



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health

231, de Saram Place, Colombo 01000, Sri Lanka
Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@slt.net.lk
Epidemiologist: +94 11 2681548, E mail: chepid@slt.net.lk
Web: http://www.epid.gov.lk

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The World No Tobacco Day

This article is published to mark the World No Tobacco Day which falls on the 31st of May 2011

The global tobacco epidemic

Tobacco use is one of the greatest public health threats the world has ever faced. It is the single leading cause of preventable death, and an estimated 5 million people will die prematurely each year worldwide from tobacco-related diseases. This does not include the 600,000 people (more than a quarter of them being children) who will die from exposure to second-hand smoke. Tobacco is estimated to kill more people than motor car accidents, suicides, homicides, tuberculosis and maternal deaths put together. Smoking is a main cause of non-communicable diseases, while chewing tobacco is a main cause of oral cancer. The majority of persons who die from smoking are males. Most of these deaths are in low and middle income countries. One out of two smokers will die prematurely. The health consequences of tobacco use are entirely preventable. If urgent action is not taken and current trends persist this death toll will rise to more than eight million by 2030 and 80% of these premature deaths will be in low and middle income countries.

Tobacco and poverty are interrelated. Tobacco use is more common among the lower income groups and tobacco use aggravates poverty. Economic costs incurred by tobacco include costs of health care expenditure due to tobacco related illness and productivity losses due to employee absenteeism and reduced labour productivity.

Around 60 persons die each day in Sri Lanka due to smoking, resulting in an annual death toll of around 20,000. According to data Sri Lankans spend around Rs. 100 million per day on cigarettes

Adverse health effects of tobacco

Cigarette smoke contains more than 4,000 toxic chemical compounds and 43 of them are known carcinogens while chewing tobacco contains at least 2550 chemicals out of which 28 are known carcinogens.

Tobacco use is a major contributor to the epidemic of non communicable diseases globally. Smoking is strongly associated with early myocardial infarctions leading to sudden cardiac death, strokes and peripheral vascular disease. Tobacco causes a large number of cancers including lung cancer, cancer of the oral cavity, oesophageal cancer, pancreatic cancer bladder cancer kidney cancer and cervical

cancer is higher. It is also associated with a range of respiratory diseases including bronchial asthma, chronic obstructive pulmonary disease (COPD), chronic bronchitis and increased susceptibility to communicable diseases such as pneumonia and influenza. Smoking significantly increases the susceptibility to tuberculosis. Tobacco use has also shown to have adverse effect on the sexual and reproductive health of both men and women. Men who smoke have a lower sperm count and poorer sperm quality leading to infertility and may develop erectile impotence. In women it leads to early menopause and infertility.

Effects of second hand smoking.

Second hand smoke also known as passive smoking causes 430 000 deaths worldwide each year. It contains many of the same chemicals that are present in the smoke inhaled by smokers. Secondhand smoke has been designated as a known human carcinogen

Exposure of pregnant mothers to secondhand smoking can cause foetal growth retardation, foetal death and various respiratory problems in the newborn. Infants exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma recurrent bronchitis, pneumonia, impaired brain development, learning difficulties and allergies. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

Response of the world community to the tobacco epidemic

As a response to the globalization of the tobacco epidemic, the World Health Organization (WHO) developed "The WHO Framework Convention on Tobacco Control (WHO-FCTC)". The WHO-FCTC is the world's leading tobacco control instrument providing an outline for tobacco control and an international platform for implementation and monitoring tobacco control. It is an evidence-based treaty that reaffirms the right of the people to the highest standard of health. The WHO FCTC is characterized by an attempt to develop a regulatory strategy to address addictive substances by asserting the importance of demand reduction strategies as well as supply issues. It is one of the most rapidly and widely accepted treaties in the history of the United Nations, having 172 parties to it including Sri Lanka,

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since its adoption in 2005.

Under the WHO-FCTC these parties are obliged to:

- Protect people from exposure to tobacco smoke
- Ban tobacco advertising and sales to minors
- Have large health warnings on packages of tobacco
- Ban or limit additives to tobacco products
- Increase tobacco taxes
- Create a national coordinating mechanism for tobacco control.

The tobacco and alcohol act

In 2006, an act that regulates the production, advertising, marketing and use of tobacco (and alcohol) was enforced in Sri Lanka. This is the National Authority on Tobacco and Alcohol Act (NATAA) No. 27. Some of the important provisions in the act are:

- Prohibition of sale of any tobacco product or alcohol product to persons under 21 years of age
- Prohibition on installation of vending machines for dispensing tobacco product or alcohol product.
- Prohibition on the sale of tobacco products without health warning and the tar, nicotine content in each tobacco product.
- Prohibition of sponsorships of any educational, cultural, social or sporting organization, activity or event by the tobacco industry.
- Prohibition of free distribution of tobacco products or alcohol product.
- Prohibition of smoking in an area to which the public have access.

Role of health professionals

While welcoming the act as a very positive move towards tobacco cessation in the country, it should be remembered that enforcing this act alone will not be sufficient to effectively control the tobacco epidemic in the country. Although the act will prevent free and irregular production, sale, advertising and use of tobacco up to some extent, it obviously offers very little to motivate people to quit. Health professionals on the other hand, can play a very important and effective role in tobacco cessation, both at the level of the individuals and at community level. They are in a unique position for this task. They have a great deal of respect and credibility among the public and are equipped with knowledge, skills and even authority to act towards tobacco cessation. Health professionals also have a duty and a moral obligation to act for tobacco cessation and save the hundreds of thousands of lives that succumb to tobacco each year.

Even some of the doctors may be of the view that “the tobacco users will never change”. This is a myth; the fact is, smoking cessation interventions have shown to be effective; either in the form of brief advice in primary care, in more intensive interventions such as nicotine replacement therapy. The evidence is encouraging. One in ten smokers will stop smoking merely if their doctor asks them to quit. A great majority of smokers in the world have stopped smoking with no medical or formal specialized support. Only a small minority will need professional help to quit. However, there is one important fact that should be remembered: in offering help to this small minority to quit, one should be careful not to give the false impression to the smoking community that “smoking cannot be stopped without professional support” The risk of, a medical professional’s help to quit being perceived as “a must for quitting” should be guarded against. While trying to provide help for quitting, one should always emphasize the power that a smoker already possess to take control of his smoking habit and make sure that he will not feel “disempowered”

- Ask the patient about his smoking habits at every possible opportunity.
- A note should be made in his medical record on his smoking status.
- All patients who have previously been identified as smokers should be asked at subsequent visits, whether they have stopped smoking. If the patient is still continuing to smoke, he should be asked about any attempts to quit, whether support was sought, if so from whom, whether he made his family and friends (especially the ones who smoke) aware about his attempt to quit? And why he is still continuing to smoke?

- They should be asked whether they know the contribution or effect smoking could have towards their current illness. Whether they know the numerous dreadful ill effects smoking could have on their health?
- Tell that his smoking is a health hazard to the whole family.
- Remind him about the amount of money wasted on smoking.
- Continuous questioning and attention will not only make some smokers quit but help change the mood among the public as well. It will help to reinforce the idea in the community, that smoking is an important health problem.
- Building an alliance with any smoker who comes to health professionals as a patient is beneficial. It is needed for the patient to feel that the health professionals are genuinely concerned about his health and interested in his welfare; the only way to do is genuinely being so. Once a bond is established even through a very short interaction, any advice or suggestion made by the health professional is taken seriously by the patient. Its success is not mostly dependent on the time spent but the feeling that is experienced by the patient.
- Advise all smokers to quit, in a clear and firm manner. People are more likely to act on advice personally directed towards them. People coming to a health facility are open to personal communication, so any advice should be person specific. It only takes a few seconds to convey such a message to someone.

A small percentage will stop merely with this advice, and health professionals may need to spend a little more time and energy to increase this percentage a little more. Reminding the patient the relevance of smoking to his illness and other health hazards and also that the risk will start coming down the moment he quits will be of use.

If you can spare a little more than five minutes you may further help someone to quit in a rather simple manner.

- Always ascertain the fact that the individual, NOT the ones who pushes tobacco is in control of his own life.
- Work out his own reasons for smoking and quitting. Explain that he should not pretend wanting to quit to please others. When someone says that he cannot control his habit it may be due to the fact that he is not really committed to the change.

The simple quit guide that will appear in the next issue of the WER can be used to help people who want to quit.

What can be done at the community level?

Every possible opportunity should be utilized to educate the public on hazards of smoking, the benefits of quitting, to build confidence among smokers that quitting is possible and to sensitize and educate the public on the provisions of the tobacco and alcohol. This could be done at school medical inspections, health talks at antenatal clinics and OPD/clinic waiting areas. Special health talks could be arranged at factories in the area, schools, youth clubs etc. Special programs such as poster competitions/campaigns and processions could be organized in collaboration with schools/youth clubs in the area to sensitize school children, their families and the general public.

Tobacco cessation is one single intervention that can save a huge number of lives, improve the health of people immensely and bring an enormous change to the world we live in. Let’s act now; let’s feel more satisfied as health professionals.

We appreciate the guidance of Prof. Diyanath Samarasinghe, Dept of Psychiatry, Faculty of Medicine, Colombo.

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This article was compiled by Dr. Athula Liyanapathirana of the Epidemiology Unit.

Table 1: Vaccine-preventable Diseases & AFP

14th - 20th May 2011(20th 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	01	30	34	- 11.7 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	01	00	00	00	01	00	0	00	01	03	02	56	38	+ 47.4 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	08	09	- 11.1 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	02	15	10	+ 50.0 %
Tuberculosis	21	06	14	07	19	00	00	09	12	88	123	3169	3485	- 09.1 %

Table 2: Newly Introduced Notifiable Disease

14th - 20th May 2011(20th 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	12	03	20	03	03	08	05	05	08	67	45	2022	1567	+ 29.0 %
Meningitis	01 CB=1	00	00	04 JF=1 MN=1 VA=1 MU=1	01 TR=1	02 KN=1 PU=1	00	00	01 RP=1	19	18	363	620	- 41.4 %
Mumps	06	05	07	01	00	01	03	04	02	29	16	924	360	+ 156.7 %
Leishmaniasis	00	00	01 MT=1	00	00	00	02 AP=1 PO=1	00	00	03	05	271	144	+ 88.2 %

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

Reduce, Reuse or Recycle the plastic and polythene collected in your home and help to minimize dengue mosquito breeding.

Table 4: Selected notifiable diseases reported by Medical Officers of Health
14th - 20th May 2011(20th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received Timely**
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	108	1976	3	89	0	4	1	65	0	8	2	162	0	5	0	20	0	2	85
Gampaha	39	709	2	58	0	9	0	21	0	12	4	279	0	13	0	36	0	2	87
Kalutara	12	361	2	67	0	3	0	27	0	14	3	113	0	0	0	4	0	0	67
Kandy	6	178	6	174	0	4	0	14	0	26	3	67	2	46	0	25	0	0	78
Matale	7	80	1	55	0	3	0	9	0	8	6	92	0	10	0	4	0	0	83
Nuwara	1	49	3	148	0	3	1	24	2	14	0	23	0	37	2	9	0	0	85
Galle	12	184	0	32	1	5	0	3	0	5	6	69	1	15	0	7	0	0	89
Hambantota	7	190	1	17	0	4	0	2	1	8	18	323	0	24	0	4	0	0	83
Matara	6	166	0	29	0	1	0	6	0	8	4	160	1	34	0	9	0	1	82
Jaffna	2	139	6	76	0	3	10	125	0	11	0	2	1	163	1	14	0	1	100
Kilinochchi	0	32	0	8	0	3	0	5	0	4	0	2	0	6	0	2	0	0	25
Mannar	1	20	2	9	0	0	0	10	0	66	0	11	0	27	0	1	0	0	80
Vavuniya	2	41	0	19	0	9	0	6	0	36	0	31	0	2	0	1	0	0	75
Mullaitivu	0	6	0	26	0	1	0	1	0	0	0	3	0	1	0	2	0	0	100
Batticaloa	21	465	14	353	0	3	0	4	0	9	0	16	0	1	0	2	0	4	79
Ampara	1	41	1	44	0	0	0	7	0	20	1	49	0	1	0	7	0	0	43
Trincomalee	3	81	29	413	0	0	0	1	1	8	3	64	0	3	0	4	0	0	73
Kurunegala	14	253	2	127	0	6	1	45	7	33	26	1193	0	42	0	14	1	1	91
Puttalam	6	227	1	82	0	0	1	13	3	5	0	74	0	10	0	5	0	2	67
Anuradhapu	6	94	2	57	0	1	0	2	0	22	6	205	0	13	1	5	0	0	74
Polonnaruw	7	115	7	32	0	1	2	8	3	11	5	68	0	1	1	6	0	0	86
Badulla	2	113	3	78	0	4	2	24	0	5	0	28	0	25	1	21	0	0	67
Monaragala	4	101	1	27	0	2	0	18	0	8	8	147	0	38	0	35	0	0	100
Ratnapura	4	288	4	226	0	3	1	19	0	13	3	242	0	21	0	20	0	2	78
Kegalle	4	151	2	42	0	11	5	35	0	18	6	153	1	13	0	38	0	0	91
Kalmunai	0	15	26	301	0	0	0	0	0	11	0	3	0	2	0	2	0	1	92
SRI LANKA	275	6075	118	2589	01	83	24	494	17	383	103	3579	06	553	06	297	01	16	81

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 20th May, 2011 Total number of reporting units =320. Number of reporting units data provided for the current week: 261

A = Cases reported during the current week. B = Cumulative cases for the year.

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ON STATE SERVICE

Dr. P. PALIHAWADANA
CHIEF EPIDEMIOLOGIST
EPIDEMIOLOGY UNIT
231, DE SARAM PLACE
COLOMBO 10