Smoke, health, and climate: updates with relation to Nepal

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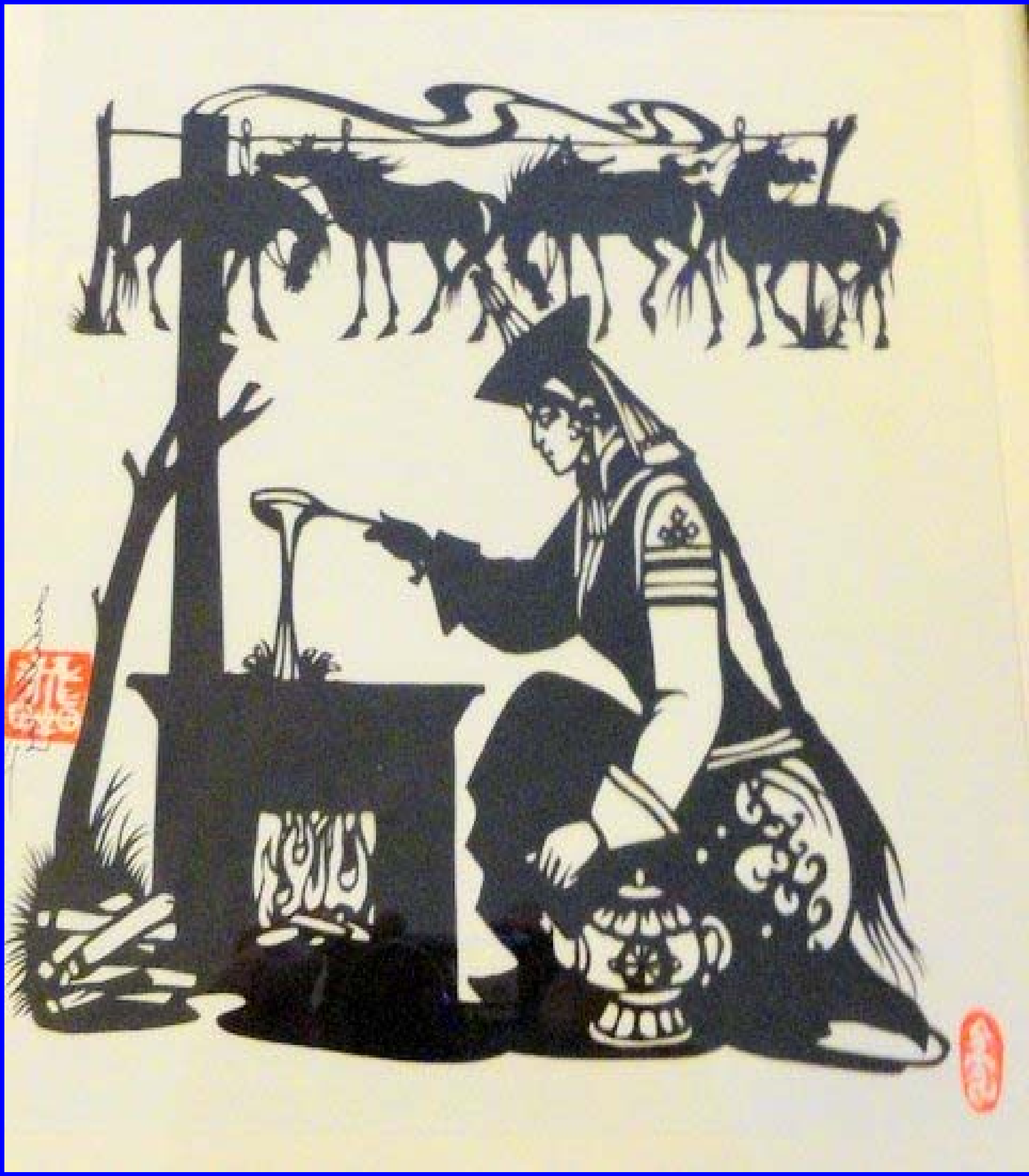
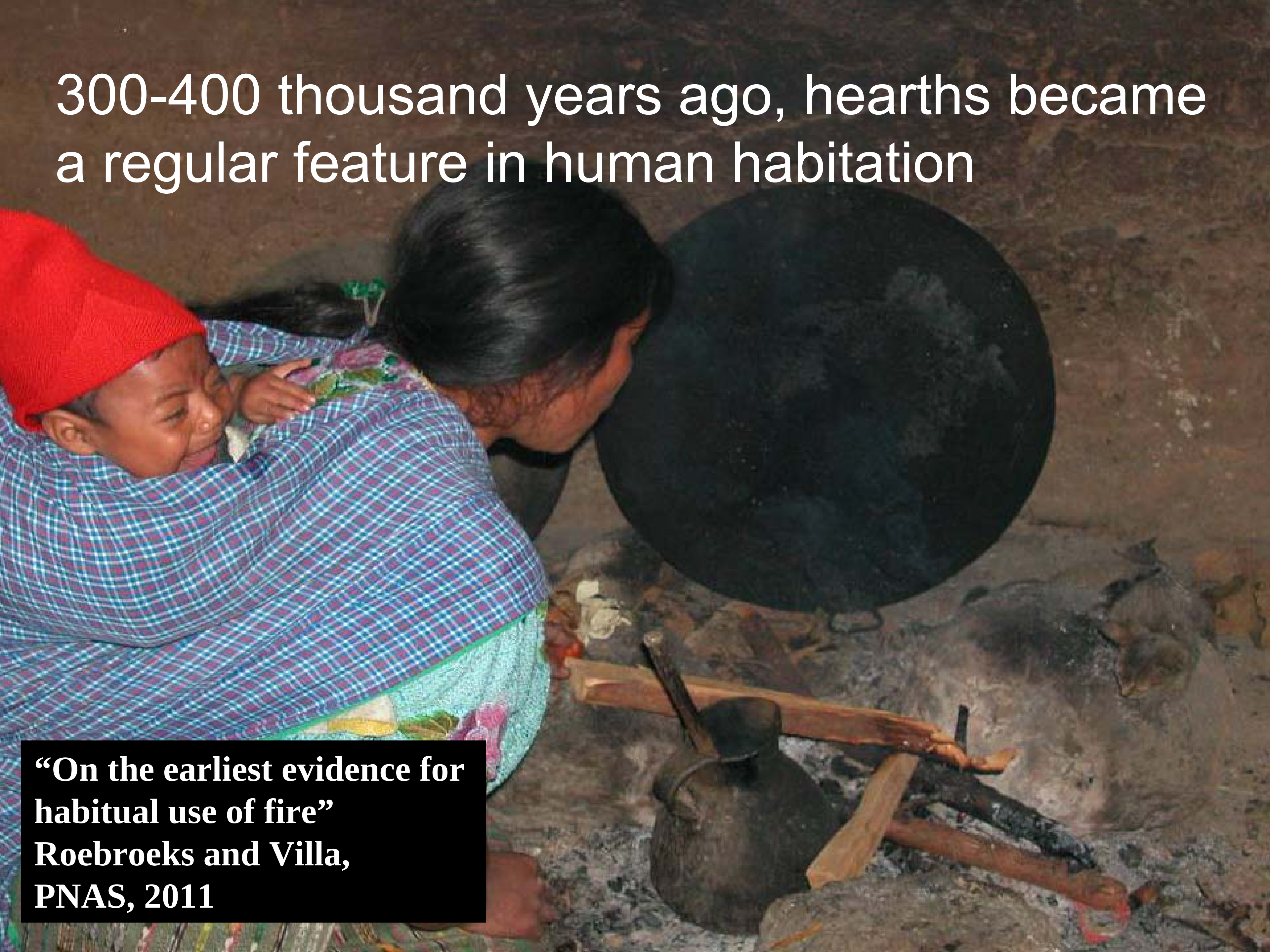
January 13, 2012



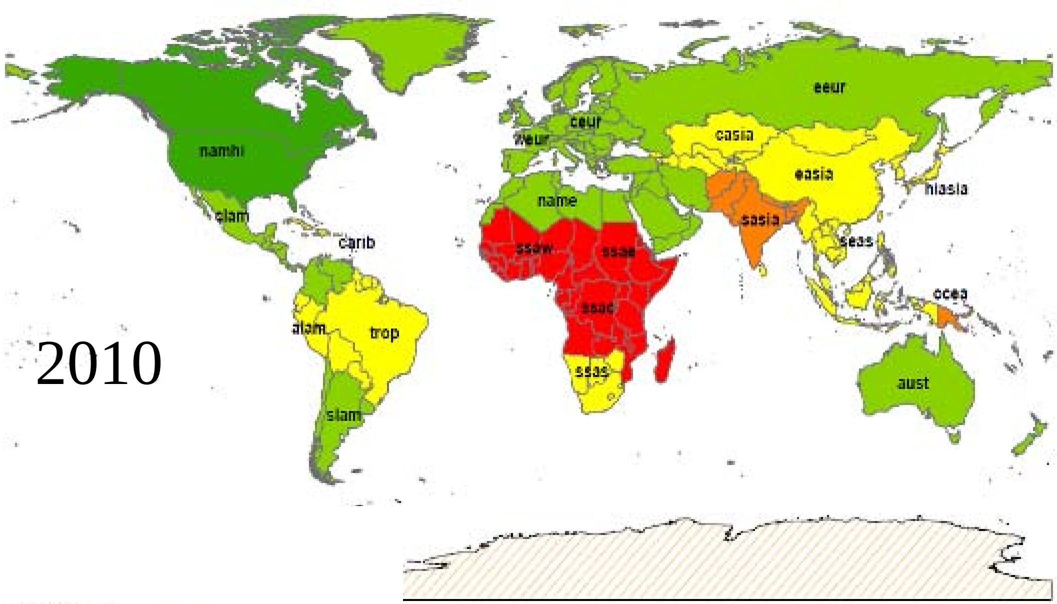
300-400 thousand years ago, hearths became a regular feature in human habitation



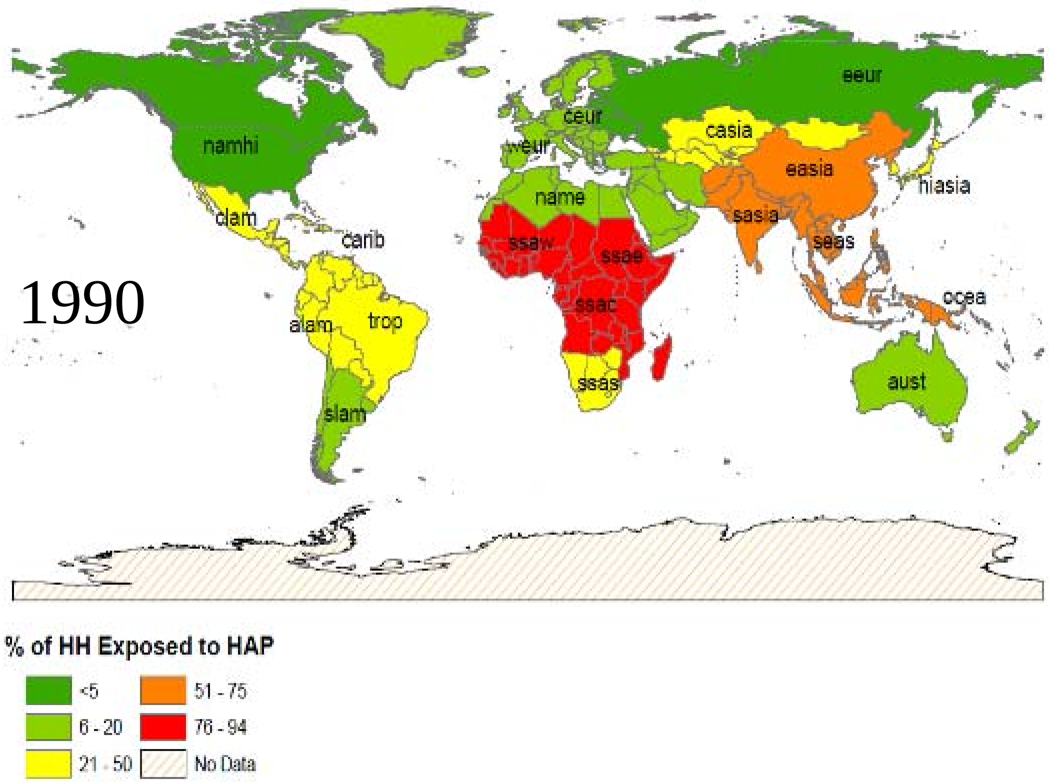
“On the earliest evidence for habitual use of fire”
Roebroeks and Villa,
PNAS, 2011

Households using biomass or coal to cook

2010

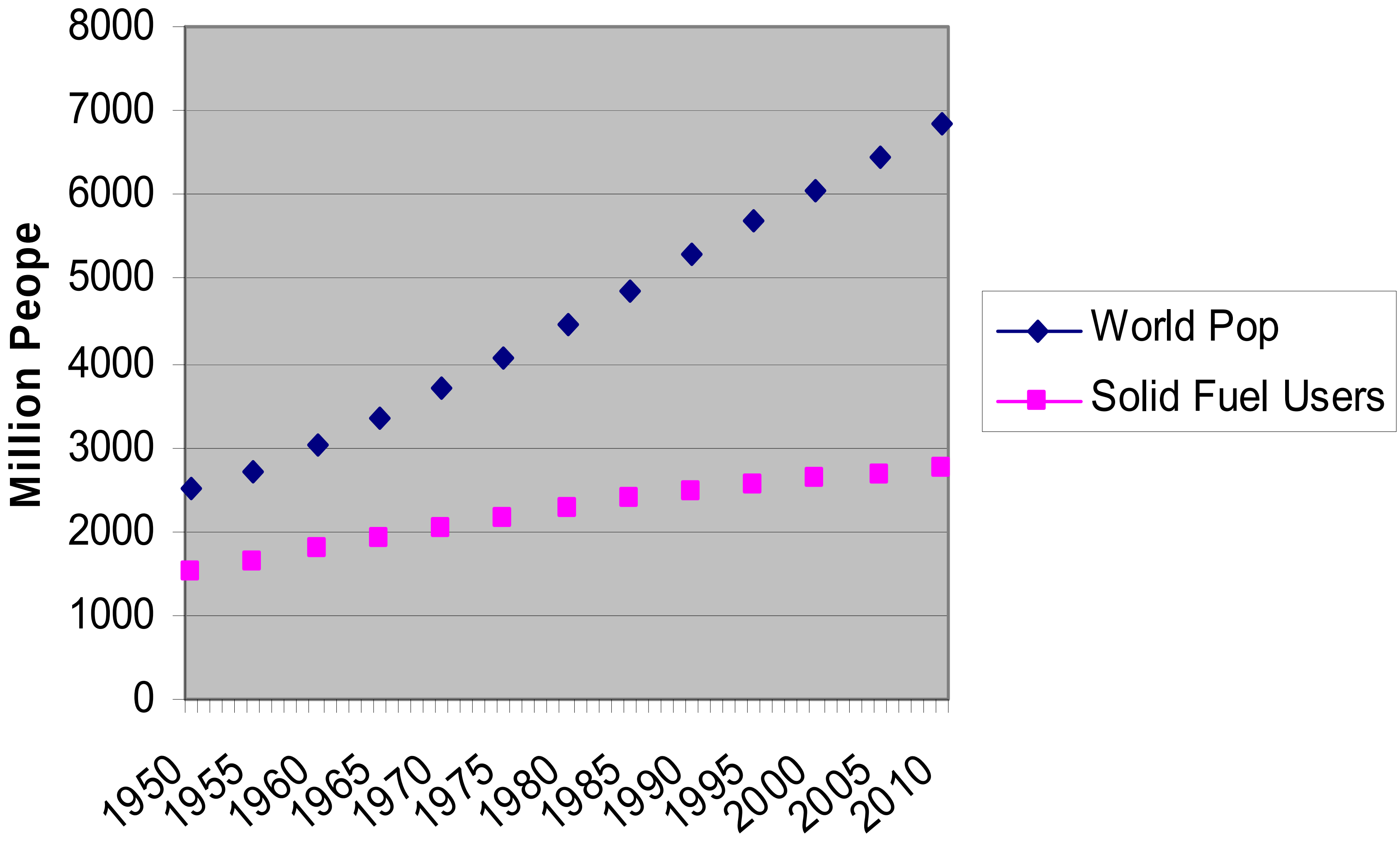


1990



Comparative Risk Assessment (CRA) 2011- preliminary, Adair, et al.

World Population Using Solid Fuels




The three major solid fuels

Woodsmoke is natural – how can it hurt you?

Or, since wood is mainly just carbon, hydrogen, and oxygen, doesn't it just change to CO_2 and H_2O when it is combined with oxygen (burned)?

Reason: the combustion efficiency is far less than 100%

Energy flows in a well-operating traditional wood-fired Indian cooking stove

A Toxic Waste Factory!!

Typical biomass cookstoves convert 6-20% of the fuel carbon to toxic substances

Into Pot	In PIC	Waste Heat
2.8 MJ	1.2 MJ	11.3 MJ
18%	8%	74%

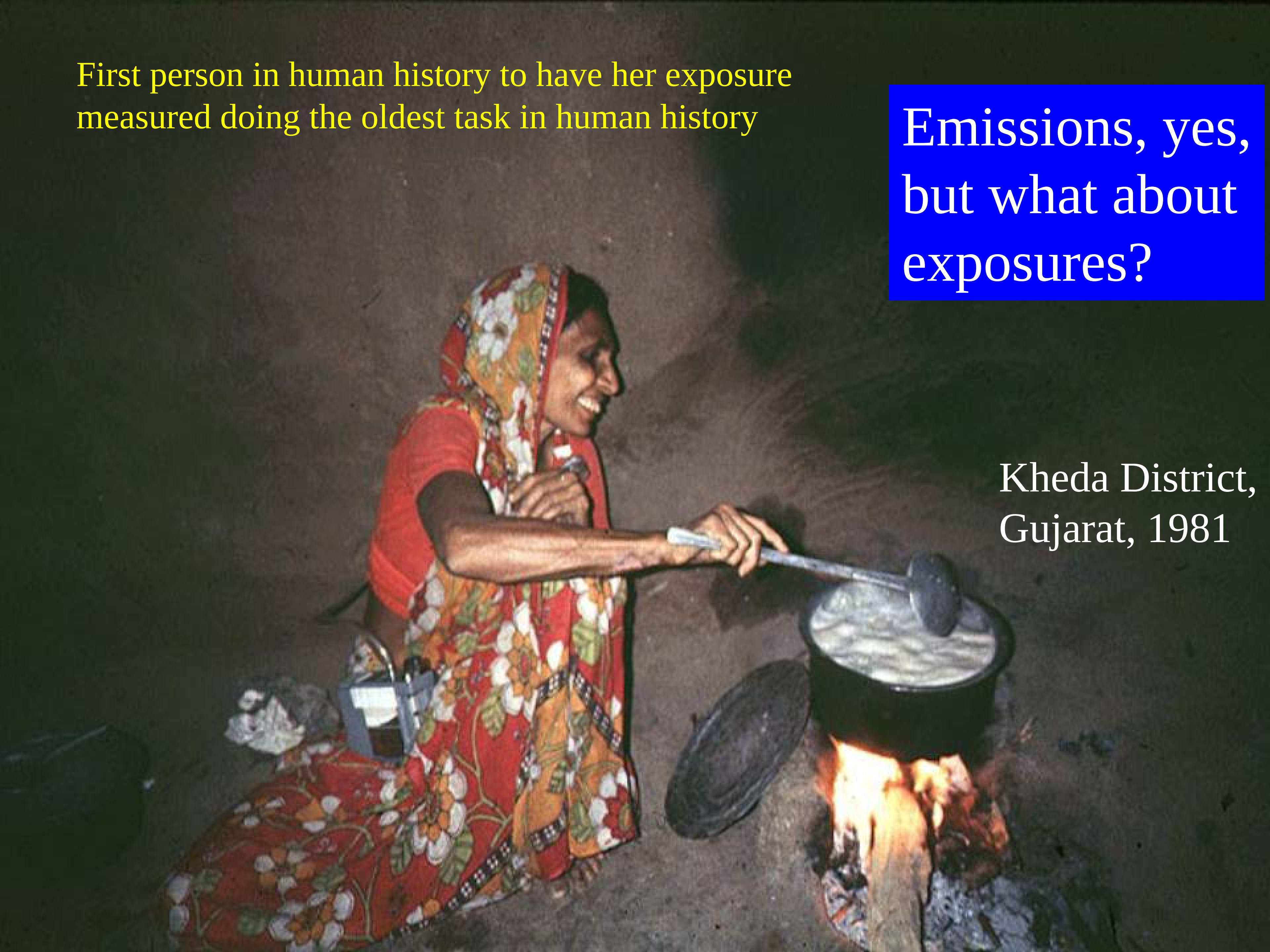
PIC = products of incomplete combustion = CO, HC, C, etc.

Source: Smith, et al., 2000

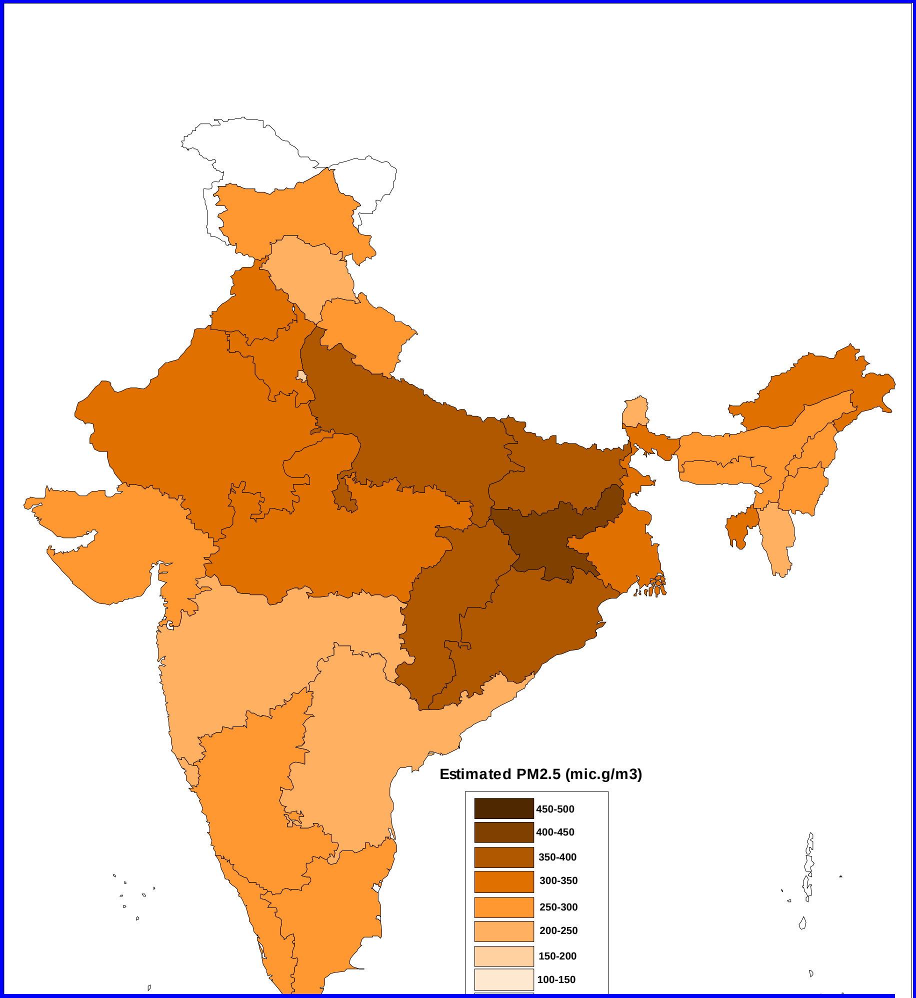
Toxic Pollutants in Biomass Fuel Smoke from Simple (poor) Combustion

- Small particles, CO, NO_2
- Hydrocarbons
  - 25+ saturated hydrocarbons such as *n-hexane*
  - 40+ unsaturated hydrocarbons such as *1,3 butadiene*
  - 28+ mono-aromatics such as *benzene & styrene*
  - 20+ polycyclic aromatics such as *benzo(*α*)pyrene*
- Oxygenated organics
  - 20+ aldehydes including *formaldehyde* & *acrolein*
  - 25+ alcohols and acids such as *methanol*
  - 33+ phenols such as *catechol* & *cresol*
  - Many quinones such as *hydroquinone*
  - Semi-quinone-type and other radicals
- Chlorinated organics such as *methylene chloride* and *dioxin*

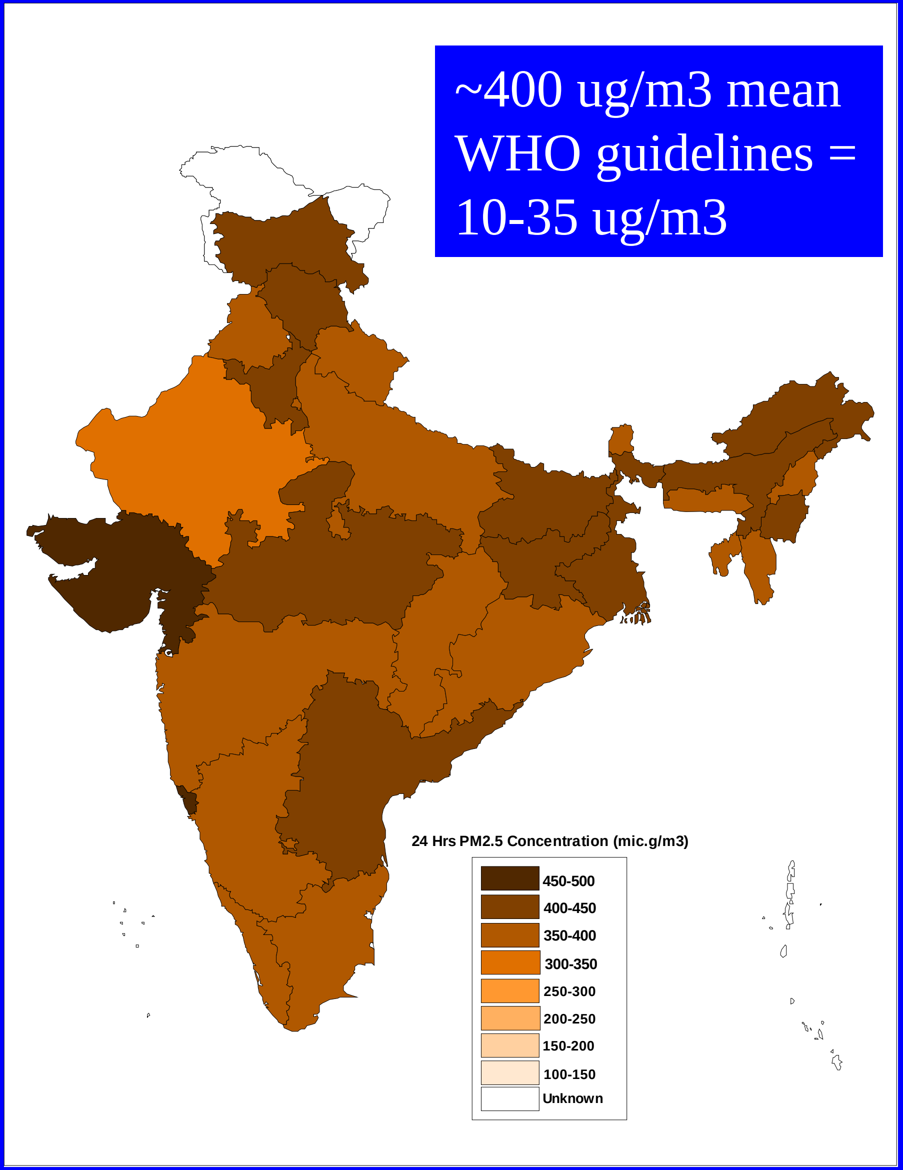
Source: Naeher et al, *J Inhal Tox*, 2007


First person in human history to have her exposure measured doing the oldest task in human history
Emissions, yes, but what about exposures?
Kheda District, Gujarat, 1981

Estimated PM2.5 indoors for all households



Estimated PM2.5 for only solid-fuel-using households



~400 ug/m3 mean
WHO guidelines = 10-35 ug/m3

Preliminary results from the Household Air Pollution Comparative Risk Assessment, 2011

Bhaktapur, Nepal 24-h PM2.5 Kitchen Levels

Stove	N	(%)	Uncorrected UCB mass Mean (SD) μg/m3	Corrected UCB mass (SD) μg/m3
Mud – wood/crop	187	(20.73)	655 (910)	688 (956)
Husk	47	(5.21)	598 (973)	695 (1128)
Kerosene	212	(23.50)	245 (304)	211 (262)
LPG	256	(28.38)	167 (240)	50 (73)
Electric Hotplate	196	(21.73)	186 (419)	67 (151)
"Improved" Cookstove	9	(0.33)	957 (892)	1071 (863)

ALRI/
Pneumonia

Low birth
weight

Stillbirth

COPD

Lung cancer
(coal)

Lung cancer
(biomass)

Blindness
(cataracts, opacity)

CV disease
Blood pressure
ST-segment

These additional diseases will be included in the
2011 Comparative Risk Assessment

In addition, using evidence from other
exposure sources, heart disease will be included

There is epi evidence for these other diseases, but considered insufficient to include in the 2011 Comparative Risk Assessment

Cognitive Impairment

Birth defects

Asthma?

Tuberculosis

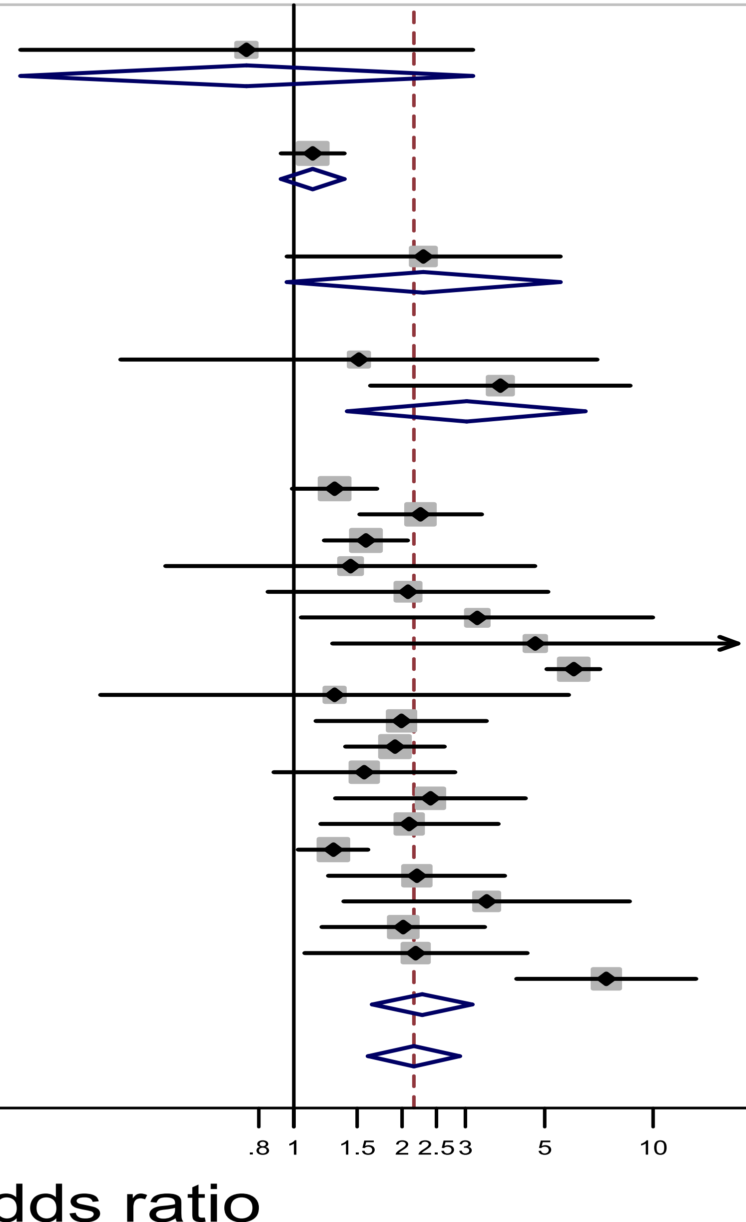
ALRI

Other cancers
(cervical, NP, upper airway)

Burns and the health/safety impacts of fuel gathering

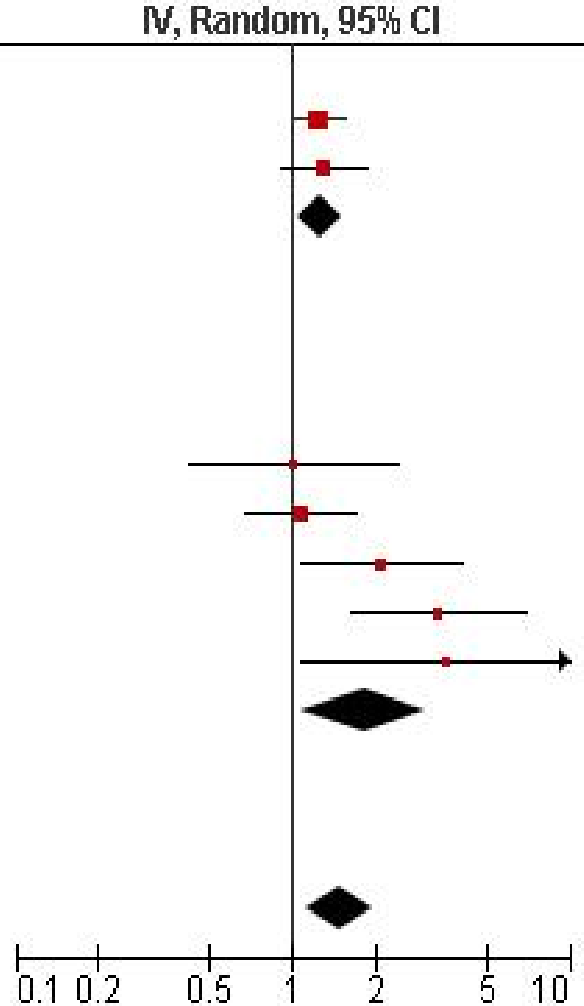
Summary risk estimates of lung cancer associated with in-home coal use for heating and cooking by geographic region

study	studyyear	casenum	contnum	ES (95% CI)
Africa				
Sasco(2002)	1996-1998	118	235	0.74 (0.17, 3.14)
Subtotal (I-squared = .%, p = .)				0.74 (0.17, 3.14)
.				
Europe				
Lissowska(2005)	1998-2001	2861	3118	1.13 (0.93, 1.38)
Subtotal (I-squared = .%, p = .)				1.13 (0.93, 1.38)
.				
North America				
Wu(1985)	1981-1982	220	220	2.30 (0.96, 5.50)
Subtotal (I-squared = .%, p = .)				2.30 (0.96, 5.50)
.				
India				
Gupta(2001)	1995-1997	265	525	1.52 (0.33, 6.98)
Sapkota(2008)	2001-2004	793	718	3.76 (1.64, 8.63)
Subtotal (I-squared = 4.4%, p = 0.307)				3.02 (1.42, 6.46)
.				
Mainland China and Taiwan				
Wu-Williams(1990)	1985-1987	965	959	1.30 (0.99, 1.70)
Sun(1991)	1985-1987	418	398	2.26 (1.53, 3.33)
Chengyu(1992)	1990-1991	135	135	1.59 (1.22, 2.07)
Ger(1993)	1990-1991	131	524	1.44 (0.44, 4.69)
Li(1993)	1986-1992	161	161	2.08 (0.85, 5.08)
Lin(1996)	1985-1990	122	122	3.24 (1.05, 9.94)
Dai(1996)	1992-1993	120	120	4.70 (1.29, 17.18)
Luo(1996)	1990-1991	102	306	6.00 (5.07, 7.10)
Ko(1997)	1992-1993	117	117	1.30 (0.29, 5.80)
Hao(1998)	1981-1986	220	440	1.99 (1.16, 3.43)
Huang(1999)	1993-1996	122	244	1.92 (1.40, 2.62)
Wu(1999)	1997	258	258	1.58 (0.89, 2.80)
Lan(2000)	1995-1996	122	122	2.40 (1.31, 4.40)
Lee(2001)	1993-1999	527	805	2.10 (1.19, 3.70)
Kleinerman(2002)	1994-1998	832	1724	1.29 (1.03, 1.61)
Sun(2002)	1996-1999	206	618	2.20 (1.25, 3.86)
Lu(2003)	1998-2001	445	445	3.44 (1.38, 8.57)
Liang(2004)	2001-2002	152	152	2.02 (1.20, 3.39)
Galeone(2008)	1987-1990	218	436	2.19 (1.08, 4.46)
Lan(2008)	1985-1990	498	498	7.40 (4.18, 13.10)
Subtotal (I-squared = 90.3%, p = 0.000)				2.28 (1.66, 3.13)
.				
Overall (I-squared = 90.4%, p = 0.000)				2.16 (1.62, 2.90)



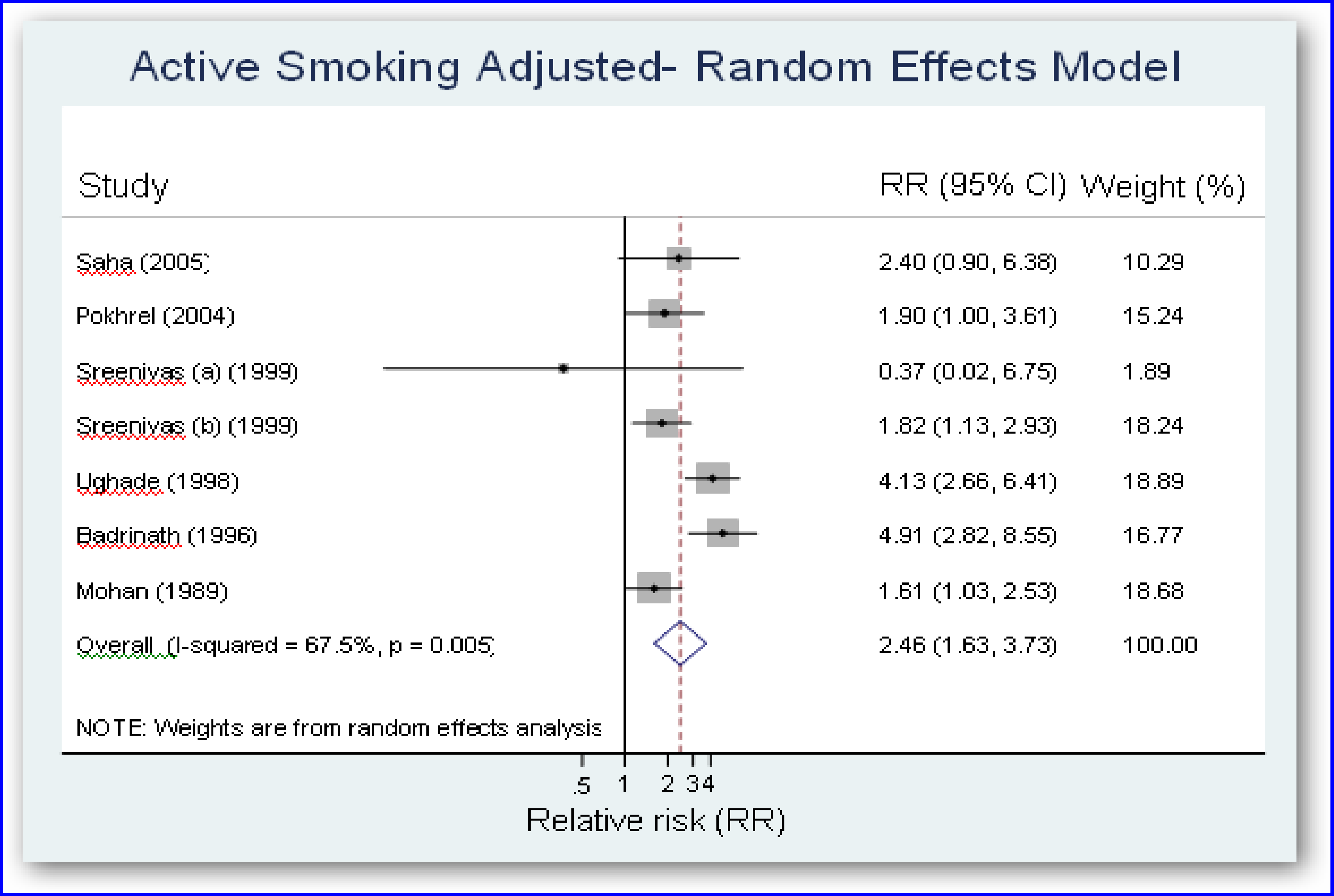
Lung Cancer: Biomass vs. clean fuel

Study or Subgroup	IV, Random, 95% CI
2.7.1 Male	
Lissowska2005	1.24 [1.00, 1.54]
Sapkota2008	1.30 [0.90, 1.87]
Subtotal (95% CI)	**1.26 [1.04, 1.52]**
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.05$, df = 1 (P = 0.83); $I^2 = 0\%$	
Test for overall effect: Z = 2.37 (P = 0.02)	
2.7.2 Female	
Sapkota2008	1.01 [0.42, 2.41]
Lissowska2005	1.07 [0.67, 1.71]
Ko1997	2.08 [1.06, 4.07]
Lee2001	3.36 [1.62, 6.96]
Behera 2005	3.59 [1.08, 11.97]
Subtotal (95% CI)	**1.81 [1.07, 3.06]**
Heterogeneity: $Tau^2 = 0.21$; $Chi^2 = 10.21$, df = 4 (P = 0.04); $I^2 = 61\%$	
Test for overall effect: Z = 2.20 (P = 0.03)	
Total (95% CI)	**1.48 [1.12, 1.97]**
Heterogeneity: $Tau^2 = 0.06$; $Chi^2 = 12.14$, df = 6 (P = 0.06); $I^2 = 51\%$	
Test for overall effect: Z = 2.75 (P = 0.006)	
Test for subgroup differences: $Chi^2 = 1.89$, df = 1 (P = 0.17), $I^2 = 47.1\%$	



CRA, Imran et al. preliminary

Cataracts and Biomass Cooking Smoke*



* Adjusted for UV

CRA Preliminary, Adair et al.

Pooled birth weight difference (low minus high exposure):

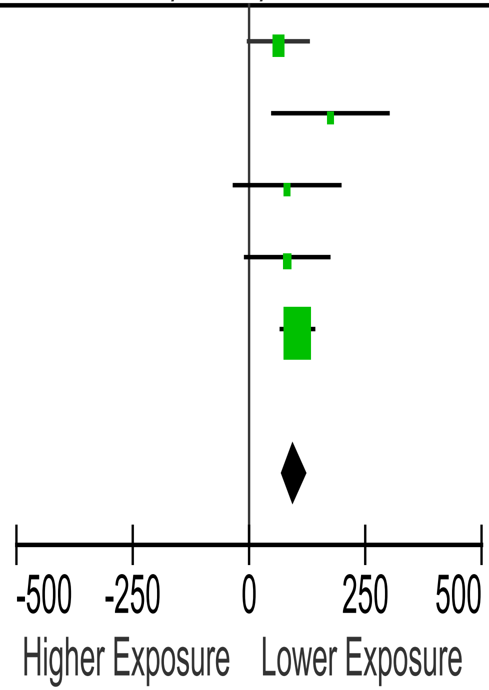
Adjusted estimates (Boy and Tielsch have GA)

Study or Subgroup	Lower Exposure Mean	Lower Exposure SD	Lower Exposure Total	Higher Exposure Mean	Higher Exposure SD	Higher Exposure Total	Weight	Mean Difference IV, Fixed, 95% CI
Boy 2002	2,835	533	357	2,772	525	871	18.5%	63.00 [-2.36, 128.36]
Mishra 2004	3,271	1,448	766	3,096	1,429	1535	5.0%	175.00 [50.00, 300.00]
Siddiqui 2008	2,812	404	80	2,730	385	108	6.0%	82.00 [-32.50, 196.50]
Thompson 2005	2,805	579	366	2,723	573	268	9.6%	82.00 [-8.69, 172.69]
Tielsch 2009	2,819	453	646	2,715	420	8958	60.9%	104.00 [68.00, 140.00]
Total (95% CI)			**2215**			**11740**	**100.0%**	**96.58 [68.49, 124.67]**

Heterogeneity: $Chi^2 = 2.85$, $df = 4$ ($P = 0.58$); $I^2 = 0\%$

Test for overall effect: $Z = 6.74$ ($P < 0.00001$)

Mean Difference IV, Fixed, 95% CI



All estimates: +96.6g (68.5, 124.7)

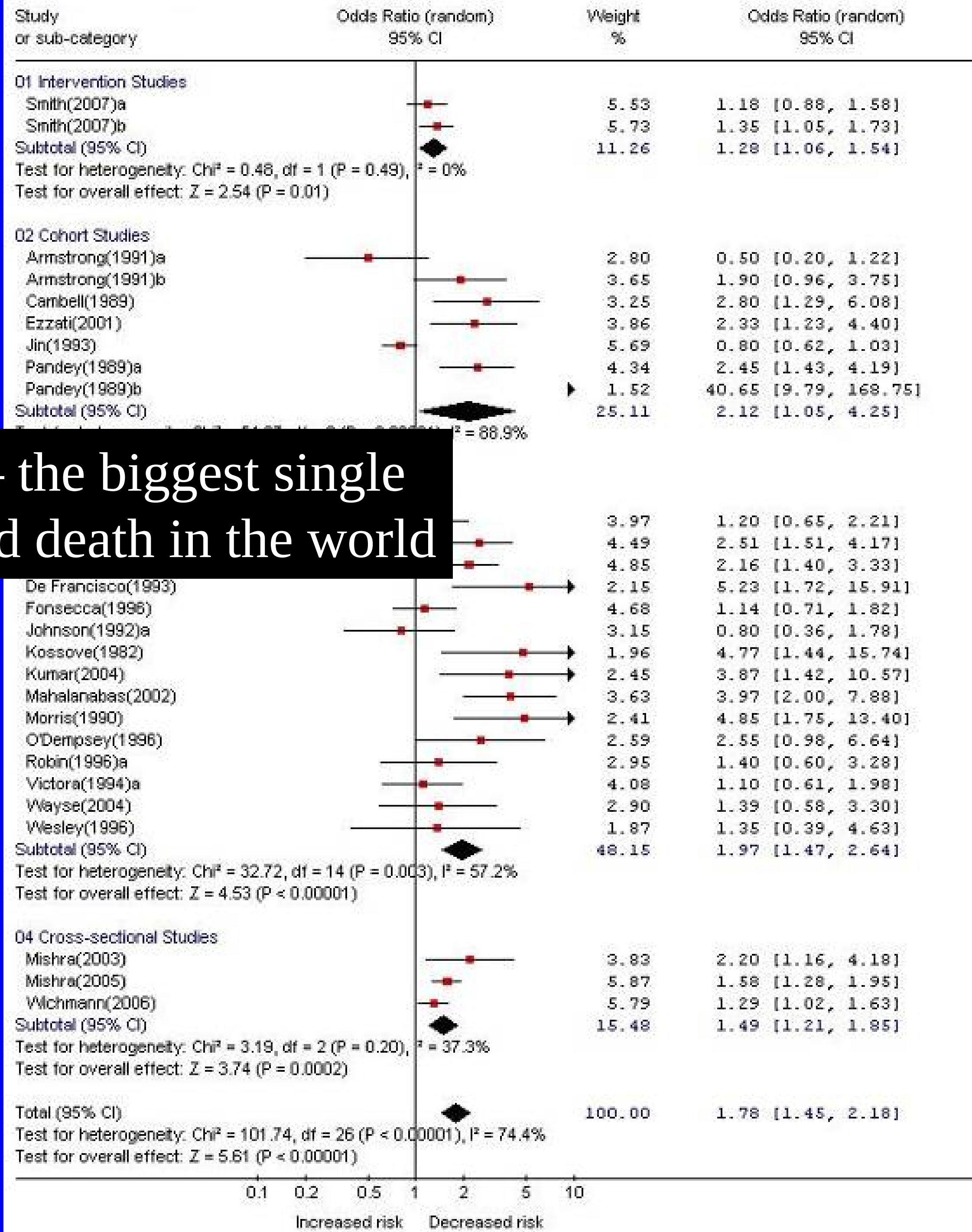
Excluding self-reports +93.1g (64.6, 121.6)

CRA: Pope et al., 2010

Study design	N*	OR	95% CI
Intervention	2	1.28	1.06, 1.54
Cohort	7	2.12	1.06, 4.25
Case-control	15	[illegible]	
Cross-sectional	3	1.49	1.21, 1.85
All	26	1.78	1.45, 2.18

Dherani et al Bull WHO (2008)

Pneumonia – the biggest single cause of child death in the world



Contents lists available at SciVerse ScienceDirect

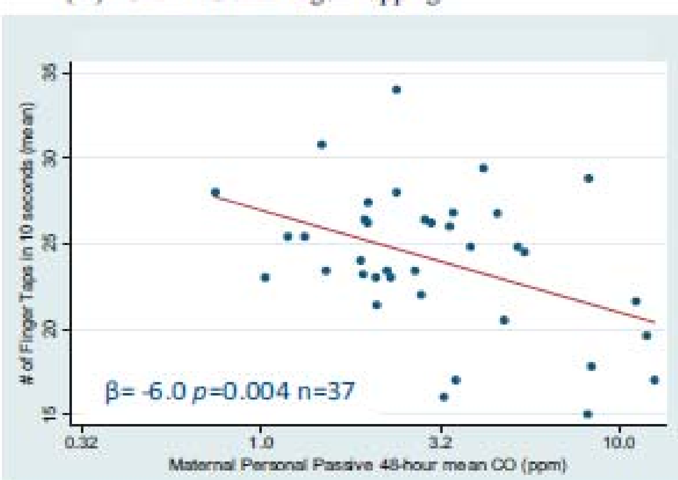
NeuroToxicology

Neurodevelopmental performance among school age children in rural Guatemala is associated with prenatal and postnatal exposure to carbon monoxide, a marker for exposure to woodsmoke

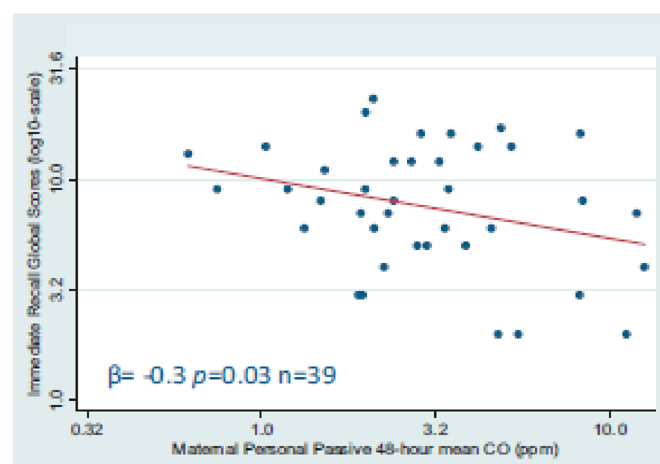
Linda Dix-Cooper [a], Brenda Eskenazi [b], Carolina Romero [c], John Balmes [a,d], Kirk R. Smith [a,*]

[a] Division of Environmental Health Sciences, School of Public Health, University of California, Berkeley, CA 94720-7360, USA
[b] Center for Environmental Research and Children's Health (CERCH), School of Public Health, University of California, Berkeley, CA, USA
[c] Centro de Estudios en Salud Universidad Del Valle, Guatemala
[d] Division of Occupational and Environmental Medicine, Department of Medicine, University of California, San Francisco, CA, USA

(D) Reitan-Indiana Finger Tapping



(B) Bender Gestalt-II Immediate Recall Figures Phase



Story of Two Conferences

- Air pollution conference
  - High exposures to large vulnerable population
  - No more health effects work needed
- International health conference
  - Need to know exact benefit to be expected
  - Still some doubt about causality
- Where are your randomized controlled trials?

History of an RCT

- ~1980: Case reports of health effects in South Asia
- 1981: First measurements of pollution levels in India
- 1984: International meeting to decide on needed research
  - Chose randomized controlled trial (RCT) of ALRI
- 1986-89: Unfunded proposals to do RCT in Nepal
- 1990: WHO establishes committee to find best sites
- 1990-1992: Criteria established and site visits made
- 1992: Highland Guatemala chosen
- 1991-1999: Pilot studies to establish data needed for proposal – does stove work and do people use it?
- 1996-1999: Unfunded proposals
- 2001: NIEHS funding secured
- 2002-2006: Fieldwork completed
- 2011: Main results published
- 25+ years from deciding to conduct RCT to results!

THELANCET-D-09-06268R3

S0140-6736(11)60921-5

Embargo: [add date when known]

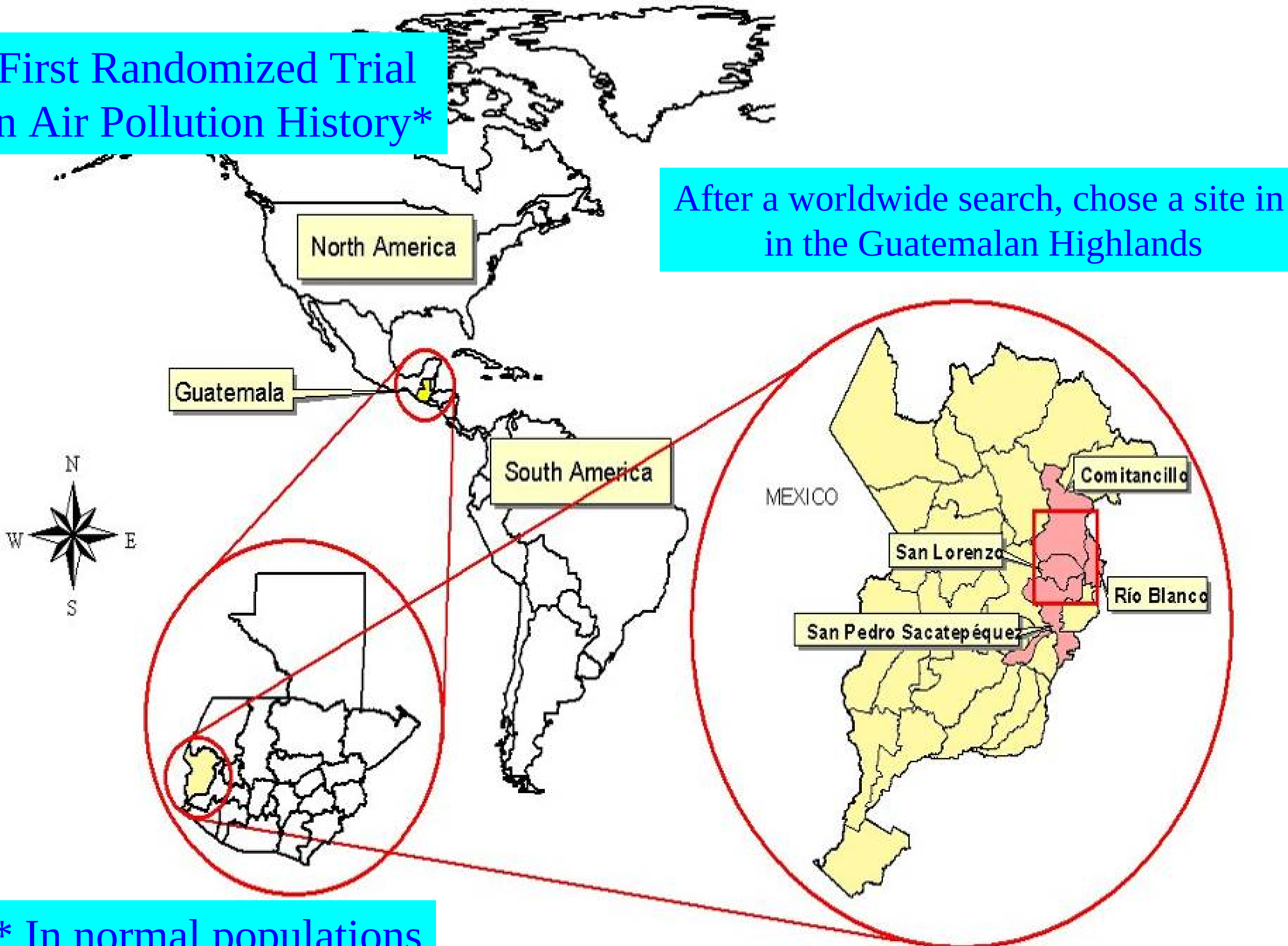
Effect of reduction in household air pollution on childhood pneumonia in Guatemala (RESPIRE): a randomised controlled trial

Kirk R Smith, John P McCracken, Martin W Weber, Alan Hubbard, Alisa Jenny, Lisa M Thompson, John Balmes, Anaite Diaz, Byron Arana, Nigel Bruce

Published Nov 2011

First Randomized Trial In Air Pollution History*

After a worldwide search, chose a site in in the Guatemalan Highlands



* In normal populations

RESPIRE – Randomized trial (n=518)

Impact on pneumonia up to 18 months of age

Traditional open 3-stone fire: kitchen 48-hour $PM_{2.5}$ levels of 600 - 1200 μg/m^3

Chimney wood stove, locally made and popular with households

Overview of RESPIRE study design

- 530 eligible households: open fire, woman pregnant or child less than 4 months
- Baseline survey and exposure assessment

Year 1

5500 Households total

Randomize

Keep open fire

Plancha

<u>Follow up till aged 18 months</u>

- Surveillance for ALRI, diarrhoea, &c
- Detailed exposure monitoring

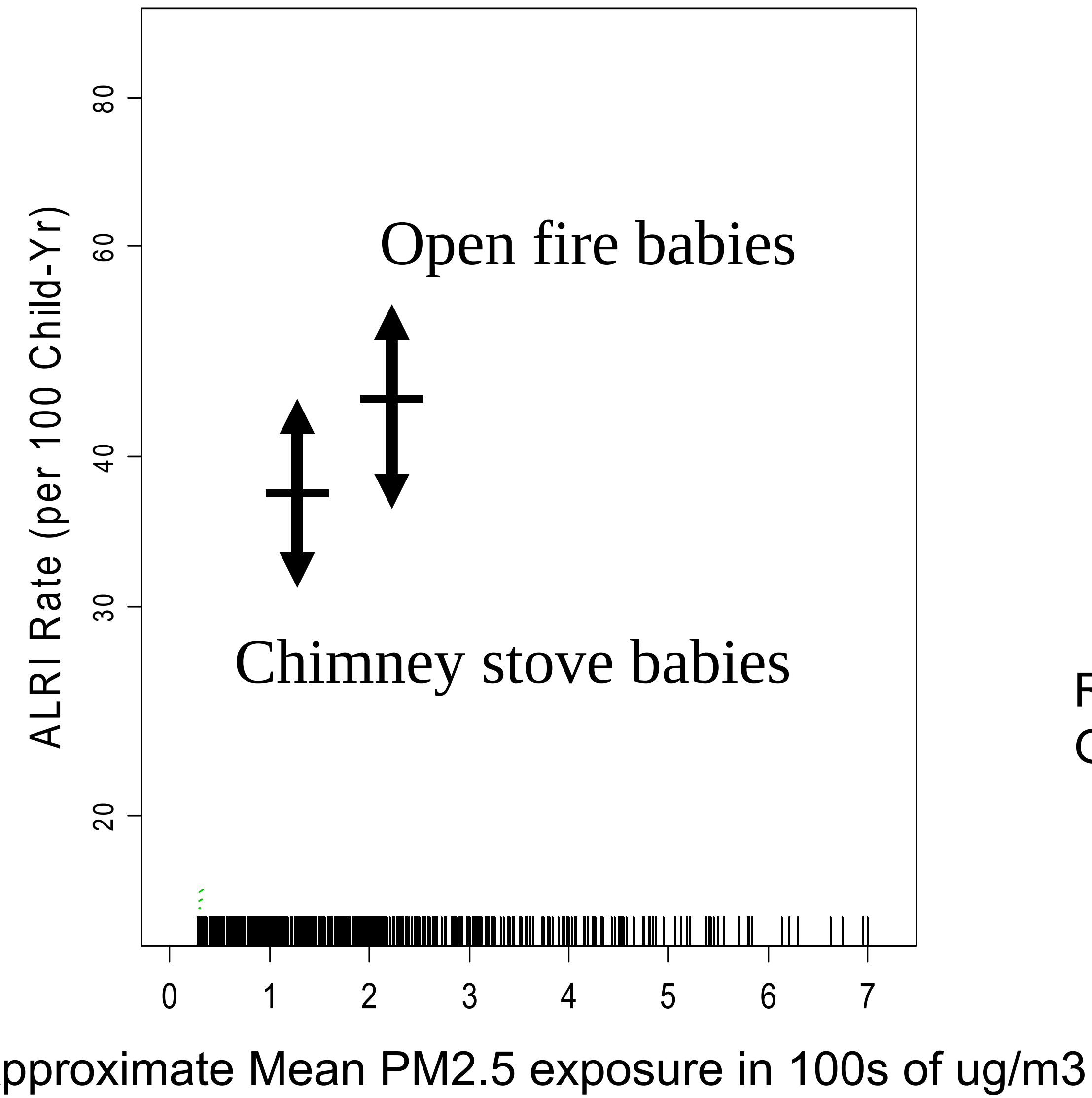
Years 1-3

Compare incidence and exposure in 2 groups
Plancha offered to ‘controls’

Years 3-4


CO monitor
CO monitor

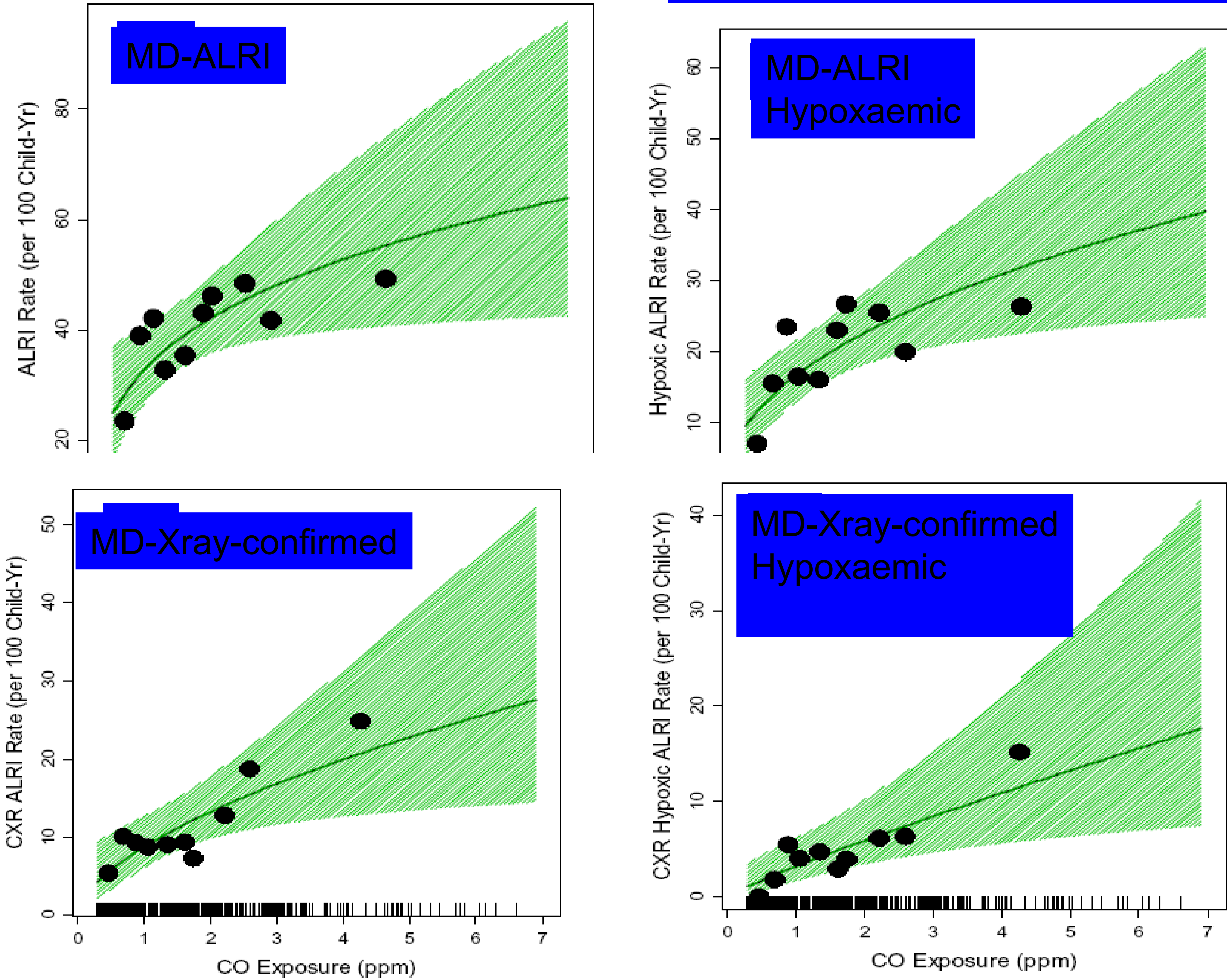
MD-diagnosed Acute Lower Respiratory Infection



RESPIRE-Guatemala

Adjustments for Exposure-Response Model

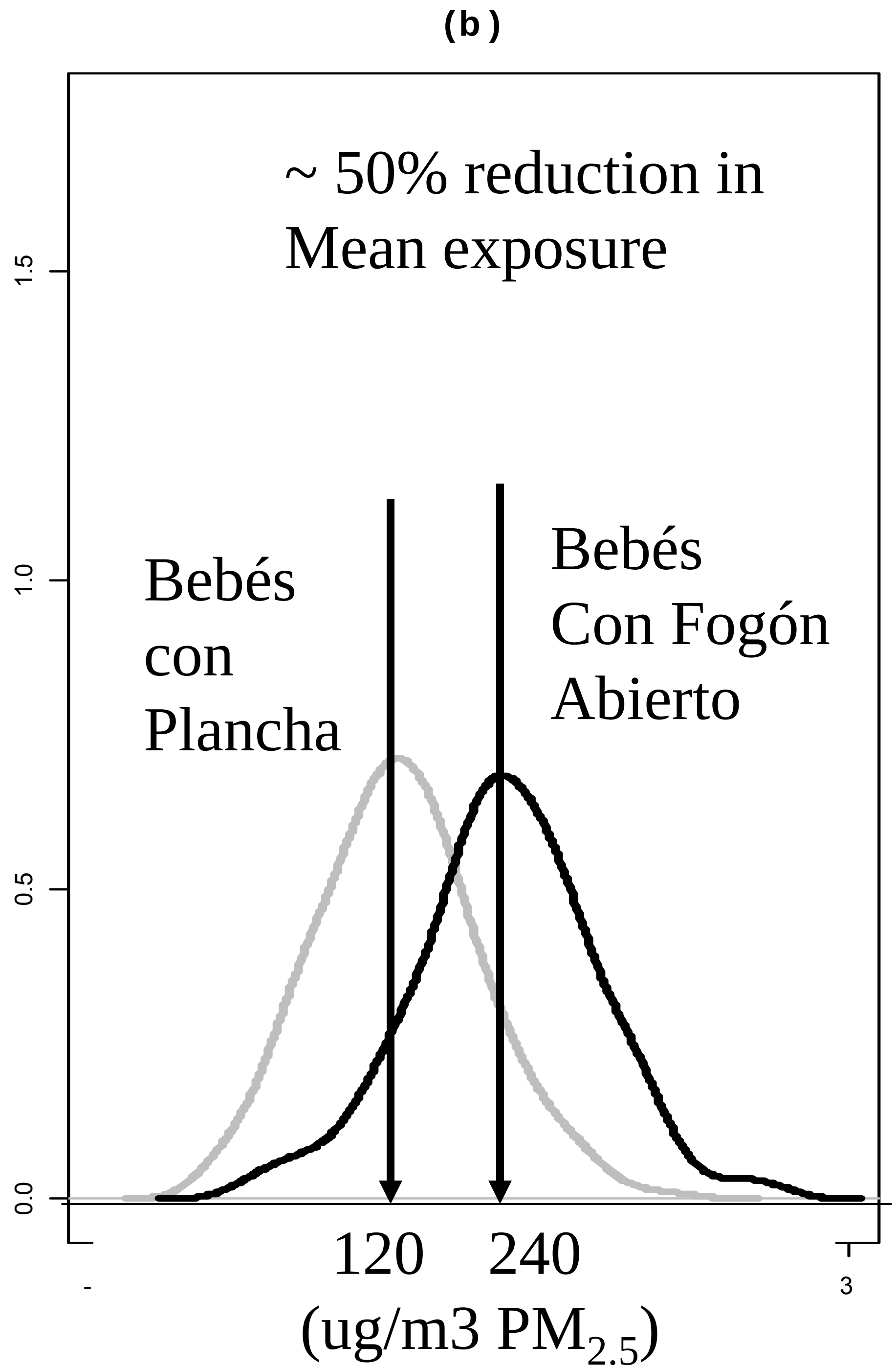
- Adjusted for child’s age (quadratic), sex, birth interval less than 2 yr (yes/no), mother’s age (quadratic), maternal education and paternal education (none/primary/secondary), secondhand tobacco smoke exposure (yes/no), latrine (yes/no), piped water (yes/no), electricity (yes/no), kerosene lamp (yes/no), wood-fired sauna (yes/no), bedroom in kitchen (yes/no), roof type (metal sheet/tiles/straw), earth floor (yes/no), asset index (linear over range 0 to 6), animal ownership index (linear over range 0 to 4), crowding index (people per room), altitude (5 categories), occupation (farm other land/farm own land/other), and season (cold dry, warm wet, warm dry).


MD-ALRI
ALRI Rate (per 100 Child-Yr)
MD-ALRI Hypoxaemic
Hypoxic ALRI Rate (per 100 Child-Yr)
MD-Xray-confirmed
CXR ALRI Rate (per 100 Child-Yr)
MD-Xray-confirmed Hypoxaemic
CXR Hypoxic ALRI Rate (per 100 Child-Yr)
CO Exposure (ppm)
CO Exposure (ppm)

RESPIRE: Pneumonia Reductions with Exposure Reduction
Preliminary Results

Exposure reduction	Overall MD-pneumonia	Severe (hypoxic) MD-pneumonia	CXR pneumonia	Severe (hypoxic) CXR pneumonia
25%	0.92 (0.86, 0.99)	0.88 (0.80, 0.97)	0.84 (0.74, 0.96)	0.79 (0.69, 0.95)
50%	0.82 (0.70, 0.98)	0.73 (0.59, 0.92)	0.66 (0.49, 0.91)	0.56 (0.40, 0.88)
75%	0.67 (0.50, 0.96)	0.53 (0.35, 0.84)	0.44 (0.24, 0.83)	0.31 (0.16, 0.78)
90%	0.51 (0.31, 0.93)	0.35 (0.17, 0.76)	0.26 (0.09, 0.74)	0.15 (0.05, 0.67)

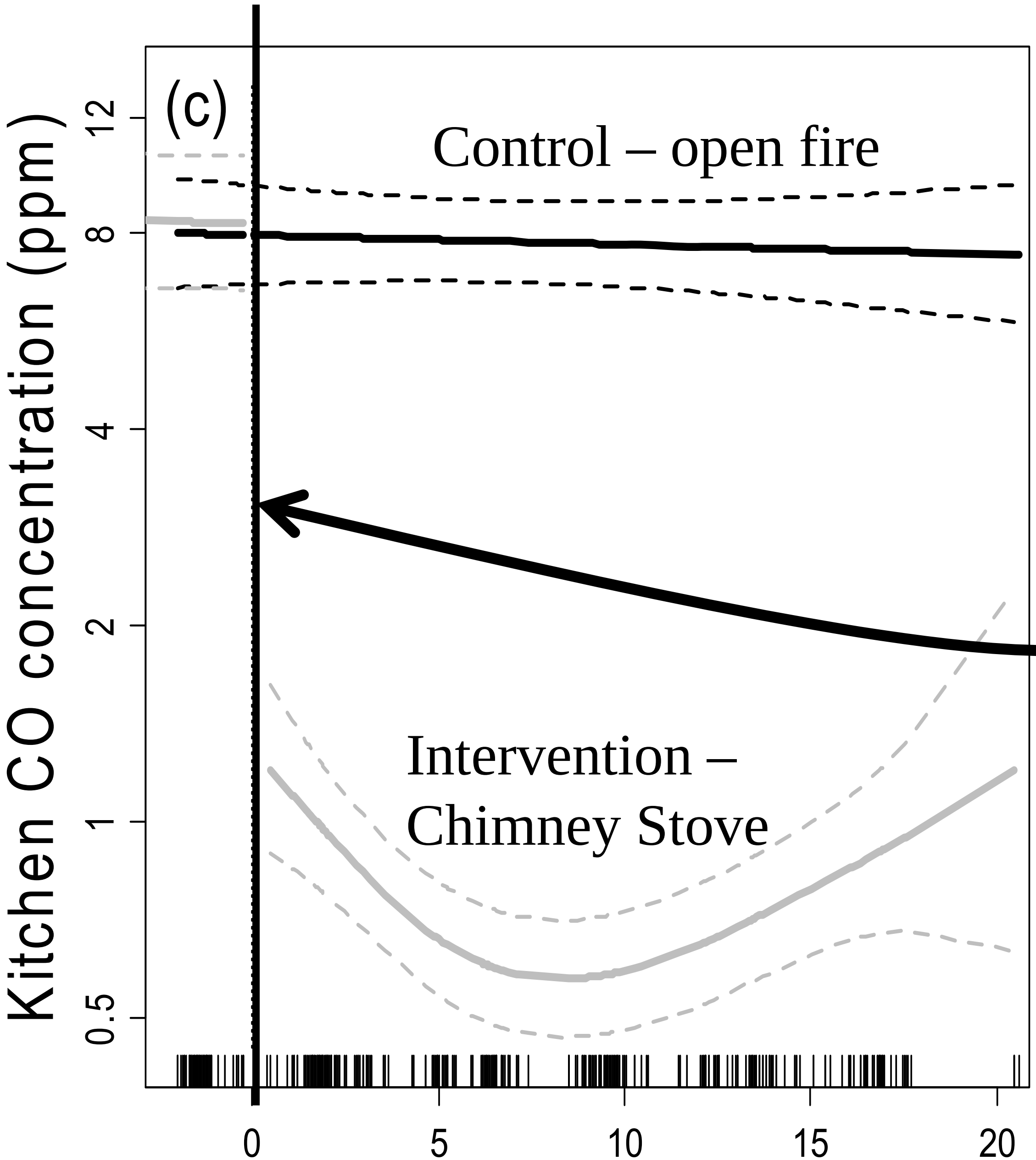
RESPIRE - Guatemala



Chimney stove did not protect all babies

McCracken et al. 2009

Guatemala RCT: Kitchen Concentrations



Effect of Chimney Stove On Kitchen CO Levels

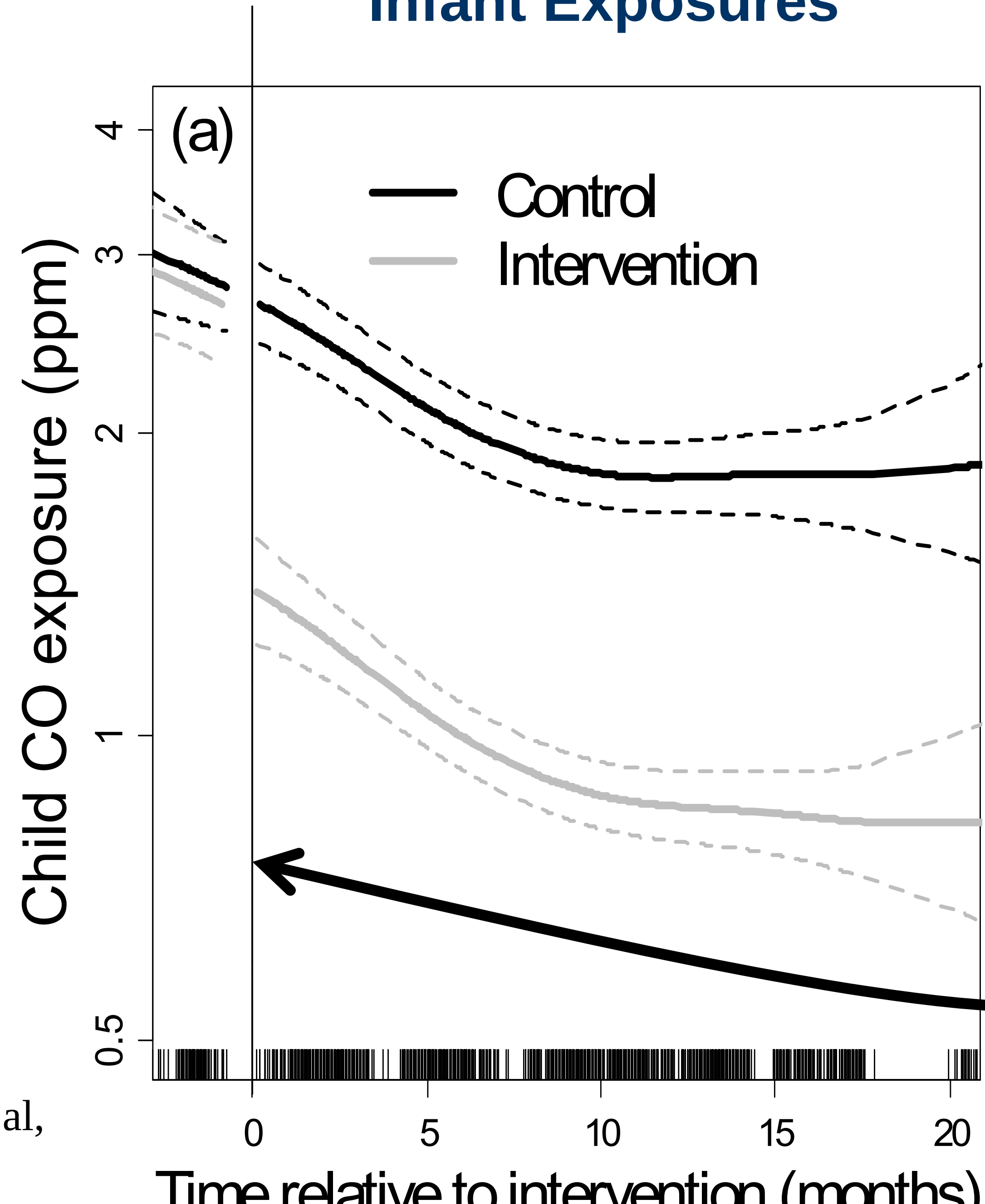
Factor of ~10 less

285 48-h measurements

Months

Smith, et al, 2010

Infant Exposures



1888 48-h measurements

Effect of Chimney Stove On Infant Exposures - 2x less

Smith, et al, 2010

RESPIRE Summary

- Results - ITT
  - Chimney stove did not reduce all MD pneumonia,
  - But did reduce severe MD pneumonia and
  - RSV-negative (bacterial pneumonia)
  - Even though well operating, chimney was not capable of sufficient exposure reduction by itself
- Results – Exposure-response
  - All major outcome showed significant results (still not RSV pneumonia)
  - Partial exposure reduction brings some benefit, but ER curve highly non-linear
  - Large reductions needed for substantial health benefits – levels not possible with chimneys

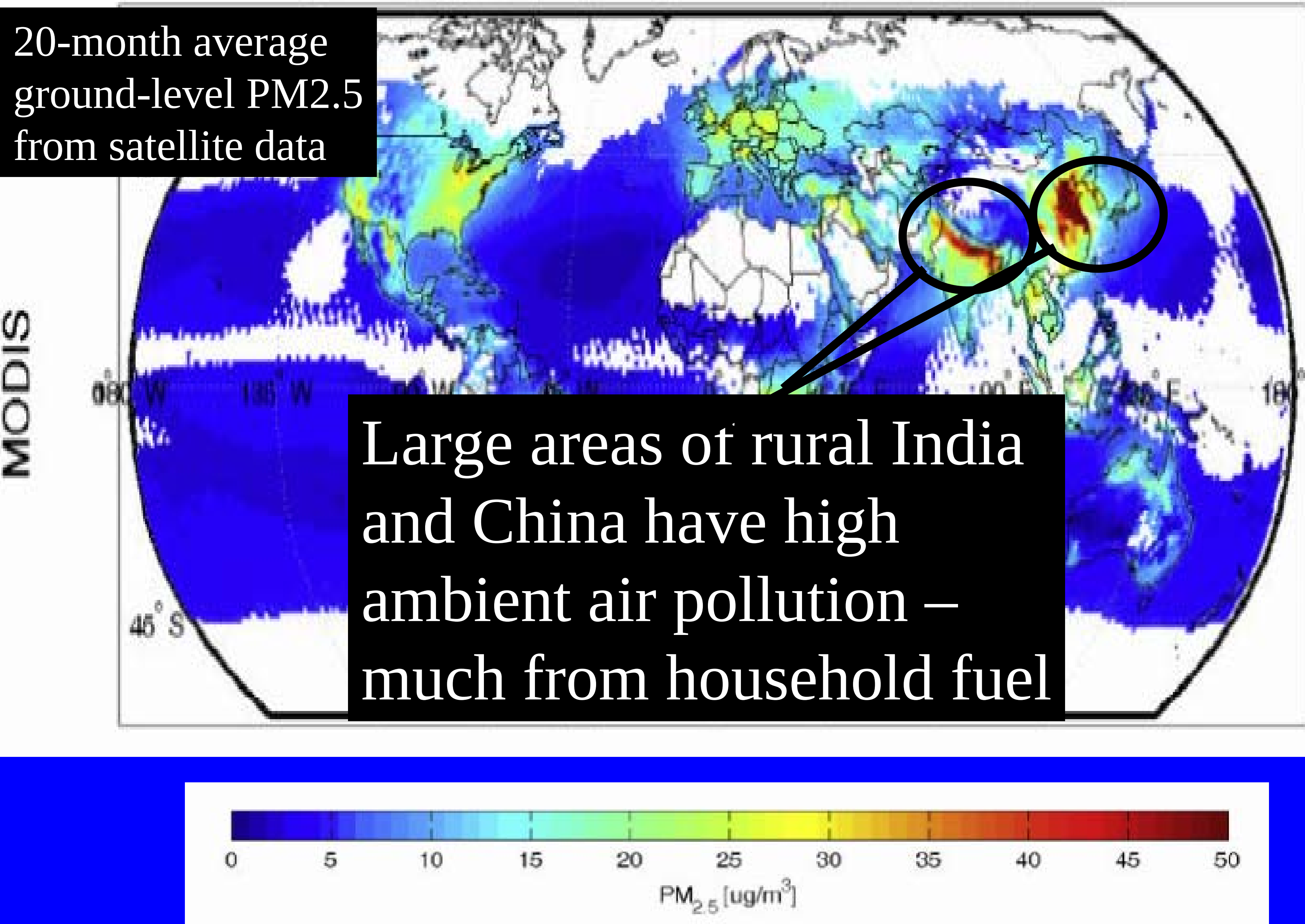
Kitchens down by 10x, but children exposure down by only 2x, because

--Time-activity: the kids do not spend their entire day in the kitchen

--Household (or “neighborhood”) pollution: a chimney does not reduce smoke, but just shifts it outside into the household environment, where the difference between intervention and control households was less

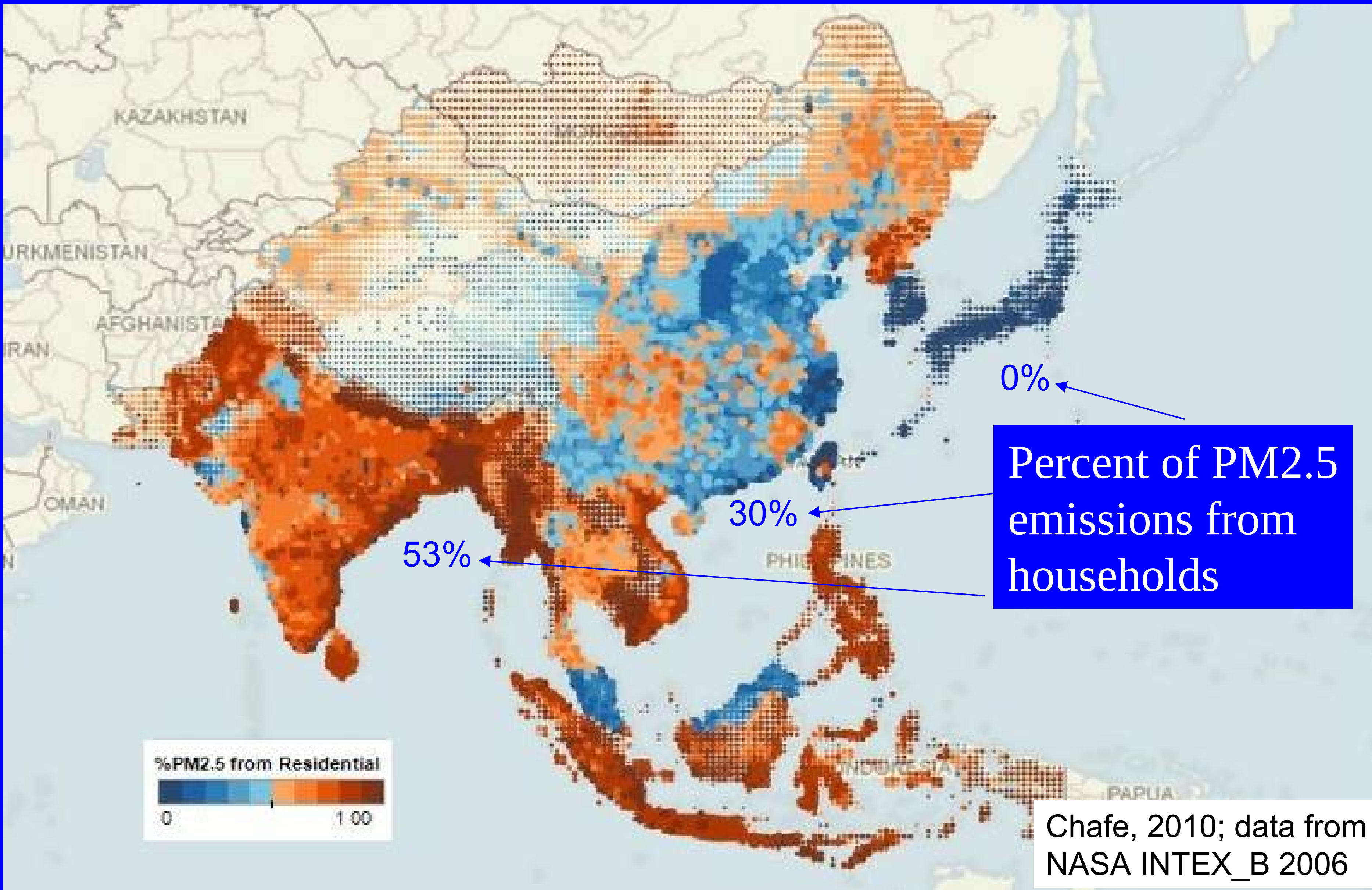
--No significant difference in bedrooms

20-month average ground-level PM2.5 from satellite data



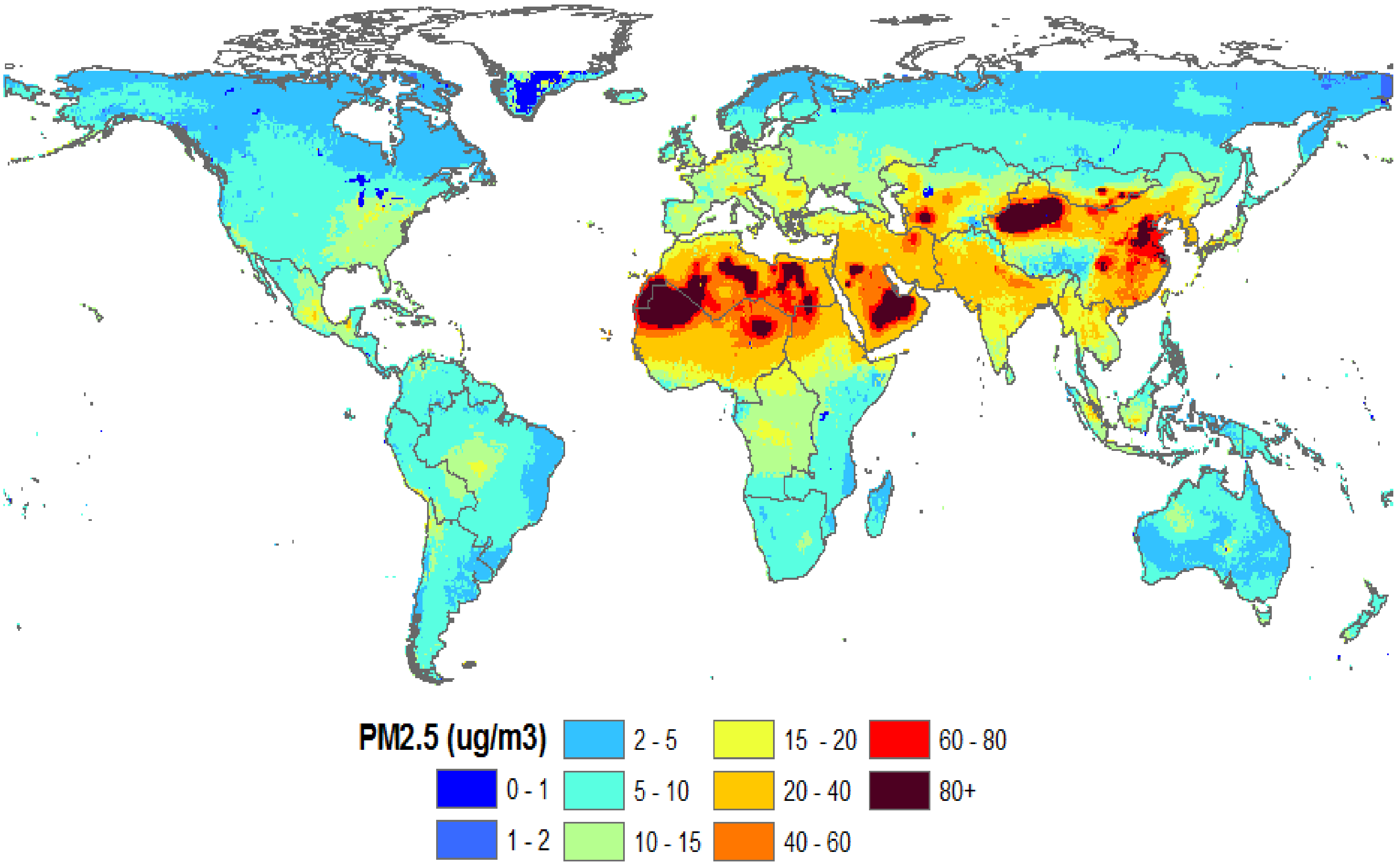
Large areas of rural India and China have high ambient air pollution – much from household fuel

NASA INTEX_B Database
Percent $PM_{2.5}$ emissions from households



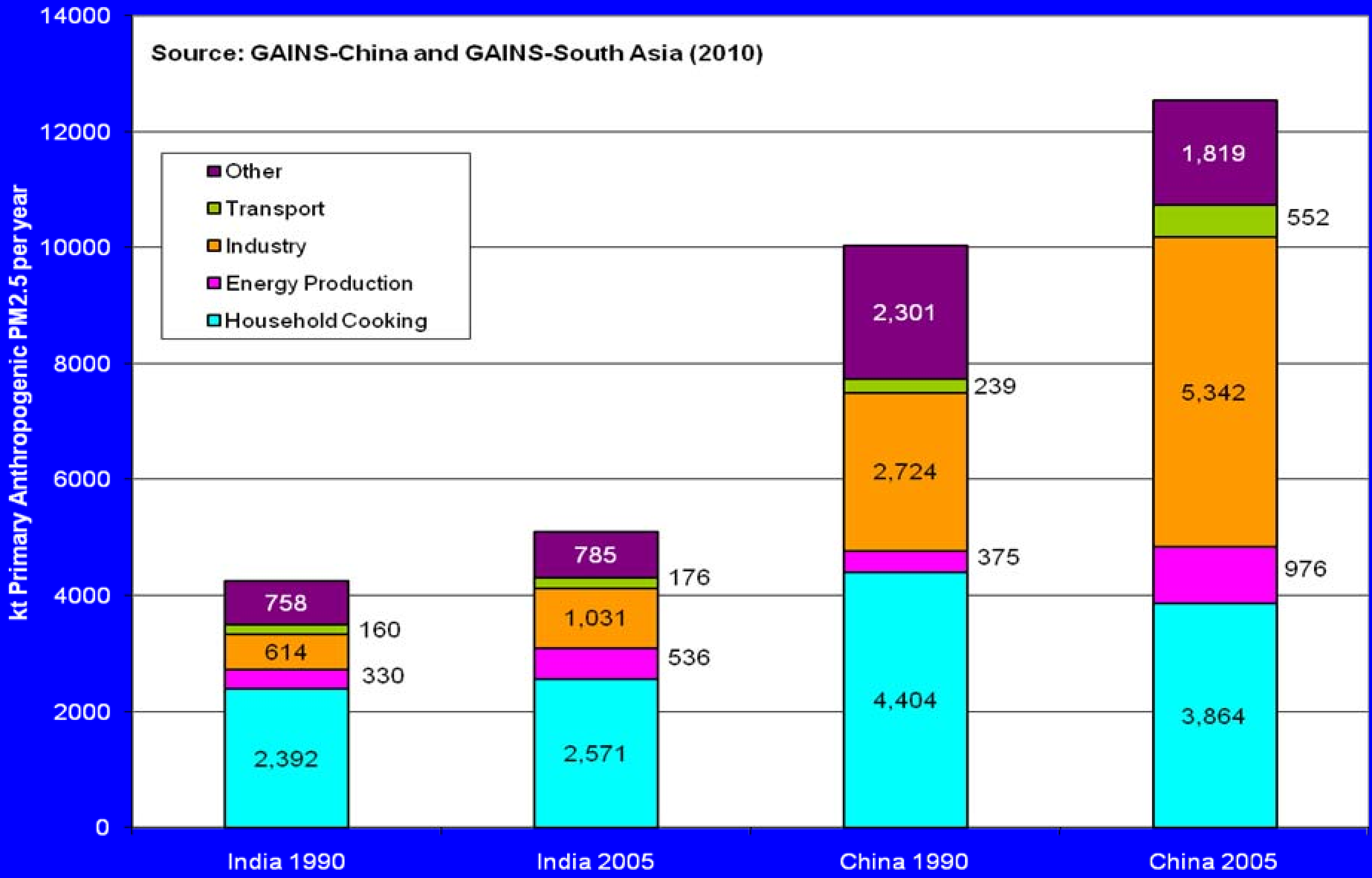
Chafe, 2010; data from NASA INTEX_B 2006

Mean $PM_{2.5}$ in 2005



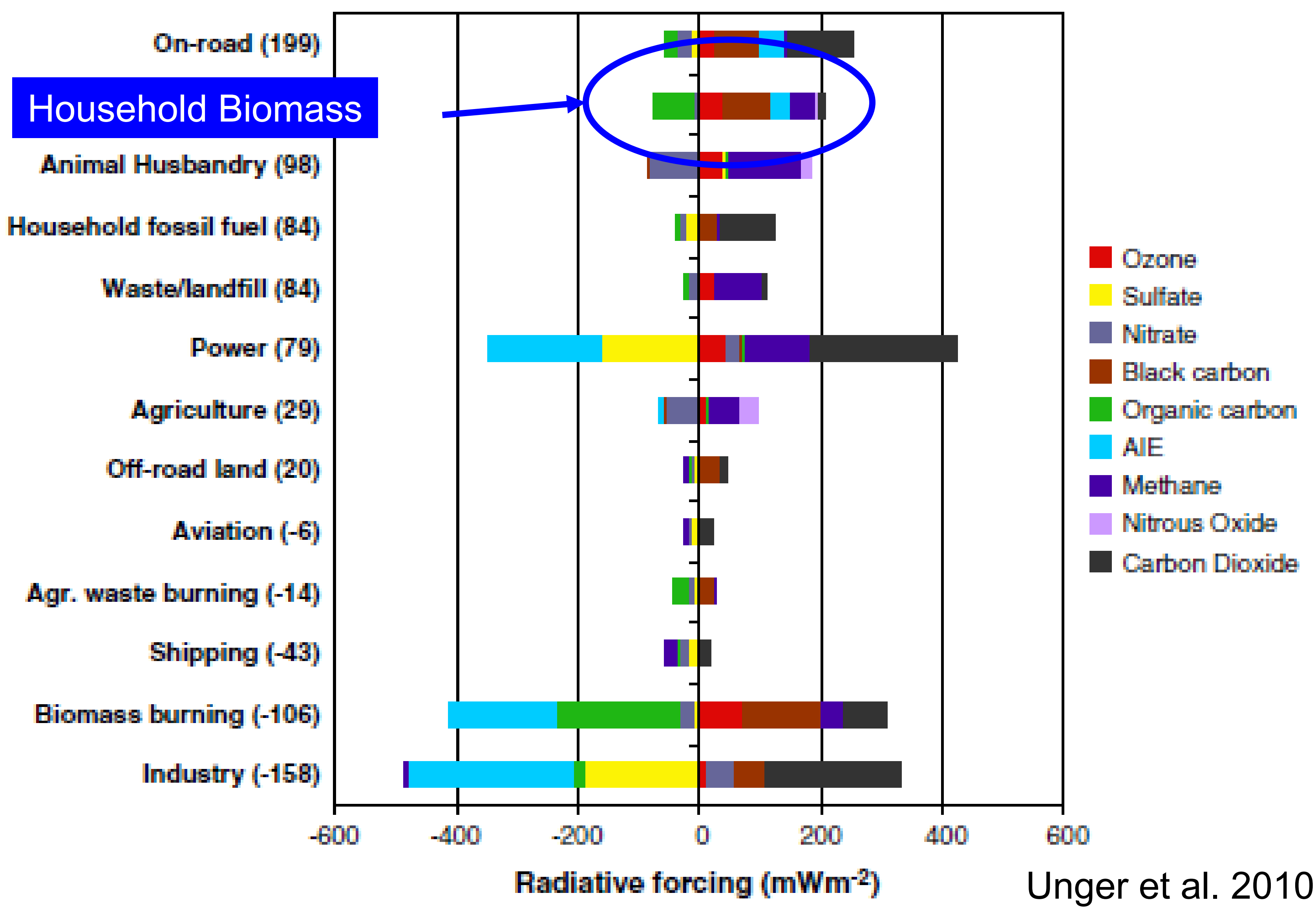
Brauer et al. EST 2011

Sources of Primary $PM_{2.5}$: India and China



IIASA, 2010

Climate Warming in 2020 Under Present Trends



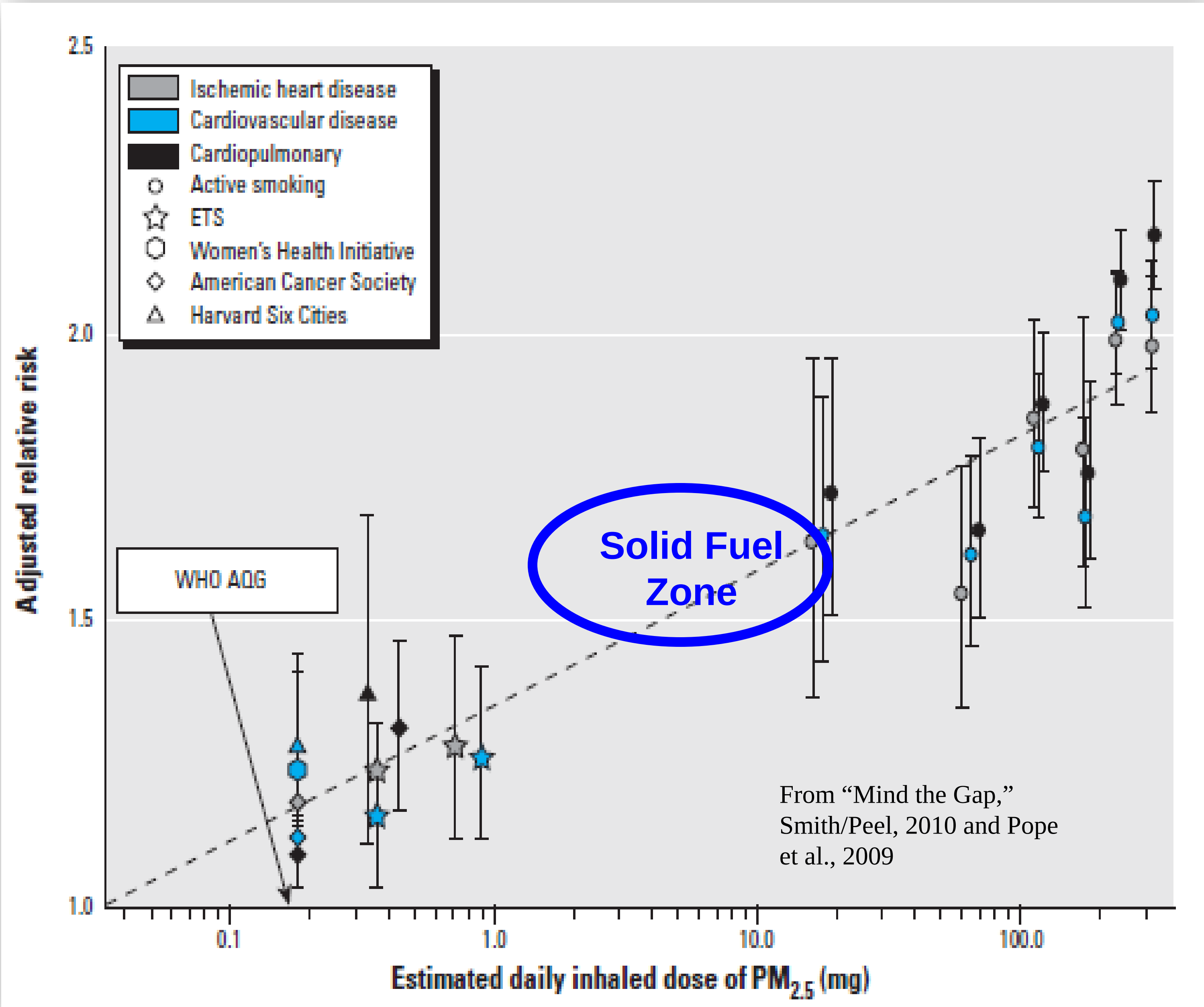
Unger et al. 2010

Combustion Particles

The Generalized Exposure Response

(GER)

Heart Disease and Combustion Particle Doses

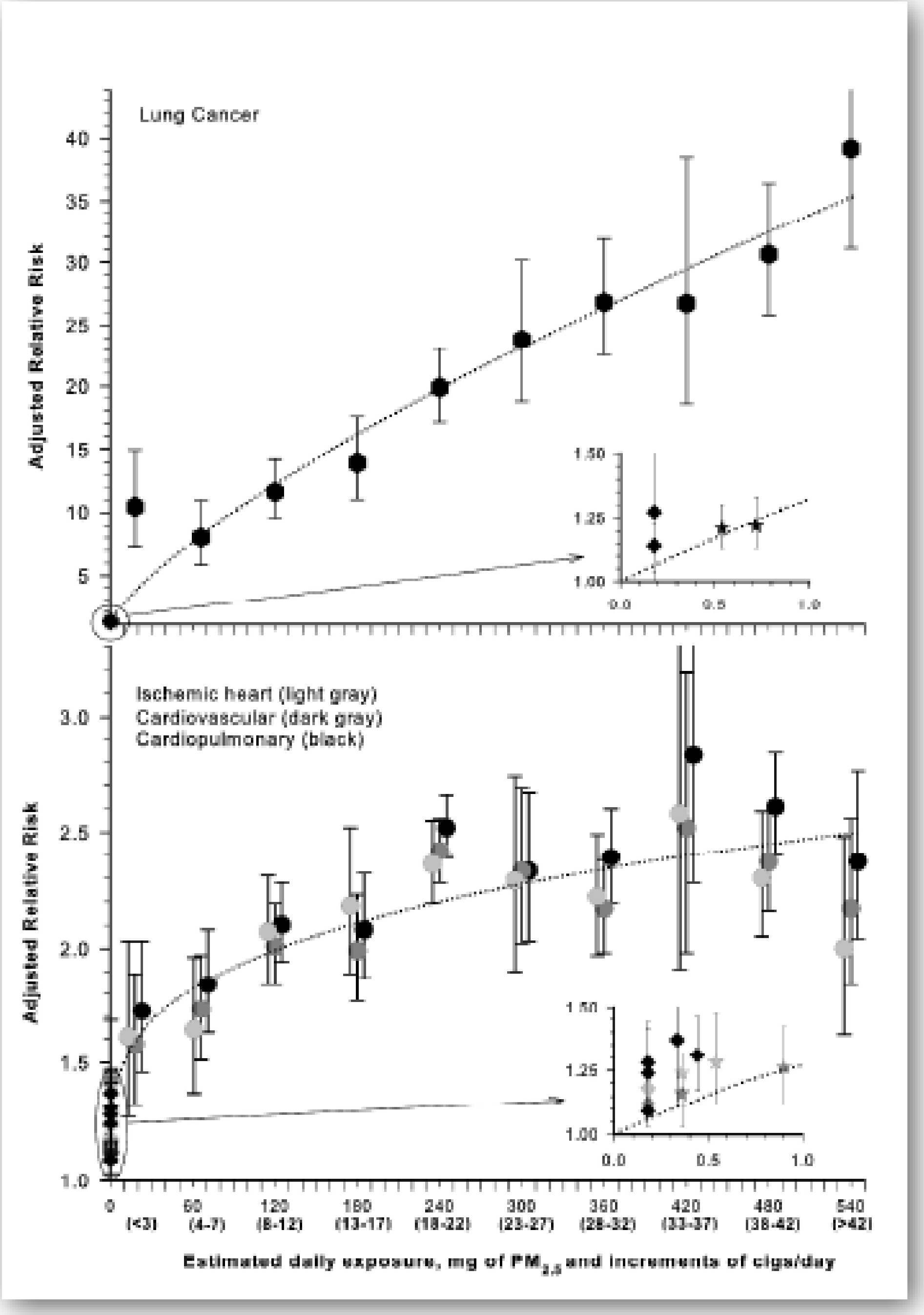


From "Mind the Gap," Smith/Peel, 2010 and Pope et al., 2009

Table 2. Adjusted relative risk estimates[a] for various increments of exposure from cigarette smoking (versus never smokers), second hand cigarette smoke, and ambient air pollution from the present analysis and selected comparison studies.

Source of risk estimate	Increments of Exposure	Adjusted RR (95% CI)				Estimated Daily Dose $PM_{2.5}$ (mg)[b]
		Lung Cancer	IHD	CVD	CPD	
ACS- present analysis	≤3 (1.5) cigs/day	10.44 (7.30-14.94)	1.61 (1.27-2.03)	1.58 (1.32-1.89)	1.72 (1.46-2.03)	18
ACS- present analysis	4-7 (5.5) cigs/day	8.03 (5.89-10.96)	1.64 (1.37-1.96)	1.73 (1.51-1.97)	1.84 (1.63-2.08)	66
ACS- present analysis	8-12 (10) cigs/day	11.63 (9.51-14.24)	2.07 (1.84-2.31)	2.01 (1.84-2.19)	2.10 (1.94-2.28)	120
ACS- present analysis	13-17 (15) cigs/day	13.93 (11.04-17.58)	2.18 (1.89-2.52)	1.99 (1.77-2.23)	2.08 (1.87-2.32)	180
ACS- present analysis	18-22 (20) cigs/day	19.88 (17.14-23.06)	2.36 (2.19-2.55)	2.42 (2.28-2.56)	2.52 (2.39-2.66)	240
ACS- present analysis	23-27 (25) cigs/day	23.82 (18.80-30.18)	2.29 (1.91-2.75)	2.33 (2.02-2.69)	2.33 (2.03-2.67)	300
ACS- present analysis	28-32 (30) cigs/day	26.82 (22.54-31.91)	2.22 (1.97-2.49)	2.17 (1.98-2.38)	2.39 (2.19-2.60)	360
ACS- present analysis	33-37 (35) cigs/day	26.72 (18.58-38.44)	2.58 (1.91-3.47)	2.52 (1.98-3.19)	2.83 (2.28-3.52)	420
ACS- present analysis	38-42 (40) cigs/day	30.63 (25.79-36.38)	2.30 (2.05-2.59)	2.37 (2.16-2.59)	2.61 (2.40-2.84)	480
ACS- present analysis	43+ (45) cigs/day	39.16 (31.13-49.26)	2.00 (1.62-2.48)	2.17 (1.84-2.56)	2.37 (2.04-2.76)	540
ACS-air pol. original	24.5 $\mu g/m^3$ ambient $PM_{2.5}$	-----	-----	-----	1.31(1.17-1.46)	0.44
ACS-air pol. extend.	10 $\mu g/m^3$ ambient $PM_{2.5}$	1.14(1.04-1.23)	1.18(1.14-1.23)	1.12(1.08-1.15)	1.09(1.03-1.16)	0.18
HSC-air pol. original	18.6 $\mu g/m^3$ ambient $PM_{2.5}$	-----	-----	-----	1.37(1.11-1.68)	0.33
HSC-air pol. extend.	10 $\mu g/m^3$ ambient $PM_{2.5}$	1.21(0.92-1.69)	-----	1.28(1.13-1.44)	-----	0.18
WHI-air pol.	10 $\mu g/m^3$ ambient $PM_{2.5}$	-----	-----	1.24(1.09-1.41)[c]	-----	0.18
SGR-SHS	Low- moderate SHS exp.	-----	-----	1.16(1.03-1.32)	-----	0.36
SGR-SHS	Moderate-high SHS exp	-----	-----	1.26(1.12-1.42)	-----	0.90
SGR-SHS	Live with smoking spouse	1.21(1.13-1.30)	-----	-----	-----	0.54
SGR-SHS	Work with SHS exposure	1.22(1.13-1.33)	-----	-----	-----	0.72
INTERHEART	1-7 hrs/wk SHS exp.	-----	1.24(1.17-1.32)[d]	-----	-----	0.36
INTERHEART	Live with smoking spouse	-----	1.28(1.12-1.47)[d]	-----	-----	0.54

Pope et al.
Environmental Health Perspectives
2011, in press

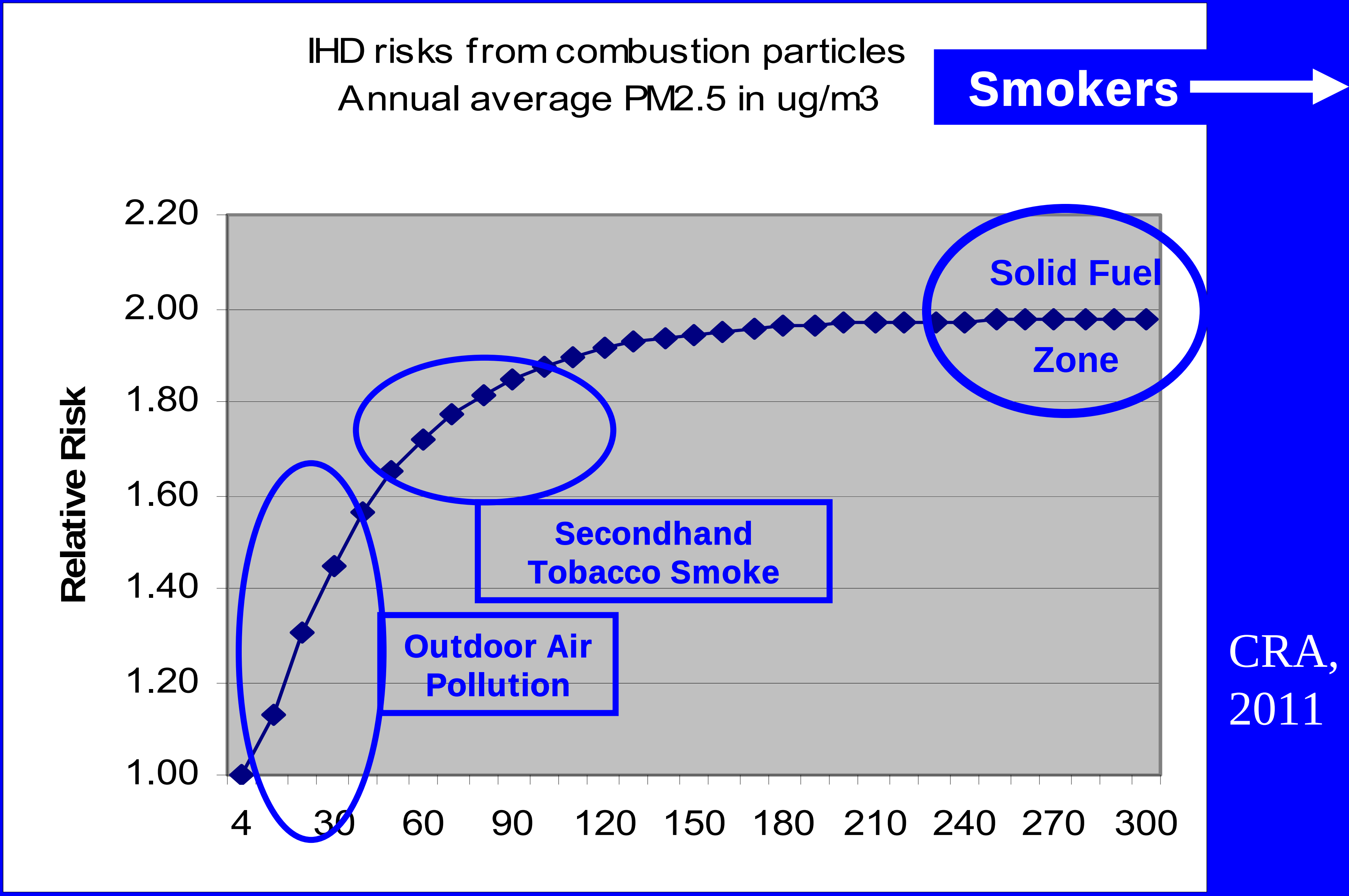


Lung Cancer

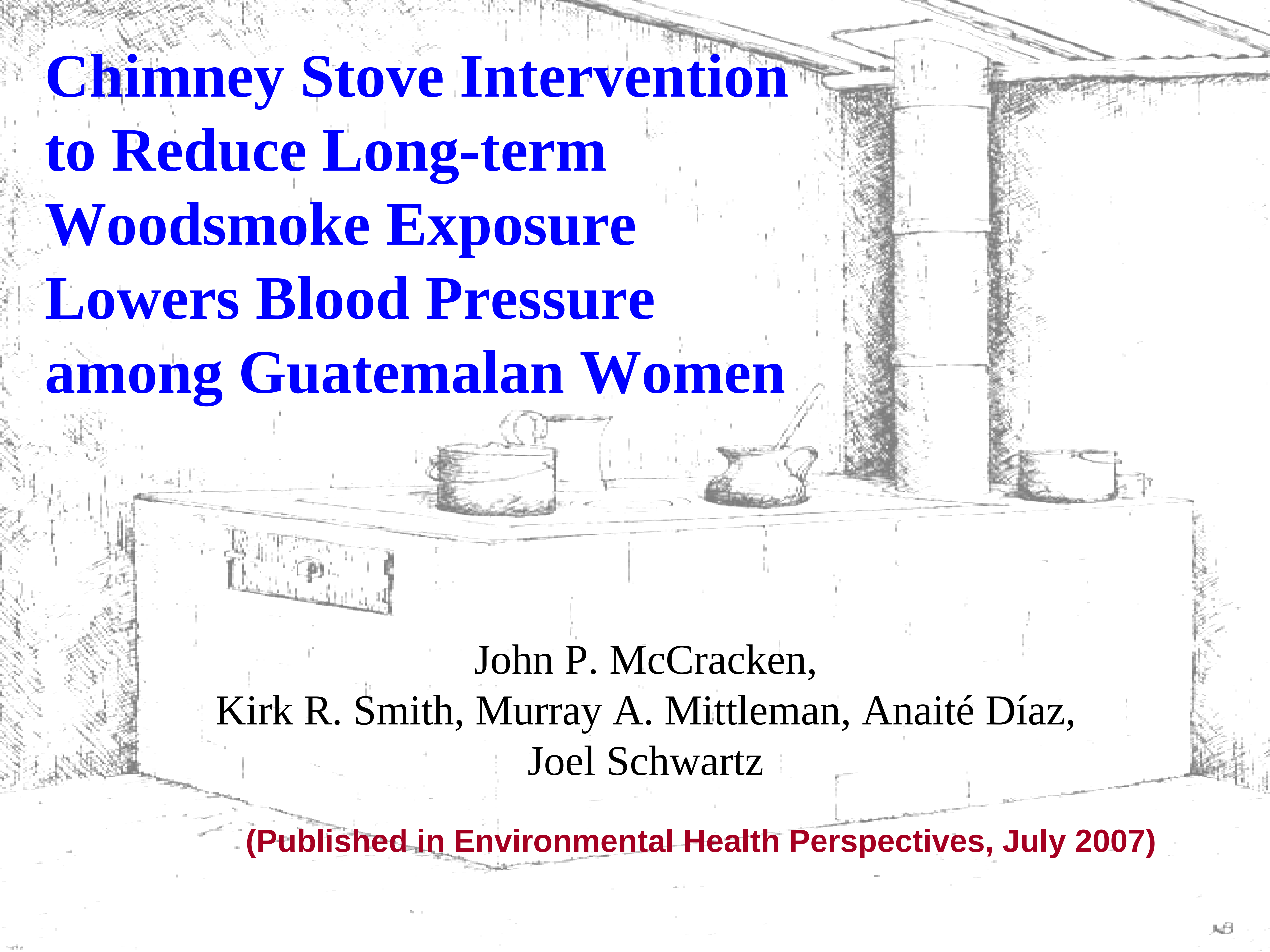
Heart Disease

Pope et al. Environmental Health Perspectives 2011, in press

Generalized Exposure-Response: Outdoor Air, SHS, and Smoking



CRA, 2011



Chimney Stove Intervention to Reduce Long-term Woodsmoke Exposure Lowers Blood Pressure among Guatemalan Women

John P. McCracken,
Kirk R. Smith, Murray A. Mittleman, Anaité Díaz,
Joel Schwartz

(Published in Environmental Health Perspectives, July 2007)

Between-Groups Results

	Number of subjects (measures)		Adjusted mean difference*		
	Control group	Intervention group	Estimate	95% CI	p-value
SBP	71 (111)	49 (115)	-3.7	-8.1, 0.6	0.10
DBP	71 (111)	49 (115)	-3.0	-5.7, -0.4	0.02

* Adjusted for age, body mass index, daily temperature, season, day of the week, time of day, use of wood-fired sauna, household electricity, an asset index, ever smoking, and secondhand tobacco smoke exposure

Before-and-After Results

	Number of subjects (measures)		Adjusted mean difference*		
	Trial period	Echo-intervention	Estimate	95% CI	p-value
SBP	55 (88)	55 (65)	-3.1	-5.3, -0.8	0.01
DBP	55 (88)	55 (65)	-1.9	-3.5, -0.4	0.01

* Adjusted for age, body mass index, daily temperature, season, day of the week, time of day, use of wood-fired sauna, household electricity, an asset index, ever smoking, and secondhand tobacco smoke exposure

Intervention to Lower Household Wood Smoke Exposure in Guatemala Reduces ST-Segment Depression on Electrocardiograms

John McCracken,[1,2] Kirk R. Smith,[2] Peter Stone,[3] Anaité Díaz,[4] Byron Arana,[4] and Joel Schwartz[1]

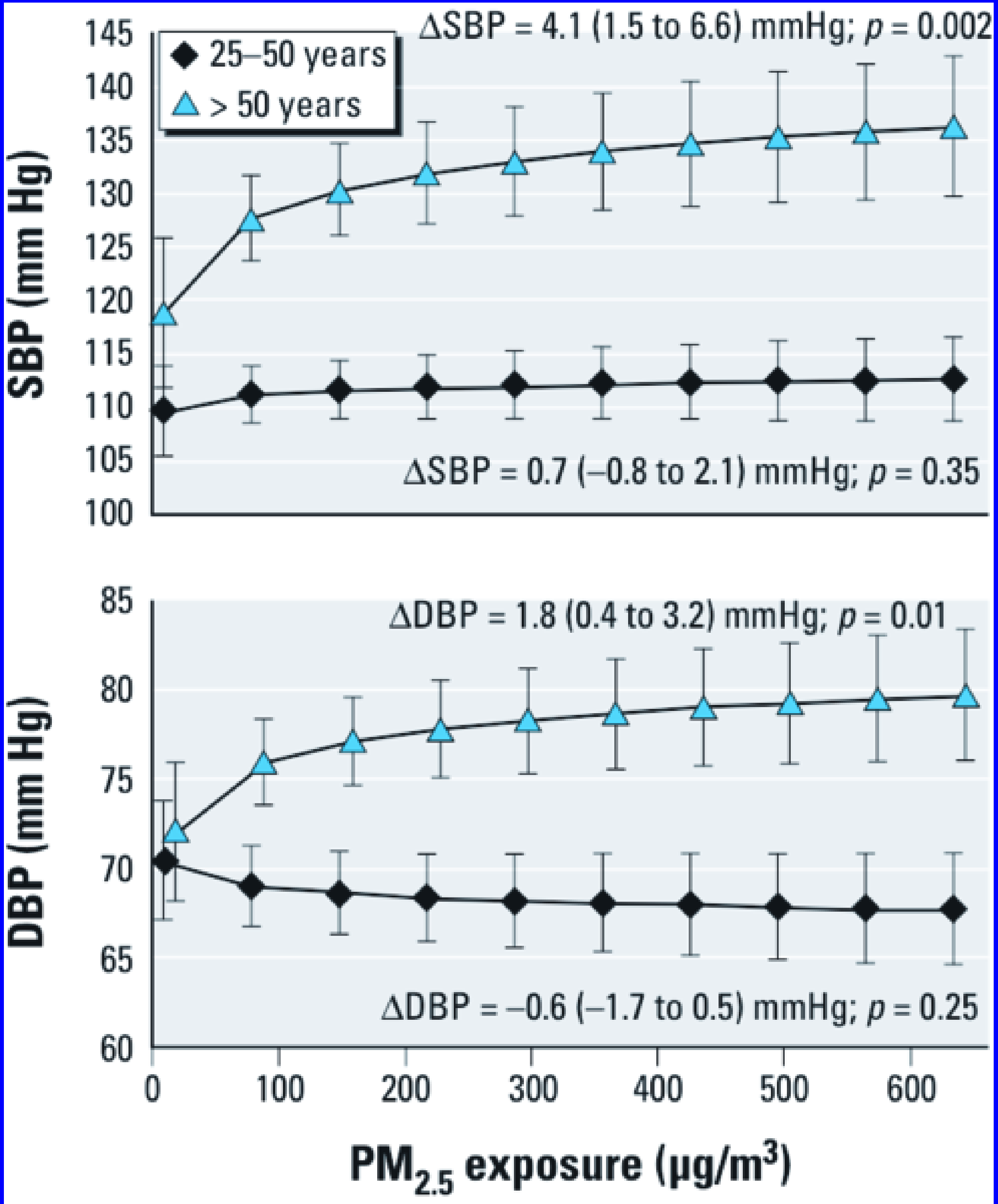
[1]Department of Environmental Health, Harvard School of Public Health, Boston, Massachusetts, USA; [2]Environmental Sciences Division, University of California, Berkeley, California, USA; [3]Brigham and Women's Hospital, Boston, Massachusetts, USA; [4]Center for Health Studies, Universidad del Valle, Guatemala City, Guatemala

EHP Nov, 2011

Table 3. Odds ratios (ORs) for nonspecific ST-segment depression (30-min average ≤ −1 mm, regardless of slope) associated with chimney-stove intervention compared with open fire from two study designs: between-groups and before-and-after analyses.

	Crude		Adjusted	
Comparison	OR (95% CI)	*p*-Value	OR (95% CI)	*p*-Value
Between-groups	0.34 (0.15, 0.81)	0.015	0.26 (0.08, 0.90)[a]	0.033
Before-and-after (only control group)	0.41 (0.24, 0.70)	0.001	0.28 (0.12, 0.63)[b]	0.002

[a]Adjusted for age (quadratic), BMI (quadratic), asset index category, ever smoking, SHS, owning a wood-fired sauna, recent use of wood-fired sauna, and time of day (natural spline with 5 degrees of freedom). [b]Adjusted for age (quadratic), day of week, season (wet/dry), daily average temperature and relative humidity, daily rainfall, interactions of weather variables with season, recent use of wood-fired sauna, and time of day (natural spline with 5 degrees of freedom).

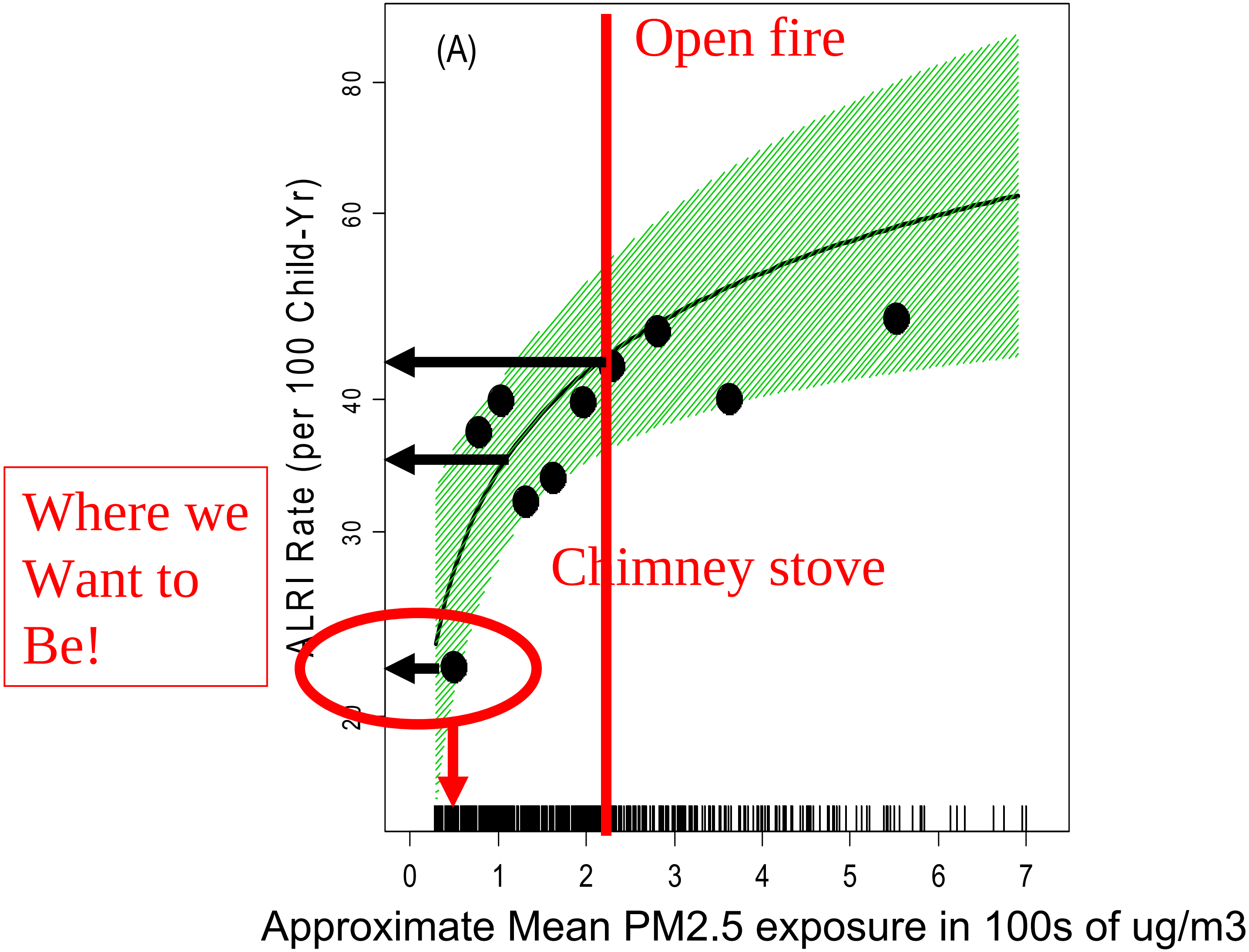


Household
Air
Pollution
and
Blood Pressure

In Yunnan

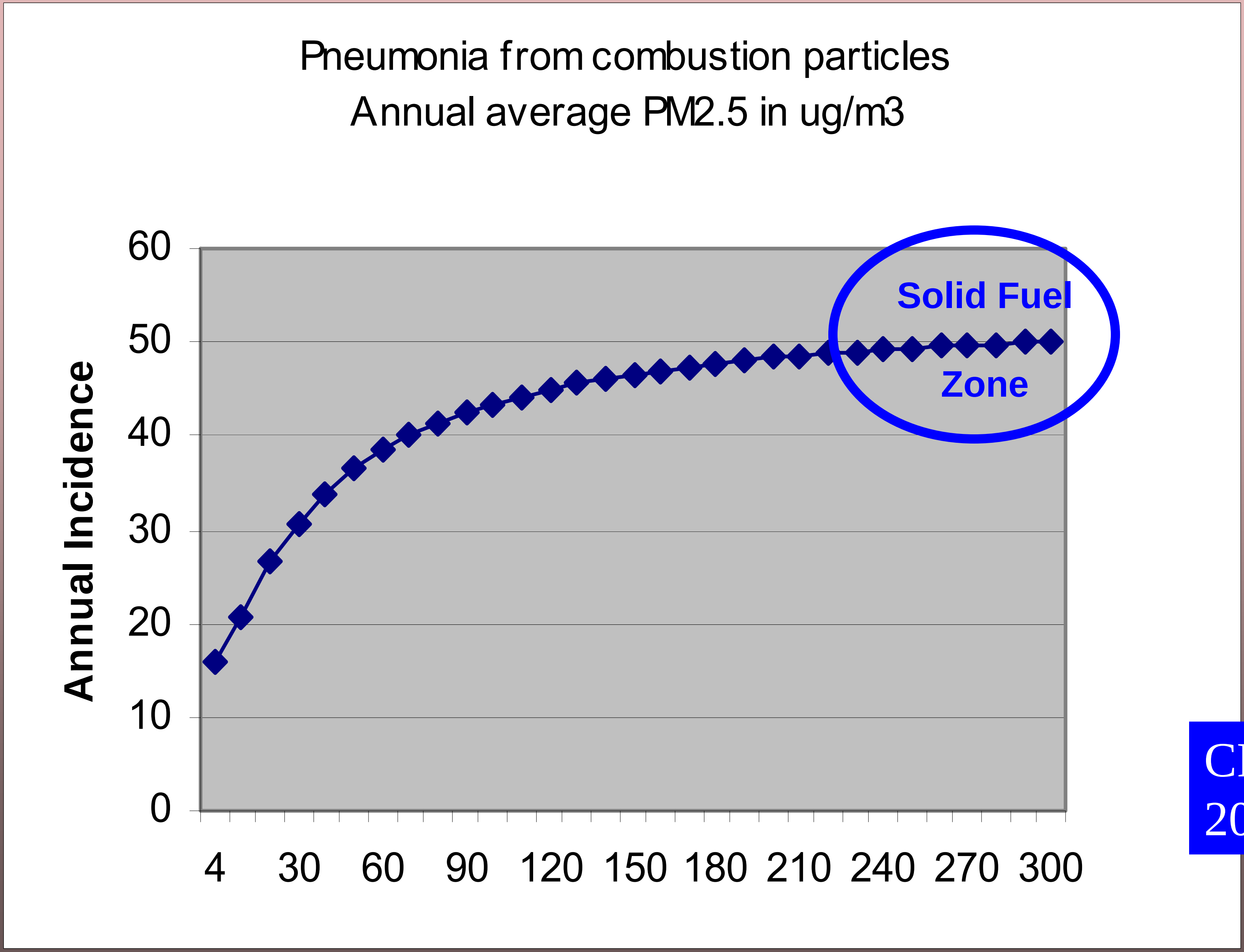
Baumgartner et al.
Environmental Health Perspectives 2011, Oct

MD-diagnosed Acute Lower Respiratory Infection



RESPIRE-Guatemala

Generalized Exposure-Response: Outdoor Air, SHS, and HAP



CRA, 2011

Bhaktapur Cooking Fuels

- Electricity--196 (21.4%)
- Gas 261--(28.5%)
- Kerosene--221 (24.1%)
- Biomass--239 (26.1%)

Bhaktapur Preliminary Results

$PM_{2.5}$ (μg/m^3) quartiles				
<55			1.00	
55 to <91			1.49	0.98-2.26
91 to <215			2.31	1.52-3.52
≥215			2.97	1.91-4.61
Main stove				
Electricity	1.00			
Gas	1.29	0.84-1.99		
Kerosene	1.65	1.04-2.61		
Biomass	1.58	1.05-2.39		

Tuberculosis and Indoor Biomass and Kerosene Use in Nepal: A Case–Control Study

Amod K. Pokhrel,[1] Michael N. Bates,[1] Sharat C. Verma,[2,3] Hari S. Joshi,[3] Chandrashekhar T. Sreeramareddy,[3**] and Kirk R. Smith[1]*

[1]School of Public Health, University of California–Berkeley, Berkeley, California, USA; [2]Regional Tuberculosis Center, Ram Ghat, Pokhara, Nepal; [3]Department of Community Medicine, Manipal Teaching Hospital, Manipal College of Medical Sciences, Pokhara, Nepal

VOLUME 118 | NUMBER 4 | April 2010 • Environmental Health Perspectives

Risks from fuel use for TB in women in Pokhara

Cookstove	
Gas	1.00
Biomass	1.21 (0.48–3.05)
Kerosene	*3.36 (1.01–11.22)*
Heating fuel	
No heating fuel use or electricity	1.00
Biomass	*3.45 (1.44–8.27)*
Main light source in the house	
Electricity	1.00
Kerosene lamp	*9.43 (1.45–61.32)*

Pokhrel et al., 2010

New Pokhara TB Case-Control Study

- Funded by US National Institutes of Health, fieldwork starting 2012
- UC Berkeley, UC San Francisco, National TB Control Center of Nepal, ISER-Nepal (Chitwan)
- 650 cases, 1300 controls
- Powered to detect differences across all fuel and stove/lamp types
- Will be able to detect separate risk factors for TB infection and TB disease
- Innovative community control selection
- Innovative household air pollution monitoring

Summary

- Worst thing to do is stick burning stuff in your mouth – 5+ million premature deaths
- Next worse is burning in your house – 2 million deaths
- Next worse is having someone else nearby sticking in their mouth – 400k deaths
- Even bad to have on your planet – 2+ million deaths
- Chimneys do not help enough – need to stop producing the pollution at all.

New Generation of Interventions to Get to Low Smoke Exposures

- Advanced biomass stoves that do not produce pollution
- Promotion of processed biomass – pellets
- Promotion of biogas
- Promotion of LPG
- Promotion of electric and solar cooking for selected tasks where highly efficient, e.g. rice cookers
- Integration with lighting solutions, such as TEG stoves and rechargeable lamps
- Discourage both open biomass fires and kerosene

Many thanks

Publications and presentations on website – easiest to just "google" Kirk R. Smith