Samples	Positives
August	6542	40	21	0	7	1085	625	0

Source: Medical Research Institute & Veterinary Research Institute

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