Contents

Prevalence of tobacco use among students aged 13–15 years in SAARC member countries, 2003–2006 1
   Dhirendra N. Sinha, Gihan Gewaifel, Sayed Ali Shah Alawie,
   S.M. Zuftiqr Ali, Sonam Phuntsho, Ahmed Waheed,
   Mrigendra Raj Pandey, Shahrzad Alam Khan, P.W. Gunasekara,
   Khalil Rahman, Fatimah El Awa, Charles W. Warren, Nathan R. Jones

Women and food safety – some perspectives from India 11
   R.V. Sudershun, G.M. Subba Rao, Kalpagam Polasa

Comment

Notes and news 14

Publications corner 22

Guidelines for contributors 27
Editorial

The main objective of the Regional Health Forum is the exchange of information and ideas on any aspect of public health. It is thus a platform where health professionals at all levels can express their views, observations and experiences rather than a scientific journal (although we do, of course, encourage submission of contributions related to health research).

We are currently examining possibilities to make the RHF more interesting and interactive. Such possibilities could include increasing the frequency of RHF issues (e.g. bringing it out every quarter); wider participation of and dialogue among readers, and devoting RHF issues to interesting and stimulating themes. Please, therefore, do not hesitate to send us your fresh ideas and contributions (addressed to editor@searo.who.int) in the form of articles or essays.

The next issue of the Forum will be devoted to the theme of World Health Day 2010 – Urbanization and health.
Prevalence of tobacco use among students aged 13–15 years in SAARC countries, 2003–2006


Abstract

Background: This article examines the differences and similarities in adolescent tobacco use among South Asian Association for Regional Cooperation (SAARC) member states using the Global Youth Tobacco Survey (GYTS) data.

Methods: Representative samples of students in grades associated with ages 13–15 years in Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Schools were selected on the basis of their proportion to enrolment size, classes were selected randomly within participating schools, and all students in selected classes were eligible to participate.

Results: The GYTS results confirmed that boys are significantly more likely than girls to smoke cigarettes or use other tobacco products in Bhutan, India and Nepal. Susceptibility to initiate smoking among “never smokers” was higher than current cigarette smoking for boys and girls in Bangladesh, India, Nepal and Pakistan, with no difference in the other countries. Exposure to second-hand smoke in public places was greater than 50% in Bhutan, Maldives, Nepal and Sri Lanka, compared to 33.9% in Pakistan. Direct pro-tobacco advertising exposure in newspapers was greater than 70% in Bhutan, Maldives, Pakistan and Sri Lanka; and 33.4% in Afghanistan. Over 10% students were exposed to indirect advertising in Afghanistan, Bhutan, Maldives, Nepal and Sri Lanka. Finally, over 7 in 10 students were taught in school about the dangers of tobacco use in the past year in Nepal and Sri Lanka; but only 21.0% in Afghanistan.

Conclusions: Intensified efforts to lessen the current and projected harm caused by tobacco use in SAARC countries are needed urgently. SAARC member states need to develop and implement national comprehensive tobacco prevention and control programmes which, hopefully, will lead to a reduction in their burden of chronic diseases and tobacco-related mortality.

Keywords: Tobacco use, adolescents, school-based.

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*South Asian Association for Regional Cooperation
Introduction

Tobacco use is one of the major preventable causes of premature death and disease in the world. A disproportionate share of the global tobacco burden falls on developing countries, where 84% of the 1.3 billion current smokers live.1 The South Asian Association for Regional Cooperation (SAARC) has made tobacco use prevention a primary health issue.2 SAARC was established in 1985 by seven original member states (Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka). Afghanistan joined in 2007. Delegates at the First SAARC Conference on TB, HIV/AIDS and Respiratory Diseases in 2005 passed the following recommendation:

“Participants note with concern increased consumption of tobacco amongst the population of SAARC region and recommends gearing of all possible anti-tobacco initiatives including ratifying of FCTC by all Member States.”3

All SAARC member states except Afghanistan have ratified the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), the world’s first public health treaty on tobacco control.4 The WHO Framework Convention urges countries to develop action plans for public policies, such as bans on direct and indirect tobacco advertising, tobacco tax and price increases, promoting smoke-free public places and workplaces, and placing health messages on tobacco packaging. SAARC countries, also, are members of either the South-East Asia Region (SEAR) (Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka) or the Eastern Mediterranean Region (EMR) (Afghanistan and Pakistan) of WHO. Both SEAR5 and EMR6 have regional tobacco control plans that each Member country can use as a guide in developing its national tobacco control efforts.

The WHO Framework Convention also calls on countries to establish surveillance programmes of “the magnitude, patterns, determinants and consequences of tobacco consumption, and exposure to tobacco smoke.”4 WHO, the Centers for Disease Control and Prevention, Atlanta, USA, and the Canadian Public Health Association developed the Global Tobacco Surveillance System (GTSS) to assist WHO Member States in establishing continuous tobacco control surveillance and monitoring.7,8 The GTSS includes collection of data through three surveys: the Global Youth Tobacco Survey (GYTS) for youth, and the Global School Personnel Survey and the Global Health Professional Students Survey for adults. The GYTS provides systematic global surveillance of tobacco use by the youth. Countries can use the GYTS data to enhance their capacity to monitor tobacco use among youth; guide development, implementation, and evaluation of their national tobacco prevention and control programme; and allow comparison of tobacco-related data at national, regional and global levels.

The purpose of this paper is to examine differences and similarities in tobacco use by adolescents among SAARC member states using the GYTS data collected in each country.

Methods

The GYTS uses a standardized methodology for constructing sampling frames, selecting schools and classes, preparing questionnaires, carrying out field procedures, and processing data. The survey queries prevalence of cigarette and other tobacco use, perceptions and attitudes about tobacco, access to and availability of tobacco products, exposure to second-hand smoke, school curricula, media and advertising, and smoking cessation.

Sample design

The GYTS is a school-based survey of defined geographic sites that can be countries, provinces, or cities. The GYTS uses a two-
stage cluster sample design that produces representative samples of students in grades associated with ages 13 to 15. The sampling frame includes all schools containing any of the identified grades. At the first stage, the probability of schools being selected is proportional to the number of students enrolled in the specified grades. At the second sampling stage, classes within the selected schools are randomly selected. All students in selected classes attending school the day the survey is administered are eligible to participate. Student participation is voluntary and anonymous, using self-administered data collection procedures.

Pakistan conducted the GYTS in Islamabad and Sri Lanka completed a nationally representative survey in 2003; Afghanistan (Kabul), Bangladesh (Dhaka), Maldives and Nepal (Mahendranagar and Dhangad) in 2004; and Bhutan and India in 2006. Only data for 13- to 15-year-old students from each country were included in this report. The school response rates ranged from 83.3% in Bhutan to 100% in Bangladesh, Nepal, Pakistan and Sri Lanka (Table 1). The student response rates were above 90% in Bhutan and Nepal; between 80–89% in India, Maldives and Pakistan; between 70-79% in Afghanistan and Sri Lanka; and 55.4% in Bangladesh. The overall response rates (calculated as the school response rate multiplied by the student response rate) were above 70% in all countries, except Afghanistan (68.2%) and Bangladesh (55.4%).

Data analysis
A weighting factor was applied to each student record to adjust for non-response (by school, class and student) and variation in the probability of selection in the school and class. A final adjustment summed the weights by grade and gender to the population of schoolchildren in the selected grades in each sample site. SUDAAN, a software package for statistical analysis of correlated data, was used to compute standard errors of the estimates, and produced 95% confidence intervals. Differences in proportions were considered statistically significant at the p < 0.05 level.

Instrument
This report describes several important indicators of tobacco use: current cigarette smoking, current use of tobacco products other than cigarettes, current “any tobacco” use (combination of current cigarette smoking

<table>
<thead>
<tr>
<th>Table 1: School and student response rates and number of students participating in the Global Youth Tobacco Survey, SAARC countries, 2003–2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Afghanistan (Kabul) 2004</td>
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<tr>
<td>Bangladesh (Dhaka) 2004</td>
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<tr>
<td>Bhutan 2006</td>
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<tr>
<td>India 2006</td>
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<tr>
<td>Maldives 2004</td>
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<tr>
<td>Nepal (Mahendranagar and Dhangad) 2004</td>
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<td>Pakistan (Islamabad) 2003</td>
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<td>Sri Lanka 2003</td>
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</tbody>
</table>
and current other tobacco use) and susceptibility to smoking initiation. In addition, information on exposure to second-hand smoke (SHS), exposure to pro-tobacco media advertising (direct and indirect), and being taught about the dangers of tobacco in school, are included in this paper (definitions of these indicators are shown in Table 2). The final country questionnaires were translated into local languages as needed and back-translated into English to check for accuracy. The GYTS country research coordinators formed focus groups of students aged 13–15 to further test the accuracy of the translation and students’ comprehension of the questions.

Results

Prevalence
The current cigarette smoking prevalence ranged from less than 2% in Pakistan and Bangladesh to 12.1% in Bhutan (Table 3). Boys were significantly more likely than girls to currently smoke cigarettes in Afghanistan, Bangladesh, Bhutan, India and Nepal. The current use of tobacco products other than cigarettes was lowest in Bangladesh (4.0%), highest in Bhutan (14.2%), and high in India (11.9%). Boys were significantly more likely than girls to use other tobacco products in Bhutan, India and Nepal. The current use of other tobacco products was significantly higher than current cigarette smoking in Bangladesh,
Table 3: Smoking status reported by students aged 13–15, by gender, Global Youth Tobacco Survey 2003–2006, SAARC

<table>
<thead>
<tr>
<th>Country/Site</th>
<th>Year</th>
<th>Total</th>
<th>Boy</th>
<th>Girl</th>
<th>Total</th>
<th>Boy</th>
<th>Girl</th>
<th>Total</th>
<th>Boy</th>
<th>Girl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan (Kabul)</td>
<td>2004</td>
<td>4.8</td>
<td>7.6</td>
<td>0.0</td>
<td>5.9</td>
<td>7.0</td>
<td>0.0</td>
<td>9.8</td>
<td>13.1</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2.7–8.6)</td>
<td>(4.5–12.7)</td>
<td></td>
<td>(3.6–9.5)</td>
<td>(3.8–12.3)</td>
<td></td>
<td>(6.7–14.0)</td>
<td>(9.2–18.3)</td>
<td>(1.6–6.4)</td>
</tr>
<tr>
<td>Bangladesh (Dhaka)</td>
<td>2004</td>
<td>1.8</td>
<td>2.3</td>
<td>0.0</td>
<td>4.0</td>
<td>3.6</td>
<td>0.0</td>
<td>5.8</td>
<td>5.9</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1.2–2.8)</td>
<td>(1.4–3.9)</td>
<td></td>
<td>(3.1–5.2)</td>
<td>(2.5–5.0)</td>
<td></td>
<td>(4.7–7.1)</td>
<td>(4.4–7.7)</td>
<td>(3.4–6.4)</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2006</td>
<td>12.1</td>
<td>18.3</td>
<td>6.3</td>
<td>14.2</td>
<td>19.7</td>
<td>9.1</td>
<td>20.2</td>
<td>28.6</td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9.6–15.2)</td>
<td>(13.8–23.8)</td>
<td>(4.1–9.6)</td>
<td>(11.7–17.0)</td>
<td>(14.7–25.8)</td>
<td>(6.7–12.3)</td>
<td>(17.3–23.4)</td>
<td>(23.2–34.7)</td>
<td>(9.6–15.8)</td>
</tr>
<tr>
<td>India</td>
<td>2006</td>
<td>4.2</td>
<td>5.9</td>
<td>1.8</td>
<td>11.9</td>
<td>14.3</td>
<td>8.5</td>
<td>14.1</td>
<td>17.3</td>
<td>9.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3–5.1)</td>
<td>(4.7–7.4)</td>
<td>(1.1–2.8)</td>
<td>(9.8–14.3)</td>
<td>(11.8–17.2)</td>
<td>(6.4–11.3)</td>
<td>(11.9–16.7)</td>
<td>(14.5–20.4)</td>
<td>(7.2–12.8)</td>
</tr>
<tr>
<td>Maldives</td>
<td>2004</td>
<td>6.9</td>
<td>9.0</td>
<td>3.1</td>
<td>8.3</td>
<td>10.2</td>
<td>5.2</td>
<td>12.1</td>
<td>15.5</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4.8–9.8)</td>
<td>(6.4–12.6)</td>
<td>(1.1–8.5)</td>
<td>(5.5–12.3)</td>
<td>(6.5–15.9)</td>
<td>(2.5–10.5)</td>
<td>(8.9–16.2)</td>
<td>(11.1–21.2)</td>
<td>(3.5–11.7)</td>
</tr>
<tr>
<td>Nepal (Mahendranagar and Dhangad)</td>
<td>2004</td>
<td>2.3</td>
<td>4.1</td>
<td>0.5</td>
<td>6.7</td>
<td>10.2</td>
<td>3.2</td>
<td>8.7</td>
<td>13.9</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1.5–3.4)</td>
<td>(2.9–5.7)</td>
<td>(0–1.9)</td>
<td>(4.8–9.2)</td>
<td>(7.7–13.3)</td>
<td>(1.4–7.3)</td>
<td>(6.8–11.0)</td>
<td>(11.5–16.7)</td>
<td>(1.6–7.4)</td>
</tr>
<tr>
<td>Pakistan (Islamabad)</td>
<td>2003</td>
<td>1.4</td>
<td>2.3</td>
<td>0.6</td>
<td>9.5</td>
<td>11.2</td>
<td>7.3</td>
<td>10.0</td>
<td>12.4</td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0.6–3.3)</td>
<td>(0.9–5.4)</td>
<td>(0.2–1.9)</td>
<td>(7.4–12.1)</td>
<td>(7.9–15.6)</td>
<td>(5.3–10.1)</td>
<td>(8.0–12.8)</td>
<td>(9.2–16.5)</td>
<td>(5.4–10.2)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2003</td>
<td>2.4</td>
<td>3.0</td>
<td>1.3</td>
<td>7.0</td>
<td>7.9</td>
<td>5.8</td>
<td>8.0</td>
<td>9.5</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1.5–3.7)</td>
<td>(1.8–4.9)</td>
<td>(0.6–2.9)</td>
<td>(5.4–8.9)</td>
<td>(5.6–11.2)</td>
<td>(4.4–7.6)</td>
<td>(6.2–10.3)</td>
<td>(6.8–13.2)</td>
<td>(4.6–8.0)</td>
</tr>
</tbody>
</table>

na — not available, question not asked

Susceptible to initiate = “never smokers” who were more likely to initiate smoking within the next year, based on survey responses.
India, Nepal, Pakistan and Sri Lanka; however in Afghanistan, Bhutan and Maldives there was no significant difference in cigarette smoking and other tobacco use. The current “any tobacco” use ranged from 5.8% in Bangladesh to 20.2% in Bhutan. Boys were significantly more likely than girls to currently use tobacco in Afghanistan, Bhutan, India and Nepal.

Susceptibility to “initiation smoking” ranged from 4.6% of “never smokers” in Sri Lanka to 15.1% in India (Table 3). There was no statistically significant gender difference in any country.

Factors influencing tobacco use
Exposure to SHS at home was highest in Sri Lanka (50.9%) and lowest in India and Pakistan (26.6%) (Table 4). Exposure to SHS in public places was over 60% in Maldives (69.2%) and Sri Lanka (68.3%) and lowest in Pakistan (33.9%). Over 90% students were in support of banning smoking in public places in Bangladesh, Pakistan and Sri Lanka; over 80% were in favour of a ban in Afghanistan and Maldives; and over 70% were in favour in India. Support for the ban was the lowest in Bhutan (47.0%).

Exposure to direct pro-tobacco advertising in newspapers or magazines was over 70% in Bhutan, Maldives, Pakistan and Sri Lanka, with a low of 33.4% in Afghanistan (Table 4). Over one in 10 students were found to possess an object with a tobacco logo on it, a form of indirect advertising, in Afghanistan, Bhutan, Maldives, Nepal and Sri Lanka. However, this form of indirect advertising exposure was found to be very low in Bangladesh and Pakistan. Approximately one in 10 students had been offered free cigarettes by a tobacco company representative in Afghanistan, Bhutan, Maldives, Nepal and Pakistan; the incidence was low in Sri Lanka (5.9%).

Over 7 in 10 students reported that they had been taught about the dangers of smoking tobacco during the past school year in Nepal and Sri Lanka (Table 4). Students in Afghanistan were the least likely to have been taught about the dangers of smoking (21.0%).

Discussion
Many SAARC countries have initiatives under way to reduce tobacco use. In Afghanistan, there is a complete ban on direct advertising on national and subnational TV and radio, national magazines and newspapers, and on billboards; a national ban on the promotion of tobacco products and brand names on TV and in films; and subnational laws banning tobacco advertising, promotion and sponsorship. In addition, the government has passed a tax of 10% per kg on tobacco products (code 24002 and 24003). The income from tobacco tax is included in the general governmental budget.

The 2005 Bangladesh Tobacco Control Act included provisions for creating smoke-free environments by prohibiting smoking in public places; prohibiting smoking on public transport; and making schools, hospitals and public transport with one compartment, completely smoke-free. The Act assigns responsibility to the owner, caretaker, controlling person or manager of a public place or public transport to mark or designate a smoke-free area. The Act also banned the promotion of tobacco products in cinemas, government and private radio and television, or the sale of any tobacco product advertisement.

While there is little formal anti-tobacco legislation in Bhutan, there have been some governmental notifications or declarations, and some districts have banned the use of tobacco. In 2004, the Ministry of Trade and Industry issued a notification that banned the sale of tobacco and tobacco-related products in shops, hotels, restaurants and bars as of December 2004. Any person or firm acting
### Table 4: Factors influencing tobacco use reported by students aged 13—15 years, Global Youth Tobacco Survey 2003—2006, SAARC

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Exposed to smoke from others at home</th>
<th>Exposed to smoke in public places</th>
<th>Favour banning smoking in public places</th>
<th>Saw pro-tobacco advertisements in newspapers or magazines</th>
<th>Possess an object with a cigarette or tobacco logo on it</th>
<th>Offered free cigarettes by a tobacco company representative</th>
<th>Taught dangers of smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan (Kabul)</td>
<td>2004</td>
<td>38.8 (32.9–45.1)</td>
<td>45.0 (32.5–58.1)</td>
<td>83.9 (79.8–87.3)</td>
<td>33.4 (25.5–42.2)</td>
<td>11.4 (8.4–15.2)</td>
<td>10.5 (6.8–15.8)</td>
<td>21.0 (17.4–25.2)</td>
</tr>
<tr>
<td>Bangladesh (Dhaka)</td>
<td>2004</td>
<td>33.8 (31.6–36.0)</td>
<td>46.7 (42.7–50.8)</td>
<td>94.4 (92.8–95.6)</td>
<td>na</td>
<td>7.2 (5.7–9.0)</td>
<td>7.7 (6.6–8.9)</td>
<td>43.3 (40.0–46.6)</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2006</td>
<td>31.9 (29.0–35.1)</td>
<td>54.5 (47.2–61.6)</td>
<td>47.0 (37.2–57.1)</td>
<td>72.5 (65.9–78.3)</td>
<td>10.5 (8.7–12.6)</td>
<td>11.1 (8.0–15.1)</td>
<td>59.8 (52.7–66.5)</td>
</tr>
<tr>
<td>India</td>
<td>2006</td>
<td>26.6 (23.9–29.4)</td>
<td>40.3 (37.2–43.4)</td>
<td>74.0 (70.6–77.1)</td>
<td>na</td>
<td>na</td>
<td>9.3 (7.8–11.0)</td>
<td>54.4 (51.9–57.0)</td>
</tr>
<tr>
<td>Maldives</td>
<td>2004</td>
<td>45.4 (41.5–49.4)</td>
<td>69.2 (64.8–73.2)</td>
<td>89.5 (86.2–92.0)</td>
<td>74.6 (70.1–78.6)</td>
<td>13.0 (9.3–17.8)</td>
<td>10.6 (6.9–15.9)</td>
<td>39.8 (33.7–46.2)</td>
</tr>
<tr>
<td>Nepal (Mahendranagar and Dhangad)</td>
<td>2004</td>
<td>42.3 (37.2–47.4)</td>
<td>55.3 (51.7–58.8)</td>
<td>68.1 (62.2–73.5)</td>
<td>na</td>
<td>16.2 (13.1–19.8)</td>
<td>12.4 (9.5–16.1)</td>
<td>70.7 (67.0–74.1)</td>
</tr>
<tr>
<td>Pakistan (Islamabad)</td>
<td>2003</td>
<td>26.6 (22.7–30.8)</td>
<td>33.9 (28.9–39.2)</td>
<td>94.5 (92.2–96.1)</td>
<td>71.0 (68.2–73.6)</td>
<td>7.9 (6.2–10.1)</td>
<td>14.8 (12.3–17.7)</td>
<td>57.0 (51.4–62.4)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2003</td>
<td>50.9 (47.6–54.2)</td>
<td>68.3 (64.9–71.4)</td>
<td>93.0 (90.9–94.7)</td>
<td>78.4 (75.5–81.0)</td>
<td>11.0 (9.3–12.9)</td>
<td>5.9 (4.7–7.5)</td>
<td>79.8 (75.8–83.3)</td>
</tr>
</tbody>
</table>

* < 35 cases in the denominator
na = not applicable, question not asked
in violation of this notification is to be fined and will lose their licence for the sale of tobacco. The Ministry of Trade and Industry issued another notification in 2005 declaring the following places smoke-free: commercial centres (shops, shopping complexes, supermarkets, showrooms, exhibition halls, hotels, bars and restaurants), recreation centres (discotheques, snooker rooms, health clubs, sports and game centres, playing fields and related offices), public institutions (all offices in public and private sectors, hospitals, schools, training centres, monasteries and their vicinity and museums); public gatherings (public meetings, festivals and national celebrations/receptions, vegetable markets, bus and taxi stands), and public transportation (all buses and taxis). This tobacco-free campaign was initially launched at the district level and gradually all 20 districts were declared tobacco-free. The Royal Bhutan Police was empowered to monitor and enforce these rules. Bhutan has banned the sale of tobacco products to minors across the country. In 2003, India passed significant anti-tobacco legislation, the “Cigarettes and Other Tobacco Products Act” (India Tobacco Control Act, ITCA 2003). The ITCA was amended in 2005 to include a ban on smoking in public places and public conveyances that included all tobacco products in all states. The ITCA explicitly declared the following places smoke-free: auditoriums, hospital buildings, railway waiting rooms, amusement centres, restaurants, public offices, court buildings, educational institutions, libraries, public conveyances, railway stations and bus stops. This definition of public places was comprehensive and covered all possible enclosed public places. Implicitly, the law prohibited smoking in “other” places (where smoking is considered to be the norm rather than the exception) to which the public has access whether by right or otherwise such as private clubs, bars, discotheques and private workplaces. The ITCA stated that the owner or manager of the public place has to ensure that a board with the message, “No Smoking Area – Smoking Here is an Offence” has to be prominently displayed; and hotels with 30 rooms or more, restaurants having more than 30 seats, and airports must designate a separate area for smoking. Furthermore, the smoking and non-smoking areas have to be physically segregated. India has also banned the sale of tobacco products to minors under the age of 18 years, and has banned all tobacco advertising, except at the point of sale. Till date, the implementation and enforcement of provisions of the ITCA have been difficult.

A number of regulations have been passed since 1984 prohibiting smoking in public places in Maldives. These regulations banned smoking at official gatherings and receptions, in all health facilities, in the compounds of educational institutions, within 100 meters of sports complexes and stadiums, in all government offices and buildings, on ferries, in air-conditioned restaurants and short-distance public land and sea transport. Four islands (Meemu Atoll Madifushi, HaaAlif Atoll Berinmadhoo, Haa Alif Atoll Hathifushi, and Haa Dhalu Atoll Nolhivaranfaru) have been declared “Tobacco Free.” Efforts are under way to expand the smoke-free island campaign across the country. Maldives has also passed a law banning the sale of tobacco products to minors under the age of 16 years, and has passed a ban on tobacco advertising.

Nepal has passed some anti-tobacco legislation. Its Executive Order BS 2059 prohibited smoking in various public places like the Secretariat of the Council of Ministers including the meeting hall of the Council of Ministers, ministries, departments, offices as well as government-owned corporations, organizations, teaching institutes, health facilities, cinema halls, theatres, public buildings, buses, trolley buses, mini buses, domestic flights, working places of industries and factories; and the Executive Order BS
2055 banned advertisement of tobacco products on radio and television. However, additional efforts are needed to implement and enforce these measures.

The Government of Pakistan passed an ordinance in 1979 that required the printing of health warning labels on packets of cigarettes. The original ordinance has been amended to ensure that 30% of the principal display area of cigarette packages include health warnings that should be large, clear, in country language and describe the harmful effects of tobacco. The government issued an ordinance in 2002 that banned smoking and other tobacco use in places of public work or use, public service vehicles, and called for protection of the health of non-smokers. Direct advertising and promotion are not completely banned (advertising is allowed over TV and radio between midnight and 6 am). However, there is a ban on indirect advertising, including a national ban on the promotion of tobacco products and brand names at sponsored events, on TV, and free distribution of tobacco products through mail. Tobacco smoking is completely banned indoors in health, educational and government facilities, but not in restaurants.

In Sri Lanka, the National Authority on Tobacco and Alcohol Act, promulgated on 1 December 2006, bans smoking in all enclosed public places. The previous legislation had provisions prohibiting smoking in buses and trains (under the Transport Board Law and Railway Ordinance) and state institutions. Under the 2006 Act, persons were prohibited from smoking or allowing any person to smoke tobacco products within enclosed public spaces. Public places include any government department, statutory authority or public institutions, office premises, banks, court house, auditorium, sports complex, hospital, clinic, dispensary, laboratory, school, university or other educational institution, library, museums, places of worship, hotel, guest house, lodge, hostel, restaurant, club, internet café, cinema, theatre, supermarket, airport, a waiting room at a railway station or bus terminal, any public conveyance, and lifts. The Act however, allowed hotels with 30 or more rooms, restaurants or clubs having a seating capacity of 30 persons or more and airports to make provisions for non-smoking areas. Sri Lanka also has a law banning the sale of tobacco products to minors under the age of 21; it has banned tobacco advertising in all media outlets, except at the point of sale.

**Conclusion**

The findings of this study suggest that in SAARC countries, interventions that have shown to decrease tobacco use among youth (including increasing excise taxes, media campaigns, programmes in schools in conjunction with community interventions, and community interventions that decrease minors’ access to tobacco) were broad-based, focused on boys and girls, and had components directed towards prevention and cessation. An estimated 1.5 billion people live in SAARC countries. Based on country estimates of adult smoking (Table 5), almost 500 million smokers live in SAARC countries (345 million males and 122 million females). If effective interventions are implemented, these measures will have a significant impact on reducing tobacco use in the region.

**Table 5: Prevalence of tobacco smoking among adults in SAARC countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Males</th>
<th>Females</th>
<th>Male : female ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>82.0</td>
<td>17.0</td>
<td>4.8:1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>54.8</td>
<td>26.7</td>
<td>2.1:1</td>
</tr>
<tr>
<td>Bhutan</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>India</td>
<td>46.6</td>
<td>16.8</td>
<td>2.8:1</td>
</tr>
<tr>
<td>Maldives</td>
<td>37.4</td>
<td>15.6</td>
<td>2.4:1</td>
</tr>
<tr>
<td>Nepal</td>
<td>48.5</td>
<td>24.0</td>
<td>2.0:1</td>
</tr>
<tr>
<td>Pakistan</td>
<td>28.5</td>
<td>3.4</td>
<td>8.4:1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>23.2</td>
<td>1.7</td>
<td>13.6:1</td>
</tr>
</tbody>
</table>

**na** – data not available
programmes are not developed and implemented throughout the SAARC countries, future morbidity and mortality attributed to tobacco will surely increase. The WHO Framework Convention (ratified by all SAARC countries except Afghanistan) and the regional tobacco control action plans of the WHO South-East Asia and Eastern Mediterranean regions provide useful frameworks for implementing such a comprehensive approach. The synergy between SAARC countries passing tobacco control laws, regulations or decrees, ratifying the WHO Framework Convention, and in conducting the GYTS offers the SAARC member countries a unique opportunity to develop, implement and evaluate a comprehensive tobacco control policy that can be most helpful to each country.

References

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Women and food safety — some perspectives from India

R.V. Sudershan*, G.M. Subba Rao**, Kalpagam Polasa***

Abstract
Throughout the world, women are the principal guarantors of food safety and quality of food at the household level. In India, according to UNICEF, an estimated 400 000 children below five years of age die each year due to diarrhoea. Given this context, the Ministry of Health and Family Welfare, Government of India carried out a household survey to understand food safety knowledge and practices among the mothers of children below five years age in India. The present viewpoint is based on the report of this study, which has provided insights into three main areas viz., (i) awareness; (ii) practices; and (iii) food safety-enabling assets, which need immediate attention of policy-makers and food safety educators.

Throughout the world, women are the principal guarantors of food safety and quality of food at the household level. They are the ones who most often produce, purchase, handle, prepare and serve food for the family. In the context that 1400 million episodes of diarrhoea occur annually in children under the age of five years across the world (excluding China), the role of mothers in ensuring food safety becomes pivotal. In India alone, 400 000 children (< 5 years) die each year due to diarrhoea and millions more suffer from other food-borne illnesses. Considering that a significant proportion of food-borne illnesses arise from practices in the home kitchen, empowering women with the wherewithal to ensure household food safety is the need of the hour. Before intensifying measures in this direction, the Ministry of Health and Family Welfare, Government of India, with financial support from the World Bank conducted a household survey among mothers of children (< 5 years) with an intention to understand their current awareness, perceptions and practices related to food safety. The study employed a multi-stage stratified, proportional random sampling technique. The states were stratified into three strata viz., small (< 35 million population), medium (35–70 million) and large (> 70 million population). In small states, two districts from two geographical regions were considered. Similarly, four and six districts were selected from the medium and large states respectively. Proportionate to the size of the state, 250–1500 households were recruited for the study. Quantitative data were collected from a sample of mother respondents from 20 719 households spread over 28 states of India. These data were triangulated with 164 focus group discussions (FGDs) with mother respondents who were not part of the quantitative study.

The study has provided insights into three main areas viz., (i) awareness; (ii) practices; and (iii) food safety-enabling assets, which need immediate attention of policy-makers and food safety educators.
Women are ensuring food safety despite all odds

The results of this study reinforce that though mothers are not always the decision-makers, they are sentinels of children’s health and are responsible for ensuring food safety at the household level. Considering that unlike in the West, raw or semi-processed agricultural produce is processed and cooked at the household level in Indian homes, it is mostly women who ensure food safety. Most women included in the study had no access to safe cooking fuel; many of them (about 76%) cooked using solid fuels like wood, coal and cowdung cakes. Most houses were so small that there was no separate designated kitchen leaving them with no other option but to cook in a common place (31%) or a verandah (courtyard) (28%). Only 33% had access to protected water while groundwater was the main source for many (59%). Despite all these limiting factors, many women (78%) cooked food twice a day. More than half of them managed to serve the food hot. Though refrigerators were owned by a mere 9% households, women evolved their own indigenous ways of storing leftover foods. For instance, some women in the same region were in the habit of storing food by keeping it in a cool place or in water or in a porous dish with water on the lid. Some women who felt that foodstuffs were more vulnerable to being spoilt in summer usually cooked as and when required in less quantity.

Awareness versus practices

As Motarjemi and Moaref (2000) observed, mere awareness may not always lead to correct attitudes that result in safe and healthy practices, and the following observations from our study appear to confirm this. In some instances it was observed that certain food safety measures were traditionally practised, perhaps even without an awareness of any scientific rationale behind them. For instance, most families (86%) stored the leftover cooked food in covered containers (99%) at room temperature (89%), and tried to consume it not beyond the next meal (67.8%). Even among the 64.1% families that consumed nonvegetarian foods (though occasionally), only about half of them stored leftover cooked nonvegetarian foods at room temperature (51.2%). Many of them usually reheated the leftover food before consumption but the importance of thorough heating was hardly known, so the practice may not necessarily ensure complete food safety.

Most Indian women seemed to believe that washing hands and maintaining personal hygiene and cleanliness of surroundings were the necessary prerequisites of food safety. This was well reflected in the practice of washing hands before undertaking all activities pertaining to food handling. A large proportion of mothers washed their hands before feeding the child (86%). They (99%) also washed their hands after defecation and cleaning the child’s stools. Other activities, which involved exposure to dirt like mopping/dusting the house and handling the cattle were also usually followed by washing of hands (94% and 72% respectively). Though women knew that washing hands before handling food was a safety measure, more than 75% washed hands only with water; using soap for handwashing was not very common. Even after defecation, only 50% used soap. Similarly, although most respondents claimed to practise washing vegetables (86.8%) and fruits (75.7%) before cutting or peeling, some women were in the habit of cleaning them by dipping them in a container of water instead of washing them under running water. This clearly indicated that they were aware that washing vegetables and fruits was an essential food safety measure but their practice was faulty because they either did not know the scientific rationale behind washing fruits and vegetables under running water or barely had enough water for drinking.

Similarly, in instances where knowledge did not materialize into sound practices, the reasons could be the lack of access to potable water and constraints related to cooking fuel and sanitation.
Need to empower women

Most existing food safety measures that women practise in their day-to-day life are innate cultural practices imbibed through generations. Such traditional wisdom is reflected in instinctive cleaning of hands before preparation and handling of food; storing food and drinking water in covered containers; inclination to cook food more number of times per day and serving it hot. Such practices can be strengthened if women are made aware of the scientific rationale behind them. It appears that 13.2% of food-borne illnesses reported at the household level are as much attributable to lack of an enabling environment as to the lack of proper food safety-related practices or awareness.

Although providing an enabling environment for food safety is essential, it may not be a sufficient condition for food safety because a review of improved water supplies and sanitation facilities for control of diarrhoeal diseases among young children has shown that even under the most favourable circumstances the rate of morbidity is reduced only by 27%\(^5\). In this scenario it should be realized that food safety education for women is a powerful and practical means that enables them to make informed choices\(^6\). The study also revealed that the anganwadi workers (grassroots-level women health functionaries) were the preferred source for food safety education. This women workforce, which has been contributing to the nutritional well-being of mothers, infants and pre-schoolers can now be effectively used to empower mothers with food safety education as well.

Women hold the key to ensuring food safety to all, provided they are empowered with an enabling environment and supported by sound awareness-creation endeavours. Since cooking and dietary practices and cultural activities are traditionally viewed as activities performed by women, they can play a key role in continuance of these practices for generations. Investing in food safety education for them is an essential and wise investment in “human capital”. However, since men are also involved in cooking in many sectors, similar studies involving them would give adequate information for devising food safety education strategies for them as well.

References


Comment

Notes and news

World Health Day

The Regional Director, Dr Samlee Plianbangchang, addressed all staff on the occasion of the World Health Day (7 April) that was celebrated in the Region with the usual enthusiasm. Dr Samlee said, “I would like to greet all of you on the occasion of the World Health Day (WHD) 2009. The theme for this year’s WHD is “Health facilities in emergencies” with the slogan, “Save lives: Make hospitals safe in emergencies”. It is a call for assurance of needed health and medical services during emergencies, especially when disasters strike. This theme is also for the biennial global campaign, 2008-2009, of the International Strategy for Disaster Risk Reduction. As we are all well aware, countries in the South-East Asia (SEA) Region are prone to disasters. During 1996-2005, natural disasters killed over 500,000 people in the Region. This number represented 58% of the world’s total deaths from disasters. The devastations due to disasters also profoundly affect health facilities in communities.”

Dr Samlee concluded, “All of us as WHO staff members have a crucial role to play in disseminating information on safe health facilities and hospitals during emergencies. We have the duty to diligently pursue advocacy to create awareness on all the issues involved at all levels; national, regional and global. Health concerns should be the primary motivation behind any action to reduce disaster risks.”

On WNTD, Regional Director stresses role of “Tobacco Health Warnings”

The Regional Director, Dr Samlee Plianbangchang, addressed all staff at the Regional Office with a message on World No-Tobacco Day (WNTD), 31 May 2009. “Tobacco Health Warnings” was the theme for this year’s “World No-Tobacco Day”.

Dr Samlee at the outset pointed out that tobacco is the only legally available product that kills people; 1.2 million die from tobacco use in the WHO South-East Asia Region annually. An effective tobacco control strategy is, therefore, not only a programmatic necessity but also a moral imperative, he said. Health warnings on packages of tobacco products are critical to the tobacco control strategy. The WHO Framework Convention on Tobacco Control obligates Parties to ensure that tobacco products carry health warnings that describe their harmful effects. The Sixty-first session of the WHO Regional Committee for South-East Asia in New Delhi in 2008 also adopted a resolution on tobacco control that urged Member States to ensure comprehensive implementation of a six-point policy package to achieve the goals of the Framework Convention. This package stresses the importance of health warnings that can increase awareness about the dangers of tobacco use.

Urging all stakeholders to “renew the pledge to strengthen efforts to introduce effective tobacco health warnings and protect
the people from this colossal public health menace," the Regional Director promised continual, unflagging support of WHO to Member States to "establish, strengthen and implement laws and other measures on health warnings for all tobacco products." WHO will work with Member States to promote the theme of the World No-Tobacco Day throughout the year among policy-makers, tobacco control advocates and NGOs in order to effect policy change in support of effective health warnings for all tobacco products," the Regional Director reiterated.

Regional consultation on pandemic H1N1 2009

A regional consultation on pandemic H1N1 2009: strengthening country capacity for pandemic preparedness was held from 9 to 11 July 2009 in Bangkok, Thailand. Speaking on the occasion, Dr Samlee Plianbangchang, Regional Director said, "The outbreaks of influenza A (H1N1) 2009 started in the Western Hemisphere in April this year and spread rapidly to other parts of the world. In responding to the threat of these outbreaks, on 25th April 2009 the Director-General of WHO declared the world’s first ever “public health emergency of international concern”. This was done in accordance with the provisions of the International Health Regulations 2005 or IHR (2005). As on 9 July 2009, 135 countries had been affected worldwide. A total of 94,574 confirmed cases have been reported with 429 deaths. We are now in Phase 6 of influenza pandemic alert; it is the maximum phase. However, this H1N1 influenza virus is generally not causing severe illness. And we hope that the majority of cases of this virus will continue not to be severe. Unlike seasonal influenza, only less than 1% clinical cases of H1N1 viral infections occur among old people. The severe or fatal form of influenza H1N1 confines itself largely to people with underlying chronic diseases. Also, pregnant women and young children appear to be at a higher risk of a more severe form of H1N1 infection."

Thirty-first session of WHO South-East Asia Advisory Committee on Health Research

The Regional Director, Dr Samlee Plianbangchang, inaugurated the Thirty-first session of WHO South-East Asia Advisory Committee on Health Research (ACHR) in Kathmandu, Nepal on 21 July 2009. Speaking on the occasion, Dr Samlee said, "The Region needs to be more self-reliant in the areas of drugs and vaccines for combating emerging infectious diseases. In this connection, we realize that to succeed in these efforts, building partnerships among all stakeholders is necessary, i.e. partnerships among research institutions, funding agencies, health services provider organizations and the private industry. We are also particularly concerned with the persistent endemcity of AI(H5N1) in the Region. We are also very concerned with countries’ capacity in the management of their research and research-related activities. We are paying particular attention to the management of “research resources”, both “human” and “financial”. We understand the importance of efficient and effective utilization of “available funds”, especially WHO funds."

Dr Samlee added, "In the case of both communicable and noncommunicable diseases, I would like that we pay special attention to epidemiological and operational research—research that can help ensure effective interventions through evidence-based programme development and management. This aspect of research includes, among others, appropriate application of available technology in disease prevention and control. This is much more needed in the areas of health services and health systems research."

Dr Samlee concluded, “Very importantly, “research for health” must also be designed to support our efforts towards equitable distribution of health resources and to help facilitate the closing of the gap between the “haves” and the “have-nots” in health. The evidence from “research for health” will help us in our attempt to “reach the unreached”: the poor, marginalized, vulnerable and the underprivileged.”

Regional Health Forum – Volume 13, Number 2, 2009 15
National Centre of Excellence for Tropical Diseases

A Task Force Meeting on the Establishment of a National Centre of Excellence for Tropical Diseases in India was held in the Regional Office on 10–11 September 2009. In his message, Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, said, “The South-East Asia Region, and India in particular, bears a disproportionate burden of tropical diseases. Moreover, the Region faces an enormous shortage of workforce skilled in tropical diseases. So great is the demand for qualified and skilled public health manpower, including in tropical diseases in the South-East Asia Region, that it has been roughly estimated that India alone will need 10 000 more of such health professionals in the near future. This includes tropical disease specialists, public health specialists, doctors, researchers, technicians and trained nurses in the area of tropical diseases. Currently, there are not enough institutions that could cater to this growing demand. Existing institutions either lack the appropriate infrastructure or do not have the desired state-of-the-art technology, laboratory facilities and research infrastructure. Thus, the quality of academic programmes are marginal, leaving no scope for enhanced specialization or improvement of competencies. Many existing institutions do not provide opportunities in the area of health economics and behavioural sciences. A better accreditation framework also needs to be evolved. There is also an urgent need to establish a national centre of excellence for tropical diseases in India. This would be possible with sustainable and effective partnerships with other important stakeholders for the overall betterment of community health through the control of tropical diseases.”

Dr Samlee concluded, “Research on other significant public health issues such as global warming and climate change, translational research, outbreak investigations, and drug and vaccine trials would be undertaken at the proposed institute. It would network with national and international institutions concerned. Funds would be mobilized with related stakeholders and agencies such as WHO, UNICEF, World Bank and NGOs, and the Government of India would also play a leading role.”

Kathmandu Declaration on Protecting health facilities from disasters
(adopted by the Ministers of Health of Member States of the WHO South-East Asia Region at their Twenty-seventh meeting)

We, the Health Ministers of Member States of the WHO South-East Asia Region participating in the Twenty-seventh Health Ministers’ Meeting in Kathmandu, Nepal, appreciate the efforts being made by Member States and partners in the South East Asia Region to keep health facilities safe from emergencies and disasters. We also recognize that by optimizing the use of advances in technology and applying current good practices, stakeholders can scale up efforts to strengthen the structural, non-structural and functional aspects of protecting and increasing the resilience of health facilities;

Concerned that from 1998-2009, natural disasters killed over 750,000 people in the South-East Asia Region, which is 61.6 % of the world’s total deaths from natural disasters;

Aware that climate change-related events can predispose to disasters which can have a detrimental effect on health facilities;

Also aware that health facilities, including staff, equipment and other related resources, can become casualties when they are most needed;

Recognizing that the Hyogo Framework for Action specified that health facilities are critical infrastructure that needs to be kept intact in emergencies;

Recognizing further that the South-East Asia Regional Benchmarks, standards and indicators for emergency preparedness and response provide a framework based on which
health facilities can be built or modified to withstand the forces of various kinds of hazards and disasters;

Acknowledging the outputs of the Global Platform for Disaster Risk Reduction held in June 2009 regarding structural evaluations of health facilities, enforcement of national building codes, financial incentives and mechanisms for retrofitting;

Noting the innovative work of Member States in the Region to reduce the structural and nonstructural risks of health facilities, as well as to increase training and contingency planning;

We, the Health Ministers, commit ourselves to:

(1) implement the goals of the Hyogo Framework for building the resilience of nations and communities to disasters;

(2) consider the outputs of the Global Platform for Disaster Risk Reduction in relation to safe health facilities;

(3) use the South-East Asia Regional Benchmarks, standards and indicators for emergency preparedness and response to build and modify health facilities to withstand events from various hazards and disasters;

(4) develop the capacity of health-sector professionals in the science and practice of health facility preparedness and risk reduction;

(5) promote assessments of health facilities in Member States using existing diagnostic tools and decision-making instruments;

(6) promote the enforcement of national building codes and specific standards for health facilities;

(7) include the private sector in all efforts so that health facilities remain resilient to disasters;

(8) engage other service and public sectors such as civil engineering, architecture, transport, public works, water and sanitation, energy and finance to strengthen infrastructure related to the functioning of health facilities in emergencies and disasters; and

(9) enhance public awareness of the need to make health facilities safe and functional in emergencies;

We, the Health Ministers of South-East Asia Region, urge all other WHO Member States as well as the Director-General and the Regional Director to continue to provide leadership and technical support in building partnerships between governments, the United Nations and relevant global health initiatives and partnerships, academia, professional bodies, NGOs, related sectors, the media and civil society, to jointly advocate and effectively follow up on all aspects of this Kathmandu Declaration on Protecting Health Facilities from Disasters.

Nepal moves ahead with healthy settings

Nepal reports a good decade of history in its practise of the Healthy Settings process. Following the example of what began in the American and the European Regions of WHO as the Healthy City programme, the South-East Asia Region has transformed this label to the more general and inclusive term "Healthy Settings".

In Nepal, this Healthy Settings process was hinged to the Nepal Environmental Health Initiative (NEHI) developed by the government, in collaboration with WHOM, in 1994 as a means to quickly ensure and implement local health action. Through a combination of networking, coordination and capacity-building actions, the following steps were taken to further the work of the National Healthy Settings Programme in Nepal. It worked on establishing a Healthy Settings team in all municipalities through the review and understanding of each
municipality’s physical, social and environmental, and economic determinants of health. It reviewed its sector policies and plans, identified relevant sector partners, and then incorporated the concept of healthy settings in the physical, social, economic and environmental planning of the setting. The implementation focus was on continuous monitoring and networking among the various municipalities, and the development of a Healthy Settings Coordination Resource Centre.

In Nepal too, the Healthy City process aims to create a healthy and vibrant community setting through the community’s involvement in the proper panning of its physical, social and the economic environment so that sustainable health development can be achieved and maintained.

For more information, please contact Mr Namraj Khatri, National Professional Officer, WHO Nepal, Kathmandu (khatrin@searo.who.int).

**Water quality partnership: WHO/AusAID prepares for Phase 2**

AusAID and WHO have agreed to explore the establishment of a second phase of their Water Quality Partnership, building on the successes of and lessons learned in Phase 1. A target country detailed scoping exercise jointly conducted by AusAID consultants and WHO staff has formulated a bridging phase project for Nepal, Bhutan and Bangladesh. The exercise was carried out through visits to these countries between 17 August 2009 and 4 September 2009. The country visits resulted in finalizing the Phase 2 proposal, agreeing on the water safety plan scaling-up strategies, and understanding the roles of various partners in implementing Phase 2.

WHO and AusAID entered into a partnership in 2005 to support a project on “Accelerating effective water, sanitation and hygiene management for health with primary emphasis on the Asian Region”. This project was jointly implemented by WHO headquarters and the WHO Regional Offices for South-East Asia (SEARO) and the Western Pacific (WPRO). It concluded in December 2008. Countries that benefited from the project are Bangladesh, Bhutan, Nepal, Myanmar and Thailand. During the first phase of the project country capacities were built, pilot projects on water safety plans regarding rural and periurban water supply systems were successfully carried out, and water safety plan manuals and strategies for scaling up were developed in some countries.

For more information, please contact Ms Payden, Regional Adviser, Water, Sanitation & Health, at Payden@searo.who.int.

**Tobacco cessation services in the South-East Asia Region**

One of the key detrimental effects of tobacco use is the addictive nature of nicotine, a key ingredient in tobacco products. Tobacco users are dependent on and addicted to it. According to research findings, tobacco users who are aware of the harmful effects of tobacco use are more likely to want to quit. However, only a few get the help they need to successfully quit this dangerous habit.

In order to help tobacco users to quit smoking, WHO recommends that Member countries establish programmes that provide low-cost, effective interventions for those who want to give up the habit. Healthcare systems hold the primary responsibility for treating tobacco dependence. Along with it, community groups, non-health-care service-providers and community leaders can greatly contribute to increase cessation rates and success in efforts to reduce tobacco prevalence.

The WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package recommends a six-point strategy to strengthen the implementation of the WHO Framework Convention on Tobacco Control. One of these six policies is “Offer help to quit tobacco use”.

For more information, please contact Ms Payden, Regional Adviser, Water, Sanitation & Health, at Payden@searo.who.int.
Basic facts about tobacco cessation

- Among all smokers who are aware of the dangers of tobacco, three out of four want to quit.
- Of daily smokers who try to quit unaided, 90-95% will relapse.
- Quit rates increase when counselling is delivered by a variety of health workers. Pharmacological therapy has shown to double quit rates.
- The combination of pharmacological treatment and counselling services will further increase the rate of successful cessation.

Tobacco cessation interventions include various methods which have differing cost efficiency levels and different degrees of impact on individual tobacco users. They should be adapted to individuals, local conditions and cultures. Three types of interventions can be considered:

(i) Tobacco cessation advice incorporated into primary health-care services;
(ii) Easily accessible and free quit helplines; and,
(iii) Access to low-cost pharmacological therapy.

Integrating tobacco cessation into primary health-care is inexpensive and provides the health-care system with repeated opportunities to warn tobacco users about the harmful effects and devastating consequences of tobacco. Advice from health-care practitioners can greatly enhance quit rates. In countries where an extensive network of primary health care is not available, tobacco cessation needs to be integrated into any easily accessible health-care facilities or community resources, which include any type of widely available health-care services, community groups, non-health-care service-providers and/or community leaders. The main expenditure of the government in this type of intervention is in providing basic training for health-care workers or community groups on cessation counselling and in developing information material for tobacco users.

The establishment of quit helplines is also an effective intervention, especially if they have well-trained staff, are accessible to a country’s entire population through toll-free phone numbers, and are tailored to the specific requirements of different population segments. Quit helplines are inexpensive to operate, provide confidentiality, can be available for long hours and can be extended to the Internet and provide instant support material and links to other services. Quit helplines can also help introduce users to other tobacco-dependence treatments such as counselling and nicotine replacement therapy. Although quit helplines are not currently popular in the South-East Asia Region, India and Thailand are in the process of introducing national helplines.

The other effective intervention for tobacco cessation is pharmacological treatment such as nicotine replacement therapy (NRT) in the form of patches, lozenges, gum and nasal sprays, and prescription medications such as bupropion and varenicline. Of these only NRT is widely available over the counter.

Of the 5.4 million tobacco-related deaths globally each year, 1.2 million occur in the South-East Asia Region. Tobacco consumption and production in the Region is high. Besides the challenges associated with the production of tobacco products, the challenges to overcome tobacco use are also colossal on account of the vast variety of tobacco products and their low prices, which make them easily accessible to the poor and the young consumer. Current male smoking rates vary from 30.6% to 58.6%. Smoking prevalence among females is less than 5% in most Member States except for Maldives (11.6%), Myanmar (13.6%) and Nepal (26.4%). Cessation services are required to address the needs of all smokers and smokeless tobacco users.
Prevalence of tobacco use

- Current levels of smoking in boys of the age-group of 13-15 years varies from 1.6% to 50.6% in the South-East Asia Region.
- Current smoking prevalence among 13-15 year-old girls varies from 0.9% to 17.3%.
- Prevalence of use of tobacco products other than cigarettes among 13-15 year-old boys ranges from 0.4% to 29%.
- Prevalence of use of tobacco products other than cigarettes among 13-15 year-old girls varies from 2.4% to 20.2%.
- Nearly 70% students who smoke want to quit.
- 70% teachers do not have access to teaching and learning materials on tobacco control.
- 80% teachers do not receive training in tobacco control.
- 70% of health students who smoke want to quit.
- More than 90% health professions students understand that their prime responsibility is to help patients quit tobacco use.
- Most doctors want to be trained in tobacco cessation techniques.


Countries in the Region are committed to tobacco control. Ten out of 11 Member countries are also party to the WHO Framework Convention. A number of countries have tobacco control legislations in place and others have started to implement the most suitably effective measures in the area of tobacco control. Countries have also started to undertake measures in the area of tobacco cessation; however, only a few have established systems in a limited way.

Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand have established tobacco cessation clinics in some of their health-care facilities and hospitals. In addition, Bangladesh, India, Indonesia, Maldives, Myanmar and Thailand have some cessation services at the community level. In Sri Lanka and Thailand the health insurance or the national health service covers the cost of this support entirely or partially.

In the Region, nicotine replacement therapy (NRT) is available over-the-counter only in India and Thailand. Pharmacotherapy (Bupropion) is available with a physician’s prescription in India, Myanmar, Sri Lanka and Thailand.

There is limited data on cessation rates in Member countries of the Region. However, findings from the Global Youth Tobacco Survey (GYTS is the survey of students aged 13-15 years with two stage cluster sampling design) and the Global Health Professions Student Survey (GHPSS is the survey of third year health professional students—medical, dental, nursing and pharmacy) suggest that seven out of every ten smokers wish to quit but do not find optimum cessation support for the same. Teachers hold an advantageous position in supporting students who want to quit. However, the Global School Personnel Survey (GSPS is the survey of school teachers and administrators in schools selected for GYTS) found that seven of ten teachers do not have access to teaching and learning materials on tobacco control and eight out of ten teachers do not receive training in tobacco control.

Figure 1: Per cent of current smokers (students aged 13-15 years) who want to quit now in selected Member countries in South-East Asia Region

Source: GYTS 2006-07
Two forms of nicotine replacement therapy
chosen as part of the corpus of
WHO “Essential Medicines”

Two forms of nicotine replacement therapy
(NRT)—transdermal patches and chewing

gum—to help people quit their addiction to
tobacco have been placed on the 16th World

Health Organization Model List of Essential

Medicines, at the recommendation of the 17th

Expert Committee on the Selection and Use of

Essential Medicines which met in Geneva on


In making its recommendation, the

Committee cited the public health need, the

high-quality evidence of effectiveness, and the

acceptable safety and cost-effectiveness of the

two therapies.

It is expected that the inclusion of the

therapies would advance discussions on the
development of guidelines for the

implementation of Article 14 of the WHO

Framework Convention on Tobacco Control.
The international treaty requires its 165 (as of
today) Parties to develop programmes to
reduce tobacco addiction. It is also expected

that the inclusion of the therapies would
promote improved access to NRT in
developing countries.

Figure 2: Access to teaching material and training on
tobacco prevention for school personnel in selected
Member countries in South-East Asia Region

Source: GSPS 2006-2007

According to GHPSS findings almost all
health students understand that health
professionals have a significant role in
providing advice or information about smoking
cessation to patients and they want formal
training on cessation. Four out of every five
students, however, have not been provided
formal training on cessation. This finding brings
out the great necessity of providing cessation
training to future health-care providers and the
respective governments should include tobacco
cessation in the curriculum of all health
courses. Some Member countries have taken
an initiative in this regard.
Publications corner

Mental health aspects of women’s reproductive health
A Global Review of the Literature
Nonserial Publication; World Health Organization
Order Number 11500726
Price CHF 30.00 / US$ 30.00
Developing countries: CHF 21.00
This book has reviewed the research undertaken on a broad range of reproductive health issues and their mental health determinants/consequences over the last 15 years from both high- and low-income countries. Evidence from peer-reviewed journals has been used wherever possible but has been augmented with results of a specific survey initiated to gather state of the art information on reproductive and mental health issues from a variety of researchers and interested parties. Valuable data from consultant reports, national programme evaluations and postgraduate research work was also compiled, analysed and synthesized.

Microbiological hazards in fresh leafy vegetables and herbs
Microbiological Risk Assessment Series,
No. 14; Nonserial Publication; in press – noted
World Health Organization
Order Number 11500752
Price CHF 40.00 / US$ 40.00
Developing countries: CHF 28.00
Problems linked with pathogens in fresh produce, including the associated public health and trade implications, have been reported in a number of countries worldwide. Furthermore, from 1980 to 2004, the global production per annum of fruit and vegetables grew by 94%. Fruit and vegetables are a critical component of a healthy diet. Thus, ensuring the safety of these products is of high importance. Reported outbreaks associated with leafy vegetables and herbs have been notable for the wide geographical distribution of the contaminated products, the high numbers of consumers exposed and thus the large number of cases. This publication addresses the pathways for contamination, survival and persistence of microbiological hazards associated with leafy vegetables and herbs, and the potential management options from primary production through to the consumer. All aspects of the farm-to-fork continuum, i.e. pre-harvest and post-harvest, have been considered.

Global Tuberculosis Control 2009
Epidemiology, Strategy, Financing;
Nonserial Publication;
World Health Organization
Order Number 11504659
Price CHF 40.00 / US$ 40.00
Developing countries: CHF 28.00
This report is WHO’s thirteenth annual report on global tuberculosis (TB) control in a series that started in 1997. It presents WHO’s latest assessment of the epidemiological burden of TB (numbers of cases and deaths), as well as progress towards the 2015 targets for global TB control that have been established within the context of the Millennium Development Goals (MDGs). It also includes a thorough analysis of implementation and financing of the WHO’s
Stop TB Strategy and the Stop TB Partnership’s Global Plan to stop TB, since in combination these have set out how TB control needs to be implemented and funded to achieve the 2015 targets. The report gives particular attention to the period 2006-2009, but selected epidemiological, implementation and financial data are presented for previous years as well. This includes epidemiological data back to 1990 and financial data back to 2002.

Guidelines for trauma quality improvement programmes
Nonserial Publications
Order Number 11500762
Price CHF 20.00 / US$ 20.00
Developing countries: CHF 14.00

In order to promote greater implementation of effective, affordable and sustainable trauma systems globally, the World Health Organization and the International Association for Trauma Surgery and Intensive Care have worked collaboratively to produce these guidelines on trauma quality improvement. The response to the growing problem of injury needs to include the improvement of care of the injured. Quality improvement (QI) programmes offer an affordable and sustainable means to implement such improvements. These programmes enable health care institutions to better monitor trauma care services, better detect problems in care, and more effectively enact and evaluate corrective measures targeted at these problems.

Brief profile on tobacco health warnings in the South-East Asia Region
SEARO Nonserial Publication; SEARO
Order Number 15400006
Price CHF 10.00 / US$ 10.00
Developing countries: CHF 7.00

This brief profile on tobacco health warnings in the South-East Asia Region emphasizes the need for health warnings to ensure tobacco control. It also depicts the situation with respect to tobacco health warnings in the Region. It gives an overview of the status of implementation of Article 11 of the WHO Framework Convention on Tobacco Control on packaging and labelling of tobacco products, and highlights the main hurdles encountered by Member States in this area.

Monitoring emergency obstetric care
A Handbook; Nonserial Publication
World Health Organization
Order Number 11500760
Price CHF 35.00 / US$ 35.00
Developing countries: CHF 24.50

This handbook is an update of an earlier publication on monitoring the availability and use of obstetric services, issued by UNICEF, WHO and UNFPA in 1997. The indicators defined within the publication have been used by ministries of health, international agencies and programme managers in over 50 countries around the world. This revision incorporates changes based on monitoring and assessment conducted worldwide and the emerging evidence on the topic over the years. It includes two new indicators and an additional signal function, with updated evidence and new resources.

Emergency exercise development
WPRO Nonserial Publication
WHO Regional Office for the Western Pacific
Order Number 15200127
Price CHF 50.00 / US$ 50.00
Developing countries: CHF 35.00

This book was prepared by the World Health Organization. It was originally designed, produced and distributed by the Federal Emergency Management Agency, Emergency Management Institute of the United States of America. The World Health Organization has added to it and reformatted many sections of this material in order for users to focus on public health emergencies.
These guidelines are intended to provide a wide range of information related to public health emergency management exercise development. The course material has been designed for emergency exercise staff to acquire in-depth knowledge and skills related to the exercise development process, including management, control, simulation and evaluation. Emphasis is on the construction of exercise planning documents; staffing and training of team leaders in control, simulation and evaluation; the development of expected player actions and points of review; and exercise administration and logistics.

Handbook on monitoring and evaluation of human resources for health
With special applications for low- and middle-income countries; Nonserial Publication
Dal Poz, M. R., Gupta, N., Quain, E., Soucat, A. L. B.; World Health Organization
Order Number 11500757
Price CHF 40.00/US$ 40.00
Developing countries: CHF 28.00

In many countries, shortage and maldistribution of trained health workers is one of the most important constraints to strengthening the delivery of primary and other health services, including curative, promotional, preventive and rehabilitative services. At the same time, many countries currently lack the technical capacity to accurately monitor their own health workforce: data are often unreliable and out of date, common definitions and proven analytical tools are absent, skills and experience for assessing crucial policy issues are lacking.

This Handbook aims to strengthen that technical capacity. It offers health managers, researchers and policy-makers a comprehensive and standard reference for monitoring and evaluating human resources for health. It brings together an analytical framework with strategy options for improving the health workforce information and evidence base, as well as country experiences to highlight approaches that have worked.

E-learning course on health and human rights
The Health and Human Rights team in WHO headquarters and InWent Capacity Building International, Germany, have organized an e-learning course on health and human rights since 2006. This online training aims to increase clarity and understanding about the important synergy between health and human rights.

The course is free of charge and is intended for public health professionals, representatives of ministries of health and other government officials, national human rights commissions, civil society and staff from UN organizations.

The course aims to build the capacity of the participants to recognize the key linkages between health and human rights, apply a human rights-based approach to their work, understand the legal framework of human rights, and analyze public health policies from a human rights perspective.

Background information can be found on http://www.who.int/hhr/news/en/. For course announcement, application form and further details please contact Riikka Rantala (HHR) at rantalar@searo.who.int.

This E-learning course could provide a great opportunity to learn the nuances of how to apply human rights to your work. We look forward to your registration!

Measles and rubella surveillance and outbreak investigation guidelines
The WHO/UNICEF comprehensive strategy to reduce measles deaths was endorsed by the World Health Assembly in 2003. The four
components of the strategy are: strong routine immunization; providing a ‘second opportunity’ for measles immunization; effective measles surveillance; and improved case management.

The overall goal of the South-East Asia regional strategic plan for 2007-2010 is to reduce the number of measles deaths by 90% in 2010 relative to 2000 estimates. Two important objectives outlined in the plan are: to conduct case-based measles surveillance within an integrated vaccine preventable disease surveillance system in countries that have conducted measles catch-up campaigns; and to achieve full investigation and appropriate clinical case management for all measles outbreaks.

Although the current regional goal is sustainable measles mortality reduction, several countries that have achieved a low incidence of measles are accelerating efforts with a view towards measles elimination.

Additionally, Member countries are integrating measles mortality reduction with rubella/ congenital rubella syndrome (CRS) control whenever possible.

These guidelines are intended to provide a framework for measles and rubella surveillance for national and sub-national level programme managers who could adapt them to local needs.

Regional guidelines for development of health workforce strategic plans in countries of the South-East Asia Region

It is an established fact that the 11 Member States of the South-East Asia Region are home to approximately 25% of the world’s population and bear almost 30% of the global disease burden.

In this context, the World Health Report 2006 highlighted the main role to be played by the health workforce (HWF). Countries need to overcome the shortage of HWF that has been identified as the most significant constraint for efforts to reach the health-related MDGs. Every country is unique in its needs and capacities. As a result, the whole process of strategic planning and implementation should be based on evidence generated through HWF situation analysis that is flexible and interactive.

These guidelines have been developed based on the WHO/SEARO “Regional Strategic Plan for HWF Development” and are designed to serve as a tool in developing country-specific HWF strategic planning.

HIV/AIDS in the South-East Asia Region – 2009

This report presents a synthesis of historical and current data on HIV epidemiology in the South-East Asia Region. It also provides the latest updates on national responses to the epidemic. Individual country profiles summarize the epidemic situation and list key programmatic and data gaps as well as priority actions. The information is presented using graphs with key messages highlighted, making this report useful to a wide audience including HIV programme managers in Asia and other countries, policy makers, donors and researchers in the field of HIV/AIDS.

Regional strategy for the elimination of congenital syphilis

Worldwide, syphilis accounts for an estimated 12 million cases, 2 million of them among pregnant women. Syphilis in pregnant women can result in adverse outcomes of pregnancy in up to 80% of cases, such as stillbirth and spontaneous abortion, perinatal death, and serious neonatal infections and low-birth-weight babies. The annual global number of cases of congenital syphilis is estimated to be between 713,600 and 1,575,000. More newborn infants are affected by congenital syphilis than any other infection including human immunodeficiency virus (HIV) and
tetanus. The morbidity and mortality due to congenital syphilis is much higher than that due to mother-to-child transmission (MTCT) of HIV, yet syphilis has not received the same attention as HIV. This is mainly due to inadequate political commitment and insufficient national and international awareness of the burden of congenital syphilis.

This Regional strategy for the elimination of congenital syphilis (ECS) is aimed at various stakeholders concerned with ECS including national policy-makers, programme officials, nongovernmental organizations, international nongovernmental organizations, community-based organizations, multilateral and bilateral donor agencies, and United Nations agencies.

**Health implications from monocrotophos use: a review of the evidence in India**

The Food and Agriculture Organization (FAO) and the World Health Organization (WHO) have encouraged countries to phase out highly hazardous pesticides. Leading Asian countries have banned the use of monocrotophos because of unacceptable health risks. In India, however, monocrotophos continues to be produced, used and exported. This publication is designed to provide health policy-makers with technical information needed for urgent action to reduce the availability of and the demand for highly hazardous pesticides, as recommended by WHO and FAO.
Guidelines for contributors

THE Regional Health Forum seeks to inform and to act as a platform for debate by health personnel including policy-makers, health administrators, health educators and health communicators.

Contributions on current events, issues, theories and activities in all aspects of health development are welcome. Contributions should be original and contain something of interest to those engaged in health policy and practice, some lesson to be learned, some idea, something that worked, something that didn't work, in fact anything that needs to be communicated and discussed on a broader scale. Articles, essays, notes, news and views across the spectrum of health development will be published.

Every year, the April issue of the Forum is dedicated to the World Health Day theme of the year. Readers may send contributions relating to the theme for inclusion in the special issue.

Papers for submission should be forwarded to the Editor, Regional Health Forum, World Health Organization, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110002, India (E-mail address: editor@searo.who.int).

Contributions should:
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• be written in an anecdotal, informal, lively and readable style (so that sophisticated technologies, for example, may be easily understood);
• be in MS Word and sent on-line to editor@searo.who.int
• not normally exceed 3000 words with an abstract (approx. 250 words) and a maximum of 30 references.

Letters to the editor should normally be between 500-1000 words with a maximum of six references.

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