WEEKLY EPIDEMIOLOGICAL REPORT

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Suicide is Preventable– Part I

This is the first in a series of three articles on prevention of suicides

Introduction

Suicide is still a prevalent cause of death in Sri Lanka as well as in other countries. According to the World Health Organization (WHO), in every 40 seconds someone dies by suicide. WHO also estimates that, for each one who takes his/her life, at least another 20 attempt to commit suicide. Although suicides can be attributed to mental health problems, many of the suicides which occur as a response to acute stressful life events like financial losses, relationship breakups etc. are impulsive.

However, suicide which is an act with a fatal outcome that is deliberately initiated and performed by a person in the knowledge or expectation of its fatal outcome is preventable. Nevertheless, it is important to prioritize suicide prevention activities in public health agendas in order to reduce the number who end their lives by themselves.

Global epidemiology of suicide and attempted suicides

Annual global age standardized suicide rate is 11.4/100 000 population (15 in men and 8 in women). In 2012 alone, globally, 804 000 individuals took their own lives. There is a male to female difference as far as the prevalence of suicide is considered. In high income countries 3 men to 1 woman commits suicide . However, this ratio decreases once it comes to low and middle income countries as in those countries male to female ratio is 1.5 to 1.

Suicide is the commonest cause of violent deaths where 50% and 71% of violent deaths in men and women respectively are due to suicide. Suicide is commonly seen in people above 70 years in both sexes globally. Suicide is the second commonest cause of death in the age group between 15 to 29 years.

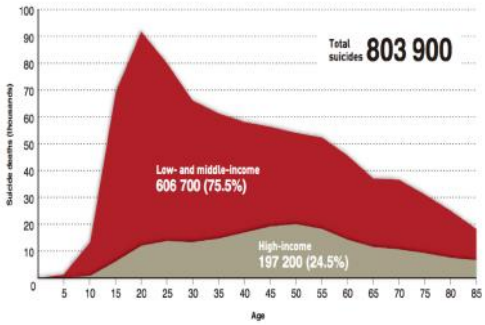

Figure 1: Global suicides by age and income level of country, 2012 *(Source : Preventing suicide, A global imperative, WHO)*

Even though the statistics are as above, there is a possibility of a considerable number of suicides to go unreported due to various reasons. The fact that suicide is illegal in certain countries is one of them. Apart from that, suicide being a sensitive issue and associated stigma, also prevent them from becoming noticed.

Situation in Sri Lanka

A new report of the WHO has ranked Sri Lanka fourth among 172 countries in suicide rate. Most recent records indicate a suicide rate of 28.8/

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100 000 population in Sri Lanka. This is well above the global suicide rate. Besides, suicide rates above 15/100 000 population is considered excessive.

Sri Lanka reported the highest suicide rate of 47/ 100 000 population in 1995 and ranked first in the world. However, suicides rates gradually reduced in the years that followed. Possibly, interventions like establishing a presidential task force in 1997, releasing a policy document on suicide prevention, de criminalization of suicide which eliminated the stigma attached, establishing the national poisons center at the National Hospital in 1991, restricting access to poisonous chemicals, introducing a life skills programme for school children in 1998 by the Department of Education and formulating guidelines on assessment of deliberate self harm patients admitted to hospitals have contributed to the reduction of suicide rates over the past few years.

Several decades before, suicide was mostly prevalent in the 15 to 25 age group where in 1980 45% of all suicides were in that age group. However, in 2007 peak age group for male suicide was 46 to 50 years. For females, the most affected age group was 21 to 25 years. Suicide rates increase again in the age group above 70 years.

Methods of suicide

Methods used to commit suicide has also changed over the past 7 to 8 decades where the trend in changing these methods in Sri Lanka has correlated well with the trend seen globally. Initially, drowning was the preferred method. Since 1950s the pattern changed to poisoning. From 1987 to 1991 poisoning was the method used in 80% of suicides. Easy availability of pesticides with local vendors, poor knowledge regarding storage and destruction of unused chemicals, poor availability of antidotes within health care settings were contributory factors.

Still, poisoning is the commonest method used in Sri Lanka where in 2006 more than half of the suicides were due to this. However, the type of poison used has significant variations in different parts of the country. In urban areas ingestion of drugs and domestic substances are commonly reported whereas ingestion of agrochemicals is the preferred method in rural areas. Apart from this, deliberate ingestion of seeds of Yellow Oleander tree is commonly seen in the North, North Central and Eastern parts of the country.

Knowledge on different methods used and their proportions is useful in planning preventive strategies.

Risk factors

There are many risk factors which make a person vulnerable to commit suicide of which prior attempts to commit suicide is the most important risk factor. Psychiatric disorders (especially depression and harmful use of alcohol), chronic pain, financial losses, family history of suicides are other risk factors (associated with the individual). Risk factors which arise from the community also contribute to suicide. Natural and man made disasters bring about emotional stress to affected people. If they are not well adopted to respond to these situations they can perceive ending their lives as the ultimate option. Acculturation stress can arise in certain groups of people in the community who are isolated from the rest like indigenous people and internally displaced people. This is again a risk factor for suicide. Being subjected to physical and emotional abuse and violence also make a person prone to commit suicide. On the other hand, people who attempt to take their lives are reluctant to come to a healthcare facility for assessment and treatment due to associated stigma. Stigmatization is also associated with psychological disorders and substance abuse which give rise to suicidal ideation. Sensationalizing suicides through mass media too contributes towards " copy cat suicides".

Protective factors

Strong personal relationships with family members, friends, peers, and significant others are protective against suicide as they can buffer the impact of external stressors. This is specifically applicable for adolescents and elderly. Religious and spiritual beliefs are also protective to some extent. Good self-esteem, self -efficacy, effective problem solving skills can mitigate the impact of external stressors thus keeping people away from suicide.

Sources

World Health Organization official website

National Council for Mental Health official website

A review of trends in suicide deliberate self harm in Sri Lanka available at http://dl.sip.ac.lk/dspace/ bitstream/123456789/924/1/a% 20Review%20of%20trends% 20in%20suicide.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

to be continued….

Table 1: Selected notifiable diseases reported by Medical Officers of Health 27th – 02nd Sept 2016 (36th 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	136	12618	1	125	0	9	0	46	0	33	3	186	0	7	0	32	0	0	4	338	1	42	0	0	50	88
Gampaha	47	5029	1	108	0	11	1	22	0	30	0	243	0	12	0	31	0	1	7	297	1	35	0	7	47	60
Kalutara	28	2705	2	78	0	8	2	29	0	29	1	346	0	7	0	21	0	0	4	208	1	66	0	0	79	93
Kandy	89	3179	2	129	0	15	2	18	0	33	5	100	2	74	0	43	0	0	9	167	2	34	0	8	96	100
Matale	29	765	1	47	0	1	0	11	0	4	2	73	0	19	1	15	0	1	1	28	0	48	0	17	77	100
NuwaraEliya	3	337	2	77	0	2	1	49	0	36	1	47	4	62	2	33	0	0	0	102	0	33	0	0	92	100
Galle	29	1616	0	113	0	8	1	7	0	8	2	209	5	88	1	8	0	0	1	231	0	33	0	3	50	80
Hambantota	4	612	1	46	0	1	0	3	0	54	2	89	1	51	2	60	0	0	1	175	0	14	1	248	67	100
Matara	17	925	2	99	0	13	0	6	0	38	3	143	0	41	0	27	0	0	6	144	0	19	4	160	94	100
Jaffna	26	1706	5	205	1	5	0	70	0	54	0	12	1	578	0	8	0	0	1	139	0	46	0	1	92	100
Kilinochchi	1	68	0	34	0	0	0	35	0	9	0	13	0	24	0	0	0	0	0	10	0	10	0	0	75	100
Mannar	0	107	0	24	0	4	0	20	0	9	0	9	0	38	0	0	0	0	0	7	0	1	0	0	60	100
Vavuniya	2	199	1	12	0	3	1	78	0	31	0	12	0	10	0	6	0	0	0	23	1	9	0	6	100	100
Mullaitivu	1	149	0	23	0	2	0	17	0	40	0	23	0	6	0	2	0	1	0	19	0	7	0	5	80	100
Batticaloa	2	422	5	235	0	3	0	41	0	91	0	38	0	5	0	10	0	0	0	79	0	12	0	1	71	93
Ampara	0	200	0	40	0	2	0	0	0	21	1	26	0	0	0	9	0	0	0	122	0	4	0	5	29	71
Trincomalee	0	340	0	49	0	2	0	11	0	24	0	28	0	23	0	32	0	1	1	127	0	11	0	5	67	83
Kurunegala	22	1999	2	249	0	11	1	2	0	13	1	125	2	35	0	19	0	2	12	259	1	47	4	70	69	79
Puttalam	7	882	0	67	0	4	0	6	0	0	0	36	0	61	0	2	0	1	0	67	0	42	0	3	57	79
Anuradhapura	4	546	2	67	0	3	0	5	0	26	2	242	0	25	0	15	0	0	1	191	0	34	0	184	53	84
Polonnaruwa	4	365	0	27	0	4	0	10	0	13	0	85	0	2	0	3	0	0	1	91	0	14	0	100	86	100
Badulla	8	607	1	98	0	13	0	8	0	24	0	108	1	82	0	100	0	0	4	183	5	159	0	3	65	94
Monaragala	7	316	5	59	0	1	0	3	0	10	0	154	2	102	0	114	0	2	3	55	0	18	0	33	91	91
Ratnapura	20	2334	5	285	0	29	0	24	0	23	3	427	0	31	1	125	0	0	4	169	0	113	0	1	67	72
Kegalle	12	1128	0	68	0	18	2	30	0	48	1	149	0	23	1	21	0	0	1	249	1	42	0	2	64	91
Kalmune	0	407	1	76	0	3	0	5	0	43	1	16	0	0	0	3	0	4	0	72	0	18	0	0	46	92
SRILANKA	498	39561	39	2440	1	175	11	556	0	744	28	2939	18	1406	8	739	0	13	61	3552	13	911	9	862	69	89

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 02nd 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

27th – 02nd September 2016 (36th 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	00	00	00	00	00	00	00	00	02	50	53	-5.6%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	00	01	00	01	00	00	00	02	04	06	284	270	+5.1%
Measles	01	00	00	00	00	00	01	00	00	02	53	318	2093	-85.1%
Rubella	00	00	00	00	00	00	00	00	00	00	00	07	08	-12.5%
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	01	01	00	00	00	00	00	00	00	02	00	15	07	+114.2%
Whooping Cough	00	01	00	00	00	00	00	00	00	01	01	50	63	-20.6%
Tuberculosis	60	32	12	06	06	21	12	09	31	189	144	6641	6907	-3.9%

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

Number of Malaria Cases Up to End of August 2016,

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All are Imported!!!

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@sltnet.lk. **Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

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