

On June 11, 2009, WHO raised the pandemic alert level to phase 6 (indicating a global pandemic) because of widespread infection beyond North America to Australia, the United Kingdom, Argentina, Chile, Spain, and Japan. [10] As of September 1, 2009, the World Health Organization (WHO) reported that H1N1 influenza had been confirmed in over 200,000 people in more than 100 countries and that they are aware of at least 2185 confirmed deaths. For an updated tally of affected countries and counts, see WHO's Influenza A (H1N1) Web page.

On October 24, 2009, President Obama declared the 2009 H1N1 influenza pandemic a national emergency, explaining that "...the rapid increase in illness across the Nation may overburden health care resources and that the temporary waiver of certain standard Federal requirements may be warranted in order to enable U.S. health care facilities to implement emergency operations plans, the in the United States 2009 H1N1 influenza pandemic constitutes a national emergency." This declaration made way for waiving certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule throughout the duration of the public health emergency. [18]

Government and public health officials are monitoring this situation worldwide to assess the threat from H1N1 influenza and to provide guidance to health care professionals and the public. Because the situation is changing rapidly, it is important to check regularly for changes in recommendations as new information becomes available. Online resources for daily guidance include the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), and Medscape's H1N1 Influenza A (Swine Flu) Alert Center.

Dominguez-Cherit et al (2009) conducted an observational study of consecutive critically ill patients in Mexican hospitals that treated most patients with confirmed, probable, or suspected H1N1 influenza during the 2009 epidemic. Critical illness occurred in 58 (6.5%) of 899 patients. Median age of critically ill patients was 44 years (range, 10-83 y). All presented with fever, and all but one with respiratory symptoms. Few patients had comorbid respiratory disorders, but 36% were obese. All patients but 2 received mechanical ventilation for severe acute respiratory distress syndrome and refractory hypoxemia. By 60 days, 24 patients had died (41.4%; 95% confidence interval, 28.9%-55%). Patients who died had greater initial severity of illness, worse hypoxemia, higher creatine kinase and creatinine levels, and ongoing organ dysfunction. Treatment with neuraminidase inhibitors was associated with improved survival (odds ratio, 8.5; 95% confidence interval, 1.2-2.8). [19]

See Medscape's H1N1 influenza algorithm adaptation for guidance in managing suspected cases.

A WHO report on the 2009 influenza pandemic indicated that nearly all countries reported cases of H1N1 virus infection, with more than 17,000 deaths worldwide. In the United States, the number of clinical illnesses was estimated at 59 million, 265,000 hospitalizations, and 12,000 deaths. [20] H1N1 strains are still prevalent in India, whose Health Ministry has reported over 2500 deaths to date.

In the second half of 2011, a novel swine influenza virus emerged. Twelve cases from 5 states were reported by the CDC in January 2012. The new strain, dubbed A (H3N2)v, includes a gene from the human pandemic strain and affects mostly children. In 3 of the 5 states where the virus emerged (Pennsylvania, Maine, and Indiana), the virus was a result of pig-to-human transmission. [21] According to the Department of Health and Human Services (HHS), a precautionary vaccine against this variant is in development and will likely be ready for clinical trials in the spring of 2012.

medicine



Socio-economic level	Men			Women			Total
	High	Middle	Low	High	Middle	Low	
Total deaths	48,469	95,873	122,436	44,289	92,189	126,146	529,402
Injuries	1,850	4,334	4,600	320	604	627	12,335
Infectious diseases	2,051	4,768	18,311	601	1,171	6,520	33,422
Chronic diseases	2,985	4,205	5,981	1,181	1,946	3,240	19,538
Total attr. to alcohol	6,086	13,307	28,892	2,102	3,721	10,387	65,295
%	14.2%	13.5%	23.6%	4.7%	4.0%	8.2%	12.3%

"Overall, approximately 62,300 adults died from alcohol-attributable causes of death in South Africa in 2015. With a total of approximately 529,400 deaths from all causes, roughly one in ten deaths was attributable to alcohol use," the researchers said.

"Roughly 60% of all alcohol-attributable deaths (~39,300 deaths) occurred in the low socio-economic group. About a quarter (~17,000 deaths) occurred in the middle group, and roughly 15% (~9000 deaths) in the high SES group.

"In the higher socio-economic group, deaths due to chronic diseases constituted the largest subcategory of alcohol-attributable deaths. In the middle income group, chronic and infectious diseases contributed approximately the same number of deaths.

"In the low income group, the majority of the alcohol-attributable deaths occurred due to infectious diseases."

Getting worse

According to the paper, the approximation of one in 10 (~12%) people dying from alcohol-related causes is much higher than the previous estimate of 7% in 2010, showing that there is a growing problem in the country.

However, the growth can also be explained by the inclusion of additional causes of death – most notable HIV/AIDS – into the research. But the problem could worsen than the research is able to show.

Specifically, it's estimated that 23% of all alcohol consumed in South Africa is unrecorded (ie, in shebeens), which is more likely than not taken in by the lower socio-economic groups.

This could mean that, while the available data shows that two in ten deaths in the lower income groups can be attributable to alcohol, the number may be higher.

The researchers said that when looking for ways to change policies or introduce interventions, this needs to be taken into account.

Read: 7 things you need to know about the Western Cape's massive alcohol clampdown



RESEARCH ARTICLE

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The socioeconomic profile of alcohol-attributable mortality in South Africa: a modelling study

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Abstract

Background: Globally, illness and life expectancy follow a social gradient that puts people of lower socioeconomic status (SES) at higher risk of dying prematurely. Alcohol consumption has been shown to be a factor contributing to socioeconomic differences in mortality. However, little evidence is available from low- and middle-income countries. The objective of this study was to quantify mortality attributable to alcohol consumption in the adult (15+ years) general population of South Africa in 2015 by SES, age, and sex.

Methods: A comparative risk assessment was performed using individual and aggregate data from South Africa and risk relations reported in the literature. Alcohol-attributable fractions (AAFs) and alcohol-attributable mortality rates were estimated for cause-specific mortality by SES, sex, and age. Monte Carlo simulation techniques were used to calculate 95% uncertainty intervals (UI).

Results: Overall, approximately 62,300 (95% UI 27,000–103,000) adults died from alcohol-attributable causes in South Africa in 2015, with 60% of deaths occurring in people in the low and 15% in the high SES groups. Age-standardized, alcohol-attributable mortality rates per 100,000 adults were highest for the low SES group (727 deaths, 95% UI 354–1208 deaths) followed by the middle (377 deaths, 95% UI 165–687 deaths) and high SES groups (163 deaths, 95% UI 71–289 deaths). The socioeconomic differences were highest for mortality from infectious diseases.

People of low SES had a lower prevalence of current alcohol use but heavier drinking patterns among current drinkers. Among men, AAFs were elevated at low and middle SES, particularly for the middle and higher age groups (35+). Among women, AAFs differed less across SES groups and, in the youngest age group (15–34), women of high SES had elevated AAFs.

Conclusions: Alcohol use contributed to vast socioeconomic differences in mortality. Where observed, elevated AAFs for people of low and middle SES arose from higher levels of consumption among current drinkers and not from the prevalence of current alcohol use per se. The findings can direct preventive measures and interventions on those at highest risk. Future research is needed to investigate socioeconomic differences in the risk functions relating alcohol use to cause-specific mortality.

Keywords: Alcohol consumption, Mortality, Burden of disease, Inequalities, Socioeconomic status, South Africa

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RESEARCH

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Heavy drinking and contextual risk factors among adults in South Africa: findings from the International Alcohol Control study



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Abstract

Background: There is limited information about the potential individual-level and contextual drivers of heavy drinking in South Africa. This study aimed to identify risk factors for heavy drinking in Tshwane, South Africa.

Methods: A household survey using a multi-stage stratified cluster random sampling design. Complete consumption and income data were available on 713 adults. Heavy drinking was defined as consuming ≥ 120 ml (96 g) of absolute alcohol (AA) for men and ≥ 90 ml (72 g) AA for women at any location at least monthly.

Results: 53% of the sample were heavy drinkers. Bivariate analyses revealed that heavy drinking differed by marital status, primary drinking location, and container size. Using simple logistic regression, only older consumption was found to lower the odds of heavy drinking. Persons who primarily drank in someone else's home, nightclubs, and sports clubs had increased odds of heavy drinking. Using multiple logistic regression and adjusting for marital status and primary container size, single persons were found to have substantially higher odds of heavy drinking. Persons who drank their primary beverage from above average-sized containers at their primary location had 7.9 times the odds of heavy drinking as compared to persons who drank from average-sized containers. Some significant associations between heavy drinking and age, race, and income were found for certain beverages.

Conclusion: Rates of heavy drinking were higher than expected giving impetus to various alcohol policy reforms under consideration in South Africa. Better labeling of the alcohol content of different containers is needed together with limiting production, marketing and serving of alcohol in large containers.

Keywords: Heavy drinking, Alcohol policy, Container size, South Africa

Background

In 2011, South African adults (aged 15 years and older) consumed 9.5 l of absolute alcohol each year -- higher than the average for Africa (6.0 l) and the world (6.2 l) [1]. In 2015, alcohol was the fifth leading cause of death and disability in South Africa [2], which is likely attributable to alcohol's role in causing sexually transmitted infections and interpersonal violence, the two leading causes of death in South Africa [3–6]. In addition, community-based samples repeatedly show atypically high prevalence of fetal alcohol spectrum disorders, ranging up to 29% [7–

9]. Altogether, alcohol caused 7.1% of all deaths and 7.0% of all disability-adjusted life years in South Africa in 2000 [10], and harmful alcohol use is estimated to cost R249–280 billion each year, 10–12% of South Africa's gross domestic product [11].

Drinking patterns shape the association between alcohol consumption and related harms, because they determine the dose of toxic effects (which cause chronic disease) and the level of intoxication (which determines risk for injuries and social problems) [12]. Many alcohol-related conditions show a dose-response relationship between volume of alcohol consumption and risk of adverse outcomes [13], suggesting that heavy drinking occasions have higher risk for both toxic effects and greater intoxication [14–16].

Heavy drinking is a pattern of consumption involving consuming large volumes of alcohol during one

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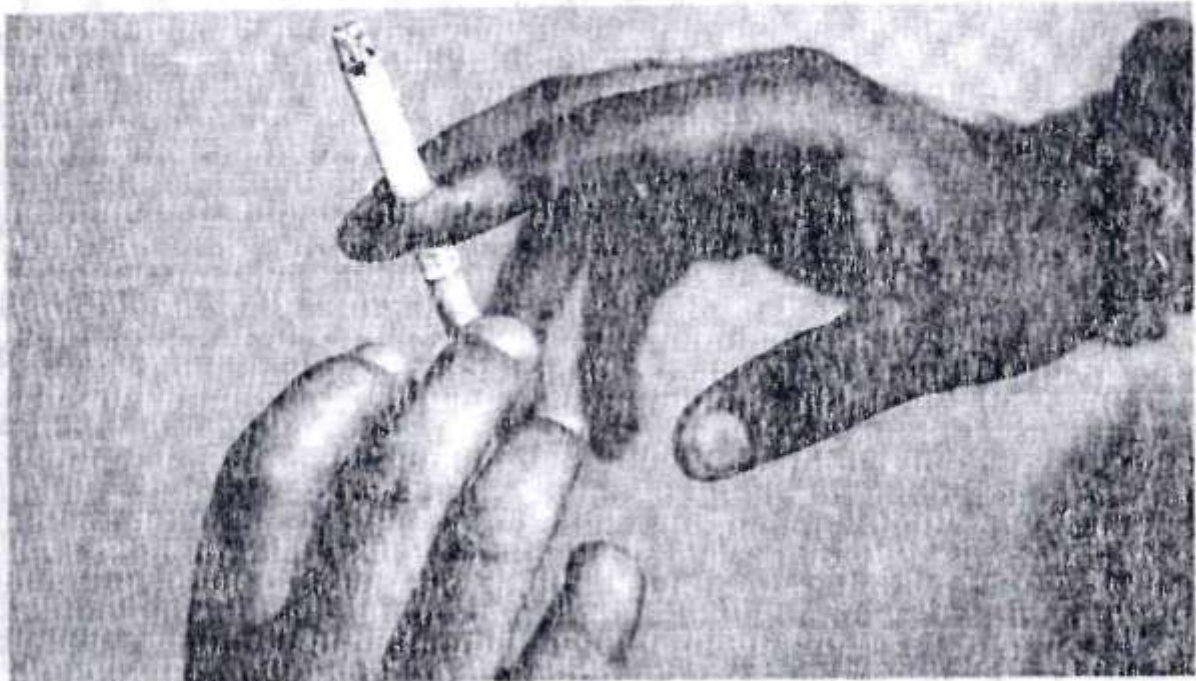
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Picture: Reuters/Adnan Abidi

#WorldNoTobaccoDay: 8 shocking facts about smoking

By Yasmine Jacobs  May 31, 2018

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Cape Town - Smoking is one of the world's biggest silent killers, resulting in millions of deaths every year.

Here are eight shocking statistics that might make you want to put that cigarette down, or at least, think twice about picking up another one ...

1. There are around one billion smokers in the world, according to World Health Organisation (WHO). This is about a seventh of the world's population.
2. Active or passive smoking kills more than seven million people every year. Consumption of tobacco is blamed for the death of on average one person every six seconds.
3. From the above mentioned 7 million, around three million deaths are due to cardiovascular disease, including heart attacks and stroke.
4. Tobacco smoke contains over 7 000 chemicals. These chemicals can narrow arteries and damage blood vessels.
5. Every minute, smokers get through nearly 11 million cigarettes and about 5.7 trillion cigarettes every year.
6. According to a report by Health-E News, about 16.5% of South Africans smoke. There are approximately 44 000 smoking-related deaths in South Africa each year, this equates to 121 deaths each day.
7. According to Tobacco Atlas, more than 55 000 South African children between the ages of 10-14 years old use tobacco on a daily basis.

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8. Smoking has a huge effect on the economy too. The cost of smoking in South Africa amounts to R59.12 billion.

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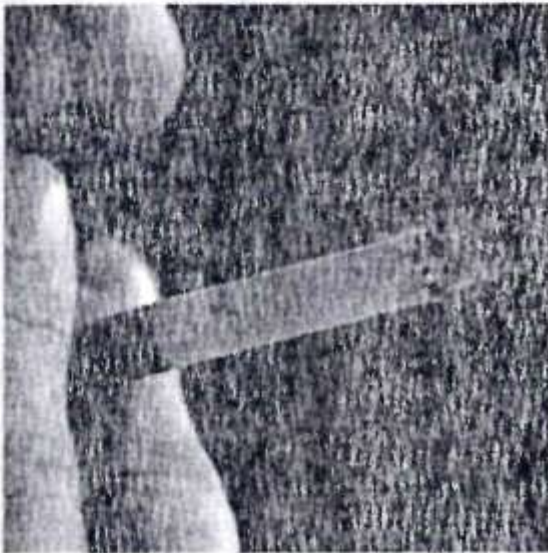
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The tobacco epidemic

Every year, an estimated 7 million people die from tobacco-related diseases across the globe.

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The tobacco epidemic is one of the biggest public health threats the world has ever faced, with smoking remaining the number-one preventable cause of death worldwide. Currently, there are about 1.1 billion smokers worldwide – a seventh of the world's population.

Every year, an estimated 7 million people die from tobacco-related diseases across the globe. Tobacco kills up to half of its users, while close to 900,000 of these deaths are non-smokers dying from second-hand smoke inhalation. Tobacco use costs the world more than \$1 trillion in healthcare expenses and lost productivity every year.

Nearly 80% of the world's 1.1 billion smokers live in low-and middle-income countries. In these countries, says the World Health Organization (WHO), the burden of illness and death is often the heaviest. Tobacco users who die prematurely deprive their families of income, raise the cost of health care, and hinder economic development.

Tobacco use in South Africa

Global estimates of tobacco use show that South Africa has a relatively low prevalence of smoking compared with the USA, Europe and Asia, but that we have a higher prevalence of smoking than neighbouring countries such as Zimbabwe and Malawi.

It's estimated that more than 44 000 South Africans die as a result of tobacco-related diseases every year. The harm done by tobacco products is devastating and is currently costing South African tax payers R59bn every year.

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