We are delighted to present the Health Connect newsletter, Volume 1 Issue 2. We present a grim reminder that noncommunicable diseases (NCDs) in the South-East Asia Region have increased the most compared to all other WHO regions, from 6.7 million deaths in 2000 to 8.5 million in 2012. However, we are fortunate to be part of the Region that is taking forward the NCD agenda through high-level political commitment and multisectoral collaboration.

The broader purpose of the Health Connect is to provide a platform to promote learning and sharing experiences and best practices among Member States in NCD prevention and control. Also, in each issue, we take one topic of focus; this time it is tobacco, one of the major killers of humankind. Therefore, this volume covers updates, issues and events around tobacco in the Region. We have tried to introduce something new also, a page on “Art for Health” - sharing public health messages through art. Similarly, we will strive to make subsequent issues informative and interesting.

Contribution to the newsletter is voluntary; many good activities occurring in Member States may not be reported in the newsletter. We invite you to contribute your articles in future issues. We look forward to your continued support and contribution to make Health Connect a voice that empowers people, inspires action, and promotes healthy lifestyles and overall well-being!

This newsletter is an information-sharing platform for Member States of the WHO South-East Asia Region. It highlights latest updates in the Region in the area of NCDs and its risk factors; injuries and violence prevention; mental health and substance abuse; water, sanitation and health; occupational and environmental health; and health promotion and education.

Got something to share? Please send your contributions (up to 200 words accompanied by high-resolution digital photographs and web links) to singhan@who.int

All articles and photos are subject to editing, available space and the acceptance policy.

Call for contributions!

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Editorial Board

Dr Thaksaphon Thamarangsi
Dr Palitha Mahipala
Dr Jagdish Kaur
Dr Gampo Dorji
Ms Anika Singh

Art entries from the ‘Art4Health’ school competition organized by the Ministry of Health & Family Welfare, Government of India, on World No Tobacco Day 2016

Art for health
The tobacco plant, scientifically known as Nicotiana tabacum belongs to the genus Nicotiana, native to the Americas around Peru and Ecuador, where it has been found since prehistoric times and tobacco cultivation goes back to 5000 bc. The use of tobacco was universal in the Americas and Cuba by the time Christopher Columbus arrived in North America in 1492 and the first European smokers were members of Columbus’s crew. It was brought back to Europe by these explores and adopted by the society and subsequently re-exported to the rest of the world as European Colonization took place. British started to smoke since late 16th century (mainly shipmasters). Smoking was taken up in the court of Elizabeth I, even by the queen herself and then by affluent English society.

Manufactured cigarettes were first marketed in England in the 1850s and the First World War resulted in them being the most popular nicotine delivery devices ever since.

It is interesting to note the accurate and prophetic description of tobacco smoke by King Louis as a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs and in the black, stinking fume thereof nearest resembling the horrible stygian smoke of the pit that is bottomless. Cigarette smoking has been taken up worldwide since the 1850s and has been described as a tragic accident of history.

A rising incidence of lung cancer was first observed in the 1920s and 1930s by pathologists in England and in 1950 four landmark studies on smoking and lung cancer was published. With substantial evidence, the attention of British society was drawn to the dangers of tobacco smoking.

In 1957, led by US Public Health Services and in 1962 by the Royal College of Physicians, London, it was concluded that there is a causal relationship between smoking and lung cancer. Since then many studies were done and today smoking is identified as a major cause of heart disease, stroke, peripheral vascular disease, chronic obstructive pulmonary diseases (COPD), cancers of the lung, oral cavity, pharynx, esophagus, stomach, kidneys, bladder, pancreas, cervix and possibly others.

WHO estimates that tobacco kills more than 7.2 million people worldwide every year; over 80% of these people live in low- and middle-income countries. In the last century, it is estimated that tobacco was directly responsible for 100 million deaths and in this century, if the same trend continues.

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**Tobacco and Health**

Tobacco contributes to:
- 12% of all deaths globally in persons > 30 years
- 5% of all deaths due to communicable diseases in persons > 30 years
- 14% of all deaths due to NCDs in persons > 30 years
- 7% of all deaths due to tuberculosis
- 12% of all deaths due to lower respiratory infection
- 10% of all deaths due to cardiovascular diseases
- 22% of all deaths due to cancer
- 71% of all deaths due to lung cancer
- 42% of all deaths due to obstructive pulmonary disease

A rising incidence of lung cancer was first observed in the 1920s and 1930s by pathologists in England and in 1950 four landmark studies on smoking and lung cancer was published. With substantial evidence, the attention of British society was drawn to the dangers of tobacco smoking.
continues, there will be 1 billion (1000 million) deaths. The tragic accident of history, the tobacco plant, has travelled along trade routes and oceans, and today tobacco use has become one of the gravest global public health hazards of humankind.

Some of the chemicals contained in tobacco are:

- Carbon monoxide
- Ammonia
- Hydrogen cyanide
- Vinyl chloride
- Volatile alcohols
- Formaldehyde
- Nitrites
- Tobacco-specific nitrosamines
- Sulphur compounds
- Hydrocarbons

Every year, 31 May is observed as World No Tobacco Day (WNTD) by WHO and partners, highlighting the health and developmental risks associated with tobacco use, and advocating for effective policies to reduce tobacco consumption. The theme of World No Tobacco Day 2017 was “Tobacco – a threat to development”.

A detailed look at the entire chain of growing, production, sale and consumption of tobacco shows interrelations extending far beyond the health arena. There are many sectors outside the health sector which are important stakeholders for the prevention and control of tobacco. Various development issues are linked to tobacco in one way or the other. A recent publication Tobacco Control for Sustainable Development reviews the links between tobacco and various development issues under the overall umbrella of the Sustainable Development Goals (SDGs) and thus places tobacco control at the centre of sustainable development. There are direct and indirect impacts of tobacco use on all aspects of development. Tobacco use may impair development directly by imposing health-care costs for the treatment of illnesses caused by both tobacco use and exposure to secondhand smoke (SHS); and indirectly, through the loss of productivity, damage to the environment, and trade-offs from food, education and health. While a rapid increase in tobacco consumption might raise the gross domestic product (GDP) in the short-term through both increased private expenditures on tobacco and higher public spending financed by higher tobacco tax revenues, such an increase would be offset by a subsequent rise in morbidity, disability and mortality among men and women at the peak of their skills and experience, thus causing overall loss of productivity. The further impact of tobacco-related illnesses on productivity would thus have an overall negative effect on a nation’s welfare and economic development. This impact is more pronounced in low- and middle-income countries.
where health services and social security systems are underdeveloped.

Tobacco control has been placed at the core of achieving sustainable development. Target 3a of the SDGs relates to strengthening implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in all countries, as appropriate.

Implementation of the WHO FCTC is a key element of the 2030 Agenda for Sustainable Development. The WHO FCTC is the first global health treaty negotiated under the auspices of WHO. One of the most widely embraced treaties in United Nations history, it has given a new legal dimension to international health cooperation. The WHO FCTC is a multilateral treaty ratified by 180 Parties, which legally bind its Member Nations to exert tobacco control measures including laws to protect people from secondhand smoke exposure.

Tobacco impedes sustainable development right through the entire cycle of growing, curing, production, manufacturing and trade to consumption.

Full implementation of the WHO FCTC will facilitate achievement of the SDGs, especially in low-resource settings. Member States of the SEA Region are encouraged to implement the full treaty to achieve the SDG targets.

Dr Jagdish Kaur
Regional Adviser
Tobacco Free Initiative (TFI) Unit
WHO Regional Office for South-East Asia

**Building capacity for tobacco cessation in WHO South-East Asia Region**

Tobacco dependence is a chronic, relapsing disorder that often requires repeated interventions and multiple attempts to quit. Article 14 of the WHO FCTC requires Parties to adopt and implement effective measures to promote tobacco cessation and ensure adequate treatment for tobacco dependence. Article 14 guidelines recommend a number of specific actions that Parties should take to successfully design and implement a comprehensive national cessation strategy.

Recommended actions include a combination of population-level and individual-level approaches to help tobacco users quit. Population-level approaches include integration of tobacco use screening and brief interventions in health-care facilities; establishment of cessation services such as a tobacco “Quit Line”, and web- and mobile phone-based cessation interventions. Individual-level approaches include provision of direct cessation support to individual tobacco users, including pharmacological and behavioural support.

Tobacco control policies, especially demand reduction strategies such as increased taxation, anti-smoking media campaigns and comprehensive smoke-free policies, increase the demand for tobacco cessation services and thus the rates of subsequent cessation. Tobacco users make multiple attempts to quit over a lifetime, and national governments can support these efforts by making affordable cessation resources readily available to all tobacco users who want to quit.

A variety of behavioural therapies, ranging in complexity from simple advice offered by a physician or other health-care providers to much more extensive therapy offered by counsellors are available to help tobacco users quit tobacco.

Pharmacotherapy is another option available to quit tobacco use. Medications available for tobacco cessation can broadly be divided into two categories:
1. nicotine replacement therapy (NRT)
2. non-nicotine replacement therapy
NRT is a method of substituting the nicotine in tobacco products by an approved nicotine delivery product so that the tobacco user does not have uncomfortable withdrawal symptoms upon stopping the use of tobacco. The dose of NRT is monitored and gradually reduced to make the process of cessation comfortable for the tobacco user. All types of NRTs, such as nicotine patch, nicotine gum, nicotine inhaler and nicotine nasal spray, have been shown to have more or less similar success rates. Better success rates are achieved when a combination of both counselling and NRTs are offered.

Non-nicotine replacement therapy includes medications that act on a similar set of neurotransmitters as those affected by nicotine. This tackles the need or impulse to use nicotine and minimizes withdrawal effects. First-line drugs include bupropion and varenicline. Some other antidepressant drugs are also used to treat tobacco dependence.

Combined behavioural and pharmacological therapies appear to be the best approach for treating tobacco dependence.

Emerging low-cost technologies (mobile phones) and system-level interventions (using electronic health records to aid the identification of tobacco users, prompt clinicians to intervene and guide interventions via evidence-based treatment algorithms) can facilitate successful implementation of cessation treatment.

**Progress in tobacco cessation services in the South-East Asia Region**

Article 14 of the WHO FCTC is one of the least implemented articles in Member States of the South-East Asia Region. Recent progress includes Member States launching different initiatives to further tobacco cessation. India launched the mTobacco Cessation programme, using mobile technology for tobacco cessation with support from WHO and the International Telecommunication Union (ITU) ‘Be Healthy Be Mobile’ initiative in 2016. India and Indonesia launched national quit lines in 2016. Sri Lanka and Thailand also have quit lines in place. WHO supported Sri Lanka in expanding existing quit line and conducted capacity-building by training counsellors. Bhutan, India and Thailand have national tobacco dependence treatment guidelines in place. WHO supported Bangladesh in conducting training of trainers on the use of brief advice for tobacco cessation in primary health-care settings, and developing a network of trainers in 2016. The Democratic People’s Republic of Korea undertook a Knowledge, Attitudes and Practices (KAP) survey on smoking cessation in 2016. Thailand recently initiated a project to build the capacity of oral health-care providers for tobacco cessation in collaboration with WHO.

**The way forward**

Countries should make efforts to build capacity for tobacco cessation using cost-effective strategies, including integrating “brief advice” in primary health-care settings and using innovative technologies such as mCessation.

Integrating tobacco cessation with other health programmes, for example NCD, maternal health, oral health and tuberculosis is another cost-effective option to gear up health-care systems for tobacco cessation.

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**Dr Jagdish Kaur**  
Regional Adviser  
Tobacco Free Initiative (TFI) Unit  
WHO Regional Office for South-East Asia
National KAP Survey in the Democratic People’s Republic of Korea reveals higher and a different tobacco product use in the rural population

In 2012, WHO estimated that almost 12% of all deaths in the Democratic People’s Republic of Korea were attributed to tobacco. The country amended its Tobacco Control Law in 2009 and in 2016 to further strengthen tobacco control. In 2016, it conducted a Knowledge, Attitude and Practices (KAP) survey to support the development and implementation of tobacco control activities in the country. It was a nationwide survey of the population aged 17 years and above, with a final sample of 5172 households and 9777 respondents.

More than one in three men (37.3%) reported smoking daily. There is no reported tobacco use among women and no reported use of smokeless tobacco.

Below are the highlights from the survey specifically comparing knowledge, attitude and practices among rural and urban respondents:

- Tobacco use was much higher among rural respondents, both in terms of daily-use prevalence (40.6% rural vs 35.2% urban) and average number of cigarettes smoked daily (11.4 in rural vs 10.6 in urban areas).
- The use of hand-rolled cigarettes was higher in rural areas: the type of product smoked varied significantly between the urban and rural population—44.1% of rural respondents reported smoking hand-rolled cigarettes compared to only 7.7% of urban respondents.
- Efforts to quit were fewer and impact of the price of cigarettes on motivation to quit in rural areas was lower: a lower proportion of rural respondents reported quit attempts in the past 1 year (46.6% rural vs 51.2% urban). Importantly, while 41.4% of urban respondents reported higher prices of cigarettes as a reason to attempt quitting, only 8.3% of rural respondents said this.
- Awareness of the harmful effects of smoking was much lower among rural respondents. For example, only 32.4% of rural respondents were aware of the linkage between smoking and cancer compared to 51.1% of urban respondents. Similarly, 24.3% of rural respondents were aware of the linkage between smoking and cardiovascular diseases compared to 43.8% of urban respondents.
- Worryingly, rural respondents not only have poorer knowledge of linkage of the linkage between smoking and diseases, but also have erroneous belief of smoking being advantageous — 41.3% of rural respondents compared to 28.8% of urban respondents either believed that smoking has advantages or they were not sure about it.

In light of the above findings, the following are the key recommendations:

- Increase tobacco prices further, as this is mentioned as one of the main factors that encourages smokers, especially in urban areas to think about quitting.
- Hand-rolled cigarettes: raise the prices and include health warnings on hand-rolled cigarette packets as these are more commonly used in rural areas, especially given the higher tobacco use and lower quitting efforts in rural areas.
- Strengthen information, education and communication efforts to fill key knowledge gaps, especially in rural areas.
- Introduce larger pictorial health warnings (as opposed to the currently used textual warning covering only 30% of the area) on packets of both manufactured cigarettes and hand-rolled cigarettes, as a substantial proportion of respondents mentioned them as the source of their knowledge on the harmful effects of smoking.

Dr Thushara Eraj Indranath Fernando
WHO Representative to DPR Korea

Dr Han Un Ju, National Professional Officer
WHO Country Office for Korea

Dr Manju Rani, Regional Adviser
Noncommunicable Diseases and Tobacco Surveillance,
WHO Regional Office for South-East Asia
Need to focus on rural areas and non-cigarette tobacco products in India: second round of the Global Adult Tobacco Survey (GATS-2) 2017

The preliminary results from a nationwide adult tobacco prevalence survey (GATS-2) of the population aged 15 years and above concluded recently in February 2017 showed:

- a reduction of six percentage points in overall tobacco use (from 34.6% to 28.6%) compared to the estimates observed in a similar survey conducted in 2009-10, an average annual decline of about 0.86%. The National Health Policy 2017 of the Government of India has set the target of “relative reduction in the prevalence of current tobacco use by 15% by 2020 and 30% by 2025”. GATS-2 showed a relative reduction of 17% in the prevalence of current tobacco use since GATS-1.

- significantly higher use of smokeless tobacco than that of smoking tobacco both among women (12.8% vs 2.0%) and men (29.6% vs 19%), and in rural (24.6% vs 11.9%) and urban areas (15.2% vs 8.3%). Among smokeless tobacco products, khaini is the most commonly used product.

- much higher overall tobacco use in the rural population (32.5% vs 21.2% in urban) of both smoking (11.9% vs 8.3%) and smokeless tobacco (24.6% vs 15.2%).

- that bidi is the most common form of smoked tobacco (7.7% of bidi smokers vs 4.0% cigarette smokers) in both urban and rural areas, but more so in rural areas. While 56.6% of all urban smokers smoke bidis, 78.2% of rural smokers smoke bidis.

- fewer quitting attempts among smokeless tobacco users: 50% of smokeless tobacco users reported planning or thinking about quitting use compared to 55% of smokers.

- fewer quitting attempts among bidi smokers: compared to cigarette smokers, a much lower percentage of bidi users (54% vs 62%) and smokeless tobacco users (46% vs 62%) thought of quitting because of warning labels on the packets.

- that despite the higher reported use of smokeless tobacco products and bidis, the average expenditure incurred on the last purchase was much lower for smokeless tobacco (INR 12.8) and on bidis (INR 12.5) compared to that on cigarettes (INR 30). This shows the relative affordability of smokeless products and bidis compared to that of cigarettes.

Conclusion: The findings suggest that future tobacco control efforts in India, including price increase through taxation and other MPOWER measures must focus on bidis and smokeless tobacco products to reduce overall tobacco use, especially in poorer and rural population groups.

Dr Manju Rani
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WHO Regional Office for South-East Asia
In Sri Lanka, smokeless tobacco use in the form of betel chewing is a deeply seated lifestyle habit especially in the villages and estate sector labour communities. Betel chewing ingredients such as betel leaf, tobacco, arecanut and lime are available in the open market or homegrown, and no taxes are imposed on the entire supply chain. Further, commercial preparations are also becoming popular among the younger generation in Sri Lanka in urban and semi-urban communities. Commercial preparations, such as mawa, gutka, panparag, hans, babul and beeda are also produced in Sri Lanka.

Recognizing the rising trend in smokeless tobacco use in the country, the Subcommittee on Smokeless Tobacco was established under the National Authority on Tobacco and Alcohol (NATA) in August 2015. It aims to monitor smokeless tobacco use and formulate preventive policies, protect the youth, offer help to quit, and enforce ban on the manufacture, import and sale of smokeless tobacco. NATA is also working on raising taxes and is conducting research on smokeless tobacco. It continues to organize activities including the National Symposium on smokeless tobacco.

The incidence of cancer of the oral cavity and oropharynx in Sri Lanka, excluding salivary neoplasms, standardized to the world standard population in the year 2010, was 20.7 and 5.4 per 100 000 population, in males and females, respectively. According to the National Cancer Registry, 2010, 14.3% of all reported cancers are oral cancer and carry the highest mortality rate among the different types of cancers (three deaths per day). The incidence of oral cancer among men is nearly four times that among women. NATA supported the formulation of an oral cancer victim group as part of the all island campaign named “Voice of Blue Pea”, and gave recommendations to the Honourable Minister of Health that led to policy action such as the issuance of a gazette notification prohibiting the manufacture, import, sale or offer for sale of any specified tobacco and smokeless tobacco product.

Mr T. Suveendran
WHO Country Office for Sri Lanka
Dr P. Abeykoon, Chairman
National Authority on Tobacco & Alcohol
Voices from the Region

World Health Day 2017 celebrations across the Region

Bangladesh acknowledged the winners of the regional MindART competition on depression at the national event on 7 April: Musanna Nabi Chowdhury, aged 21 years (left) and Fariza Tanvir, aged 14 years (right) (http://www.searo.who.int/bangladesh/enbanwhd2017/en/)

Bhutan celebrated WHD 2017 with 500+ students and teachers (http://www.searo.who.int/bhutan/WHD-2017-Bhutan/en/)

Maldives organized poetry reading, skit drama, and displayed a message board depicting the coping mechanisms for depression, and hosted a live musical band of young artists who performed during the Country Office event for World Health Day 2017 (http://www.searo.who.int/maldives/mediacentre/world-health-day-2017/en/)

India organized a talk on “From depression to well-being” by Brahma Kumari Shivani, global spiritual teacher and inspirational speaker (http://www.searo.who.int/india/mediacentre/events/world_health_day/health_Baithak2017/en/)

Sri Lanka organized activities to raise awareness on depression (http://www.searo.who.int/srilanka/photos/en/)

Artwork inspired by World Health Day produced by Academy of Design students, Sri Lanka, as part of their ‘Depression: let’s talk’ exhibit
The progress made on Colombo Declaration to accelerate delivery of NCD services at the primary health care level

The Colombo Declaration on Strengthening Health Systems to Accelerate Delivery of Noncommunicable Disease (NCD) Services at the Primary Health Care Level was endorsed at the Sixty-ninth session of the WHO Regional Committee for South-East Asia on 9 September 2016 in Colombo Sri Lanka (SEA/RC69/R1). This is yet another timely response by Member States will help in realizing the regional targets of ensuring 80% availability of essential NCD medicines and technologies, and 50% of high-risk populations receiving drug and counselling therapies by 2025.

Health Ministers of Member States have agreed to establish a high-level national multisectoral task force to monitor and ensure the implementation of the Declaration in their countries and report back in a timely manner. In an effort to support the decision, the WHO South-East Asia Regional Office will release intermittent reports of progress...
in implementation of the Declaration in Member States. The first report will document actions after one year of endorsement. The subsequent reports will be released in 2019 and 2021.

All Member States have made advances in endorsing the national multisectoral action plan on NCDs among numerous ongoing initiatives. Some of the highlights of strengthening screening, early detection and management of NCDs at the primary health care level conducted within one year of the Colombo Declaration are noted in the below table.

After the Colombo Declaration was signed, cancer registry training was conducted for eight Member States. Following this training, Sri Lanka conducted in-country training on capacity-building in collaboration with Ministry of Health, International Agency for Research on Cancer (IARC) IARC and WHO.

The technical unit at the Regional Office is also coordinating sharing of experiences and information. An intercountry video conference between Bhutan, Nepal and Timor-Leste was organized on 26 May 2017 to discuss innovative approaches for better integration of PEN at the primary health care level. Senior members of the Ministries of Health, health training institutes and academia participated in the video conference. The countries noted that setting-up a PEN peer coaching programme at health facilities should be introduced to foster team work, build staff competency, and improve patient-centred services.

### Highlights of the progress made post-Colombo Declaration

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<tr>
<th>Country</th>
<th>Description</th>
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<tr>
<td>Bhutan</td>
<td>Package of Essential Noncommunicable Diseases (PEN) protocols have been implemented at the primary health care level nationwide since 2013. PEN clinical audit was conducted and quality improvement plans of action for basic NCD services have been developed.</td>
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<tr>
<td>India</td>
<td>Expanded the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke across the country. Over 400 districts (nearly 60% of the administrative districts) are now covered under the Programme, with NCD cells and NCD clinics that coordinate and support NCD initiatives in the districts. Treatment protocols for common NCDs, risk factor counselling manuals and programme managers training manuals have been developed which will help in building capacity for more effective implementation of National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS). Situational assessments of NCD service delivery in three states (West Bengal, Maharashtra and Kerala), with additional focus on urban NCD service delivery in the former two states, have been completed to further strengthen health-care delivery.</td>
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<td>Indonesia</td>
<td>A multisectoral NCD Action Plan has been finalized and steps taken to scale up PEN implementation.</td>
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<td>Maldives</td>
<td>PEN protocols have been adapted in early 2017 two atolls have been identified for the first phase of implementation of PEN.</td>
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<td>Myanmar</td>
<td>A PEN training of trainers (ToT) for the central team was organized in Yangon on 1–2 February 2017 and subsequent training is planned in 10乡镇ships in 2017 covering 50 Rural Health Centres and 150 sub-centres—a total of 200 primary health care centres. Myanmar has introduced a cancer control policy and conducted a review of the cervical cancer programme through the UN Global Joint Programme on Cervical Cancer Prevention and Control mission</td>
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<tr>
<td>Nepal</td>
<td>The year 2017 has been declared as a Year of Health in the country. Hon Minister of Health, Mr Gagan Kumar Thapa initiated the national health campaign, “My Year 2074: Healthy Me, Healthy my Nation”. The government has allocated resources from the national budget to expand the PEN programme to eight additional districts in addition to the WHO-supported districts of Kailali and Ilam. By 2017, Nepal would have covered 13% of the administrative districts in the country, providing essential NCD services at the primary health care level using the PEN protocols.</td>
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<td>Sri Lanka</td>
<td>The country reviewed cardiovascular risk using WHO evidence and has taken measures for further strengthening the primary health care approach through Healthy Lifestyle Centres</td>
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<td>Timor-Leste</td>
<td>A training of trainers (ToT) programme for PEN was conducted in October 2016, and service delivery planning and preparation are in the final phase. The PEN protocols have been launched in July 2017, with a plan to start the delivery of the PEN services in two out of 13 districts in the country.</td>
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Recognizing intrinsic and extrinsic motivations (monetary incentive, certification, credits, individuals, organizational recognition) of staff and developing linkages with the PEN peer coaching programme were necessary.

An approach to build collective capacity at the health facility level is the best way forward. It is vital for all Member States to capitalize on the early phases of NCD program development at primary health care level and introduce innovative transformative solutions to bring about a seamless integration of NCD services at the health facilities.

Dr Gampo Dorji
Technical Officer
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Health promotion campaign and urban health initiatives in Nepal

Health has been identified as a basic human right in the Constitution of Nepal. Health promotion and tackling NCDs is high on the agenda of the Ministry of Health. To highlight the government’s commitment to promote the health of the people of Nepal, on Friday 14 April, New Year’s day of the Nepali calendar year 2074, the Honourable Health Minister of Nepal, Mr Gagan Kumar Thapa launched a yearlong national health campaign “Mero Barsha 2074” with the theme “Ma Swastha, Mero Desh Swastha” (My year 2074: Healthy me, Healthy my Nation). The campaign was inaugurated by the Honourable Prime Minister of Nepal, Pushpa Kamal Dahal “Prachanda”. It invites people to adopt healthy lifestyles by making five commitments for a healthier life: I will not use tobacco products and alcohol; I will exercise regularly; I will eat healthy and nutritious food; I will go for regular health check-ups; I will be aware of my family’s health and community’s too. These commitments are in line with the government’s interventions on raising taxation on alcohol, tobacco and sugary drinks. The approach of this campaign, led by the National Health Education, Information and Communication Centre (NHEICC), is to make individuals act upon the five commitments and to give the message that being healthy is not only the responsibility of the government and society but also that of the people themselves. The campaign has been launched in all 75 districts down to the village level and run by health posts, primary health care centres, district hospitals and public health offices in collaboration with other stakeholders. The primary focus will be on schools where students are encouraged to exercise and eat healthy.

The health and development sectors are brought together in the Urban Health Policy 2015 of Nepal including the Ministry of Health (MoH), Ministry of Urban Development (MoUD) and Ministry of Federal Affairs and Local Development (MoFALD) and other stakeholders. A recently launched initiative, led by the Primary Health Care Revitalization Division of the MoH, to upgrade Urban Health Clinics to Urban Health Promotion Centres (UHPC) as “Janata Urban Health Centres”, aims to ensure access, utilization and delivery of quality essential health-care services to the urban population, particularly focusing on the urban poor, women, children and marginalized groups. The supply, services and systems for UHPCs are designed, delivered and managed through local participation and multisectoral partnerships. The WHO-supported pilot will start with 13 wards in Kathmandu municipality and gradually expanded to all wards within the next 3 years. The first two UHPCs were launched in Kathmandu Municipality on 19 May 2017.

Health promotion and urban health initiatives in Nepal have been partly inspired by the 9th Global Conference on Health Promotion in Shanghai, where the Honourable Health Minister shared Nepal’s achievement regarding water, sanitation and health (WASH). Community participation has been a key driver for improving WASH in Nepal, for example
open defecation free campaign: a community-led initiative promoted by female community health volunteers (FCHVs). There are also several collaborative activities between sectors such as Hygiene Master Plan 2011 and Multisectoral Nutrition Plan 2013–2017. Currently there are initiatives to mainstream health across sectors and implement Health in All Policies approach in all policy-making in Nepal to support achievement of UHC and the SDGs, and improve health outcomes and overall development.

**Ms Aurora Saares**  
WHO Country Office for Nepal

**Mr Badri Khadka**  
National Health Education, Information and Communication Center, Ministry of Health

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**Nepal strengthens multisectoral collaboration for NCD Prevention and Control and Management**

The Ministry of Health (MoH) takes forward its commitment to accelerate implementation of the National Multisectoral Action Plan (MSAP) for the Prevention and Control of NCDs (2014–2020) through a “whole-of-government” approach. The first high-level committee meeting was held in September 2016 and was organized by the WHO Country Office and MoH. The meeting was chaired by the Chief Secretary with the Secretary of the MoH, as the Member Secretary, and attended by Secretaries and Joint Secretaries of key line ministries (e.g.: Ministry of Federal Affairs and Local Development, Ministry of Physical Infrastructure and Transportation, Ministry of Law, Ministry of Women, Children and Social Welfare, Ministry of Home Affairs, Ministry of Urban Development, Ministry of Information Communication and others), senior MoH official, the WHO Representative to Nepal and the Director, Noncommunicable Diseases and Environmental Health, WHO Regional Office for South-East Asia.

After piloting the Package of Essential Noncommunicable Disease Interventions (PEN) in two districts with WHO support, the MoH has now scaled up PEN to eight districts starting in 2017 with the Ministry’s budget. Behind this approach is the high-level political commitment, including from the Honourable Minister, Secretary, Director, Primary Health Care Revitalization Division and MoH officials.

The MoH, with a team of experts and support from WHO, has developed the National Cancer Treatment Protocol for the treatment of common cancers in Nepal. The protocol endorsed by the MoH will be made available for mandatory use in all hospitals providing treatment to cancer patients who are covered by government funding. The Ministry of Health intends to reduce inequalities in cancer care, improve outcomes and reduce the cost of treatment through implementation of this national treatment protocol.

**Dr Jos Vandelaer, Dr Reuben Samuel and Dr Lonim Prasai Dixit**, WHO Country Office for Nepal

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**Knowledge Centre**

**Tobacco control for sustainable development**

In line with the World No Tobacco Day 2017 theme - “Tobacco - a threat to development”, this publication has been developed to provide guidance to Member States of the South-East Asia Region regarding the relationship between tobacco use and the Sustainable Development Goals (SDGs). Although the WHO Framework Convention on Tobacco Control has been recognized as a means of implementation of SDG 3 (the health goal), the relationship of tobacco use with sustainable development extends far beyond this goal. The document speaks of opportunities offered by tobacco control to support efforts to achieve implementation of the SDGs.

**Accelerating WHO FCTC Implementation in the WHO South-East Asia Region – a PRACTICAL approach**

This document has been developed to support the Member States in implementing the Treaty using a ‘PRACTICAL’ approach, which pertains to identified demand and supply reduction strategies under the Treaty.
Art for health
A creative illustrative way to give out health messages.

Climate change and health

I am the universe - a masterpiece of brilliance
With the perfect blend of my four elements came LIFE into existence
The Earth provides the rocks, the minerals and the soil to grow vegetation
But man’s greed led to its invasion, erosion and destruction
Abundance of water keeps the planet’s temperature in the right range
But man’s hunger has poisoned it for centuries in exchange
The Air is the warm, invisible, protective blanket which Man breathes in every moment
Yet his indulgence has contaminated it to an irreversible extent
Fire gives the heat, the light
But man’s lust has wounded me, testing my might
And now man complains of the changing environment, and the impact it has on his health
The extreme weather events lead to illnesses, heat stress, injuries and deaths
The rising air pollution and changing patterns of vector-, food- and water-borne diseases
Man alone is responsible for my changing climate and now must find ways to reduce his carbon footprint and reverse this trend, please
If he destroys me more I might not tolerate,
He calls me ‘Mother Nature’ so he must take care of me and I shall cooperate.

Ashish Chawla and Anika Singh

Unhealthy diet

Tête-à-tête between potato and lady finger
Dear cute little potato,
Today for a walk: Let’s go!
O’ how I would love to,
but I can’t miss this talk show.
My lady, please enjoy your walk and have fun,
On your way back get me chips, pizza and bun.
Cutie pie start thinking of a healthy diet soon,
You have already become a huge balloon.

Poem by: Mrinaal Garg, 11
Illustration by: Sidhant Garg, 11
Children of staff member Aarti Garg, WHO Regional Office for South-East Asia
Announcements

16–18 August 2017: Inter-party and expert consultation on smokeless tobacco control policy

The WHO FCTC Secretariat’s Global Knowledge Hub on Smokeless Tobacco, based in Noida, India in collaboration with the WHO FCTC Secretariat and WHO Regional Office for South-East Asia, is organizing a smokeless tobacco control policy meeting on 16–18 August at New Delhi, India. This is the first ever meeting being organized on the smokeless tobacco policy by the Global Knowledge Hub. It aims to discuss opportunities for strengthening policies to control smokeless tobacco use in line with the mandate given to the WHO FCTC Secretariat by the Conference of Parties.

9–11 October 2017: SEA regional forum to accelerate NCD prevention and control in the context of the Sustainable Development Goals (SDGs), Bangkok, Thailand

Noncommunicable diseases (NCDs) are now the number one cause of death, years of life lost, and burden of disease in the WHO South-East Asia Region. The four major NCDs account for an estimated 8.5 million lives lost each year. This forum is one of the largest regional NCD assemblies designed to be action-oriented, and an opportunity for national change-makers to meet with global experts and partners to discuss how to strengthen national capacity in implementing “best buys”, in an informal, innovative and collegial setting to accelerate NCD prevention and control in the context of the SDGs.

18–20 October 2017: WHO Global Conference on NCDs, enhancing policy coherence to prevent and control noncommunicable diseases, Montevideo, Uruguay

World leaders will meet to promote health and national development through taking action to beat noncommunicable diseases, cardiovascular diseases, cancer, chronic lung diseases and diabetes. For more information, please see: http://www.who.int/conferences/global-ncd-conference/en/

29 November–2 December 2017: South-East Asia Ministerial meeting on accelerating actions for implementation of the Decade of the Action for Road Safety, Bangkok, Thailand

Road traffic injuries kill approximately 316,000 people each year in the WHO South-East Asia Region, equivalent to 25% of global road traffic deaths. The meeting is expected to inspire and accelerate actions on all the five pillars: road safety management, safer roads and mobility; safer vehicles; safer road users; post-crash response; at national and subnational levels. This conference aims to strengthen high political commitment to address road safety issue and enhance collaboration within and among the ministries, UN agencies and other stakeholders on road safety.

News and updates

FCTC 2030: strengthening WHO FCTC implementation to strengthen tobacco control in SEAR Region countries

Three countries in the WHO South-East Asia Regions: Myanmar, Nepal and Sri Lanka, have been selected to receive direct support for the FCTC 2030 project that focuses on the achievement of the general obligations and the time-bound measures of the Convention, strengthening tobacco taxation, implementing other articles of the WHO FCTC according to national priorities and promoting the implementation of the Convention as part of the 2030 Agenda for Sustainable Development.

To kick-start the process, a meeting was organized with the Convention Secretariat, the United Nations Development Programme (UNDP), focal points of the respective WHO Country Offices, and Ministry of Health representatives, at the WHO Regional Office or South-East Asia on 12–13 July 2017. The objective of the meeting was to promote and support governments to accelerate implementation of the WHO FCTC 2030.

Bhutan makes its people healthier, happier by beating noncommunicable diseases

In Bhutan, protecting people from cardiovascular and lung diseases, cancers and diabetes is a national priority. It has put in place a national plan, linking all sectors from health to finance and education, to prevent and control these noncommunicable diseases. In 2018, Bhutan rolls out a new 5-year socioeconomic plan, which prioritizes NCD prevention and control across all sectors.
‘Thimphu Declaration’ puts autism and other neurodevelopmental disorders high on the health agenda of countries

Autism and other neurodevelopmental disorders are lifelong disabilities that affect brain functioning, when and left without proper support, can cause significant impairment in exercising an individual’s human rights and fundamental freedoms.

In recognizing the gaps in the care of those living with autism spectrum disorders and other neurodevelopmental disorders, the Thimphu Declaration was endorsed at the “International Conference on Autism and Neurodevelopmental Disorders (ANDD2017)” in April 2017, which was inaugurated by the Honourable Prime Minister of Bangladesh and Honourable Prime Minister of Bhutan.

The declaration calls for a whole-of-society and whole-of-government approach, with a focus on strengthening national capacities in the health, education and social care sectors to provide effective services and support to people with autism and other neurodevelopmental disorders.

The Thimphu declaration was facilitated by Ms Saima Wazed Hossain, WHO Goodwill Ambassador for Autism in the South-East Asia Region. She is a strong advocate for autism, and with her support and effort, WHO aims to put autism high on the health agenda of countries in the Region to address autism as a public health challenge.

India’s Health Minister gets WHO’s special recognition for tobacco control; Maldives, Bhutan Ministers conferred World No Tobacco Day Award 2017

The World Health Organization has conferred the Director General’s Special Recognition Award to India’s Minister of Health and Family Welfare, H.E. Mr J.P. Nadda, for his leadership and commitment to advancing tobacco control, while also selecting the Ministers of Health for Maldives and Bhutan among five individuals/institutions from the WHO South-East Asia Region for this year’s World No Tobacco Day Award.

The World No Tobacco Day 2017 awardees in the WHO South-East Asia Region include: H.E. Mr Tandin Wangchuk, Minister of Health and the Chairperson of Bhutan Narcotic Control Authority, Kingdom of Bhutan; H.E. Mr Abdulla Nazim Ibrahim, Honourable Minister of Health, Republic of Maldives; Mr Saber Hossain Chowdhury, Member of Parliament, People’s Republic of Bangladesh; National Authority on Tobacco and Alcohol, Democratic Socialist Republic of Sri Lanka; Dr Supreda Adulyanon, Chief Executive Officer, Thai Health Promotion Foundation, Kingdom of Thailand.

“The true face of smoking is disease, death and horror – not the glamour and sophistication the pushers in the tobacco industry try to portray.”

David Byrne

Health Connect newsletter:
http://www.searo.who.int/about/administration_structure/sde/health-connect-newsletter/en/