Impact of alcohol consumption on Asia (Part II)

Part I of this article was published in the previous issue of the WER.

Loss for the nation: Drinking costs a nation billions of dollars. While the hidden cost has not been calculated for many of our countries, the burden on any nation is bound to be substantial when the cost of medical care, lost productivity through absenteeism, accidents at work, loss of job skills, salaries for police and social workers, court costs, damage to property and cars, insurance payments, etc. are added together. According to the available data:

- In Malaysia - 38 per cent of those who died in road accidents; 30 per cent of hospital admissions for head injuries; 25 per cent below average in work performance of alcoholics; 10 per cent reported having health problems; Alcoholics are 16 times more likely to be absent from their jobs.
- In India - 300 die from methanol poisoning; 3000 suffer long term disabilities such as blindness; 10 per cent of male suicides.
- In Sri Lanka - the number of liver cirrhosis patients is increasing, among oral cancer patients 68 per cent were alcohol users; driving under influence of alcohol is 20 per 100,000.
- In Myanmar (Burma) - 11 per cent of psychiatric inpatients received primary diagnosis of alcohol dependence.

Burdens are greater on poorer countries: Effects of alcohol are more devastating on developing countries. There are 1.3 billion people in the developing countries living on less than US$1 a day. In these countries, which are already faced with other more urgent problems of basic needs, such as malnutrition, infectious diseases, and drought, losses and burdens due to alcohol are a criminal waste and will further stretch the already limited resources. Resources for the assessment of the alcohol problem, its prevention, and treatment are simply non-existent. Consuming alcohol will make them even poorer.

The living standards of the developing countries tell us that these countries are totally unprepared to face the onslaught of an alcohol epidemic. In a country like India, where about 53 per cent of the population live below the income poverty line, spending money on alcohol will have serious consequences. In the state of Orissa, all 170 families in the Chautua village were spending Rs One lakh every year on sharaab, the local brew. This amount saved within one and a half years will suffice to construct an ayurvedic hospital at Chautua for the benefit of the people in 42 villages of the area.

A more serious problem for India would be a threat to food security for the poor and this is already starting to happen through a business venture by the Canadian Multinational, Seagram. The Indian government has approved Seagram to turn coarse grains, which is the poor person's staple food, into whisky, a rich man's drink. According to Indian scientists this will have a serious impact on India's food security as 150 – 200 million people still depend on coarse grains for nutrition.

The Indians do know how to make alcoholic beverages from food grains but never pursued it because of the low yield (40 litres of alcohol per tonne).
More importantly, in a country where 50 per cent of its population are undernourished, it would be unethical to convert food grains into whisky. The scientists predict that the farmers will start off as contractors supplying grains to Sea-gram but may end up as bonded labourers.

Prohibition – India’s experience: In Asia’s context, India’s experience serves as a good reference as to whether prohibition is the right strategy to adopt. Prohibition is enshrined in the Constitution of India and the states of Andhra Pradesh, Haryana and Gujarat have imposed it. The Andhra people were formerly among the heaviest drinkers in India.

Women blamed arrack, the local liquor popular among the rural folk, for rising domestic violence and the impoverishment of families. A grassroots movement led by women led to prohibition, which brought a dramatic effect on the society. However, Andhra Pradesh had to reverse the prohibition policy for several reasons including smuggling, failure of the state agencies to monitor the state’s long border, illicit brewing, which had gone up by 20-30 times, and loss of revenue. What is clear is that there must be well-grounded economic policy in place such as taxation of various kinds, safeguards against corruption, measures to deter illegal production, promotion of a social climate which discourages drinking, along with efficient enforcement, if prohibitions are to work.

Conclusion and recommendations: It is clear that alcohol should be seen from a broader perspective for us in Asia. Borrowing some lessons learnt from the tobacco epidemic the following are some suggestions for action to be taken:

1. We need to monitor the industry closely and familiarise ourselves with its tactics, language, and arguments.
2. Self-regulation does not work: Codes, especially those initiated and drafted by the industry are not effective in controlling alcohol.
3. The industry will attempt to establish partnership with the government and groups working on alcohol control which will water down their initiatives.
4. When the industry sponsors control activities it is usually because they will get more mileage out of it while the programme itself is rendered ineffective. The industry is already sponsoring drunk driving education in Thailand, which is not effective.
5. We need to organise and mobilise a more active ground movement to take up the alcohol issue.
6. Alcohol control advocates need to utilise the media more effectively. News coverage of alcohol problems is one effective way to put alcohol on the political agenda.
7. There are many transborder issues that need to be addressed regionally or internationally such as satellite TV advertising, Internet advertising, Octoberfest, and sponsorship of international events. The alcohol control community needs to establish networks in order to address these issues collectively.

National Action: Nationally governments must have a commitment to tackle the alcohol problem and not denounce it on one hand and promote it on the other. There must be a national policy to control alcohol abuse.

1. Ban advertising and promotions - Ban on all forms of advertising, direct and indirect, and the promotional activities of alcohol companies.
2. Limiting the packaging, licences and availability - Ban the sale of liquor in small bottling such as 145ml. There should be a limit on the size of bottles, limit drinking hours, and limit places where alcohol can be bought. Increase legal age for purchase of alcohol to 21 years.
3. Alcohol tax - If health budgets of developing countries are averaging 1 per cent of the national budget it is unrealistic to expect any resources from government for comprehensive alcohol control activities. It would be more realistic to generate money from taxing alcohol more. Experience from tobacco control shows us that a separate dedicated taxation for alcohol to ensure these agreements such as the World Health Organization and the United Nations Drug Control Programme. We must also address market expansion to developing countries.

4. Eliminate subsidies - Government subsidies in the form of tax deductions for alcohol marketing as cost of doing business must be eliminated.

5. Community-based health programmes - Most countries cannot afford to train health and social workers specifically to tackle alcohol problems. In communities where a major portion of the population does not read or write, it is crucial to devise simple, creative, and low budget health programmes. Local government, health groups and other community organisations should all be involved in alcohol control programmes. Health groups can play a key role in the development of comprehensive national alcohol control programmes.

International action: The alcohol problem must be addressed in a more concerted manner by international organisations such as the World Health Organization and the United Nations Drug Control Programme. We must also address market expansion to developing countries.

1. Global Treaty on alcohol - There must be a Framework Convention on Alcohol Control to bring countries together to set basic standards on alcohol control.
2. World Trade agreements - World trade agreements need to make special provision for alcohol to ensure these agreements may not be used to weaken health and safety regulations regarding alcohol.
3. Duty-free status should be removed - Remove the duty free status of alcoholic beverages sold at airports and during in-flight services.

Source: Impact of alcohol consumption on Asia The Globe
Table 1: Vaccine-preventable Diseases & AFP

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Cases by Province</th>
<th>Number of cases during current week in 2007</th>
<th>Number of cases during same week in 2006</th>
<th>Total number of cases to date in 2007</th>
<th>Total number of cases to date in 2006</th>
<th>Difference between the number of cases to date between 2007 &amp; 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Flaccid Paralysis</td>
<td>W=01 C=01 S=01 NE=01 NW=00 NC=00 U=00 Sab=00</td>
<td>03</td>
<td>02</td>
<td>68</td>
<td>98</td>
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<td>00</td>
<td>00</td>
<td>00</td>
<td>0.0%</td>
</tr>
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<td>00</td>
<td>65</td>
<td>36</td>
<td>+80.6%</td>
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<tr>
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<td>01</td>
<td>30</td>
<td>38</td>
<td>-21.1%</td>
</tr>
<tr>
<td>Whooping Cough</td>
<td>W=00 C=00 S=00 NE=00 NW=00 NC=00 U=00 Sab=00</td>
<td>01</td>
<td>01</td>
<td>36</td>
<td>67</td>
<td>-46.3%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>W=41 C=02 S=04 NE=09 NW=08 NC=16 U=16 Sab=08</td>
<td>96</td>
<td>245</td>
<td>7833</td>
<td>8042</td>
<td>-2.6%</td>
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Table 2: Diseases under Special Surveillance

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Cases by Province</th>
<th>Number of cases during current week in 2007</th>
<th>Number of cases during same week in 2006</th>
<th>Total number of cases to date in 2007</th>
<th>Total number of cases to date in 2006</th>
<th>Difference between the number of cases to date between 2007 &amp; 2006</th>
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<tbody>
<tr>
<td>DF/DHF*</td>
<td>W=011 C=005 S=010 NE=023 NW=026 NC=004 U=002 Sab=022</td>
<td>131</td>
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<td>4842</td>
<td>8661</td>
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<tr>
<td>Encephalitis</td>
<td>W=000 C=000 S=000 NE=000 NW=000 NC=000 U=000 Sab=000</td>
<td>04</td>
<td>03</td>
<td>170</td>
<td>101</td>
<td>+68.3%</td>
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<td>Human Rabies</td>
<td>W=000 C=000 S=000 NE=000 NW=000 NC=000 U=000 Sab=000</td>
<td>01</td>
<td>01</td>
<td>53</td>
<td>53</td>
<td>0.00%</td>
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Table 3: Newly Introduced Notifiable Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Cases by Province</th>
<th>Number of cases during current week in 2007</th>
<th>Total number of cases to date in 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>W=007 C=002 S=006 NE=003 NW=002 NC=000 U=004 Sab=002</td>
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<td>Meningitis</td>
<td>W=005 C=002 S=001 NE=001 NW=002 NC=001 U=003 Sab=001</td>
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<td>Mumps</td>
<td>W=006 C=002 S=001 NE=002 NW=002 NC=002 U=002 Sab=002</td>
<td>23</td>
<td>1811</td>
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Table 4: Laboratory Surveillance of Dengue Fever

<table>
<thead>
<tr>
<th>Samples</th>
<th>Number tested</th>
<th>Number positive</th>
<th>Serotypes</th>
<th>D1</th>
<th>D2</th>
<th>D3</th>
<th>D4</th>
<th>Negative</th>
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<tbody>
<tr>
<td>Number for current week</td>
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<td>01</td>
<td>00</td>
<td>00</td>
<td>00</td>
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<td>00</td>
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<tr>
<td>Total number to date in 2007</td>
<td>431</td>
<td>46</td>
<td>01</td>
<td>22</td>
<td>13</td>
<td>00</td>
<td>09</td>
<td>00</td>
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Source: Genetech Molecular Diagnostics & School of Gene Technology, Colombo. * Not all positives are subjected to serotyping.
## Table 5: Selected notifiable diseases reported by Medical Officers of Health

**15th - 19th Oct 2007 (42nd Week)**

<table>
<thead>
<tr>
<th>DPHS Division</th>
<th>Dengue Fever / DHF*</th>
<th>Dysentery</th>
<th>Encephalitis</th>
<th>Enteric Fever</th>
<th>Food Poisoning</th>
<th>Leptospirosis</th>
<th>Typhus Fever</th>
<th>Viral Hepatitis</th>
<th>Returns Received Timely**</th>
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</thead>
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<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
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<td>B</td>
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<td>Colombo</td>
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<td>00</td>
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<td>03</td>
<td>65</td>
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<tr>
<td>Gampaha</td>
<td>11</td>
<td>554</td>
<td>01</td>
<td>289</td>
<td>00</td>
<td>24</td>
<td>01</td>
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<td>Kalutara</td>
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<td>00</td>
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<td>Kandy</td>
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<td>Matale</td>
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<td>87</td>
<td>00</td>
<td>184</td>
<td>00</td>
<td>06</td>
<td>01</td>
<td>25</td>
<td>00</td>
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<tr>
<td>Nuwara Eliya</td>
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<td>36</td>
<td>00</td>
<td>213</td>
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<tr>
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<td>03</td>
<td>260</td>
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<tr>
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<td>114</td>
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<td>06</td>
<td>52</td>
<td>00</td>
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<td>02</td>
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<tr>
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<td>00</td>
<td>08</td>
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<td>184</td>
<td>02</td>
<td>03</td>
<td>00</td>
<td>08</td>
<td>01</td>
</tr>
</tbody>
</table>

**SRI LANKA**

| 131      | 4842 | 86 | 5733 | 04 | 170 | 38 | 1417 | 62 | 908 | 27 | 1265 | 13 | 860 | 45 | 5226 | 54 |

**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 27 October, 2007. Total number of reporting units =290. Number of reporting units data provided for the current week: 173

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