This Issue: Noncommunicable diseases including mental health and neurological disorders
Determinants and risk factors of noncommunicable diseases

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This issue of Health in South-East Asia looks at noncommunicable diseases (NCDs) including mental and neurological disorders.

For much of the past century, NCDs, including mental health and neurological disorders, have been neglected, globally as well as in WHO’s South-East Asia Region. Now, however, NCDs are beginning to receive due attention from Member States.

Last year was a turning point in the battle against NCDs when a high-level meeting on NCDs was held in New York during the UN General Assembly Session in September. This meeting was successful in generating a consensus that NCDs are not only a health issue but also a development concern. The meeting also drew attention of world leaders to the urgent need to prevent and control NCDs. The UN General Assembly adopted a political declaration calling for multisectoral commitment of Member States and other stakeholders and partners in the prevention and control of NCDs through concrete and comprehensive global actions.

NCDs contribute to about 8 million deaths every year in WHO’s South-East Asia Region. It is of grave concern that one third of these deaths are preventable and occur before the age of 60 years among economically productive groups. The burden of NCDs is accelerated by several factors, such as rapidly ageing population, unplanned urbanization and a progressive increase in unhealthy lifestyles.

At the same time, millions of people worldwide are affected by mental disorders. However, NCDs, including mental disorders, are largely preventable by means of “public health interventions” and the “primary health care approach” through which the underlying risks and determinants are primarily tackled.

Dealing with NCDs is not the task of ministries of health alone. It needs multisectoral and multidisciplinary cooperation and collaboration. Education and empowerment of the community is a crucial strategy in prevention and control of NCDs, which, in time, need a well balanced development between promotive/preventive care on one hand and curative/rehabilitative care on the other.

A very large number of people need treatment and rehabilitation. The majority of these cases require long-term or even lifelong care. A lot of medicines and medical devices are needed. In most cases, specialized services are required. This situation entails a high cost of care for NCD patients. Care in the community should be an important part of services for the chronically NCD-affected people. This part of the services, if properly organized and managed can significantly contribute in reducing the cost of care.

Using public health interventions and the PHC approach are cost-effective. Such activities accord priority attention to promotive and
preventive care. This can help prevent unnecessary morbidity and reduce the severity of the disease. Consequently, the quality of life of people affected by NCDs is enhanced. The known burden of NCDs may represent only the tip of an iceberg. What lies below the surface is far greater.

A public health strategy using a community-based approach, along with appropriate multisectoral research can help bring the invisible portion of NCDs to our attention. Since some NCDs are preceded or triggered by infectious disease, integrated research should be pursued to ensure earlier detection and timely treatment of certain NCDs. Different sectors should come forwards, together, to develop appropriate national policies for tackling NCDs.

The “health-in-all policies” or “healthy public policies” approach is meant to secure the commitment of all sectors to NCD prevention and control either collectively or individually. This approach requires continued advocacy to all stakeholders.

Comprehensive care of NCD patients needs a well-coordinated system including public health and medical interventions, whereby the patients can be efficiently referred back and forth between primary care facilities in the community and specialized care at medical institutions. These institutions also have an important role to play in training and supervising community-based health workers and in ensuring the quality of health care at community level.

Several Member States in the Region have started developing national plans for follow-up actions of the UN political declaration. WHO is supporting Member States in the development of a global monitoring framework and the development of policy options for multisectoral actions through partnerships. WHO will continue to play a coordinating role in the UN system in addressing NCDs.

Dr Samlee Plianbangchang
Regional Director
Indian communities participating in controlling women’s cancers

S. Shastri, S. Pimple, and G. Mishra, Tata Memorial Centre, Mumbai, India; S. Patil, BKL Walavalkar Hospital, Dervan, Maharashtra, India; and S. Banavali, Tata Memorial Centre, Mumbai, India

By 2020, an estimated 0.7 million new cancer cases and 0.45 million cancer deaths will occur each year among women in India. Over 50% of this burden is due to breast, cervix and oral cancers, which are largely preventable. The Tata Memorial Hospital (TMH), Mumbai, India, a WHO Collaborating Centre for Cancer Prevention, Screening and Early Detection, has been working since 1998 to provide cancer control services to women in rural and poor urban communities. TMH works to increase cancer awareness, develop local health human resources, initiate screening for cervical, breast and oral cancers, and to connect people to and establish locally appropriate diagnostic and treatment capabilities.

The first challenge was to prepare population databases to determine the exact magnitude of the problem in the selected communities. In rural and poor urban communities women did not know their cancer risks or options for cancer care. We had to conduct door-to-door surveys to sensitize the communities and collect data about the community to determine the number of women who should receive information about cancer, cancer screening and cancer treatment.

The terrain, poverty, ignorance, fear, suspicion, discriminatory social cultures and poor health-seeking behaviour presented several challenges. We partially overcame these hurdles by training and empowering the local communities to develop a sustainable health care model.

Involving men in women’s health issues was crucial to the success of the programmes.
Local women’s groups, youth groups, political leaders, school teachers, schoolchildren and local alternative medicine practitioners were involved, resulting in improved health-seeking behaviour and creating useful partnerships. Involving men in women’s health issues was crucial to the success of the programmes. Gaining the support of all stakeholders, including political and religious leaders, helped create a strong sense of community ownership of the programmes.

Following the awareness programme, eligible women were invited for screening. Women aged 30–65 years were invited for cervical and breast cancer screening, while all tobacco-users were screened for oral cancer. All screened women were provided with an identification card and asked to provide information on sociodemographics, reproductive history, lifestyle risk and relevant clinical history.

All primary screening procedures were performed by locally recruited and trained 10th-grade-graduated women. Without recruiting and training the local personnel the project may not have been successful. We conducted annual personnel reviews and refresher courses to ensure high-quality outputs. This also helped in checking frequent personnel turnover.

Doctors accompanying the team provided on-the-spot clinical confirmation and performed needed biopsies for confirming diagnosis when screening tests were positive. Tobacco-cessation counselling was provided on the spot. All further diagnostic work-up and treatment was carried out either at a locally designated facility, the BKL Walavalkar hospital at Dervan, Ratnagiri, Maharashtra, or at the TMH, Mumbai. The rural programmes are efficiently supported by telemedicine services.

Each person with a positive screen was enrolled in a case-tracking system developed specially...
for these programmes to ensure good follow-up. Trained counsellors worked hard to track and get the non-compliers back into the system.

Despite all services being offered free of cost, many patients lacked the funds needed to travel to referrals for treatment and feared the loss of daily wages. Furthermore, in some areas the large majority of cases diagnosed were already at an advanced stage and no palliative care was available.

We periodically reviewed participation rates, screening positivity, case-detection rates, compliance to referrals and treatment completion. We plan to assess the success of the programme by monitoring disease-downstaging, as well as reduction in incidence and mortality from cervical, breast and oral cancers in women. However, the absence of a population-based cancer-registry hampers a robust analysis of programme efficacy.

Overall, the TMH programmes have succeeded in fulfilling the objectives of creating cancer awareness and making available local, good-quality cancer screening, diagnosis and treatment services for the poor and marginalized populations, thereby creating models that might be useful in closing the cancer control gaps in resource-poor countries. Building community partnerships and empowering the communities in their own health care issues have resulted in highly efficacious cancer control programmes.

Acknowledgements
The authors acknowledge the contributions of the following towards the success of the programmes: Mr Ashok Joshi (Kaka Maharaj), Mr Vikas Walawalkar, Dr Netaji Patil, the Medical-Surgical-Radiation Oncology and Pathology teams from Tata Memorial Hospital which render yeomen service during the monthly diagnostic and treatment camps. The authors also thank Dr R. Badwe and the late Dr K. Dinshaw for their valuable guidance and support.
CHRONIC RESPIRATORY DISEASES

Mother of four, Kanchhi Maya Jimma, cannot talk for more than a few minutes without breaking into a violent, coughing fit. Gasping for air, she quickly reaches out for her inhaler; it is constantly by her side. The 46-year-old suffers from severe asthma and has been crippled by the disease over the past seven years. She lives in Palung, Makwanpur district, Nepal, where she earns the equivalent of US$ 1.50 a day working as a farm labourer.

“It’s very difficult to breathe, to walk, to talk and even eat. There is a constant pain in my chest and the constant coughing takes its toll too. My life is unbearable. I can’t even walk up and down the stairs without having to stop and catch my breath again. I am isolated here. I can’t go to the market or go and visit my friends and neighbours.

“It gets really bad at night. I cannot breathe properly when I am lying down so I need to sit upright to breathe. So I am never able to get a proper night’s sleep. I then spend the days tired and unable to do much.

“I was very strong before. I could do anything. I could carry firewood and fodder from the forest. I used to work in the rice fields and earn money. Now, I am unable to walk or work. I feel like crying when I see other women working. I wish I could work like that again.”
Cooking indoors for over 30 years – without any ventilation – is an important factor responsible for Kanchhi Maya’s chronic asthma.

“I wish I did not have to cook in this dust and smoke – that is when my asthma is at its worst. But what’s the alternative? How else will we be able to eat? We are poor and cannot afford to install a chimney in our home. We have to use firewood to cook our food – there is no other choice.

“I feel I am a burden on my family. What little my husband earns is spent on my medicine. We barely earn around US$ 35–40 a month. Almost half of that goes on my medication. Thankfully, the district doctor comes to visit me once a month to give me more medicine and to monitor my condition.

“I am just so helpless. I cry a lot. I always ask God: Why me? Why do I have to suffer like this? I cry so much. Deep inside, I know this disease will kill me. I am losing all hope.”

CHRONIC RESPIRATORY DISEASES: FACT BOX

Most chronic respiratory diseases are preventable and manageable. Yet, an estimated 1.4 million people died of chronic respiratory diseases in the South-East Asia Region in 2008.

In addition to genetic factors, tobacco smoke and indoor air pollution due to domestic fuels such as coal and biomass fuels as well as air pollution are important avoidable risk factors for asthma.

Asthma can be controlled with medication.

In addition, it is important to avoid factors that trigger asthma.
Delivering care for mental and neurological disorders

WHO South-East Asia Region perspective

Professor Dr Md Waziul Alam Chowdhury; Director-cum-Professor, NIMH, Dhaka;
Dr Md. Faruq Alam, Associate Professor, NIMH, Dhaka; Dr Helal Uddin Ahmed,
Psychiatrist, NIMH, Dhaka

High morbidity from mental, neurological and substance abuse disorders globally and in the South-East Asia Region

There have been many developments in the field of mental health including better medications, better understanding, better treatment and better management. However, despite these developments, a large proportion of the population, particularly in rural and remote areas is not getting appropriate care and treatment. This is because of several reasons: lack of trained manpower; lack of appropriate services which reach out to the people even in remote and rural areas; shortage of psychotropic medications; and stigma against patients etc.

There is a huge burden of mental, neurological and substance abuse disorders globally, as pointed out in the report Global Burden of Disease in 2004. Mental and neurological disorders accounted for 13% of the total disability adjusted life years globally in 2004. Unipolar depressive disorder is the third leading cause of disease burden globally and it is predicted that it will be the second leading cause of disease burden by 2030. The World Economic Forum 2011 estimated the cost of illness due to mental and neurological disorders to be US$ 2.5 trillion, which could increase to US$ 6 trillion by 2030. Surveys conducted in some Member States of the South-East Asia Region (Bangladesh, Bhutan, Maldives, Thailand and Timor-Leste) suggest that the morbidity from mental, neurological and substance abuse disorders is as much if not more in the South-East Asia Region than in other Regions.

Scarcity of resources

This huge burden of neuropsychiatric disorders is a challenge in the backdrop of limited resources including funds, infrastructure and manpower.

Analysis of global data by WHO presented in the Mental Health Atlas 2005 revealed that the median number of psychiatrists per 100 000 people in South-East Asia was only 0.2 compared with 9.8 in Europe and a global average of 1.2. The corresponding figure for psychiatric nurses was 0.1 in South-East Asia compared to 24.8 in Europe and 2.0 globally. Out of the funds allocated, 50% of countries in the South-East Asia Region spend less than 1% of their health budget on mental health care. 2012 information update which is currently in progress, reveals a marginal improvement.
High treatment gap

The huge treatment gap (number of persons in need of treatment but not getting treatment) in developing countries, which can be as high as 95% depending on disease and geographical location, indicates a lack of resources. People who need treatment are simply not getting it.

The reasons for the high treatment gap can be summarized in four ‘A’s: Availability (services for mental and neurological disorders are available only in metropolitan centres and not in rural areas); Acceptability (people would rather go to sorcerers and faith healers rather than doctors); Accessibility (services geographically out of reach); and Affordable medications (people cannot afford to buy even the most basic psychotropic medications).

Global strategy to address mental and neurological disorders

Globally, WHO has developed the Mental Health Global Action Programme (mhGAP). This was introduced in 2008 for scaling up care for mental and neurological disorders. The programme aims to increase the commitments of governments, international organizations and other stakeholders and to achieve significantly higher coverage with key interventions in resource-poor countries. An action plan to address mental and neurological disorders has to be developed in 2012 as mandated by the WHO Executive Board.

WHO’s Regional strategy to strengthen the primary health care system to deliver care for mental and neurological disorders

To address the problem of shortage of human resources and to reach out to people in the community, the WHO Regional Office for South-East Asia, in collaboration with experts from Member States has developed innovative solutions to deliver care through the existing primary health care system. The strategy calls for training of community-based health workers in the identification of priority mental and neurological disorders and then treatment by a primary health care-based physician. Pilot projects with technical support from the WHO South-East Asia Regional Office have been conducted in three Member States (Bangladesh, Bhutan, and Timor-Leste) for reduction in treatment gap of epilepsy. A similar strategy is also being used by Thailand.

<table>
<thead>
<tr>
<th>Site</th>
<th>Treatment gap for epilepsy (%)</th>
<th>Treatment gap for psychosis (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namkum, Ranchi, India</td>
<td>89.9</td>
<td>97.6</td>
</tr>
<tr>
<td>Sarsol, Kanpur, India</td>
<td>90.2</td>
<td>96.5</td>
</tr>
<tr>
<td>Chattarpur, Delhi, India</td>
<td>81.5</td>
<td>72.3</td>
</tr>
<tr>
<td>Bogor, West Java, Indonesia</td>
<td>90.6</td>
<td>96.5</td>
</tr>
<tr>
<td>Nyaungdun, Myanmar</td>
<td>94.6</td>
<td>98.4</td>
</tr>
<tr>
<td>Sonargaon, Bangladesh</td>
<td>86.6</td>
<td>---</td>
</tr>
</tbody>
</table>

These pilot projects clearly demonstrate that people who need treatment can get it through the existing primary health care system.
Impact assessment of these pilot projects has shown that the treatment gap can be substantially reduced as shown in the table.

### Impact assessment of intervention for epilepsy through primary health care

#### Activities in Bangladesh

A pilot project in Sonargaon upazila, Bangladesh, has taken advantage of the excellent primary health care infrastructure consisting of upazila health complexes and 18,000 community clinics, to deliver care for mental and neurological disorders. The objectives of the project were to identify generalized tonic clonic (GTC, major fits) seizures among children in the community and to treat these cases in the community with phenobarbitone. All children (11,669) in the 5–14 years age group in two unions of Sonargaon model sub-district were assessed. The treatment gap was found to be 87%. This changed dramatically after the project. Despite having overburdened health workers, limited supply of pheobarbitone in the study area, stigma against those with seizures, superstitious beliefs and lack of secondary-level treatment facilities hampering referrals for complicated cases, the Sonargaon upazila of Bangladesh now treats all those requiring medication. They successfully narrowed their treatment gap from 87% to 5%.

<table>
<thead>
<tr>
<th>Country</th>
<th>Treatment gap before intervention (%)</th>
<th>Treatment gap after intervention (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>86.6</td>
<td>0</td>
</tr>
<tr>
<td>Bhutan</td>
<td>40.0</td>
<td>26</td>
</tr>
<tr>
<td>Myanmar</td>
<td>94.6</td>
<td>5</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>70.7</td>
<td>53.7</td>
</tr>
</tbody>
</table>
Recognizing the high prevalence of mental and neurological disorders and the success of the pilot project, the Government of Bangladesh has prioritized programmes for mental and neurological disorders in its Health, Population and Nutrition Sector Development Programme (HPNSDP), including a focus on autism.

The commitment of the Government of Bangladesh to the cause of learning and behavioural disorders including autism is reflected in the high-level advocacy meeting held on ‘Mental Health and Autism’, in Dhaka, in 2011, which led to the formulation of the Dhaka Declaration in order to improve access and quality of health care services for individuals with autism and developmental disorders. This meeting was attended by dignitaries and high officials providing a powerful platform to the care for mental and neurological disorders.

As a follow-up, a national autism workshop was held in India. In support of this workshop, the WHO South-East Asia Regional Office is developing a community-based strategy for identification and management of children with disability including autism in the community with referral to community-based follow up.

**Conclusion**

These pilot projects clearly demonstrate that people who need treatment can get it through the existing primary health care system with the only additional investment of training the primary health care-based health professionals and health workers, and provision of essential drugs (such as phenobarbitone). These are sustainable programmes as they become part of the existing health care delivery system. Member States will greatly benefit from scaling up these projects where they have been piloted and adapting these programmes in other countries.

Lucretius, the great Roman philosopher and poet who lived from 96 BC to 55 BC wrote: “The mind, like a sick body, can be healed and changed by medicine”. Two thousand years later, we must accept and implement what Lucretius said. To this, we must add social and psychological support which should be extended to those suffering from mental and neurological disorders to ensure that they get optimum treatment, care, love and affection to enjoy life with dignity.
Noncommunicable diseases including mental health and neurological disorders

Prevention and control through cost-effective interventions

Noncommunicable diseases cause premature deaths
Noncommunicable diseases including mental health and neurological disorders

Multi-sectoral actions are needed

Noncommunicable diseases hamper the achievement of MDGs
DIABETES

Peerada Quanpet is a 26-year-old medical student who lives in Bangkok, Thailand. Four years ago she was diagnosed with Type-2 diabetes and hypertension. She spends US$ 175 a month on medication.

“In 2010, I had a stroke. I knew something was wrong as I was unable to hear anything in my right ear. I went to see a specialist and he told me that the hearing loss was due to a minor stroke. A week later, I had another stroke – this time the right side of my face was paralysed. The underlying cause of the stroke was high blood pressure and diabetes.

“I was diagnosed with diabetes four years ago. The reason behind it is pretty simple – I was extremely overweight and never did any exercise. Looking back, my diet was pretty bad. I only used to drink soft drinks – never any water – and would live on fast foods and sweets.

“The worst part about having diabetes is having to monitor my sugar levels and injecting myself twice a day – once in the morning and again at night. I also have to take 10 pills every morning and evening too. Even though I’ve been injecting insulin for four years, the needle still hurts each time.
“As part of my medical training, I am working in the obstetrics ward in a hospital in Bangkok. Each day I see the joy and happiness a mother feels when she has given birth to a healthy, newborn baby. Sadly, for me this will never happen. I once saw a case of a pregnant woman with diabetes and there were a number of very serious health problems for her and her newborn baby. This had made my very fearful – not only about the risks to my health but also to my baby’s health. Therefore, I have decided that I will never have any children.

“I have dramatically changed my diet in order to manage and control my diabetes. I no longer eat fast foods or overeat. I also drink 2–3 litres of water every day and eat lots of fresh fruit and salad. I also go to the gym a couple of times a week. That is the only way I can control my condition.”

**DIABETES: FACTS**

An estimated 81 million people have diabetes in the South-East Asia Region.

Diabetes raises heart attack and stroke risk at an early age, as fatty deposits caused by high blood pressure clog arteries and lead to premature death. Over time, diabetes can damage the heart blood vessels, eyes, kidneys, and nerves. Diabetes exacerbates major infectious diseases such as tuberculosis, malaria and HIV/AIDS. People with diabetes are three times more likely to develop TB when infected.

Healthy diet, regular physical activity, maintaining a normal body weight and avoiding tobacco use can prevent or delay the onset of Type 2 diabetes.
In Sri Lanka, the national noncommunicable disease (NCD) programme of the Ministry of Health is working to improve the health of the nation starting with its youngest citizens. One of the country’s main objectives is “behavioural change through early intervention”. This idea is being incorporated into school curricula in order to expose children to three main concepts: healthy diet, physical activity and avoidance of tobacco. The curriculum is designed to introduce basic concepts to children as young as six years of age and to provide all the details needed for children to adopt a healthy lifestyle by age 11.

To address the first concept – “healthy diet” – the Education Ministry teamed up with the Ministry of Health to write the School Canteen Health Policy for all schools in Sri Lanka. In addition to directing all schools to establish healthy canteens, this circular spells out exactly what should be available (rice-based food, fruits, etc) and what should be avoided (junk food and fizzy drinks). Furthermore, public health inspectors check each school’s canteen for compliance with the healthy food policy during routine school health inspections.

For increasing physical activity, the Ministry of Education initiated Shareera Suwatha which means “health of the body” in the local language. While schools already have standard physical education, Shareera Suwatha takes it a step further requiring a standardized choreographed exercise routine be performed by all schoolchildren for 20 minutes at the
beginning of every school day. The Ministry of Education designed the 20-minute exercise routine, set it to music and distributed videos and cassettes to each school in the country. This requirement is designed to encourage children to make physical activity part of their daily routine.

In addition to encouraging students to avoid tobacco, the Directorate of NCD of the Ministry of Health helps schools form anti-tobacco clubs where children work to share the consequences of tobacco use with others. Students can participate in poster competitions, art exhibits and essay competitions to help others learn about the negative side-effects of tobacco. This way children not only hear the message but also convey it to others.

Schools are judged on national school assessments by how well they employ these three concepts. Points are awarded for having a healthy canteen, and for students’ performance on generalized testing that includes questions on healthy lifestyle. Teachers are also given the opportunity for in-service training in health and physical activity, particularly at the master’s level. This enables them to teach a healthy lifestyle and lead one themselves.

After implementing these changes, the Ministry of Education, in collaboration with the Ministry of Health reviewed the health curriculum at all grades and is working to include modifications in the next curriculum. The goal is to strengthen the current efforts in these three main concept areas: healthy diet, physical activity and avoidance of tobacco and to develop innovative ways to evaluate their effectiveness. Together, the Ministry of Education and the Health Ministry are looking for results and ultimately a healthier nation as a healthy schoolchild today will be a healthy citizen tomorrow.
Oloan Gultom was diagnosed with lung cancer in June 2011. Oloan, who is 40 years old, is married and has a young son. Before the illness, he worked as a tyre fitter, earning around US$ 4 a day. The family is now struggling to make ends meet.

Despite losing his hair and several kilos in bodyweight due to chemotherapy, Oloan Gultom remains upbeat that he can beat cancer.

“It all started about a year ago. I was coughing all the time and was always feeling weak. Then I started to cough up blood – that was when I decided to go and see a doctor. The doctor told me I need a CT scan and that is when they found a tumour in my lungs. I didn’t know how serious it was or what type of cancer it was.”

When the doctor explained everything to me, I was in shock and kept saying: “Are you sure doctor, are you sure – is it really a tumour?” It hit me really hard. I kept thinking – how could I have cancer? How could this happen to me? We are poor. How will I pay for the treatment? I was in a state of shock.
“The chemotherapy has been very difficult. At first I could handle it. But the second session was very bad. It felt like my body was ripped apart and torn into shreds. I was very sick for a long time afterwards. But in order to get better I have to go through this.”

Gultom had been smoking since he was 15 and had no idea that it could cause lung cancer.

“I started smoking at school about 25 years ago. There was a lot of pressure to smoke back then. If you didn’t smoke, all the other boys would tease you and say you’re not a real man. We all believed that to be a real man, you had to smoke.”

Since being diagnosed with cancer six months ago, Gultom has finally quit smoking.

“When my five-year old son grows up, I do not want him to smoke. I want him to see how much I am suffering. He should learn from my mistakes. He should know how harmful smoking is. I want him to tell others of the dangers of smoking, what it has done to his father and how it causes cancer.”

CANCER: FACT BOX

Cancer kills an estimated 1.1 million people in the WHO South-East Asia Region each year.

Lung and oral cancers are the most common cancer among males in the Region. Cervical and breast cancers are the leading ones among females.

Tobacco use is a major modifiable risk factor for lung cancer. The South-East Asia Region is home to 250 million smokers and an equal number of smokeless tobacco users.

About 30% of cancer deaths are due to the five leading behavioural and dietary risks: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use, alcohol use.

Cancer mortality can be reduced if cases are detected and treated early.
Reducing harm from alcohol use in the WHO South-East Asia Region

Dr Sajeeva Ranaweera, Technical Consultant, National Authority on Tobacco and Alcohol, Sri Lanka

Each year 2.5 million people die from alcohol globally. Alcohol directly causes over 60 types of disease and injury and is a component in at least 200 others. People in their working years are particularly hard hit as alcohol-related injuries, violence and cardiovascular disease kill more men aged 15–59 years than any other cause of death.1 Alcohol also contributes significantly to noncommunicable diseases (NCDs), as the fourth leading risk factor for NCDs in the world.1

The South-East Asia Region has been a pioneer in developing innovative solutions to reduce harm from alcohol use in the community. This article details experiences in the Region showing that when alcohol control measures are owned by the community, implementation rates are high and the results are more sustainable.

Problems of alcohol use in the Region

In WHO’s South-East Asia Region, alcohol use is changing. Many Member States have histories of locally brewed or home-brewed alcohol that continues to be consumed widely. Meanwhile, other traditions that limited alcohol use are

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gradually being replaced by so-called ‘modern lifestyles’ which glamourize alcohol use. Alcohol companies encourage this ‘modern lifestyle’ through marketing a wide variety of spirits.2

The new modern lifestyles mix with traditional celebrations to encourage binge drinking. Binge drinking means drinking large amounts at one time. Binge drinking centres around pay days or special occasions, such as marriages and festivals. Binge drinking is very different from occasionally or socially drinking 1 to 2 glasses of wine everyday, without becoming drunk. Drinking to get drunk leads to more domestic violence, quarrels, injuries and road traffic accidents. Throughout the Region families are hurt both physically and financially as disproportionate amounts of family income are spent on alcohol, leaving very little money for food, education, housing and health, thus perpetuating a vicious cycle of poverty. Few Member States have national alcohol control policies, and even if they exist, these are easily by-passed3.

Reducing harm from alcohol use

Advocacy at global and regional levels

To address the issue of harm from alcohol use at a global level, the Global Strategy to Reduce the Harmful Use of Alcohol was endorsed by the Sixty-third World Health Assembly in May 2010. It sets priority areas for global action, recommends target areas for national action and gives a strong mandate to WHO to strengthen action at all levels.4 In 2006, the WHO Regional Committee for South-East Asia, through resolution SEA/RC59/R8, requested the Regional Office to support Member States in building and strengthening institutional capacities for developing information systems, policies, action plans, programmes, guidelines and monitoring/ evaluation programmes on prevention of harm from alcohol use.

What is WHO doing?

Through the Alcohol Control Series published by the SEA Regional Office, WHO addressed the harm of alcohol use and described how it is combating the problems caused by alcohol. In addition to harming individuals and families, alcohol affects the whole country/region, as can be seen in the report Burden and socioeconomic impact of alcohol: the Bangalore Study, which estimates that the Government of India spends nearly Rs 244 billion every year to manage the consequences of alcohol use, primarily on medical care for alcohol-related accidents. This (Rs 244 billion) is more than the total Rs 216 billion that India collects from alcohol taxes.

Six Member States (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand) compiled and analysed community-based data on alcohol use in their countries. The next step was to design and implement community-based pilot projects

2 Programme on reducing harm from alcohol use in the community. Alcohol Control Series No. 7., New Delhi, World Health Organization Regional Office for South-East Asia, 2009 (http://www.searo.who.int/LinkFiles/Alcohol_and_Substance_abuse_7-ACS.pdf accessed 15 May 2012).
3 Chandra V. Strengthening multisectoral actions for reducing harmful use of alcohol. Presentation at World Health Organization Regional Meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, Myanmar, April 2012.
What are countries doing?

**Bhutan:** A country where over 20% of the food grain was used to brew alcohol decided to tackle binge drinking head-on with community-based programmes implemented in six basic health unit areas. The basic premise strictly prohibits alcohol in most social gatherings and alcohol is not served to guests. The communities themselves are framing rules and related fines for alcohol consumption. The local communities benefit by earning money through the fines, while individuals and families save money that would have been lost on alcohol. For example, the cost of a funeral in Bhutan was around 33 000 Nu which included alcohol and meat provided for all guests. A rule recently implemented by the local monk and district administration forbids serving meat and alcohol during funerals. This simple rule decreased alcohol use by 70% in the basic health units involved and brought down the cost of a funeral to 3000 Nu. If this policy alone is implemented all over Bhutan, the country could save 60 million Nu annually.\(^5\)

**Sri Lanka:** WHO supported cooperation between local anti-alcohol and pro-alcohol groups by giving them a common goal: reduce the harm from alcohol. A programme carried out in the rural Thelikada village community surveyed over 1000 families. This survey revealed that factors that increase attractiveness of alcohol use include media and other promotions, antisocial behaviour including violence following alcohol use, pay day use, use of alcohol on special occasions and availability of alcohol. All of these issues were addressed by the community and serving alcohol at weddings had completely stopped. Evaluation two years later showed that the programme is being sustained by the community.\(^6\)

**Thailand:** A programme targeted alcohol-using families in an effort to show them the financial benefits of not buying alcohol. In two villages in Lop-Buri province, families were encouraged to put money into a voluntary money box for every instance where they would have bought alcohol. The families who saved the most money received cash rewards from the District Officer. Over 100 households participated out of the 500 houses in the villages. Families were very happy at the end of the month when they received the money from the money box that they had saved.

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\(^5\) Wangchuk K. Reducing harm for alcohol: a Bhutanese experience. Presentation at World Health Organization Regional Meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, Myanmar, April 2012.

\(^6\) Sumanasekera P. Reducing harm from alcohol use in 3 selected locations in Sri Lanka. Presentation at World Health Organization Regional Meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, Myanmar, April 2012.

Perngparn U, Waeewong O. A pilot project on community action to reduce harm from alcohol use in Thailand. Presentation at World Health Organization Regional Meeting on Noncommunicable Diseases including Mental Health and Neurological Disorders, Myanmar, April 2012.
rather than wasted on alcohol. The women also reported less alcohol-related abuse as well as fewer alcohol-related accidents. In just over six months the villages saved 60,000 baht.

In addition to the money-box project, there are ongoing movements in Thailand to make the Buddhist Lent (mid-July through mid-October) alcohol-free. One of the main components of the programmes in Thailand is the inclusion of the entire community – heavy users, light users and alcohol abstainers, thereby including all alcohol users. As alcohol use is a common risk factor for noncommunicable diseases (NCDs), focusing on decreasing alcohol related-problems throughout a community helps address many NCDs, and makes it easier to talk about NCDs in communities without stigmatizing NCDs.

Community involvement helps ensure success

The South-East Asia Region has been a pioneer in developing innovative solutions to reduce harm from alcohol use in the community. As all of the community-based projects have been evaluated by specific impact indicators to assess their success, we are able to see their success. These experiences in WHO’s South-East Asia Region show that when alcohol control measures are owned by the community, implementation rates are high and the results are more sustainable.
CARDIOVASCULAR DISEASES

Teashop owner Usman Ahmed suffered a major heart attack in 2009. Following the attack, the father of three was diagnosed with cardiovascular disease and hypertension and put on a regimen of aspirin, a statin and blood pressure-lowering drugs. He lives in Delhi, India’s capital, and earns the equivalent of US$ 4–5 a day.

“It was a terrifying time. I was standing at the teashop and suddenly felt this massive pain in my chest. I was rushed to hospital and the doctors told me I had had a heart attack. The doctors said I was lucky to be alive.

“I now have to take drugs every day to control my blood pressure and am very careful about what I eat. At one point they thought I might need an operation. The operation would have cost around Rs. 60 000 (US$ 1250) and I simply would not have been able to afford it.”

Usman supports his wife and three children who live in a small village 450 km from Delhi.
“After the attack, I was unable to work for six months and so had no money. This was very difficult for my wife and family. I had to borrow a lot of money just to get by. If I had died that day I don’t know what would have happened to my wife and children. I am the sole breadwinner and send most of my earnings to the village each month for family support.

“Before the heart attack, I had a very unhealthy diet. I would eat a lot of oily, fried foods and a lot of red meat. I was also a heavy smoker and never exercised. Today, I eat a lot of fresh food and fruit and have even quit smoking. I also do 30 minutes of exercise each morning and go for long walks in the evenings. I feel lucky that I was able to change my life. Before the heart attack I had no idea about the dangers of smoking or of a bad diet. But now I know about bad habits like smoking, and try to live as healthily as I can.

“I actually educate my customers about their unhealthy lifestyles now. I always say to them: ‘I will charge for the tea but will give you health advice for free!’”

CARDIOVASCULAR DISEASES: FACTS

In the South-East Asia Region, cardiovascular diseases cause an estimated 3.6 million deaths or a quarter of all deaths annually.

Modifiable risk factors for heart disease include unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol. These lead to raise blood pressure, raised blood sugar, raised blood lipids and overweight and obesity.

Nearly 80% of premature heart attacks can be PREVENTED by eliminating risk factors such as tobacco use, unhealthy diet, and physical inactivity.

Comprehensive action to reduce the burden of heart disease requires combining approaches that seek to reduce the risks throughout the entire population with strategies that target individuals at high risk or with established disease.
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