

## Public Health, Patient Care and Psychiatry PART II

Chair: A McCaw-Binns

(O – 14)

**Colourism: a health and legal issue for the sustainable development of Jamaica***EM Campbell-Daenen**Faculty of Law, Mona, The University of the West Indies*

In Canada, “trauma and violence-informed approaches to policy and practice” take into account the outcomes of trauma and violence on persons who are exposed to “systemic violence such as racism and discrimination” as part of its wider health services agenda. Here it is argued that colourism, which includes the practice of skin bleaching in Jamaica, is a form of racism and discrimination. Just, like the outcome of the practice of bullying, it is a tort which could result in emotional and psychological harm to those who are exposed to it. In Jamaica, this not only adversely affect human health, colourism also has a ripple effect at all levels of society. Arguably, at the inter-personal level, colourism perpetuates the cycle of trauma and violence which cripples the development of the country. Viewed from the perspective of tort law and sustainable development, colourism requires a legal analysis to address this phenomenon. The question therefore is. Does the tort of colourism constitute an impediment for Jamaica’s sustainable development? Colourism is seen in the light of historical discrimination, class segregation and criminal propensities in Jamaica. The practice of skin bleaching is approached from the aspects of health, fashion, economics and a right to autonomy. However, the government has not yet taken steps to classify colourism as a tort, health and a sustainable development issue. Therefore, in addressing the outcomes of trauma and violence, Jamaica, should also take steps to counter the adverse effects of colourism on the society and its sustainable development goals generally.

(O – 15)

**Prevalence of ideal cardiovascular health and its components in urban Jamaica: The Jamaica Health and Lifestyle Survey 2016–2017***TS Ferguson<sup>1</sup>, NO Younger-Coleman<sup>1</sup>, MK Tulloch-Reid<sup>1</sup>, I Govia<sup>1</sup>, JA McKenzie<sup>1</sup>, NR Bennett<sup>1</sup>, SR McFarlane<sup>2</sup>,**DK Francis<sup>3</sup>, K Webster-Kerr<sup>4</sup>, A Grant<sup>4</sup>, T Davidson<sup>4</sup>, RJ Wilks<sup>1</sup>, DR Williams<sup>5</sup>**<sup>1</sup>Epidemiology Research Unit, <sup>2</sup>Tropical Metabolism Research Unit, <sup>3</sup>Sickle Cell Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Kingston, Jamaica, <sup>4</sup>Ministry of Health, Jamaica and <sup>5</sup>Department of Social and Behavioural Sciences, Harvard TH Chan School of Public Health, Boston, MA, USA*

**Background:** The American Heart Association defines ideal cardiovascular health (ICH) as having seven characteristics: non-smoker, body mass index < 25 kg/m<sup>2</sup>, ≥ 150 minutes of moderate physical activity weekly, healthy diet, normal blood pressure (< 120/80 mmHg), normal glucose (< 5.6 mmol/L) and normal cholesterol (< 5.2 mmol/L). Ideal cardiovascular health is associated with reduced risk of cardiovascular disease and longer life expectancy. This study estimated the prevalence of ICH and its components in urban Jamaica.

**Methods:** Data from urban participants (age ≥ 20 years) in a national health survey were analysed. Data were collected using standardised protocols for questionnaire administration, measurement of blood pressure and anthropometry. A finger-stick capillary glucose sample was used to measure fasting glucose and cholesterol. Multiple imputation was used to handle missing data. Gender differences in ICH and its components were compared and logistic regression used to determine independent determinants of ICH status.

**Results:** Analyses included 1026 participants (360 males, 666 females) with mean age of 47.2 ± 17.6 years. Mean number of ICH characteristics was 3.3 and was similar in males and females. Estimated prevalence of overall ICH (all seven characteristics) was 0.26%, while 16% of participants (males 18%, females 14%) had ≥ 5 ICH characteristics (ICH5). Prevalence of the individual ICH characteristics was lowest for healthy diet (24%) and highest for non-smoking (88%). Only age remained significantly associated with ICH5 in multivariable models adjusted for gender, household socio-economic status and education (OR 0.96, 95%CI 0.95–0.98, *p* < 0.001).

**Conclusion:** Prevalence of ICH is low in urban Jamaica and is inversely associated with age.

## (O – 16)

### Sleep disorders and behavioural disorders in Jamaican children with epilepsy: a case-control study

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**Background:** Children with epilepsy (CWE) are known to have a higher-risk for developing sleep and behavioural disorders. Our aim is to evaluate sleep and behaviour in Jamaican CWE.

**Methods:** This study was a cross-sectional case-control study. Participants were recruited from the University Hospital of the West Indies and the Bustamante Hospital for Children between September 2017 and March 2018. Cases were identified along with age and gender matched controls. Informed consent was obtained from the parent/guardian of participants followed by the completion of Demographics questionnaire, the Sleep Disturbance Scale for Children (SDSC) and the Strengths and Difficulties Questionnaire (SDQ) by both cases and controls.

**Results:** Parents of 61 children (26 cases and 35 controls) participated in the study. There was no difference in sleep scores or frequency of sleep disorder between cases and controls ( $p > 0.05$ ). Children with epilepsy had higher scores than controls in peer problems (3.85 vs 2.32,  $p < 0.01$ ), internal problems (7.42 vs 4.71,  $p < 0.01$ ) and total SDQ scores (16.27 vs 12.09,  $p < 0.01$ ). When compared to controls, CWE had a higher frequency of abnormal peer problems (66% vs 32%,  $p < 0.05$ ) and emotional problems score (42% vs 15%,  $p < 0.05$ ). Learning difficulty was a risk factor of having abnormal total SDQ score (OR = 3.818,  $p < 0.05$ ).

**Conclusion:** Jamaican CWE have similar sleep scores to their healthy peers but have a higher frequency of peer problems and emotional problems.

## (O – 17)

### Level of agreement between adolescents' self-assessment and parent proxy report of health related quality of life

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**Background:** Adolescents with sickle cell disease may be severely impacted by their condition and at times may be too ill to provide a self-report of their status. We aim to assess the level of agreement between parent proxy and child using paediatric quality of life (PedsQL) and parent proxy report of health-related quality of life (HRQOL).

**Method:** Data including sociodemographics of patients and HRQOL using the PedsQL by 102 patient/proxy pairs were collected. Levels of agreement for the patient/proxy pairs were determined using the Wilcoxon Signed-Rank test; difference between scores (proxy score minus patient score); intraclass correlation coefficients and Bland-Altman plots.

**Results:** Most patients (76.5%) had homozygous SS disease (45.1% females; mean age 15.2 + 1.5 years). Median total PedsQL scores were 79.1 for patients and 80.2 for the parent-proxies (Wilcoxon signed-rank test  $p$ -value = 0.6037) with 5.9% underestimation and 8.8% overestimation of overall QOL by parents. Good agreement was observed for pain burden (ICC = 0.65), problems with treatment (ICC: 0.57) where it was low for emotional impact (ICC: 0.24) and communicating with healthcare professionals (ICC: 0.34) and community (ICC: 0.29) subscales. Parents tended to overestimate communication with community (28.4%) and pain management and control (19.2%); whereas 19.2% underestimated pain management and control and emotional impact (18.6%) on their adolescent.

**Conclusion:** The study highlights that parents and their adolescents may differ on their assessment of the latter's HRQOL. This may lead to a disconnect in parents understanding their child's needs and may affect the support that the child receives from within the family and the healthcare team.