

Tackling the health burden of air pollution in South Asia

Bhargav Krishna and colleagues call for health driven, multisectoral policy making with defined air quality targets to curb the impact of air pollution exposure in South Asia

Air pollution exposure is the second most important risk factor for ill health in South Asia, contributing to between 13% and 21.7% of all deaths and approximately 58 million disability adjusted life years (DALYs) through chronic and acute respiratory and cardiovascular illnesses.¹ Of the top 30 cities in the world with the poorest air quality in 2016, 17 are in South Asia.² The impact of air pollution transcends boundaries. The “brown cloud”—caused by pollution from carbon aerosols—is a phenomenon captured in satellite images of atmospheric haze over South Asia, as well as China. South Asia has one of the highest concentrations of black carbon emissions from cars and trucks, cooking stoves, and industrial facilities. In addition to their effect on health, black carbon particles are a short lived climate pollutant with a possible impact on precipitation patterns and on the Himalayan glacier system, which threatens water resources in the region.³

Collective regional action to monitor air quality and implement evidence based policies and interventions is needed. While countries have introduced promising initiatives in recent years, comprehensive health centred strategies are lacking. We present the status of air pollution and health effects in South Asia, and propose urgent, concerted action across sectors to achieve recommended air quality standards for the people of the region.

Air pollution exposure and trends

Household (indoor) and ambient (outdoor) air pollution both contribute to ill health.

KEY MESSAGES

- Air pollution is a major risk factor for ill health in South Asia
- The interconnected nature of the South Asian airshed necessitates regional cooperation
- Tackling the sources of air pollution requires systematic collection of air quality data and a scientific approach to air quality management
- Tackling the health burden of air pollution will require coordinated, multi-sectoral response, using a “health in all policies” framework

Box 1: Air quality standards recommended by WHO⁹

	PM ₁₀ (µg/m ³)		PM _{2.5} (µg/m ³)	
	Annual mean concentration	24 h concentration	Annual mean concentration	24 h concentration
Interim target-1	70	150	35	75
Interim target-2	50	100	25	50
Interim target-3	30	75	15	37.5
Air quality guideline*	20	50	10	25

¹ PM₁₀: Airborne particulate matter smaller than 10 µm (includes both coarse and fine particles that enter the respiratory tract).

² PM_{2.5}: Airborne particulate matter smaller than 2.5 µm.

³ Interim targets represent incremental steps in a progressive reduction of air pollution. Annual mean concentrations provide an estimate of long term exposure for comparison.

⁴ *Lowest levels at which total, cardiopulmonary, and lung cancer mortality have been shown to increase in response to long term exposure to PM_{2.5}.

Rural and urban areas are both affected by poor air quality. However, the sources and pollutant profiles vary. For instance, use of cooking fuels varies between urban and rural households, vehicular density is higher in cities, and different climate and geography across the region affect levels of air pollution.

Household air pollution

Approximately 74% of South Asian households use solid fuels such as wood, dung, or coal for cooking and heating.^{4,6} These are inefficient fuels and their use in open fires or leaky stoves contributes to high levels of indoor smoke. Studies on indoor air pollution in South Asia show average daily PM_{2.5} concentrations range from 300 µg/m³ to 3000 µg/m³,^{5,7,8} which is much higher than is recommended by the World Health Organization (box 1).⁹ The proportion of households relying on solid fuels has decreased over the past few decades (fig 1); however this decrease has largely been offset by the increase in population.¹⁰

The type of fuel and stove, kitchen area ventilation, quantity of fuel, age, gender, and time spent near the cooking area influence exposure within and between households. Women and children tend to have higher exposure. Use of solid cooking fuels also contributes to ambient air pollution as a result of emissions carried outdoors. In densely populated communities of India, household air pollution has been estimated to contribute to nearly 27% of ambient air pollution.¹¹

Since few studies report direct measures of household air pollution,⁷ trends are estimated (for purposes of comparative risk assessment) using spatiotemporal Gaussian process regression modelling that

incorporates data on the proportion of solid fuel use in each country from nationally representative household surveys and select co-variables, including maternal education and proportion of population living in urban areas¹²

Ambient air pollution

The population in South Asia, with the exception of Sri Lanka, is among the most highly exposed to PM_{2.5} in the world (table 1). Estimates from the Global Burden of Disease Study 2015 (GBD) indicate that the population weighted mean ambient PM_{2.5} concentration in South Asia* was 73 µg/m³, compared with the global average of 44 µg/m³. Nearly 99.9% of the South Asian population is living in areas with poorer air quality than the minimum standards recommended by WHO (box 1).

Population weighted PM_{2.5} concentrations have increased by 24% in South Asia between 1990 and 2015, with an increase in all countries except Pakistan and Sri Lanka (fig 2). Ozone concentrations

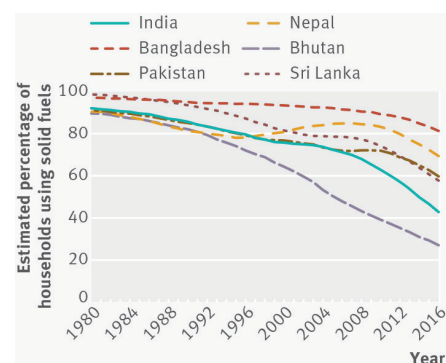


Fig 1 | Trends in estimated percentage of households using solid fuels in South Asian countries

Table 1 | GBD 2015 estimates of exposure to ambient air pollution in South Asia

Country	Population (millions)	Population weighted mean annual ambient PM _{2.5} (2015)	Percentage increase in population weighted mean annual PM _{2.5} (1990 to 2015)	Percentage of population in 2015 living in areas exceeding WHO IT-1	Population weighted seasonal mean ozone (2015)	Percentage increase in population weighted seasonal mean ozone (1990 to 2015)
India	1282.3	74	23	89.9	76	23
Bangladesh	148.9	89	39	99.9	74	25
Pakistan	202.8	65	-4	94.5	69	17
Nepal	31.3	75	34	90.6	78	26
Bhutan	0.9	56	40	81.6	69	25
Sri Lanka	19.5	28	-7	21.9	54	17
South Asia*	1693.8	73	24	91.2	74	21
Global	7155.5	44	10	50.2	61	7

* Here and elsewhere South Asia refers to the GBD regional definition which includes Bangladesh, Bhutan, India, Nepal, and Pakistan. Data for Sri Lanka added separately. WHO IT-1 is World Health Organization PM_{2.5} Interim Target -1 of 35 µg/m³ (annual average).

have also increased across the region at a rate exceeding the global increase.

The sources of ambient air pollution vary across the region, and across rural and urban settings. Vehicular emissions, construction and road dust, residential biomass use, and industrial emissions are major contributors.¹³⁻¹⁶ The main sources of fuel used for power generation such as coal, natural gas, and oil can influence air quality. In Bangladesh, localised sources like brick kilns and motorised transport contribute to the base pollution load throughout the year. Additionally, in winter, transboundary transport of particulate matter across the Indo-Gangetic Plain airshed contributes to higher levels of PM_{2.5}.¹⁴ Similarly, in Pakistan, transboundary transport of dust and pollutants from the Arabian Peninsula^{15 16} and from India¹⁷ is noted to cause episodic spikes in PM₁₀ and PM_{2.5} levels.

Impact on health

Exposure to ambient PM_{2.5} was the third ranking risk factor for mortality (1.4 million deaths, 10.6% of total deaths) and DALYs (5.8% of total DALYs) in South Asia in 2015. Household air pollution ranks fourth (5.5% of DALYs and 1.2 million deaths, 9.6% of total deaths).¹⁸ No studies

to date have evaluated the health impacts of co-exposure to household and ambient air pollution.

Over the past 25 years, deaths attributable to ambient PM_{2.5} exposure have increased, with some acceleration since 2010 (fig 3). Increase in PM_{2.5} levels, population growth, and ageing contribute to this trend. Bangladesh, India, and Pakistan have a higher burden because of larger populations, high exposures, and increasing numbers of people affected by chronic diseases. Common diseases affected by air pollution include ischaemic heart disease, stroke, acute lower respiratory infections, chronic obstructive pulmonary disease, and lung cancer. Deaths attributable to household air pollution have remained high and relatively stable with only a modest increase from 1.1 million to 1.2 million between 1990 and 2015.

The age standardised attributable death rates indicate a small decrease, from 158 deaths per 100 000 in 1990 to 133 per 100 000 in 2015, while there has been a large decrease in the rate of attributable DALYs (fig 4) between 1990 and 2010, possibly driven by a decrease in the incidence of acute lower respiratory infections. Deaths attributable to ozone exposure, while much lower than those

attributable to PM_{2.5} exposure, have increased sharply throughout South Asia from 48 000 in 1990 to 122 000 in 2015 (a 154% increase) driven by increased exposure and increasing rates of chronic obstructive pulmonary disease in the region, and in India especially.

Air pollution propagates existing environmental vulnerabilities.¹⁹ Children and older people are particularly vulnerable. Air pollution exposure results in low birth weight,²⁰ poor lung development in children,²¹ mortality from respiratory infections,²² and may also affect cognitive development.²³ Older people are more likely to develop chronic respiratory and cardiac illnesses, and are more susceptible to heart attacks and strokes from long term exposure, and during episodic high pollution events.²⁴ Lower socioeconomic groups are more susceptible to insults from air pollution exposure for a variety of reasons including occupation and housing.^{25 19}

Fragmented efforts to reduce air pollution

With the lack of high quality data on air pollution and on health effects in South Asian countries, interventions are usually ad hoc, and their impact cannot be assessed. Public

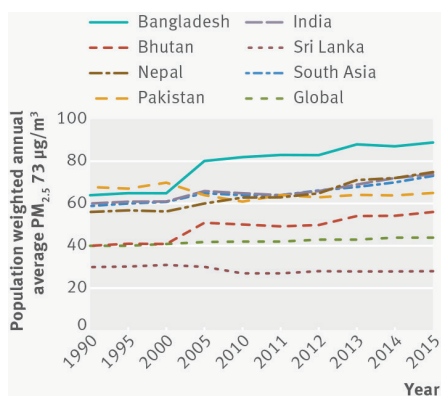


Fig 2 | Trends in annual average population weighted PM_{2.5} exposure in South Asia, 1990 to 2015. These figures were adapted from estimates developed for the Global Burden of Disease (2015) study

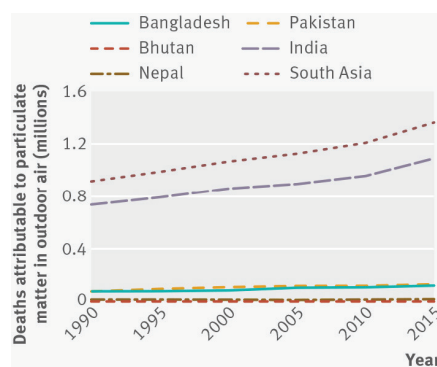


Fig 3 | Trends in deaths attributable to ambient PM_{2.5} in South Asia, 1990 to 2015. These figures were adapted from estimates developed for the Global Burden of Disease (2015) study.

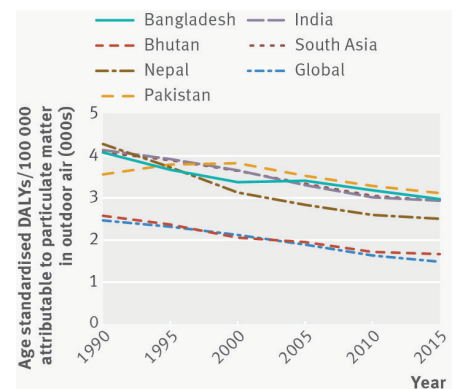


Fig 4 | Trends in age standardised DALYs/100 000 attributable to ambient PM_{2.5} exposure in South Asia, 1990 to 2015. These figures were adapted from estimates developed for the Global Burden of Disease (2015) study

and media attention on levels of air pollution in South Asian cities have led to sporadic measures; however, a robust strategy with targeted reductions in pollutant levels is lacking.

Availability and quality of air pollution data

Continuous ground monitoring of air quality across a range of locations is essential to understand the concentration of pollutants at different time points and implement control strategies. South Asian countries lag far behind global standards in the density and coverage of air quality monitoring networks. Routine monitoring of PM_{2.5} and ozone in the region is minimal. Epidemiological studies currently rely on modelled exposure estimates based on satellite data.

In India, for example, the National Air Quality Monitoring Program collects pollutant data twice a week from 629 stations across 264 cities, with 35 cities also hosting continuous air quality monitoring stations.²⁶ Monitoring is restricted to urban areas with virtually none carried out in rural areas. There are also challenges with the data collected, including calibration errors, gaps in data, and wide variation in uptime of monitoring stations.

Research on health outcomes

A growing body of literature from South Asia indicates an association between short term exposure to air pollution and a range of health outcomes such as decrease in lung function, respiratory symptoms, emergency department visits, and mortality. To date, however, no direct epidemiological studies of long term exposure to ambient PM_{2.5} and mortality from chronic diseases in South Asia have been published. The evidence on acute and chronic health effects at the high levels of exposures commonly encountered in South Asian countries needs to be strengthened.^{27 28}

Large scale household surveys, census, and vital registration systems are the primary sources of data on mortality in South Asia. Incomplete or inconsistent recording of cause of death, and structural deficiencies in data collection result in under-reporting of deaths, especially in rural areas, and thereby provide little understanding of the impact of air pollution.

Air quality management and exposure reductions

South Asian countries have taken some steps to address specific categories of emissions and exposures (table 2) and improve air quality. There is no coherent strategy, however, with defined targets for air quality and regular monitoring to understand the impact of these measures.²⁹ Political will and effective governance are central to tackling the problem.

Table 2 | Sector specific policies and interventions undertaken to reduce emissions and exposures

Country	Target sector	Policies or interventions
Pakistan ³⁰⁻³⁴	Transport	Introduction of Euro IV standards for exhaust emissions from passenger cars Retrofitting diesel buses and trucks with PM emission controls
	Power	Coal gasification, carbon sequestration
	Industry	Gas to replace fuel oil and coal Low sulphur furnace oil and diesel
	Domestic	Promote cleaner cooking and increased use of natural gas
India ³⁵⁻⁴⁰	Transport	Introduction of Euro VI equivalent standards for vehicles and fuels
	Industry and power	Emissions standards for various industries
	Domestic	LPG connections to 50 million rural households by 2019
	Localised action plans	Graded Response Action Plan for Delhi Comprehensive Action Plan for pollution control in the National Capital Territory
	Brick kilns	Transition to “induced draft zig-zag” technology
Bangladesh ⁴¹⁻⁴³	Transport	Ban on 2-stroke engines, introduction of compressed natural gas vehicles in Dhaka
	Brick kilns	Introduction of Hybrid Hoffman kilns
	Multiple sectors	Air Pollution Reduction Strategy for Bangladesh
Sri Lanka ⁴⁴	Transport	Phasing out 2-stroke engines Introduction of vehicular testing programmes
Nepal ⁴⁵	Transport	Vehicle inspection and emissions testing Ban on 2-stroke engines Pollution cess on fuel
	Brick kilns	Ban on movable bull trench kilns
	Dust control	Road improvement and footpath development in Kathmandu

Health centred environmental policy making is required

With the multiplicity of sources, modes of exposure, and complexity of outcomes, there is no easy solution to the problem of air pollution in South Asia. While household air pollution needs targeted interventions with substitute fuels, tackling ambient air pollution, with its varied sources, requires a broader approach. Systematic collection of air quality data and a scientific approach to air quality management are essential to tackle the varied sources of emissions. South Asian countries can learn from and adapt evidence based initiatives implemented in other parts of the world such as the Clean Air Act in the US⁴⁶ and China’s five year, targeted 10 point action plan to improve air quality in three provinces.⁴⁷ Local solutions and policies must be designed to tackle the major sources and contributors. Box 2 provides an example of a recent programme launched in India to reduce household air pollution by expanding access to clean cooking fuel.

An evidence informed, multisectoral approach to policy making is required.⁵⁴

While the health sector can play a convening role on initiatives to minimise exposure and ameliorate health impacts, the onus of action lies outside, with the implementation of policies and programmes across the ministries of environment, energy, industry, and finance, among others.

The emphasis on “health in all policies” laid out in the 68th World Health Assembly’s resolution on air pollution provides a roadmap to tackle a cross sectoral issue like air pollution where health is adversely affected as a result of ineffective policy making across sectors. The resolution emphasised the need for health related benchmarks of progress in air pollution control measures, and advocated health impact assessments in policy design, implementation, and evaluation related to air pollution.⁵⁵ In the context of growing energy use, rapid urbanisation, and increased demand for personal and public transport, the health

Box 2: Increasing access to clean cooking fuel in India

The Indian government has historically provided a subsidy for liquefied petroleum gas (LPG). Access to this subsidy, however, was skewed heavily in favour of the urban population.⁴⁸

To tackle this imbalance, the Pradhan Mantri Ujjwala Yojana was launched in May 2016 with the aim of providing 50 million rural households with subsidised LPG connections by 2019, where hitherto they had been using solid fuels for cooking (fig 5).

This was coupled with a campaign to encourage urban recipients to give up their subsidy, and the PAHAL scheme for direct transfer of LPG subsidies to beneficiaries’ bank accounts.^{49 50} The programme exceeded its connection targets in the first year.⁵¹ The investment both by way of political will and finances is vital. The question, however, of whether access equates with usage remains—newspapers have recently reported on beneficiaries dropping out after initial refills.^{52 53}



Fig 5 | An advertisement for the Pradhan Mantri Ujjwala Yojana (Source: www.assams.info/images/2016/05/PMUY.jpg)

impacts of air pollution can be a conscience keeper for the principles of sustainable urbanisation and development.

While localised sources and emissions are important to tackle exposure, it is also vital to recognise the role of long distance and transboundary transport of air pollution in an interconnected airshed like the Indo-Gangetic Plain which links Bangladesh, India, and Pakistan. Existing political platforms, such as the South Asian Association for Regional Cooperation, must be leveraged to drive action on air quality. WHO's multisectoral action plan on non-communicable diseases provides a platform through which national and regional consensus can be fostered on the health impacts of air pollution. In addition to the nine traditional risk factors outlined in the action plan, member states of WHO's South East Asia region included the reduction of exposure to household air pollution from biomass as a target for the region. This platform can be the basis for coordinated and innovative regional action to reduce exposures and improve health outcomes.

Sources and methods

We used data from the Global Burden of Disease Study (GBD) 2015 on ambient and household exposure to air pollution and health burden estimates. Details on the methods for exposure estimation are described elsewhere.^{29 30}

We do not know of any other study that provides national level estimates for the purpose of comparison across different countries. In this context, we acknowledge the need to strengthen the

local evidence base by conducting more direct epidemiological studies on the health effects of ambient and household air pollution which would accord greater confidence to the burden estimates.

During the preparation of this manuscript, the GBD estimates for 2016 were released. We believe that the minor revision in overall numbers did not necessitate shifting to the 2016 estimates for this article.

For other information covered in this article, we conducted searches on PubMed, Google Scholar, and Science Direct for relevant reviews and reports published in the region, and drew on our collective experience in this field.

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Bhargav Krishna, manager (technical)

Kalpna Balakrishnan, associate dean (research) and director

Amna R Siddiqui, associate professor

Bilkis A Begum, chief scientific officer

Damodar Bachani, director

Michael Brauer, professor

¹Centre for Environmental Health, Public Health Foundation of India, Gurgaon, India

²Department of Environmental Health Engineering, Sri Ramachandra University, Chennai, India

³Department of Community Health Sciences, Aga Khan University, Karachi, Pakistan

⁴Chemistry division, Atomic Energy Centre, Dhaka (AECD), Dhaka, Bangladesh

⁵School of Population and Public Health, University of British Columbia, Vancouver, Canada

Correspondence to: Bhargav Krishna
bhargavkrishna@gmail.com

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