

Message from the Regional Director



The Department of Sustainable Development and Healthy Environments, WHO Regional Office for South-East Asia, covers many important areas such as environment and health, climate change, prevention and control of noncommunicable diseases including the tobacco free initiative, road safety, urbanization and health, violence, emergency and humanitarian action, occupational health etc. Most of these areas are not only of a cross-cutting nature but which can uniquely contribute to primary prevention efforts.

Among WHO's priority activities as the lead technical agency in international health development is to collaborate with Member States in policy and strategy development and in programme implementation. WHO also provides a forum for information exchange.

This newsletter, I am happy to note, provides a channel for sharing country experiences and also an opportunity to learn from each other. I hope that national programmes in the concerned areas, health professionals and scientists will use this newsletter to widely disseminate and share their experiences, insights and health innovations in the above-mentioned areas.

I wish this initiative all success and hope that it will generate a lively dialogue among concerned stakeholders.

Samlee Plianbangchang

Dr Samlee Plianbangchang
Regional Director

Preventing noncommunicable diseases: a top priority for the Region

The South-East Asia (SEA) Region, home to 25% of the world's population and 30% of the world's poor, suffers from a double disease burden—while communicable diseases remain an important public health problem, noncommunicable diseases (NCDs) have emerged as the leading cause of death. Globally, each year NCDs account for 60% of the total deaths. Of an estimated 35 million deaths due to NCDs globally in 2005, 8 million or 23% occurred in the SEA Region. Moreover, the burden continues to increase. It is projected that there will be a 21% increase in the number of NCD deaths in the Region during 2006-2015,

whereas deaths due to infectious diseases will fall by 16% during the same period.

Besides the health impact, NCDs also pose an economic and development challenge, with a strong link with poverty. Without progress in successfully combating these chronic diseases, it may be difficult to achieve many MDGs.

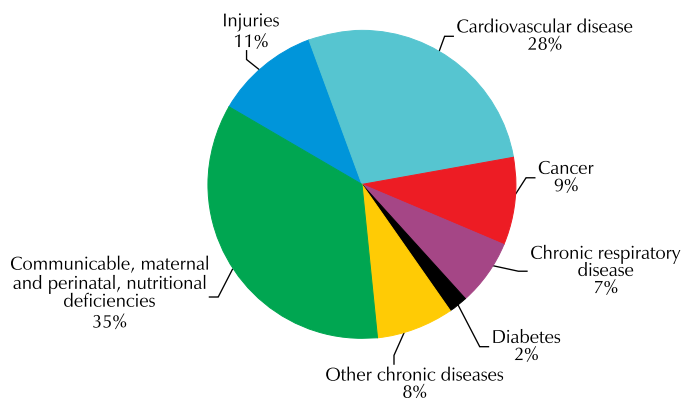
Four NCDs take the highest toll—cardiovascular diseases (CVDs), cancers, chronic respiratory disease, and diabetes mellitus. These diseases can be prevented. About 80% of CVDs and over a third of cancers can be prevented by eliminating

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shared risk factors — use of tobacco, unhealthy diet, lack of physical activity, and harmful use of alcohol (Table 1). These risk factors are prevalent in our Region although their prevalence varies from country to country and from area to area within a country.

Estimated proportion of deaths by cause, SEAR, 2005



Source: WHO-CHP, Geneva [http://www.who.int/chp/chronic_disease_report/media/searo.pdf]

Contrary to popular belief, NCDs in the Region affect at a younger age than in the West, and not only the rich and affluent, but also the poor are affected. Globally, as many as 9 million people who die from NCDs are below 60 years and 90% of the premature deaths from NCDs are in developing countries.

Table 1: Shared risk factors for major noncommunicable diseases

	Causative Risk Factors			
	Tobacco use	Un-healthy Diet	Physical inactivity	Harmful use of alcohol
Heart Disease and stroke	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓
Cancers	✓	✓	✓	✓
Chronic obstructive pulmonary disease	✓			

Available data clearly show that NCDs are not only closely related to poverty they also contribute to poverty. The poor not only have an increased exposure to risk factors such as smoking, unhealthy diet etc. but also suffer from lack of access to health care services. Due to the high health care costs or catastrophic expenditures associated with NCDs, poor families slide further into poverty. This is especially true of the SEA Region where out-of-pocket expenditure is very high.

Global and regional response to address NCDs

While NCDs have so far received limited attention in terms of policy support or resources, globally and in the Region, the situation is changing. A high level meeting called by the United Nations General Assembly in 2010 and another scheduled for September 2011 to be attended by the heads of State and Government could act as a “game changer” for NCD prevention and control efforts. This UN summit could generate global commitment and momentum for prevention and control of NCDs. In particular, it should provide an impetus to implement the global strategy for the prevention and control of NCDs (2000) as well as the action plan (2008-2013) endorsed by the World Health Assembly in 2008.

To prepare for the UN high-level meeting, a number of meetings and consultations are planned. For example, the Russian Federation is organizing the First Global Ministerial Conference on NCDs and Healthy Lifestyles on 28-29 April 2011 in Moscow. In addition, a number of regional consultations have been planned in the six WHO Regions, including one to be held in Jakarta, Indonesia from 1-4 March 2011. A Regional Civil Society Meeting on NCDs held in January 10-12, 2011 in Kathmandu formed part of the regional consultation process and an effort to bring regional perspectives to bear at the UN high-level meeting.

The Way Forward

Given the disproportionately high burden in the Region and the high prevalence of risk factors and underlying social determinants, NCDs need to be tackled with a sense of urgency. Business as usual will not do!

We need a **paradigm shift** in terms of the priority given to NCDs as a part of national policy and programme as well as from the point of view of resource allocation. In this regard, some of the principles that should guide our actions in NCD prevention and control include:

- application of the primary health care approach with integration, inter-sectoral involvement including empowerment and engagement of the community, ensuring equity and social justice in service delivery as foundations,
- affordability and sustainability of prevention and care interventions that are cost-effective and culturally appropriate,
- strategies based on evidence or public health innovation, and finally,
- attention given to programme monitoring and evaluation in improving the public health infrastructure with appropriate allocation of resources, both financial and human, is fundamental to address this pandemic of NCDs in the Region.

In summary, there is a need to tackle NCDs at policy level, at resource level, and at the population level using a coordinated, integrated and inter-sectoral approach. A key role should be played by individuals themselves, by NGOs and civil society, based on the principles of primary health care and tapping the power of prevention because preventing NCDs is by far better and cheaper than treating them!

Failure to prevent will lead to greater burden and rising costs associated with NCDs. Action is therefore needed urgently and now!

Contributed by:

Dr Jai P Narain, SDE & Dr Renu Garg, NCD

email: narainj@searo.who.int

gargr@searo.who.int

Update on emergencies and disasters

Cyclone GIRI Myanmar (22 October 2010)

A cyclonic storm with wind velocity of 110 mph hit the western coast of Rakhine State of Myanmar, starting from late night on 22 October. The category 4 storm affected five townships of which Myebon and Kyaukpyu were severely affected. The major challenges faced were disruption of electricity, communication and transportation to affected areas, especially to nearby islands. Two hospitals, many health facilities and an estimated 5,600 homes were damaged. Based on available information, 41 deaths were reported. WHO deployed surveillance officers to accompany MOH rapid assessment teams and supported local public health initiatives. The National Disaster Preparedness Coordination Committee (NDPCC) in close collaboration with other ministries and partners provided emergency relief support, set up temporary shelters and health posts for the affected communities. A disease surveillance system was activated and attention was given to prevent water-borne diseases. EHA-SEARO provided Inter Agency Health Kits from its Bangkok stockpile.

Earthquake and Tsunami in Indonesia (25 October 2010)

On 25 October 2010, 21:42 local time, an earthquake registering at magnitude 7.2 on the Richter Scale (RC), a shallow type, at a 10 kilometer depth in the sea, followed by a tsunami affected Mentawai Island, West Sumatra Province in Indonesia. Twenty-two aftershocks, ranging from 5.0 to 6.2 RC were recorded. A total of 18 villages in four sub-districts were affected. The two worst affected sub-districts were North Pagai and South Pagai. As a result, 428 persons died and 96 were reported missing. While 14,983 people were displaced from their homes and villages. 753 buildings including six health facilities were damaged. Due to bad weather, limited boats and helicopters, transportation of relief supplies to affected areas became a major challenge. EHA-WHO Indonesia deployed one staff to Mentawai Island

and conducted a joint rapid assessment with UN and NGO teams, and supported the Crisis Centre, MOH, in setting up an information command post. MOH set up 18 health posts, mobile clinics, field hospitals and provided health services for the affected population.

Mount Merapi Volcanic Eruption in Indonesia (26 October 2010)

Mount Merapi began unleashing torrents of hot gas, rock and other debris on 26 October 2010 after years of dormancy. The second most significant eruption came on November 5, 2010. Up to date, Mt. Merapi's activities remain on alert level 4. The death toll from Mt. Merapi's ongoing eruption is 304. Until 19 November, a total of 33,841 patients were treated and at the peak of the volcanic eruption, more than 400,000 persons were internally displaced. The major challenge faced was to evacuate the large number of people to temporary shelters set up in the safe zone, 20 kilometers from the crater. In the initial emergency phase, Yogyakarta airport was closed for two weeks and many international flights to Jakarta were cancelled due to volcanic ashes.



EHA-WHO deployed two staff to the Crisis Centre and UN rapid assessment teams. EHA-SEARO provided 175,000 USD through its SEARHEF¹ and facilitated MOH in setting up the health command post, health cluster coordination, mobile clinics, water, sanitation, waste management, psychosocial and mental health services and activated EWARS². MOH deployed 1,163 health staff in rotation to support health activities. The number of internally displaced persons (IDPs) is declining on a daily basis from a peak of 400,000.

Flash floods in Sri Lanka (January 2011)

Starting from November 2010 up to January 2011, due to continuous rain, flash floods affected 16 districts in the central and eastern parts of the country. Ampara, and Vavuniya districts were the most affected. A total of 1,061,194 people, consisting of 282,045 families became IDPs. Forty-three deaths, 52 cases of injuries and four missing persons were reported. A total of 324 temporary shelters were established. MOH opened mobile clinics, deployed health staff and provided health supplies to the affected districts. WHO immediately provided 500,000 LKR to MOH, supporting public curative and preventive health activities in the three most affected districts.

¹ South-East Asia Regional Health Emergency Fund (see related story)

² Early Warning Surveillance and Alert



In addition, WHO provided 60,000 chlorine tablets for safe drinking water and EHA-SEARO sent two New Emergency Health Kits (NEHK) to support the health clinics. Each kit could serve 10,000 cases for three months. To date, all health facilities are back to normal and there are only a few hundred of IDPs left in the shelters. No outbreak of disease was reported.

*Contributed by:
Dr Roderico Ofrin, EHA
email: ofrinr@searo.who.int*

Best practice reports

Ecological sanitation: best practice example from Nepal

Poor sanitary conditions in human settlements increase exposure to contaminated water and provide a habitat for mosquito breeding, leading to an increase in water-borne and vector-borne diseases. In Nepal, the most common types of latrines used in rural areas are pit latrines, ventilated improved pit latrines (VIP) and pour-flush latrines while in urban areas, the conventional sewerage system is used where sewage is collected through a pipe network and taken to a centralized treatment plant. The disadvantages of pit and VIP latrines are that they cannot be built near the house because of its smell and attraction of flies - it also pollutes ground water and nearby water sources. These are also not suitable for flooded areas or in areas where the ground water table is high. The pour-flush latrines need water to flush and it can pollute ground water if it is not built properly. These latrines are not suitable in water-scarce areas. The centralized sewerage systems deployed in urban areas use a



Vegetable fertilized by urine.

lot of water for flushing as well as transporting the contents to a centralized treatment system which is located far away from the houses.

To overcome these disadvantages, one of the sanitation concepts that have been tested in Africa, Europe and Asia is Ecological Sanitation (EcoSan) which is found to be sustainable and a holistic approach that regards human excreta not as a waste but as a resource that can be beneficially used as fertilizer in agriculture after proper treatment. The basic idea is to collect urine and faeces separately which makes it simpler to treat.



In Nepal, the concept of EcoSan was introduced in 2002 with an initiation of a pilot programme by the Department of Water Supply and Sewerage and WHO at Siddhipur village in Lalitpur district. The EcoSan toilets were well accepted by the community mainly because of the economic and health benefits. Followed by the success of the pilot projects, various international/nongovernmental organizations and donors have expanded the EcoSan toilets to other parts of the country. It is estimated that some 1,135 EcoSan toilets which are called urine diversion dehydrating (UDD) toilets are in use in the country. A majority of EcoSan toilets are built in the peri-urban areas of Kathmandu valley. Due to the popularity of the project, Ecosan resource centre was established in Darachowk.

The UDD toilets collect urine and faeces separately. The farmers use urine as fertilizer after diluting it around seven times. Faeces is collected in the vault and after it is full, it is left to dry for about a year and in the process all pathogens including cysts are killed. The dried faeces is then removed and put in the field as soil conditioner. A study to assess user perspective indicated that farmers noticed increase in quantity and quality of their farm produces

A study was conducted in 2009 to understand the impact of EcoSan on diarrhoeal diseases. The study was carried out in

108 households in seven clusters where EcoSan toilets were used. The study showed that 30% of the households reported a decrease in diarrhoeal diseases and 35% did not have any diarrhoeal diseases after they started using EcoSan toilets.

According to a pilot project in Bhutan, EcoSan is found relevant and appropriate in rural villages where farming is practiced. A study carried out in Bangladesh, showed the EcoSan toilets are also accepted by the community at large especially in flooded areas, while in India, several NGOs have piloted Ecosan UDD toilets in Tamil Nadu, Maharashtra, West Bengal, Arunachal Pradesh and Bihar. These are mostly in coastal areas and flood-prone areas. The EcoSan initiative is based on traditional wisdom combined with modern toilet designs to reuse urine and excreta in a more organized and safe manner.

WHO guidelines for the safe use of wastewater, excreta and grey water in agriculture and aquaculture are used in the implementation of EcoSan in countries. WHO is supporting countries to pilot test the technologies and special attention is provided to the duration of sanitization of excreta, proper application of urine and dried excreta to soil and hygienic practices of the users. EcoSan becomes relevant not only in the context of MDG7, but also from the point of view of climate change, as it has a direct impact on water resources.

*Contributed by:
Ms Payden, WSH
email: payden@searo.who.int*

SEA Regional Health Emergency Fund (SEARHEF): responding to needs, protecting health, saving lives

In the decade 1998-2008, 61.6% of mortalities from natural disasters globally were accounted for by the 11 Member States of the WHO South-East Asia Region. Cyclones, tsunamis, floods and earthquakes are common events which often leave hundreds of thousands of people devastated. Immediate assistance is always the need of the day- and so financial, human and technical resources need to be available at the earliest. In many cases global and UN funding mechanisms take time to be consolidated. At the same time, there is a need to respond urgently. The South-East Asia Regional Health Emergency Fund (SEARHEF) was created to fill this gap.

The Fund was established during the Sixtieth Session of the WHO Regional Committee for South-East Asia, held in Thimphu, Bhutan, in 2007 through Resolution SEA/RC60 R7. Member States of the Region can obtain SEARHEF funds within 24 hours, provided there is:

- a declaration of a state of emergency,
- official request for external assistance by the national government, or
- appointment of a humanitarian coordinator for that particular emergency by the UN Secretary-General.

The maximum total funds that can be disbursed from SEARHEF for one emergency is \$350 000. It has to be used within the first three months of the emergency and, as such, does not replace the larger funding mechanisms available to countries. The business rules of the Fund were developed by the SEARHEF Working Group.

SEARHEF has been used for procurement of essential medicines and supplies, mobility of health staff, strengthening functioning of health facilities, and public interventions which include early warning, alert and surveillance, water and sanitation and psychosocial support.



SEARHEF has served Member States well in both large-scale emergencies, and also in small and underfunded ones and continues through to the current biennium.

A few examples are provided below with a listing of recent emergencies where SEARHEF helped to save lives.

Cyclone Nargis – Myanmar May 2008

Interventions supported by SEARHEF

- **Procuring essential medicines**
Essential medicines and equipment to treat the sick and injured, including antibiotics, emergency medical kits, bandages and surgical equipment.
- **Mobility of health staff**
Mobilized health workers from other parts of the country to serve health clinics in the affected areas.
- **Ensuring safe water.** Chlorine tablets and bleaching powder procured.
- **Preventing vector-borne diseases.** Fogging machines and insecticide-treated bednets.
- **Protecting against snakebites:** Snake anti-venom purchased.

Conflict in Northern Sri Lanka, 2008- 2009

Interventions supported by SEARHEF

- **Human resources:** SEARHEF helped to provide the budget for mobility and accommodation for health staff at hospitals and mobile clinics
- **Hospitals and health infrastructure:** In three districts, the funds helped build semi-permanent wards and emergency medical care units. Four temporary wards with a bed capacity of 40 each have been constructed in collaboration with NGOs, as well as two primary health clinics in Vavuniya. Facilities at other hospitals were also scaled up.
- **Mental health:** WHO supported training for building a mental health workforce at the community level. SEARHEF funds have allowed this to continue and provide much-needed assistance to the internally displaced people.
- **Medical supplies and health interventions:** Chlorine tablets, bandages, antibiotics, emergency medical kits and surgical kits were provided. SEARHEF helped provide medical supplies quickly so that more lives could be saved.



SEARHEF continues to assist in the health response in various emergencies as per immediate need. In 2009, apart from the post-conflict needs of Sri Lanka, the Sumatra (Padang) earthquake was another emergency that was supported by SEARHEF funds which made a difference prior to the call made for the joint emergency response plan. Moreover, in 2010, SEARHEF supported :

- Procurement of supplies for burn patients and the necessary antibiotics for the care of burn victims in a Dhaka fire which killed over 100 people in July 2010
- The mobility of health staff and procurement of essential medicines and supplies during the eruption of Mt Merapi in October 2010 (see related story).

Resources that arrive early during emergencies help prevent further deaths and diseases that disasters and emergencies cause. SEARHEF contributes to that larger cause.

Reference: *Sout- East Asia Regional Health Emergency Fund – Making a Difference; World Health Organization, Regional Office for South East Asia, New Delhi, India, 2009*

*Contributed by:
Dr Roderico Ofrin, EHA
email: ofrinr@searo.who.int*

Smoke-free Chandigarh: an example of innovative use of judiciary

Chandigarh was the first city in India to become smoke-free in 2007 through concerted efforts at advocacy, awareness building, partnership and legal innovations. After the enactment of the Tobacco Control Act in 2003, a highly active campaign led by the Burning Brain Society and a series of focused actions, raised the profile of the smoke-free law in Chandigarh and spurred the local authorities to accelerate and intensify the enforcement.



Civil society partners adopted a twin strategy of using legal mechanisms – (a) pushing local authorities into action; and (b) seeking to raise public awareness of the smoke-free law and the reasons for it. Civil society partners used “Right to Information” legislation to push the police and the Health Department to implement the Tobacco Control Act. In May 2006, numerous petitions were filed seeking information on whether the public sector was complying with the law.

Based on a Public Interest Litigation filed by the Brain Burning Society with the High Court in July 2005, the Chandigarh Administration notified the law with immediate effect. It empowered police officers (at sub-inspector level or above) and food and drug inspectors



within the Department of Health to take action against violations of the law. A constructive working partnership developed between NGOs and the city administration. A period of intensive activity followed to ensure that procedures were in place for enforcing the smoke-free law. It included training the police, focusing on the health rationale for the law. Finally, Chandigarh was declared a smoke-free city on 15 July 2007.

Chandigarh city is recognized as an example for other Indian cities to follow. Various stakeholders have shared their experience with tobacco control advocates from other parts of the country. Several cities are now following the footsteps of Chandigarh and progressing with their own smoke-free initiatives.

Smoke-free policy initiatives at sub-national level, Indonesia

The Government of Indonesia has not yet signed the WHO Framework Convention on Tobacco Control and the National Tobacco Control Legislation. However, smoke-free policy is gaining ground at a fast pace in many sub-national areas in Indonesia. Several local government units have promulgated and are implementing smoke-free policies such as in Jakarta, Bogor, Cirebon and Yogyakarta. Among these regulations and implementation of smoke-free policies the following two examples are significant;

- In Jakarta, smoke-free policies were introduced by the People’s Order No. 2/2005 on Air Pollution and Governor’s Regulation No. 75/2005 on smoke-free area. Tobacco control partners are working with the city administration to reinvigorate anti-smoking campaigns and support the adoption of a new byelaw on smoking in public buildings. Building owners and managers violating of the regulation will face administrative sanctions and be publicly named and shamed in the local media. The Jakarta Environmental Management Agency has started

compliance checks at malls and other buildings around the city.

- In Padang Panjang City in West Sumatra, the Mayor has shown dynamic and consistent leadership in tobacco control. By imposing a ban on tobacco advertisement, promotion and sponsorship in Padang Panjang, efforts to ensure a tobacco-free society are gaining ground. The World Health Organization acknowledged the outstanding contribution of the Mayor, Dr Suir Syam, and the city of Padang Panjang on World No Tobacco Day 2010.

These local level efforts showcase strong political will at sub-national level. The challenge in Indonesia has been to document lessons learnt from the experiences of these different cities and provinces and ensure that other towns and cities can also be benefited. In 2010, partners assessed progress made in key cities and provinces and have developed a more standardized approach to the development of sub-national legislation and enforcement. The process has led to a clearer understanding of the need to go 100% smoke-free and the need to empower civil society to support enforcement if smoke-free legislation is to be successfully applied across the country

*Contributed by:
Dr Dhirendra Sinha, TFI
email: sinhad@searo.who.int*

UN declares the Decade of Action for Road Safety, 2011-2020



In 2009, WHO published a global status report on road safety which revealed a few facts: that two out of 10 countries with the highest number of deaths are in SEAR, that half of all road traffic deaths are among “vulnerable road users” – motorcyclists, cyclists and pedestrians – and that

only a few countries have comprehensive legislation on major risk factors. The United Nations General assembly in 2010, based on the Commission for Global Road Safety recommendations, proclaimed under resolution 64/255, 2011-2020 as the Decade of Action for Road Safety to Reduce Traffic-related Deaths.

WHO will coordinate as secretariat for the Decade of Action and has prepared a Plan of Action for the Decade (<http://www.who.int/roadsafety/en/>) Wider consultations will

ensue. WHO has supported development and launch of the symbol for the Decade, and has supported the planning of local, national and international launch events. The Decade will be officially launched on 11 May 2011.

The Plan of Action includes five categories of actions:

- (1) improve the management of road safety through multi-sectoral mechanisms;
- (2) assess road infrastructure and improve road design;
- (3) make vehicles safer;
- (4) change the behaviour of road users; and
- (5) improve emergency-care and rehabilitation services.

Clearly, road traffic injury prevention requires the involvement of many sectors. The ministry of health may take the lead or it may be ministries of transport, interior or other who are in charge of transportation. While this variation across countries is recognized, it is hoped that ministries of health will play a key role in contributing to national road safety efforts in all the countries, and that WHO Country Offices will engage with them, as well as with other appropriate government counterparts.

Already, NGOs and the private sector are in the process of defining contributions towards the Plan. Progress will be monitored through various processes, including global status reports and a mid-term review.

WHO has communicated with all Member States about the Decade: inviting the governments to consider creating national multi-sectoral planning committees and appoint one person on the committee to be the national focal point for the Decade; as well as to develop their own national plans including planning for a high-profile national launch event on 11 May 2011, involving dignitaries from all sectors of society, road traffic victims and their families.

A toolkit for organizers of the launch event has been developed to guide Member States and their partners in preparing for the launch. This toolkit includes the description of an ideal launch event and can be found at http://www.who.int/roadsafety/decade_of_action/toolkit/en/index.html.

As countries strive to make roads safer, it is clear that millions of lives could be saved if the national plans for the Decade of Action for Road Safety are implemented effectively and efficiently!

*Contributed by:
Dr Chamaiparn Santikarn, IVP
email: santikarnc@searo.who.int*

Energy saving and contributing to climate change mitigation: a SEARO experience



In keeping with the World Health Day 2008 theme which underlined the ever increasing risk of climate change on human health, one initiative that SEARO undertook was to carry out an assessment of environmental performance of the SEARO premises, and to contribute towards reducing energy consumption, improving video conferencing facilities and encouraging staff to make greater use of video/tele conferencing. Specific measures to reduce energy consumption proposed were:

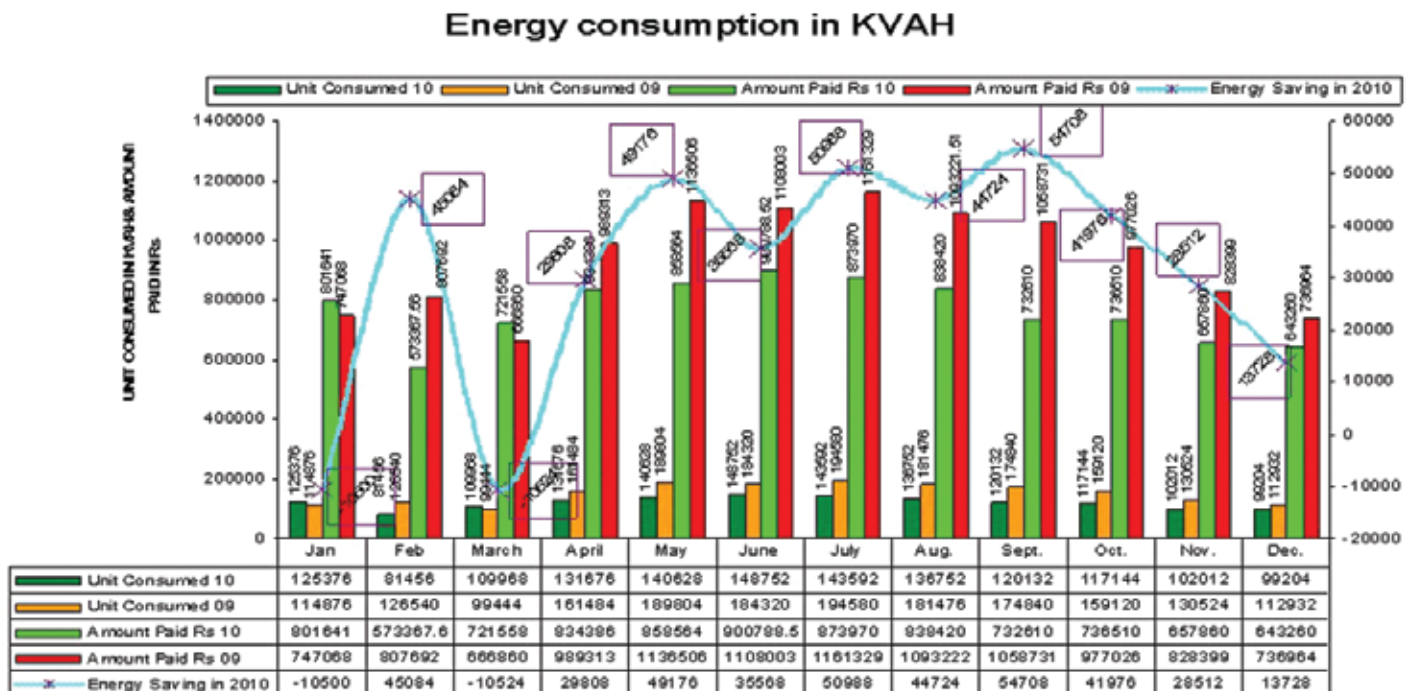
- (1) Replacing the old air conditioning system with an energy efficient plant alongwith environmental safe refrigeration and allied equipment.

- (2) Covered most split / window air-conditioned areas with water cooled system to reduce power consumption.
- (3) Photovoltaic System (electrical grid connected) of 147.5 Kilowatt peak was installed on the roof of the Regional Office building to generate and supply power to the building.
- (4) Solar water heating system was installed for supplying hot water to the cafeteria.
- (5) Motion sensors were installed in corridors and all toilets.
- (6) Old tubelights (36 watts) were replaced with more efficient tubelights (28 watts).
- (7) Both the main and annexe building roofs were insulated to restrict the transfer of solar heat in the building to save energy consumption in air-conditioning.

After these measures were put in place, the energy use in 2009 was compared with that in 2010. An impressive saving of 20.53% in electricity consumption was reported which translates to a saving of 18.90% (US\$47200) on electricity billing amount in 2010. This was calculated without taking into account the additional load of several newly installed equipment in the campus which are run continuously and which were not there in 2009.

*Contributed by:
Ms Payden, WSH
email: payden@searo.who.int
Mr RM Kaushal, AC
email: kaushalr@searo.who.int*

Comparative graph showing energy consumed in 2009 and 2010 and the energy savings in 2010 for each month



News and events

WHO initiates studies to assess health impact of climate change

In July 2007, the Joint Meeting of Health Secretaries and the Consultative Committee for Programme Development and Management recommended that WHO “Enhance the global, regional and sub-regional collaboration for joint action towards conducting research on the health effects of climate change and strengthening institutional capacity thereby leading to evidence-based policy and action”. This was endorsed at the Twenty-eighth Meeting of Ministers of Health held in Thimphu in 2007.

Since then SEARO flagged climate change and health relevant research in many subsequent meetings, e.g., Regional Workshop on Climate Change and Human Health in Asia : From Evidence to Action, Bali, Indonesia, (2007), the First Ministerial Regional Forum on Environment and Health in Bangkok (2007), the New Delhi Declaration (2008); the Parliamentarian’s Call for Action on Protecting Human Health from Climate Change in the South-East Asia Region in Thimphu (2010) and the Dhaka Declaration (2010). adopted` during the South-East Asia Regional High Level Preparatory, Dhaka, Bangladesh. Technical Discussions on “Protecting Human Health from Climate Change” were held in New Delhi in 2009 and a Regional Plan of Action to Protect Health from Climate Change was prepared by the SEARO Working Group for Protecting Health from Climate Change in May 2009, pursuant to the World Health Assembly resolution WHA 61.19 of 2008, giving importance to research on climate change and health.

During 2010, the Communicable Disease Department, WHO-SEARO developed generic research protocols (retrospective and prospective studies) to assess the impact of climate change on diarrhoeal diseases and another on vector-borne diseases. These protocols were shared with Member States and pilot tested in India and Nepal in collaboration with the WHO Kobe Centre.



In a consultation held in Delhi in September 2010, all SEAR Member States were invited to use these generic protocols in particular to look at all available secondary data on disease trends over the past 10 years and correlate the same with climate data. Presently SEARO is providing technical support to finalizing research proposals submitted by

Bangladesh, India, Myanmar, Maldives, Nepal, Sri Lanka, and Thailand, each of which will be supported by WHO.

*Contributed by:
Dr A.M. Zakir Hussain, EHC
email: hussainamz@searo.who.int*

Regional Consultation addresses Health of the Urban Poor, 13-15 October 2010, Mumbai, India

One of the challenges of the 21st century is managing the accelerating pace of urbanization. Projections suggest that by 2030, six out of ten people all over the world will live in cities. Most of the growth in urban population will occur in Asia, Africa and Latin America.

Currently, the urban population in South-East Asia is estimated to be about 600 million, of which about 150 million are estimated to be poor. In the wake of the often unplanned and unregulated urbanization, the urban poor face physical, environmental, social and psychological problems. These impose a heavy burden of disease and inequity on them. There is an urgent need to identify biological, socio-cultural and financial determinants of health inequity in the urban poor in order to mount a multisectoral effort to address the health concerns of this burgeoning disadvantaged section of the population.

To deliberate on the various facets of the health of the urban poor including the health status and determinants of the health of the urban poor and to discuss a framework of strategic actions to improve health and health care services for this segment of society, the WHO Regional Office for South-East Asia organized a Regional Consultation on Health of the Urban Poor in Mumbai, India, in October 2010. In addition to policy makers, programme managers, experts and representatives of civil society and academia from the Member States of the WHO South-East Asia Region, representatives from UNICEF, World Bank, USAID and Population Foundation of India attended the consultation.

The participants made several recommendations to Member States and WHO calling for a multi-sectoral approach to address the issue of the health of the urban poor. The draft strategic framework for action that includes focus on healthy public policy; community education and empowerment; improving availability of and accessibility to health services for the urban poor, national health policy and plans; health information systems; and, operational research was endorsed.

*Contributed by:
Dr Sudhansh Malhotra, PCH
email: malhotras@searo.who.int*

Health in all Settings: high time to promote and apply the concept

Most Member States in the Region are undergoing significant social and demographic changes, marked by rapid urbanization, expanding industrialization, rising income and improved health care. The rapid pace of industrialization, urbanization and globalization is resulting in high prevalence of risk factors that contribute to noncommunicable diseases including cardiovascular diseases, cancer, chronic obstructive pulmonary disease and diabetes mellitus which form the biggest causes of death in the Region. An estimated 24% of the global disease burden and 23% of all deaths can be attributed to environmental factors.

WHO defines the concept of Health in All settings as 'a place or social context in which people engage in daily activities in which environment, organizational, and personal factors interact to affect health and wellbeing' and provides the opportunity to bring all the concerned sectors together. A setting is where people actively use and shape the environment; thus it is also where people create or solve problems relating to health. The healthy settings concept recognizes the complex connections and inter-linkages between existing human settings and health risks, and that ultimately the concern is about people. Settings can normally be identified as having physical boundaries, a range of people with defined roles and organizational structure such as schools, worksites, hospitals, villages and cities. .

The successes of settings-based approaches have been validated through internal and external evaluation and experiences. For instance the WHO/UNDP-LIFE Healthy City Projects in Five Cities including Cox's Bazar, Bangladesh showed that as a result of the settings approach at the city level there was: (a) increased political mobilization and community participation in preparing and implementing the municipal health plan; (b) increased awareness of health issues in urban development efforts by municipal and national authorities, including non-health ministries and agencies; (c) creation of increased capacity of municipal government to manage urban problems and formation of partnerships with communities and community-based organizations in improving living conditions in poor communities; (d) creation of cities that provides information exchange and technology transfers. Healthy settings provides a cross-over approach that is applicable to many intervention efforts covered by WHO's mandate. Thus, given appropriate and accessible information sharing to guidance and programme development, Healthy Settings stands to be a strong tool to protect public health and foster sustainable development.

Contributed by:
Dr Salma Burton, OCH
email: burtons@searo.who.int

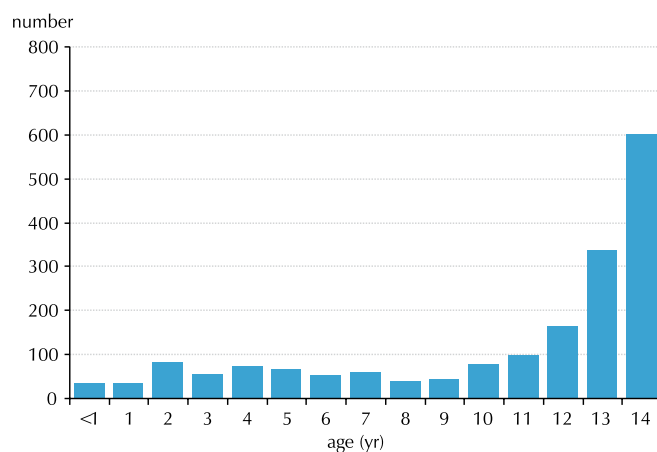
WHO calls for preventing motorcycle injuries in children

In low- and middle-income countries in the SEA Region, the motorcycle is used as a family vehicle, with children routinely transported as passengers. The current scenario is alarming with motorcycles accounting for 50%-82% of registered vehicles in the Member States of the Region (except Bhutan 18%) and motorcycle riders (drivers and passengers) accounting for the largest proportion of road traffic injuries and deaths. Children severely injured in motorcycle use, reported from SEA Region Member States, are as young as less than one year of age. (Data below from Thailand).



As motorcyclists are 35 times more likely to die in a crash per vehicle mile travelled than car occupants this is a great concern for Member States as expressed by delegates at the sixty-third Session of the WHO Regional Committee for South-East Asia. Prevention of motorcycle injuries among children in the developing world particularly in the SEA Region was hampered by limitations of knowledge, absence of reliable estimates of the current level of injuries, and community perception about injuries.

Head injuries in child motorcycle riders, by age



Source: 27 hosp. National Injury Surveillance, Ministry of Public Health, Thailand, 2003

The Expert Group Meeting on Preventing Motorcycle Injuries in Children, was organized by WHO-SEARO in collaboration with the WHO Collaborating Centre in Khon Kaen, Thailand, 21-23 December 2010, Bangkok, Thailand. The group consisted of experts from multiple sectors including bio-mechanics, epidemiology, policy and law-enforcement officer, Orthopaedics, traumatology, psychosociology, paediatrics, police and transport etc.

Based on the available evidence regarding motorcycle related injury in children, the expert group made recommendations to the Member States and WHO in preventing motorcycle injuries in children. The recommendations and the full report can be seen in our website.

*Contributed by:
Dr Chamaiparn Santikarn, IVP
email: santikarn@searo.who.int*

Parliamentarians' Call for Action to protect human health from climate change

A Regional Conference of Parliamentarians on Protecting Human Health from Climate Change was organized by WHO-SEARO in Thimphu, Bhutan from 5-7 October 2010. The conference was inaugurated by H.E Lyonchhoen Jigmi Y Thinley, Honourable Prime Minister of Bhutan. Several Ministers of the Royal Government of Bhutan and the WHO Regional Director for South-East Asia, Dr Samlee

Plianbangchang, attended the inaugural session. The conference was attended by 32 parliamentarians from seven countries of the South-East Asia Region (Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Timor-Leste).

The conference took note of the challenges posed by climate change in achieving the health-related Millennium Development Goals and the need for collaborative efforts by several agencies in addressing the issue.

Climate change causes extreme weather events and the parliamentarians voiced their concern at the increasing frequency and intensity of extreme weather events in the Region, which would overwhelm the already overstretched health sector capacity to respond.

The conference concluded with the endorsement of the "Parliamentarians' Call for Action for Protecting Human Health from Climate Change in the South-East Asia Region", which urges all Member States to promote applied research and pilot projects to assess the scale and nature of the vulnerability of health to climate change, to strengthen health and education systems capacity to provide protection from climate-related health risks, to ensure that health concerns are addressed in decisions related to climate change in other sectors and to support policies that will substantially reduce greenhouse gases.

*Contributed by:
Ms Payden, WSH
email: payden@searo.who.int*



Briefing of WHO staff on health and human rights

Despite a decade of advocacy and capacity building efforts, the human rights-based approach has remained a somewhat unknown and under-utilized concept within WHO. As a specialized United Nations agency, WHO has several policy commitments to integrate human rights into public health work under various frameworks, such as the 1945 Charter of the United Nations, the 1997 UN Programme of Reform, and the 2005 World Summit. All SEAR Member States have ratified at least two international human rights treaties, and all have health-related human rights obligations also in their domestic legislation.

In order to increase the knowledge and build the capacity of WHO staff on human rights, SEARO organized a two-day training course on health and human rights for the WHO country office and SEARO technical staff on 2-3 February 2011. The objective of the course was to: (1) increase knowledge of WHO staff on the UN human rights system, health as a human right commitments of the Member States, and human rights principles in general, and (2) strengthen the capacity of WHO staff to integrate human rights-based approaches into the programming/ project cycle.

The course was facilitated by Helena Nygren-Krug (Human Rights Adviser, WHO-HQ), and Riikka Rantala (JPO-HHR, WHO-SEARO), and it was attended by seven participants from different country offices as well as five SEARO technical staff members. In the future, plans are to

organize similar regional training courses for ministries of health and national human rights commissions.

Contributed by:

*Ms Riikka Rantala, HHR
email: rantalar@searo.who.int*

Training on epidemiology of ear and hearing health

A training course on “epidemiology of the ear and hearing health” was conducted from 22-24 November 2010 by the Otological Centre, Bangkok unit, ENT department, Siriraj Hospital Faculty of Medicine, Bangkok Thailand. (WHO Collaborating centre).

Forty participants from Thailand, Indonesia, Nepal and Sri Lanka, attended the training. An overview of the country situation of ear and hearing diseases and the systems of serving these patients at primary, secondary and tertiary levels were presented. Strategies were developed for addressing the three most important causes of hearing loss – otitis media, congenital hearing loss and noise induced hearing loss, and also for establishment of linkages between the levels of service structures.

Contributed by:

*Dr Sara Varughese, DAR
email: varugheses@searo.who.int*

Forthcoming meetings/conferences

Regional conference of Partners for Health: an update

The Conference of “Partners for Health in South-East Asia”, which will take place in New Delhi from 16-18 March 2011, seeks to strengthen regional collaboration for health, and encourage effective and sustainable partnerships between various stakeholders. The Conference will provide a venue for WHO and its Partners from the 11 Member States to engage in a frank and dynamic discussion on the health priorities of the Region, and the challenges and opportunities in advancing these priorities. The Conference will also provide an opportunity to share best practices and lessons learnt, and highlight the importance of research and innovation, as well as partnerships in action.

With the focus on the health-related **Millennium Development Goals**, the challenge of **Non-communicable Diseases** and the need for **Strengthening Health Systems**, the main objective of the Conference is to enhance partner involvement in health development in the South-East Asia Region.

In addition to high-level participation from the 11 Member States, over 350 high level representatives are expected from donor countries, multilateral and intergovernmental organizations, civil society, foundations, corporations, and research/academic institutions.

The Conference of Partners for South East-Asia is expected to culminate in a declaration of commitment from the various partner constituencies, which will lead to the elaboration

of an Outcome Document “2011 Delhi Declaration on Partnerships for Health in South-East Asia”

Contributed by:

*Ms Maria Manuela Enwerem Bromson, SAP
email: enwerembromsonm@searo.who.int*

International consultation on healthy workplaces; WHO-SEARO, New Delhi, 16-18 March 2011

In line with the WHO Global Plan of Action, WHO has proposed a framework for developing healthy workplace initiatives adaptable to diverse countries, workplaces and cultures. Practical guidance specific to sectors, enterprises, countries and cultures are under development, in collaboration with countries, experts and stakeholders. This consultation will aim at learning more about good practices in the four areas of the healthy workplace model – physical work environment,

psychosocial work environment, personal health resources and enterprise community. Approximately 60 participants are expected from companies of all sizes, occupational health and safety experts, stakeholders including employers and worker representatives, international organizations, NGO representatives, and WHO Regional Offices. Details about the consultation and online registration form can be accessed via: https://extranet.who.int/datacol/survey.asp?survey_id=1718

Contact persons: Evelyn Kortum, WHO-HQ, Global Initiative Leader for Healthy Workplaces and Dr Salma Burton, WHO-SEARO, Regional Adviser - Occupational Health.

Contributed by:

*Dr Salma Burton, OCH
email: burtons@searo.who.int*

Forthcoming Conferences:

- 15th World Conference on Tobacco or Health, 21-24 March 2012, Venue: Singapore <http://wctoh2012.org/>
- 42nd Union World Conference on Lung Health, 26-30 October 2011, Venue: Lille, France http://www.theunion.org/component/option,com_conference/Itemid,91/

Selected WHO publications

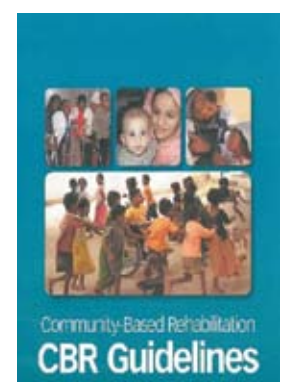
Fact sheet on wheelchairs: A fact sheet on wheelchairs has been produced and distributed.

The CBR guidelines have been launched and are available at <http://www.who.int/disabilities/cbr/guidelines/en/index.html>

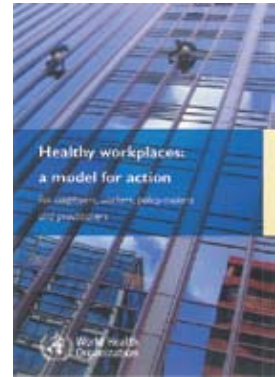
The CBR Guidelines provide guidance on how to develop and strengthen CBR programmes; promote CBR as a strategy for community-based inclusive development; support stakeholders to meet the basic needs and enhance the quality of life of people with disabilities and their families; encourage the empowerment of people with disabilities and their families.



This is a summary report of the Regional Conference of Parliamentarians on Protecting Human Health from Climate Change was held in Thimphu, Bhutan from 5-7 October 2010. The conference concluded with the endorsement of the “Parliamentarians’ Call for Action for Protecting Human Health from Climate Change in the South-East Asia Region”.



Based on the WHO Global Plan of Action on Workers' Health 2007, the "Healthy workplaces: a model for action" provides a framework for developing healthy workplace initiatives adaptable to diverse countries, workplaces and cultures. It outlines four areas (physical, psychosocial working environment, personal health resources, and enterprise-community involvement) where actions towards a healthy workplace can be best taken. The model also provides practical guidance specific to sectors, enterprises, countries and cultures.



'Focus' is the annual, theme-based, advocacy magazine of the Emergency and Humanitarian Action (EHA) unit, SEARO. This issue focuses on 'earthquakes' including lessons learnt from the Padang Earthquake of 2009, and the Haiti earthquake. It also highlights the need for primary healthcare in emergencies.

Community Resilience in Disasters: In this publication, specific examples from emergencies in the Region have been compiled to look at how the concept of primary health care has been applied and how it has worked in previous emergencies in the WHO South-East Asia Region. It provides snapshots of how communities can be more resilient in the protection and promotion of health in emergencies.



Urbanization and Health: snapshots from the SEA Region

Data corner:

Risk factor survey for noncommunicable diseases, India

The Ministry of Health and Family Welfare, Government of India, has recently released results of NCD risk factor survey conducted in seven States using WHO STEPS methodology. A total of 5000 households were contacted in urban and rural areas of each of the seven selected states. The overall response rate for the survey was 89%. Key results on the four major risk factors are presented in the Table below.

Risk factor	Andhra Pradesh	Madhya Pradesh	Maharashtra	Mizoram	Kerala	Tamil Nadu	Uttarakhand
Current tobacco use							
Smokers	18	22	10	44	13	14	20
- Male	32	41	16	67	27	27	35
- Female	4	1	3	19	0.2	*	5
Alcohol Consumption (%)							
Consumed Alcohol (last 30 days)	14	14	10	6	11	11	12
- Male	27	24	16	11	24	21	24
- Female	2	3	3	1	*	*	*
Fruits and Vegetables consumed (%)							
<i>Less than five servings per day</i>	88	83	76	85	87	99	89
- Urban	86	71	74	79	82	98	88
- Rural	90	88	77	91	92	99	89
Physical Activity (%)							
<i>Low Physical Activity</i>	68	42	81	71	76	66	67
- Urban	78	68	86	79	79	71	92
- Rural	64	32	77	63	75	62	58

Source: Report of IDSP-NCD Risk Factor Survey (2010), Ministry of Health and Family Welfare, Government of India

Editor: Dr Jai P Narain

Editorial support: Dr A M Zakir Hussain and Mr Jitendra Tuli

Design, pre-press support and layout: TPD

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For complimentary copies, write to

SDE Newsletter, Department of Sustainable Development and Healthy Environments
World Health Organization, Regional Office for South-East Asia, World Health House, IP Estate, New Delhi 110002, India
Tel : +91-11-23370804, Fax :+91-11-23378412, email: sdesnewsletter@searo.who.int

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