News and Updates

EPHA Updates

12TH WORLD PUBLIC HEALTH CONGRESS ENDED WITH GREAT SUCCESS

The 12th World Congress on Public Health was held in Istanbul, Turkey from April 27 to May 01, 2009 under the auspices of H.E. Abdullah Gül, President of the Republic of Turkey and hosted by Turkish Public Health Association (TPHA).

Experts, governmental bodies, universities, NGOs and occupational institutions and private sector from various countries and Turkey have attended to the Congress.

In the World Congress, more than 80 panels, 400 oral presentations and more than 960 poster presentations took place under the 200 main themes. The scientific program of the Congress has been prepared by more than 3000 experts in health field and decision makers from all over the world. Participants of the Congress discussed their views and experiences on the main theme of the Congress: "Making a Difference on Global Public Health: Education, Research and Practice".

Dr. Margret CHAN, Director General of World Health Organization (WHO), Prof. Recep AKDAG, Minister of Health of the Republic of Turkey, Dr. Marc DANZON, European Regional Director of WHO, Mr. Ahmet SELAMET, Deputy Mayor of the Istanbul, Prof. Paulo BUSS, President of WFPHA and Prof. Hikmet PEKCAN, M.D, President of TPHA delivered a speech in the Opening Ceremony of World Congress. The importance of preventive health care, Global Pandemic, influenza A / H1N1, and combating the epidemics were issues underlined in all speeches.

Also in the occasion, Prof. Hikmet PEKCAN (Co chair of the World Congress), Prof. Paulo BUSS (Chair of the Congress), Prof. Ulrich LAASER (President of the Scientific Programme), Dr. Mengistu ASNAKE (Ethiopia, Host of the 2012 World Congress) and Bekir METİN (General Coordinator of the World Congress) have delivered a speech and evaluated the Congress. During this time, award winners for presentations and the 2012 World Public Health Congress host country have been announced.

At the end of the closing ceremony "Istanbul Public Health Declaration" was issued. This declaration, which points out most of the public health problems in the world and their solutions, is going to serve as a basis for the activities in Public Health Field.

EPHA Executive Board Members.......
1. Dr. Mengistu Asnake...........President
2. Dr. Solomon Worku...........V/ president
3. Dr. Wagari Deressa ....Member
4. Dr. Yilma Melkamu..............Member
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Become EPHA Member , share your ideas and enrich the Public Health Situation !

Calendar: Upcoming Events

Upcoming Events *(vertical side text)*

World Breastfeeding Week

1–7 August 2009

World Breastfeeding Week is celebrated every year from 1 to 7 August to encourage breastfeeding and improve the health of babies around the world. It commemorates the Declaration made UN in August 1990 to protect, promote and support breastfeeding.

Breastfeeding is the best way to provide newborns with the nutrients they need. World Health Organization recommends exclusive breastfeeding until a baby is six months old, and continued breastfeeding with the addition of nutritious complementary foods for up to two years or beyond.

The theme of World Breastfeeding Week 2009 is "Breastfeeding - a vital emergency response. Are you ready?". It highlights the need to protect, promote and support breastfeeding in emergencies for infant and young child survival, health and development.

Children are among the most vulnerable groups during emergencies, and small children are the most vulnerable of all, due to increased risk of death due to diarrhea and pneumonia. During emergencies, unsolicited or uncontrolled donations of breast-milk substitutes may undermine breastfeeding and should be avoided.

As part of emergency preparedness, hospitals and other health care services should have trained health workers who can help mothers establish breastfeeding and/or overcome difficulties.

Source: http//www.who.int

World Suicide Prevention Day

10 September 2009

World Suicide Prevention Day on 10 September promotes worldwide commitment and action to prevent suicides. On average, almost 3000 people commit suicide daily.

International organizations advocate for the prevention of suicidal behaviour, provision of adequate treatment and follow-up care for people who attempted suicide, as well as responsible reporting of suicides in the media.

At the global level, awareness needs to be raised that suicide is a major preventable cause of premature death. Governments need to develop policy frameworks for national suicide prevention strategies.

World Rabies Day

28 September 2009

World Rabies Day highlights the impact of human and animal rabies and promotes how to prevent and stop the disease by combating it in animals. International organizations report that 55 000 people die every year from rabies, an average of one death every 10 minutes.

There are safe and effective vaccines available for people who have been bitten by an animal that might have the disease, but usage in developing countries is low due to the high cost.

World Heart Day

28 September 2009

Cardiovascular diseases are the world's largest killers, claiming 17.5 million lives a year. Risk factors for heart disease and stroke include raised blood pressure, cholesterol and glucose levels, smoking, inadequate intake of fruit and vegetables, overweight, obesity and physical inactivity.

On this day, agencies working in the issue organize awareness events in more than 100 countries - including health checks, organized walks, runs and fitness sessions, public talks, stage shows, scientific forums, exhibitions, concerts, carnivals and sports tournaments.

Thematic Concerns

Thematic Concern

GLOBAL: Earlier ARV treatment saves lives

Findings from a clinical trial in Haiti bring the first conclusive evidence that HIV-positive people in developing countries have a significantly better chance of survival if they start antiretroviral (ARV) treatment earlier.

In recent weeks, an independent data and safety monitoring board recommended immediately ending a trial being carried out by the Haitian Group for the Study of Kaposi's Sarcoma and Immune Deficiency Disorders (GHESKIO) Centers, because the evidence in favour of earlier treatment was so overwhelming.

Recent studies in the developed world have found that starting HIV-infected patients on treatment when their CD4 cell count (a measure of immune system strength) drops below 350 greatly reduces AIDS-related mortality. Waiting until it fell below 200 was previously thought to be optimal.

The trial in Haiti, known as CIPRA HT 001, started in 2005, when 816 HIV-positive participants with CD4 counts between 200 and 350 were recruited. Half of them were randomly assigned to begin ARV treatment immediately; the other half were to start treatment only when their CD4 counts dropped below 200, in line with national treatment guidelines in Haiti and many other developing countries.

By the time the trial was stopped, six participants in the group that began treatment earlier had died, compared to 23 in the group that started treatment later.

The number of patients who contracted tuberculosis (TB), a common and often deadly opportunistic infection in people living with HIV, was 18 in the early-treatment group, compared to 36 in the other group.

The monitoring board recommended that all the trial participants now be offered ARV treatment and followed for 12 months to ensure that they adhered to the timetable for taking their medication.

"The public health community now has evidence from a randomized, controlled clinical trial — the gold standard — that starting ART [antiretroviral treatment] at CD4 cell counts between 200 and 350 in resource-limited settings yields better health outcomes than deferring treatment until CD4 cell counts drop below 200," said NIAID Director Anthony S. Fauci in a statement.

Although some countries changed their ARV treatment protocols after evidence from earlier studies, many in the developing world still wait until patients have a CD4 count of 200 or less to begin treatment. The study investigators were confident that many more countries would revise their treatment guidelines.

Carl Dieffenbach, director of the NIAID Division of AIDS, noted that raising the threshold for starting ARV treatment would greatly increase the number of people needing medication, and the need for the global community to provide more support to buy ARVs.

Emerging Concern

Flu Update

Behavioral Interventions for Reducing the Transmission and Impact of Influenza A (H1N1) Virus: A Framework for Communications Strategies

The following is a guidance developed jointly by WHO and United Nations Children's Fund (unicef) intended for institutions and partners who wish to develop communication interventions and activities to reduce the spread and impact of the new influenza (H1N1) virus. It is also meant as a technical guidance in preparing communication strategies, messages and materials in relation to the outbreak. It focuses on control measures at individual and family level.

Key Points

The strategic advice on priorities for behavioral interventions (control and prevention measures) is for the global level, and countries should adapt the advice to reflect regional, national and local realities. The public health goal of the behavioral interventions is to reduce transmission, morbidity and mortality related to influenza A (H1N1) virus among:

⇒ People who are well, to avoid becoming infected;
⇒ People who are sick, to avoid infecting others and to recover from illness; and
⇒ People who are caring for sick people, to protect themselves and other family members from infection.

    Two important premises are:

⇒ Information about the characteristics of the influenza A (H1N1) virus is limited. Therefore, communication approaches and recommended behaviors will have to be adjusted as more evidence becomes available.
⇒ In order for the approaches to have an impact on behavior, sociocultural and economic factors, such as poverty and gender, must be addressed, so that people are empowered to act on the information provided, and materialized and vulnerable groups have access to the information and resources.

Importance of Sharing Information About the new Influenza A (H1N1) Virus and empowering people to adopt risk reduction practices

Influenza A (H1N1) virus is a newly emerged virus that is currently circulating among humans. It is an agent that causes an acute infectious disease of the respiratory tract and has the potential to cause a pandemic.

The term 'epidemic' means that there are more cases of a certain disease than expected. A 'pandemic' is a worldwide epidemic of a disease. An influenza pandemic occurs when a new influenza virus appears, against which the human population has no immunity, as in the case of the current influenza (H1N1) virus. With increases in global transport and with growing urbanization and overgrowing in some areas, an epidemic due to a new influenza virus might become a pandemic rapidly.

As of May 2009, the symptoms of most people infected with influenza A (H1N1) virus have been mild, and they have generally recovered without significant medical intervention. As the virus circulates around the world, however, it might change into a type that causes more serious disease.

Families and communities can protect themselves by adopting a few key practices that will reduce their chances of becoming infecting. Everyone should follow these preventive behaviors in order to protect themselves and their families from the disease at each stage of the emerging threat. Milder cases can be treated at home, thereby reducing the burden on health care services. However, severe cases need to seek care promptly, and people caring for sick persons at home should know how to recognize symptoms of severity. National authorities and health-care providers should provide the latest advice and information suitable for local circumstances.

Flu Update

- Share the rationale. Explain to people why certain behavior is important. Transparency in sharing information and its rationale helps build trust and is more likely to result in cooperation.

- Encourage active engagement. Encourage people to seek information from credible sources; ensure that neighbors, communities and networks receive and understand accurate information, report possible influenza cases and help communities in managing ill people. In this approach, people are viewed as 'partners in prevention' and not as simple recipients of information. The approach is therefore likely to create ownership, resulting in better adoption of recommended behaviors and more proactive communities. Such 'partners in prevention' are also likely to find creative ways of mobilizing community resources and help build capacity that might be useful in the future.

- Empower people with information. Be aware that people and communities will take their own decisions on the basis of the balance of forces of their own circumstances. The communication approach should emphasize information-sharing and community problem-solving as ways of helping people to find a set of do-able actions: "How can we effectively prevent infection and protect ourselves, our families and our community?"

- Adapt recommendations to the local context. Take into account people's capacity to act on the advice being given. The recommended behavior must be do-able and be adapted to people's lifestyle; otherwise, it will not be widely adopted. Ensure that marginalized groups, such as slumdwellers, religious minorities and people beyond the reach of the mass media, are also engaged in prevention and protection, have access to information and have the capacity to act upon it.

- Use existing resources and partnerships to develop effective communications strategies, messages and materials quickly. Work through existing communication and coordination bodies to harmonize messages, approaches and use of channels.

Checklist for strategic communications planning and implementation

This is a checklist for rapidly assessing the current communications environment. It helps identify critical areas which will need to be addressed to ensure that the communications process is participatory, takes into account different perspectives and distils these findings into the development and implementation of communications strategies as well as broader decision making and outbreak management activities.

- Is there technical consensus by agencies on the control measure s and is there harmonization of these interventions and messages to at-risk populations and other stakeholders?

- Is there a coordinating mechanism among authorities and institutions involved in providing communications interventions? Is there agreement on the priority behavioral interventions, audiences and channels for the different stages of a pandemic?

- Are existing networks and partnerships being used effectively e.g. for communications strategy development, message development, and material production and dissemination?

- Are communications products (materials such as posters, leaflets, etc) being developed to contribute to an overall strategic communications plan with clear public health objectives? i.e. to minimize disease transmission, mortality and morbidity? Is this linked to clear communications objectives?

- Has a quick assessment of knowledge, awareness and perceptions among at-risk and other populations been carried out? Are there any gaps?

- Are participatory methods being used to learn from community groups including the vulnerable and marginalized, on how to adapt priority behaviors to local contexts .i.e. are the proposed control measures specific, realistic and culturally appropriate? Are there existing cultural and societal values and practices that could be used to promote the uptake of control measures? Have these been incorporated into the messaging and design?

- Are communications strategies and messages consistent with social and cultural values of target populations such as at-risk populations and other stakeholders?
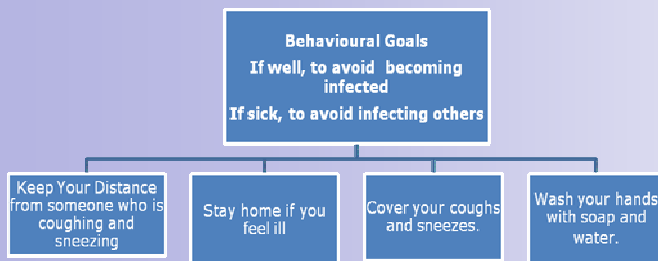
Emerging Concern…..cont'd

⇒ Do communications materials and messages clearly promote the proposed control measures? i.e. inform target audiences on what to do, how, why, and when? Have these been quickly pre-tested with the target audiences?

⇒ Have non-communications barriers to proposed control measures been identified and therefore control measures adjusted accordingly e.g. access to water and soap if promoting hand hygiene?

⇒ Have credible, empathetic and trustworthy sources of information been identified for multiple audiences, activities and channels?

⇒ Is there a system for getting feedback on the reach, and effect of communications interventions? E.g. are people doing things differently as a result of the communications interventions? Are there rumors, misunderstandings circulating that need to be corrected?

Priority Behavioral goals in a country with Cases of Influenza A (H1N1) Virus Infection
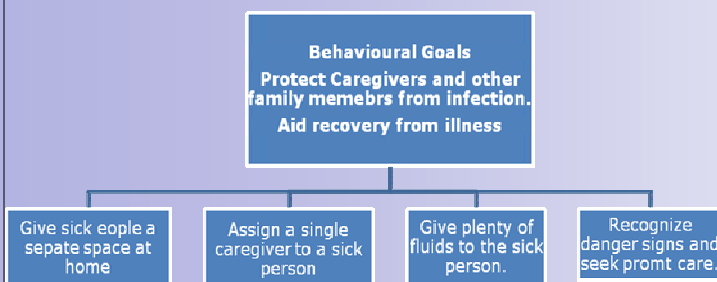
Public Health Goal

To Reduce Transmission

Behavioural Goals
If well, to avoid becoming infected
If sick, to avoid infecting others

Keep Your Distance from someone who is coughing and sneezing	Stay home if you feel ill	Cover your coughs and sneezes.	Wash your hands with soap and water.

Priority Behavioral goals for Home Care of Influenza A (H1N1) Illness

Public Health Goals

To Reduce Transmission

To Reduce Mortality

Behavioural Goals
Protect Caregivers and other family members from infection.
Aid recovery from illness

Give sick eople a sepate space at home	Assign a single caregiver to a sick person	Give plenty of fluids to the sick person.	Recognize danger signs and seek promt care.

Flu Update@ena

EAST AFRICA/HORN:

Preparedness gaps evident as first flu cases diagnosed

NAIROBI/ADDIS ABABA/KAMPALA, 2 July 2009 (IRIN) - Although some countries within East Africa and the Horn region have scaled up their influenza A(H1N1) contingency plans, overall pandemic preparedness remains "relatively inactive", a UN agency has said, as the first cases were reported in Ethiopia, Kenya and Uganda.

According to an overview prepared by the pandemic influenza coordination (PIC) unit in the UN Office for the Coordination of Humanitarian Affairs (OCHA PIC) in Nairobi, the countries that have updated their contingency plans include Ethiopia, Eritrea, Kenya, Tanzania, Djibouti, Rwanda, Burundi, Democratic Republic of Congo, Central African Republic (CAR), and the Republic of Congo.

"These countries are considered well prepared in mobilizing both health and non-health sector measures in the event of a pandemic," OCHA PIC said on 1 July.

OCHA PIC is a member of the regional rapid response team, which is planning technical support missions between July and September to accelerate preparedness and response in countries considered most vulnerable to so-called swine flu, including Somalia, Sudan, Kenya, Equatorial Guinea, CAR, Chad and Eritrea.

OCHA PIC said regional partners had expressed concern over the inadequate communication

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messages and channels used to reach the public with regard to pandemic preparedness and re- sponses.

"It is recommended that a communication centre be hosted within respective ministry of health structures but supported by technical agencies in disseminating well-packaged messages on H1N1, H1N5 [avian flu] and other trans-boundary dis- eases," OCHA PIC said.

Symptoms of A(H1N1) were confirmed in Kenya on 29 June in a British student visiting the coun- try. "[Another] three suspected cases are under investigation," OCHA PIC said.

In Ethiopia, the Ministry of Health has confirmed a third A(H1N1) case and is investigating four sus- pected cases.

"Out of 17 suspected individuals, 10 of them were found to be free and returned to their homes," Ahmed Imano, head of the public relations service at the Ministry of Health, said. "Four of them are still under surveillance."

In Uganda, the Ministry of Health announced on 2 July that one case of H1N1 had been diagnosed at Entebbe International Airport. The ministry said the 40-year-old had been isolated at a medical facility at the airport.

In Africa, Algeria, Egypt, Morocco and South Af- rica have also reported A(H1N1) cases.

Although no deaths have been recorded, more than 10 cases have been confirmed on the conti- nent, according to the World Health Organization (WHO).

Ethiopia reported its case on 19 June. The first cases were detected in two teenagers returning from the United States. The third was reported on 29 June, of an air hostess with Ethiopian Airlines. "All of them came from abroad," Ahmed said. "It is not necessary at this time to reveal where they came from." He added: "We have a good mechanism of tracing [the epidemic.] All flight attendants have received training and are doing a good follow-up."

Pandemic (H1N1) 2009 – update: 6 July 2009 09:00 GMT

Laboratory-confirmed cases of pandemic (H1N1) 2009 of the African States is given in the following table just as officially reported to WHO.

Country, territory and area	Cumulative total		Newly confirmed since the last report- ing period	
	Cases	Deaths	Cases	Deaths
Algeria	5	0	0	0
Cap Verde	3	0	0	0
Ethiopia	3	0	0	0
Kenya	15	0	3	0
Cote d'Ivoire	2	0	0	0
Egypt	78	0	11	0
Guyana	2	0	2	0
Morocco	17	0	0	0
Papua New Guinea	1	0	0	0
South Africa	18	0	6	0
Trinidad and To- bago	65	0	12	0
Tunisia	5	0	2	0
Uganda	1	0	0	0
Grand Total				

Benefit More

Benefit More

EPHA Library
and
e-learning Center

The Ethiopian Public Health Association Library and E-learning Center was inaugurated and launched in January 2007 by HE Dr. Tedros Adhanom, Minister, Ministry of Health, delegates from CDC-Ethiopia and Executive members of the Association.

The Center marks the first public health information center in the history of the Association and is expected to provide publications and other health related materials to all potential users. The Center is also expected to provide internet services for members, health professionals, students and researchers free of charge.

The Center is making attempts to communicate with national and international organizations working on health information system. This will enable to collect materials from these organizations and add to its library collection. All the materials are registering in the Win/ISIS database system to facilitate quick searches by users as well as through website.

The Center is planning to establish and organize Library and e-learning Centers in Addis Ababa and Regional Chapters to provide effective and up-to-date health related materials and e-learning services to its regular and external researchers and thereby fully attain the mission and objectives of the Association.

At present, the Center has upgraded its manpower capacity by employing two library and information professionals. This will assist the Center to increase multimedia (print, electronic and audiovisual) collection of health materials and systematic provision of library services to users.

Major Services:

The Center provides public health information services. Although the centre currently has a limited number of public health materials, it is in the process of acquiring up-to-date resources through purchase,

donation and exchange. By doing so, the Center plans to satisfy the interest and need of potential users. Our major services:

⇒ **Reading**

The Library and e-learning Center has a small reading room and a collection of EPHA and partners' publications.

⇒ **Internet Service**

Currently, there are email and internet services free of charge

⇒ **Circulation Service**

There is also plan to lend reading materials.

Target users

The use of the Library and e-learning Center materials and services is free of charge to all members. Viz. professionals, researchers, public health students and the general public. While we give priority to professional and organizational members of the Association, non-members including the public are also welcome to use the service.

Working hours

EPHA Library and e-learning Center is open during the following working hours:-

Monday - Friday: - 8:30 am - 12:00 O'clock
                           - 12:00 – 5:00 pm

Contact Address

Visit us at Ambessa Building, 5th Floor, Meskel Road.

For More information, please contact:
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P. O. Box 7117
Addis Ababa
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Phone: 011 551 - 86 - 65
Fax: 011 551 - 48 - 70
E-Mail: ephalib@etpha.org
Website: www.etpha.org

Social Aspect of Health

Social Aspects

Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Responding to increasing concern about these persisting and widening inequities, UN established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report was launched in August 2008, and contained three overarching recommendations which seem relevant to every country to be aware of the growing equity concern amid widening social divide :

1. Improve daily living conditions

Equity from the start
At least 200 million children globally are not achieving their full potential. This has huge implications for their health and for society at large. Investment in early years provides one of the greatest potentials to reduce health inequities. The Commission calls for:

• an interagency mechanism to be set up to ensure policy coherence for early child development;

• a comprehensive package of quality programmes for all children, mothers and caregivers; and

• the provision of quality compulsory primary and secondary education for all children.

Healthy places, healthy people
Where we live affects our health and chances of living flourishing lives. According to recent figures, almost 1 billion live in urban slums. The daily conditions in which people live have a strong influence on health equity. Access to quality housing and clean water and sanitation are human rights. The Commission calls for:

• greater availability of affordable housing by investing in urban slum upgrading including, as a priority, provision of water, sanitation and electricity;

• healthy and safe behaviours to be promoted equitably, including promotion of physical activity, encouraging healthy eating and reducing violence and crime through good environmental design and regulatory controls, including control of alcohol outlets;

• sustained investment in rural development; and

• economic and social policy responses to climate change and other environmental degradation that take into account health equity.

Fair employment and decent work
Employment and working conditions have powerful effects on health equity. When these are good, they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial illness. The Commission calls for:

• full and fair employment and decent work, to be a central goal of national and international social and economic policy-making;

• economic and social policies that ensure secure work for men and women with a living wage that takes into account the real and current cost of healthy living;

• all workers to be protected through international core labour standards and policies; and

• improved working conditions for all workers.

Social protection throughout life
Everyone needs social protection throughout their lives, as young children, in working life, and in old age. People also need protection in case of specific shocks, such as illness, disability, and loss of income or work. Four out of five people worldwide lack the back-up of basic social security coverage. Extending social protection to all people, within countries and globally, will be a major step towards achieving health equity within a generation. The Commission calls for:

• establishing and strengthening universal comprehensive social protection policies;

• ensuring social protection systems include those who are in precarious work, including informal work and household or care work.

Social Aspect _ Universal Aspect

Universal Health Care

Access to and utilization of health care is vital to good and equitable health. Without healthcare, many of the opportunities for fundamental health improvement are lost. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. The Commission calls for:

• healthcare systems to be based on principles of equity, disease prevention, and health promotion with universal coverage, focusing on primary health care, regardless of ability to pay.

2. Tackle the inequitable distribution of power, money, and resources

Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies and practices, and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources. The Commission calls for:

• health equity to become a marker of government performance;

• national capacity for progressive taxation to be built;

• existing commitments to be honoured by increasing global aid to 0.7% of GDP;

• health equity impact assessments of major global, regional and bilateral economic agreements;

• strengthening of public sector leadership in the provision of essential health-related goods/services and control of health damaging commodities;

• gender equity to be promoted through enforced legislation;

• a gender equity unit to be created and financed;

• the economic contribution of housework, care work, and voluntary work to be included in national accounts;

• all groups in society to be empowered through fair representation in decision-making;

• civil society to be enabled to organize and act in a manner that promotes and realizes the political and social rights affecting health equity;

the UN to adopt health equity as a core global development goal and use a social determinants of health framework to monitor progress.

3. Measure and understand the problem and assess the impact of action

Action on the social determinants of health will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the social determinants of health, are put in place so that more effective policies, systems and programmes can be developed. Education and training for relevant professionals is vital.

Who should be doing what?

While the Commission advocates strongly the central role of government and the public sector in taking action, it also recognises the need for support and action across the field – global institutions and agencies, governments themselves (national and local), civil society, research and academic communities, and the private sector.

Multilateral agencies

The Commission calls for coherence between sectors in policy-making and action to achieve improvements in health equity. The Commission calls on multilateral specialist and financing agencies to:

• adopt health equity as a fundamental shared goal, and use a common global framework of indicators to monitor development progress;

• ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action among recipient governments;

• support equitable participation of Member States and other stakeholders in global policy-making. adopt health equity as a fundamental shared goal, and use a common global framework of indicators to monitor development progress;

• ensure that increases in aid and debt relief support coherent social determinants of health policy-making and action among recipient governments;

Tobacco Corner

• support equitable participation of Member States and other stakeholders in global policy-making.

National and local government

Underpinning action on the social determinants of health and health equity is an empowered public sector, based on principles of justice, participation, and collaboration. Actions include: policy coherence across government; strengthening action for equity and finance; and measurement, evaluation, and training.

Civil society

Civil society can play an important role in action on the social determinants of health. Actions include: participation in policy, planning and programmes; and evaluation and monitoring of performance.

Private sector

The private sector has a profound impact on health and well-being. Actions include: strengthening accountability; and investing in research.

Research institutions

Knowledge – of what the health situation is; of what can be done about it; and of what works effectively to alter health inequity – is at the heart of the Commission. Actions include: generating and disseminating evidence on the social determinants of health.

Health effects of smoking among young people

• Among young people, the short-term health consequences of smoking include respiratory and non respiratory effects, addiction to nicotine, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. Cigarette smokers have a lower level of lung function than those persons who have never smoked. Smoking reduces the rate of lung growth.

• In adults, cigarette smoking causes heart disease and stroke. Studies have shown that early signs of these diseases can be found in adolescents who

• Smoking hurts young people's physical fitness in terms of both performance and endurance—even among young people trained in competitive running. On average, someone who smokes a pack or more of cigarettes each day lives 7 years less than someone who never smoked.

• The resting heart rates of young adult smokers are two to three beats per minute faster than nonsmokers.

• Smoking at an early age increases the risk of lung cancer. For most smoking-related cancers, the risk rises as the individual continues to smoke.

• Teenage smokers suffer from shortness of breath almost three times as often as teens who don't smoke, and produce phlegm more than twice as often as teens who don't smoke.

• Teenage smokers are more likely to have seen a doctor or other health professionals for an emotional or psychological complaint.

Teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex.

Ethiopia and the WHO Framework Convention on Tobacco Control

After its adoption by the 56th World Health Assembly in May 2003, the WHO Framework Convention on Tobacco Control (WHO FCTC) was open for signature until 29 June 2004. And Ethiopia, by signing the framework on 25 February 2004 became one of the 168 States signed the WHO FCTC and during this period the country expressed its willingness to become a Party to the Convention.

Tobacco's Corner

Editor's Message

Dear Readers,

In the last several editions, EPHA through its "Felege Tena" newsletter has striven to contribute in a most effective ways to the Public Health issues in the nation's changing health situation. To help achieve its principal aim, which is to promote evidence based policy making and practice in the public health sector, the newsletter has been trying to articulate research outputs and news in the sector. As it is the most effective means of informing the sector actors, the newsletter will continue to make its contents more readable, more reliable and that cover host of current issues. To this effect, in its upcoming editions the newsletter will try to include among other agendas: organizational updates, research findings and best practices, humors, thematic concerns, Social concerns, information on upcoming events as well as editor's messages.

Therefore, hoping that you will enjoy reading the newsletter, we also welcome your feedback. Your views on topics of mutual concern are important to enrich the debate and practice in the public health issues. Please send your views and comments to:

Publications Officer, EPHA

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Addis Ababa, Ethiopia

Humors

Wired Shut

Jim was in a terrible wreck. He was taken to the hospital where he remained comatose for two weeks and when he awake he was starving. Finding the call button he rang for the nurse and asked if he could have something to eat.

She told him, "You have a broken jaw and it is wired shut. I can't think of anything that you could eat in that condition."

"Well, could I have a cup of coffee?" Jim asked through his clenched jaw.

"We'll try," the nurse told him. "Maybe we can get a straw between your teeth."

But try as they would, it just wouldn't go. Jim grumbled and moaned and swore he was going to die without coffee until the nurse finally said, "Maybe we could give it to you in an enema."

She fixed up the syringe and began to administer it when suddenly Jim winced and drew up.

"Is it too hot?" the nurse asked.

"No, but could you please put some sugar in it?"

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Your comments, suggestions and ideas will improve our Felege Tena.