WEEKLY EPIDEMIOLOGICAL REPORT
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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.

Burden is 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 Chatua 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 Chatua 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).

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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 Seagram 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 can be used for health promotion and health sponsorship funds to replace alcohol industry support of sports and other sponsorship activities, public education and rehabilitation programmes.

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

13th - 19th Oct 2007 (42nd Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Number of cases during same week in 2006	Total number of cases to date in 2007	Total number of cases to date in 2006	Difference between the number of cases to date between 2007 & 2006
	W	C	S	NE	NW	NC	U	Sab					
Acute Flaccid Paralysis	01 GM=1	01 NE=1	01 MT=1	00	00	00	00	00	03	02	68	98	-30.6%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00.0%
Measles	00	00	01	00	00	00	00	00	01	00	65	36	+80.6%
Tetanus	00	00	00	00	00	00	00	00	00	01	30	38	-21.1%
Whooping Cough	00	00	00	00	00	00	00	01 KG=1	01	01	36	67	-46.3%
Tuberculosis	41	02	04	09	00	08	16	16	96	245	7833	8042	-2.6%

Table 2: Diseases under Special Surveillance

13th - 19th Oct 2007 (42nd Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Number of cases during same week in 2006	Total number of cases to date in 2007	Total number of cases to date in 2006	Difference between the number of cases to date between 2007 & 2006
	W	C	S	NE	NW	NC	U	Sab					
DF/DHF*	39	05	10	23	26	04	02	22	131	218	4842	8661	-44.1%
Encephalitis	00	00	01 GL=1	02 KM=2	01 PU=1	00	00	00	04	03	170	101	+68.3%
Human Rabies	00	00	00	00	01 KR=1	00	00	00	01	01	53	53	0.00%

Table 3: Newly Introduced Notifiable Diseases

13th - 19th Oct 2007 (42nd Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Total number of cases to date in 2007
	W	C	S	NE	NW	NC	U	Sab		
Chickenpox	07	02	06	03	02	00	04	02	26	2804
Meningitis	05 GM=3 CB=2	02 KD=1 NE=1	01 HB=1	02 JF=1 KM=1	01 KR=1	01 AP=1	00	03 KG=2 RP=1	15	556
Mumps	06	02	01	06	02	02	02	02	23	1811

*DF / DHF refers to Dengue Fever / Dengue Haemorrhagic Fever.
NA= Not Available.

Sources:

Weekly Return of Communicable Diseases:
Diphtheria, Measles, Tetanus, Whooping Cough, Human Rabies, Dengue Haemorrhagic Fever, Japanese Encephalitis, Chickenpox, Meningitis, Mumps.

Special Surveillance:
Acute Flaccid Paralysis.

National Control Program for Tuberculosis and Chest Diseases:
Tuberculosis.

Details by districts are given in Table 5.

Provinces: W=Western, C=Central, S=Southern, NE=North & 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.

Table 4: Laboratory Surveillance of Dengue Fever

13th - 19th Oct 2007 (42nd Week)

Samples	Number tested	Number positive *	Serotypes				
			D_1	D_2	D_3	D_4	Negative
Number for current week	06	01	00	00	01	00	00
Total number to date in 2007	431	46	01	22	13	00	09

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

13th - 19th Oct 2007 (42nd Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Returns Received Timely**
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	23	1270	01	318	00	10	03	65	02	68	02	120	00	03	01	125	**54**
Gampaha	11	554	01	289	00	24	01	66	00	45	00	181	01	15	03	175	**64**
Kalutara	05	298	02	394	00	05	00	40	04	42	02	124	00	01	00	55	**27**
Kandy	04	337	02	247	00	03	02	58	00	09	00	73	01	71	08	1896	**59**
Matale	00	87	00	184	00	06	01	25	00	12	02	53	00	05	01	128	**17**
Nuwara Eliya	01	36	00	213	00	02	01	107	00	368	00	09	00	32	03	512	**43**
Galle	02	77	00	147	01	11	00	18	00	39	05	69	00	26	00	19	**63**
Hambantota	05	69	02	161	00	06	00	21	00	17	01	39	00	48	01	21	**64**
Matara	03	154	03	260	00	08	01	36	00	24	05	196	01	188	00	29	**88**
Jaffna	20	114	01	158	00	02	11	391	01	12	00	00	03	88	00	23	**75**
Kilinochchi	00	01	00	00	00	00	00	05	00	00	00	00	00	02	00	04	**25**
Mannar	00	07	02	23	00	00	06	79	00	00	00	02	00	00	02	21	**50**
Vavuniya	03	23	06	52	00	04	02	20	00	53	00	02	00	00	00	08	**75**
Mullaitivu	00	00	01	27	00	08	00	20	00	01	00	00	00	00	00	14	**80**
Batticaloa	00	75	00	455	00	09	00	18	00	10	00	00	00	22	04	1064	**36**
Ampara	00	03	00	101	00	00	00	04	00	01	00	03	00	01	00	28	**14**
Trincomalee	00	54	02	229	00	04	00	26	00	23	00	10	00	15	00	106	**44**
Kurunegala	22	569	16	412	00	07	00	58	00	32	04	49	00	36	03	82	**72**
Puttalam	04	126	04	132	01	14	01	75	00	04	00	25	00	06	01	75	**67**
Anuradhapura	03	169	06	111	00	08	00	21	01	17	00	23	00	18	00	40	**53**
Polonnaruwa	01	59	13	99	00	03	01	13	53	57	00	20	00	00	02	43	**71**
Badulla	02	57	10	503	00	05	03	81	00	10	00	45	06	151	05	308	**47**
Monaragala	00	39	03	288	00	02	00	48	00	28	00	43	01	73	00	40	**40**
Ratnapura	01	337	05	498	00	18	02	60	00	19	00	60	00	24	03	92	**50**
Kegalle	21	324	06	248	00	08	03	54	00	08	06	118	00	33	03	199	**64**
Kalmunai	0	03	00	184	02	03	00	08	01	09	00	01	00	02	05	119	**38**
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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