WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health

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WEEKLY EPIDEMIOLOGICAL REPORT - SRI LANKA - 2011

Suicide –An Emerging Epidemic

This is the first in a series of three articles published to mark the suicide prevention day, which falls on the 10th of September. Subsequent articles will discuss suicide prevention.

Suicide is the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. Suicide is now a major public health problem. Cumulative research, media reports and anecdotal evidence over the past three decades reveal that suicides are an emerging epidemic the world over.

Suicide has been glorified or condemned through the ages and the debate continues even today. With the thinking on and understanding of suicides changing, it is now regarded more as a tragedy than a ritual. The first scientific attempt to understand the rationale behind suicide started in 1763 with the work of Merian who emphasized that suicide was neither a sin nor a crime, but a disease.

Global situation

Globally, the exact number of people ending, attempting or thinking of ending their lives is not known. Deaths recorded due to suicide across the world indicate only the tip of the iceberg because of under reporting.

Every year, almost one million people die from suicide; a "global" mortality rate of 16 per 100,000 or one death every 40 seconds.

Suicide is estimated to represent 1.8% of the total global burden of disease in 1998 and estimated to be rising with time

In the last 45 years suicide rates have increased by 60% worldwide. Suicide is among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group; these figures do not include suicide attempts which are up to 20 times more frequent than completed suicide.

Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in one third of countries, in both developed and developing countries.

Mental disorders (particularly depression and alcohol use disorders) are a major risk factor for suicide in Europe and North America; however, in Asian countries impulsiveness plays an important role.

Sri Lankan Situation

Sri Lanka had a low suicide rate of 6 per 100,000 in 1950s. This rate doubled to 12 per 100,000 by 1964 and increased to 19 per 100,000 by 1969. This was followed by a sharp increase. Highest recorded suicide rate occurred in 1995, 46.6 suicides per 100,000 people. Current rate is around 20 per 100,000 people but a study revealed substantial underreporting and the real extent of the problem is much higher.

In 2006 more than half of the suicides were due to poison, with some 2,268 men and 519 women consuming poisonous substances.

Why do people commit suicide?

Human beings are unique, as are their reasons for suicide. An occasional fleeting thought passes through the minds of people at one time or the other, depending on individual strengths, weaknesses and life situations. Some factors known to influence suicide are low frustration tolerance, severe hostility, life expectations and failures, interpersonal conflicts between family members and peers, mental health problems, behavioural problems of alcohol and drug abuse, suffering from diseases such as HIV/AIDS etc.

Patterns of suicide

There are three separate patterns observed in suicides. The first category is the class of "impulsive suicides", spurred or triggered by one or more sudden emerging factors, often resulting in hospitalization and/or death. The second category is a group of suicides "likely or unlikely to be definitive", especially among high-risk individuals, groups or communities. The third category is "decisive and planned" and includes those passing through the suicidal process at the end of a tortuous and struggle filled journey of life.

Who is at risk?

Research has demonstrated that it is possible to identify such individuals if one is sensitive and open to words, actions and signals. Some "high-risk individuals" live in certain situations and are more prone to suicides. These are the persons:

- Losing their status, jobs and income
- Facing sudden economic loss due to migration, crop failure, economic upheaval, loss of day-to-day livelihood, natural disasters
- Expressing their loss of confidence, self esteem and faith
- Feeling guilt, shame, hatred, worthlessness, hopelessness and helplessness
- Repeating that "destiny is calling them", "hearing words from God" or "joining a known person in heaven"
- Participating in excessive religious activities, significantly more than previously observed
- Showing decreasing interest in hobbies, sex and other activities which they enjoyed earlier

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- With history of previous suicidal attempt(s)
- Complaining of "persistent boredom", inertia, lethargy and "don't know what to do"
- Experiencing recent loss of a person due to death, violence, separation or a broken relationship
- Unemployed and unable to find employment, specially youth
- Victims of domestic or other forms of violence, specially women
- Having conflicts within themselves or with other members of the family on a continual basis
- Recently discharged from hospitals, especially those with mental disorders or other terminal illnesses (such as cancer, HIV/AIDS, tuberculosis and congenital health problems)
- Staying at home and suffering from terminal illness without familial and economic support
- Pressurized by family for economic gains (such as dowry or high achievement in studies).

Identification of suicide prone persons.

There are some common symptoms noticed among suicide-prone individuals such as:

- Sadness
- Weeping spells
- Anxiety and restlessness
- Mood swings (extreme happiness to sadness)
- Excessive smoking and /or drinking
- Repetitive, continuous sleep disturbances
- Confusion and irritability
- Decreased interest in daily activities (hygiene, appearance, eating and sleeping)
- Hinting at suicide (e.g. "This is the last time we meet," "I will put an end to all this suffering," "There is no point going on")
- Difficulty in decision making
- Self-injurious behaviour (starving, injuring self)
- Having strained and difficult relations with spouse or other family members
- Becoming highly religious/atheist
- Exercising special care in distributing money or property

There are families whose members are more prone to suicides. These families are:

- Going through recent bereavement(s)
- Having a mentally ill or terminally ill patient, or handicapped child at home
- Living with a person who is alcohol-dependent or a drug addict
- With a person who has attempted or completed suicide in the past
- Showing strong likelihood of a break-up in relations, disturbed emotional state
- With interpersonal conflicts (regular, continuous, never-ending) between family members and others
- Subsisting on poor incomes, unemployment (sudden loss of job)
- Living in dangerous (crime-ridden), underprivileged environment
- With recent migration to urban areas and living in situations without social support systems

It is also possible to identify communities or localities or specified places within defined geographical areas with high suicide rates. These are:

- Certain pockets in geographical areas with higher rates of suicide
- Economically impoverished communities (slums, migrant population)
- Communities facing frequent natural disasters (floods, cyclones, droughts)
- Agricultural communities with recent crop failures
- Regions with political and communal violence where hero worship is in vogue
- Societies with high rates of alcohol use, drug abuse, violence and prostitution
- Certain high-risk places such as prisons, police stations, isolated places, hotels/ lodges and even hospitals

Sources

Suicide Prevention- available from http://www.searo.who.int/en/section1174/section1199/section1567_6745.htm, http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1824_8078.htm, http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1824_8080.htm, http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1824_8085.htm

Humanitarian news and analysis, available from http://www.irinnews.org/report.aspx?reportid=83435

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 3 : Water Quality Surveillance
Number of microbiological water samples - August / 2011

District	MOH areas	No: Expected *	No: Received
Colombo	12	72	NR
Gampaha	15	90	31
Kalutara	12	72	6
NIHS	2	12	NR
Kandy	23	138	NR
Matale	12	72	5
Nuwara Eliya	13	78	NR
Galle	19	114	NR
Matara	17	102	0
Hambantota	12	72	NR
Jaffna	11	66	34
Kilinochchi	4	24	NR
Mannar	5	30	15
Vavuniya	4	24	NR
Mullativu	4	24	1
Batticaloa	14	84	NR
Ampara	7	42	NR
Trincomalee	11	66	NR
Kurunegala	23	138	58
Puttlam	9	84	NR
Anuradhapura	19	114	NR
Polonnaruwa	7	42	43
Badulla	15	90	22
Moneragala	11	66	46
Rathnapura	18	108	NR
Kegalle	11	66	11
Kalmunai	13	78	NR

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

Table 1: Vaccine-preventable Diseases & AFP

20th – 26th August 2011(34th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	00	02	60	60	0 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	01	00	00	00	00	01	00	00	00	02	00	100	67	+ 34.3 %
Tetanus	01 CB=1	00	00	00	00	00	00	00	00	01	00	16	16	0 %
Whooping Cough	01	00	01	00	00	00	00	00	00	02	00	27	20	+ 35.0 %
Tuberculosis	174	14	07	11	40	15	31	05	16	313	62	6088	5942	+ 02.5 %

Table 2: Newly Introduced Notifiable Disease

20th – 26th August 2011 (34th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	04	01	08	01	04	10	18	03	04	43	51	2953	2281	+ 29.5 %
Meningitis	02 GM=1 KL=1	00	02 GL=2	01 JF=1	12 AM=12	02 KN=1 PU=1	00	00	00	19	19	583	1187	- 50.9 %
Mumps	05	06	07	05	14	09	04	06	15	71	39	2134	764	+ 179.3 %
Leishmaniasis	00	00	25 HB=1 HB=24	00	00	01 PU=1	03 AP=2 PL=1	00	00	29	03	507	223	+ 127.3 %

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.

DPDHS 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, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

You have a duty and a responsibility in preventing dengue fever. Make sure that your environment is free from water collections where the dengue mosquito could breed.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

20th – 26th August 2011 (34th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	97	6660	1	147	0	6	4	127	0	48	0	286	1	7	3	50	0	2	**62**
Gampaha	70	2602	1	98	0	14	1	48	0	27	5	388	0	20	4	195	0	6	**67**
Kalutara	12	909	0	103	0	4	1	44	0	21	3	205	0	2	0	5	0	1	**67**
Kandy	36	599	5	306	0	7	1	23	1	37	3	133	2	84	0	43	0	0	**87**
Matale	10	245	2	125	0	3	1	25	0	18	0	149	0	13	0	6	0	0	**75**
Nuwara	3	136	2	291	0	3	2	43	0	89	0	41	0	53	1	18	0	1	**100**
Galle	23	586	2	72	0	6	0	13	0	6	2	122	1	30	0	9	0	5	**79**
Hambantota	2	325	2	42	0	4	0	3	1	21	4	433	3	51	2	9	0	1	**75**
Matara	11	340	1	60	0	2	0	11	0	28	5	212	3	55	0	15	0	1	**100**
Jaffna	7	230	3	166	0	3	4	193	0	68	0	2	1	191	2	21	0	1	**100**
Kilinochchi	0	43	0	15	0	3	0	9	0	12	0	2	0	8	0	3	0	0	**75**
Mannar	0	26	1	16	0	0	2	26	0	78	1	13	0	32	0	2	0	0	**100**
Vavuniya	0	64	0	24	0	11	0	8	0	47	1	44	0	2	0	1	0	0	**100**
Mullaitivu	0	15	0	40	0	1	0	3	0	9	0	5	0	1	0	2	0	0	**75**
Batticaloa	7	687	2	524	0	4	0	5	0	25	0	26	0	3	0	2	0	6	**71**
Ampara	2	105	3	92	0	1	0	9	0	28	0	54	0	1	0	7	1	0	**43**
Trincomalee	2	131	7	560	0	2	0	5	0	9	0	87	0	7	0	7	0	0	**83**
Kurunegala	19	661	3	251	2	12	2	77	0	69	3	1401	0	64	2	28	0	4	**65**
Puttalam	3	369	7	153	0	1	1	25	0	9	1	99	0	17	0	6	0	2	**67**
Anuradhapu	10	207	0	100	0	1	0	3	0	33	1	237	0	16	0	14	0	1	**79**
Polonnaruw	0	230	2	96	0	1	0	9	0	22	0	77	0	1	0	15	0	0	**71**
Badulla	7	444	4	263	0	5	1	48	0	9	2	63	0	63	2	49	0	0	**88**
Monaragala	5	172	1	70	0	4	1	30	0	10	0	170	0	56	3	49	0	0	**73**
Ratnapura	16	657	4	406	0	5	2	41	0	17	17	397	1	26	1	33	0	2	**72**
Kegalle	18	505	2	90	0	12	3	58	1	23	3	263	2	27	5	141	0	0	**73**
Kalmune	0	27	3	496	0	0	0	1	6	25	0	5	0	2	0	3	0	1	**69**
SRI LANKA	**360**	**16975**	**58**	**4606**	**02**	**115**	**26**	**887**	**09**	**788**	**51**	**4914**	**14**	**832**	**25**	**733**	**01**	**34**	**77**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 26th August , 2011 Total number of reporting units =327. Number of reporting units data provided for the current week: 254
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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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.**

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