Report of the Thematic Meeting on Healthy Environments

Addressing respiratory disease, obesity and injuries through health-promoting environments

Luxembourg, 28–29 January 2009
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Introduction

1. A thematic meeting hosted jointly by the Ministry of Health of Luxembourg and the European Commission (EC) Directorate-General for Health and Consumers was held at the Jean Monnet Building in Luxembourg on 28–29 January 2009. The aim of the meeting, which was a milestone in the process of preparing for the Fifth European Ministerial Conference on Environment and Health (Parma, Italy, March 2010), was to provide an opportunity to discuss specific environment and health issues that had not yet been properly addressed:

- respiratory diseases arising from indoor air pollution and inappropriate indoor environments;
- obesity in children resulting from lack of appropriate urban and spatial planning; and
- injuries in children arising from unsafe indoor and outdoor environments.

The conclusions and recommendations from those discussions would lead to the identification of priority actions for insertion in the latest draft of the Conference Declaration. The second day of the meeting would be devoted to reviewing the draft Declaration in more detail.

2. Participants (see Annex 1) were welcomed by Mr Mars di Bartolomeo, Minister of Health and Social Affairs of Luxembourg, Dr Andrzej Rys, Director, Public Health and Risk Assessment, EC Directorate-General for Health and Consumers, and Dr Marc Danzon, WHO Regional Director for Europe.

Reducing health impacts from indoor environments

The indoor environment: European situation and policy options

3. Professor Matti Jantunen, National Institute for Health and Welfare, Finland described a number of ongoing European activities on indoor air quality (research projects, meta-studies, pre-normative programmes, etc.), looking variously at health effects, exposures and sources of pollution, and pointed to the existence of several European policies such as European Union (EU) directives on construction products, general product safety and energy performance of buildings, as well as WHO’s indoor air quality (IAQ) guidelines and its Framework Convention on Tobacco Control.

4. One project of particular interest was EnVIE, a coordinated action under the Sixth EU Framework Programme for Research and Technological Development, designed to quantify the health impacts of poor IAQ and evaluate the potential of policies to reduce adverse impacts. In the 27 EU member countries, indoor air contaminants (excluding environmental tobacco smoke – ETS) were responsible for a total burden of disease of 2.2 million disability-adjusted life years (DALYs) per year, with cardiovascular diseases, asthma and sick building syndrome/sensory irritation accounting for 84% of that total. Combustion products and bioaerosols were the two largest categories of contaminants. Outdoor air was the largest single source of indoor air contaminants, followed by water systems, dampness and mould, and heating and combustion. Where smoking was still unrestricted, ETS was comparable to all other indoor air pollution combined. According to data from WHO’s European Environmental Health Information System (ENHIS), more than 50% of children in many countries were exposed to ETS at home, and children of the most deprived families suffered from the highest exposures.
5. The EnVIE project had also found that, at population level, five chemicals (including benzene, naphthalene and formaldehyde) were responsible for most of the indoor air chemical risks, but that all chemicals combined accounted for only 8 – 20% of all indoor air health risks. Most such risks were caused by ETS, outdoor air pollutants that penetrated into indoor air, indoor combustion sources, and building dampness and mould. It had concluded that the highest public health benefits at the lowest cost and the smallest delay could be achieved by smoking restrictions. Other policies with high or substantial benefits in the medium or long term included those on buildings and ventilation (controlling indoor exposure to particulate matter, allergens, ozone and radon, as well as noise); on building management and training of the responsible individuals; on moisture accumulation and exposure to exhausts of indoor combustion sources, and on harmonized testing and labelling of indoor materials and consumer products.

6. A number of general “qualifiers” needed to be taken into account, however, when selecting policy options. Some policies could be implemented quickly and cheaply, while others required decades and were very expensive. Policies which provided only marginal health benefits might still be quite cost-effective. Again, some policies affected only certain product manufacturers, while others set requirements on every citizen. Policies that appeared to be marginal for public health might be critical for individual risks, and vice versa. Lastly, the estimated policy benefits could not be summed, because they sometimes overlapped or even contradicted each other.

**Action on indoor environments – policy examples**

7. Mr Ralph Baden, Department of Occupational Health, Ministry of Health, Luxembourg reported on his country’s “indoor air survey programme”. At the request of patients, general practitioners or environmental health physicians, the National Health Laboratory carried out analyses of chemical, biological and physical “stressors” and prepared reports identifying the contaminating source, evaluating exposure and possible health effects, and outlining measures to minimize exposure. In the period 2004–2007, 1424 sets of symptoms (mainly irritation of the mucosa and respiratory disorders) had been investigated in 2024 homes. The main groups of contaminants found were permethrin, chlorinated flame retardants, low-frequency electric fields and mould. While some indoor pollutants (e.g. formaldehyde) had been successfully regulated, others showed the dangers of regulatory substitution (benzene, toluene) or gave evidence of the failure of regulation (PCP, eulan).

8. While there was no systematic follow-up of patients to evaluate the success of the programme, spontaneous feedback testified to improvement or disappearance of symptoms in up to 95% of cases. In view of the fact that the system was financially self-sufficient, that investigations were as comprehensive as possible (to take account of “cocktails” of exposures), that demand for the service was increasing and that the staff involved were highly trained and professional, the programme was judged to be a useful tool. Comparability of results would facilitate the exchange of experience and know-how between Member States.

9. Mr Matthias Braubach, Technical Officer, Housing and Health, WHO Regional Office for Europe described the local housing and health action plans (LHHAPs) that had been developed jointly by the Ministry of Health of Portugal and the WHO European Centre for Environment and Health. Local authorities (who were primarily responsible for housing conditions) could use the project’s manual and software to collect a wide range of data on different aspects of housing conditions (building structure, energy consumption, humidity and mould, health and illnesses, etc.). Data collection could be completed within two weeks, and descriptive analysis typically took the same amount of time. The outcome could take the form of a city or district report and the implementation of technical or policy-related actions to mitigate social and health inequities and prevent further housing-related health effects and injuries. The
approach entailed setting up intersectoral working groups, ensuring that national governments worked with local authorities, making health and safety considerations the main criteria for housing regulations, and launching information and prevention campaigns aimed at the general public.

Discussion

10. In the area of housing, ministries of health would need to cooperate with other branches of government (construction, finance) in order to carry out rehabilitation programmes, and reports generated using the LHHAP approach could be a useful foundation for such joint work. Measures to prevent adverse health effects should be applied not only in housing but also in the use of hazardous chemicals, participants believed. The problem of substitution could be overcome by including many more chemicals in the EU’s scheme for the registration, evaluation, authorization and restriction of chemical substances (REACH) and encouraging non-EU countries to adopt similar measures.

11. One country reported on its success in changing smokers’ behaviour as a result of an intensive information campaign on the dangers of ETS: a baseline survey in 2005 had found that 75% of smokers smoked in their houses and cars, whereas a pilot study in 2008 had found that 64% of smokers’ houses were nicotine-free. A balanced approach would need to be adopted in order to tackle both outdoor and indoor air pollution and to reconcile the demands of energy efficiency and more compact cities, on the one hand, with people’s increased proximity to sources of pollution, on the other. With the growing economic and energy crisis, WHO guidelines on combustion products would be of particular importance: return to extensive biomass burning could have significant health effects.

Time to move - addressing obesity through spatial planning

Obesity and physical activity - the European Union dimension

12. Dr Michael Hübel, Head, Health Determinants Unit, EC Directorate-General for Health and Consumers (DG SANCO) gave an overview of the situation of overweight and obesity in the European Union, focusing on teenagers and adolescents. The Directorate-General had released a white paper on a strategy for Europe on nutrition, overweight and obesity-related health issues (COM(2007) 279 final, Brussels, 30 May 2007). The main elements in the strategy were to develop Community actions across a range of sectors, to challenge all stakeholders to take action to counter obesity, and to develop partnerships at all levels. The European Platform on Diet, Physical Activity and Health brought together 33 active members from the food and catering sectors, advertising and broadcasting, and consumer and health organizations, as well as observers, including WHO (urban planners and architects were not represented, however). Of the 151 commitments made by the Platform in 2008, 76 were tabled under “Healthy lifestyles” and 19 specifically related to physical activity. Examples of ongoing projects included promotion of healthy mobility behaviour, a European network for training of public health (environment) physicians, and support for sustainable urban transport actions.

Case studies

13. Dr Yolande Wagener, Department of Preventive and Social Medicine, Ministry of Health, Luxembourg pointed out that in her country 35% of the total population (25% of adolescents and 20% of children) were overweight or obese, and cardiovascular disease prevalence was
higher than the EU average. The ministries of education, family, sports and health had therefore committed themselves publicly in 2006 to a coherent political approach and a common action plan with three main objectives: sensitization to health-promoting lifestyles; promotion of health and balanced nutrition; and increased physical activity, especially for children. A multidisciplinary group of health experts had drawn up a set of common messages and a national reference tool, while an interministerial committee had been established to strengthen cooperation, improve communication, and coordinate and carry out the action plan. A large number of partners were involved in the 80 projects currently under way (half in school settings, half with municipalities or associations) under the overall slogan of “Gesond iessen, méi bewegen” (“Eat healthily, move more”).

14. Ms Bente Moe, Primary Health Services, Norwegian Directorate of Health presented her country’s experiences with physical planning and physical exercise. A policy platform had been built up with “white papers” from the ministries of environment and health, a national action plan on physical activity (involving eight ministries), a national environment and health strategy for children and youth, a new planning and building act and developments related to the national transport plan. The main approaches were to promote more physical activity in leisure time (better sports and recreation facilities), everyday life (kindergartens, schools and work settings), local environments (better urban and neighbourhood planning) and transport (cycling and walking). Action was being taken at three levels of authority (national, regional and, most importantly, local or municipal) and in three fields (legal measures, knowledge and mobilization).

15. Norway’s new planning and building act constituted the backbone of those efforts: it formed the legal framework and offered a planning tool at municipal level, both for land use and for long-term development; it was the main instrument to secure participation and democracy in planning; and it laid down requirements and methods for impact assessment. Despite the challenges of limited financial resources and pressure on green areas through increased urbanization, planning legislation had been improved, more health-friendly transport policy had been adopted and positive results had been achieved at local level. In response to the current financial crisis, infrastructure for cycling and walking might be developed earlier than originally planned. Key factors in that success had been cross-sectoral cooperation and mobilization of actors at different levels, identification of common goals and synergistic effects, and anchoring of public health development work in “ordinary” planning processes.

Discussion

16. Some countries in the eastern part of the WHO European Region were focusing efforts on building fitness centres, where parents could become involved through the participation of their children. Nonetheless, they acknowledged the dual benefits of cycling as a means of both transport and physical activity, while emphasizing the need for good urban planning to secure a safe transport environment, and they welcomed the international support given to increased physical activity in schools. Participants also endorsed the use of social marketing and behaviour change techniques in public health, as was being promoted by the EU platform with regard to smoking. They noted that policies on walking and cycling had been shown to have a major impact on both climate change (greenhouse gas emissions) and health and welfare. Physical activity should be presented as a part of everyday life, rather than in terms of engaging in sport.

17. Intersectoral cooperation was difficult to achieve in practice. As a result, some countries were placing emphasis on that approach in professional education and training, and others were developing a specific strategy on how best to bring together disparate groups while taking account of cultural and religious aspects. In that context, useful tools included WHO’s health
economic appraisal tool (HEAT) for cycling, which provided guidance for the inclusion of health effects of transport-related physical activity in economic analyses of transport infrastructure and policies, and its European network for the promotion of health-enhancing physical activity (HEPA Europe).

Protecting children from injuries through safe and supportive environments

Tackling social inequalities in childhood injuries - the environment matters

18. Professor Lucie Laflamme, Department of Public Health Sciences, Karolinska Institut, Sweden observed that childhood injuries were increasing in both absolute and relative terms, with high morbidity and the possibility of repetition. The pattern of injuries changed with stages of individual development, and social inequalities exacerbated those particularities. The environment influenced the three domains of prevention, which aimed to modify total exposure to sources of danger, the consequences of injuries and opportunities for protection. Two complementary approaches were needed to address the “safety divide”: targeted strategies and “safety-for-all” ones.

19. In “safety-for-all” strategies, it was known that a number of actions were effective: legislation, regulation and enforcement (such as setting minimum safety standards at work and in the built environment, or restricting dangerous products or substances); community-based programmes (to promote both environmental and individual changes, but not necessarily in all groups); and home visits (focusing on safe practices and with a protective effect on child abuse and neglect). Haddon’s ten strategies\(^1\) could also be applied to tackle differential susceptibility and exposure to and consequences of injuries, in conjunction with specific measures to redress social inequalities. Lastly, efforts would need to be made to influence differential social mobility; those might include promoting integration, financial empowerment and the acquisition of knowledge. Inequalities in injuries were both avoidable and reversible.

Domestic injuries: risk factors and preventive approaches

20. Professor David Ormandy, Warwick University Law School, United Kingdom noted that the risk factors for domestic injuries in children included unsafe design, lack of maintenance, misuse or careless positioning of furniture and furnishings, careless behaviour or negligence by carers, and children’s lack of experience and awareness of danger. The actions to be taken could be classified in terms of Haddon’s ten strategies and involved identifying the risk, eliminating, isolating and modifying the danger, and training/instructing, warning and supervising people. Numerous examples of what worked could be given for preventing incidents such as falls, entrapment, burns and scalds, poisoning and drowning. Preventive strategies therefore rested on awareness and education campaigns, implementation of engineering refinements and safety devices, design and modification of the built environment, legislation, and research and monitoring. In carrying out those strategies, inequalities would need to be addressed – there were more childhood injuries in low- to middle-income population groups and in deprived areas. Investment in preventive policies would yield dramatic public health and financial gains.

\(^1\) Haddon W. The basic strategies for preventing damage from hazards of all kinds. *Hazard Prevention* 1980, 16:8-12
Policy options

21. Professor Maria Segui Gomez, Department of Preventive Medicine and Public Health, University of Navarra, Spain reiterated the magnitude of the problem: each year, 42 000 children and adolescents in the WHO European Region died of accidental injuries. For each child who died, 140 were admitted to hospital and 13 times that number attended an emergency department as an outpatient. In the ranking of leading causes of death, road traffic injuries were in fifth place, self-inflicted injuries were sixth, drownings were eighth, violence was tenth and poisonings were twelfth. In terms of DALYs, falls were in eighth place and road traffic injuries ninth. There were considerable differences in prevalence both between and within countries; in Scotland, for instance, road traffic injuries were the leading cause of inequality in children’s health.

22. Two major groups of interventions were effective in preventing injuries: those aimed at modifying behaviour, and those designed to modify the environment. While the latter were far more effective and cost-efficient, the two approaches needed to be pursued concurrently. Safety experts should be involved in a wide range of decisions (such as on transport modalities and energy efficiency), in order to avoid unwanted adverse health repercussions.

Discussion

23. Representatives of a number of countries reported that injury prevention was a priority for them and that national action plans or reports, some prepared by interministerial working groups, were to be issued later in the year. While progress had been made in preventing injuries in young children, morbidity rates among adolescents were increasing and more research was needed, both in that area and with regard to social inequalities. The aim was to obtain evidence of the holistic benefits of injury prevention, in order for the right technical solutions to be adopted at minimum cost. Links could be made, for instance, between reduction of inequalities, obesity and injuries: encouraging physical activity by making streets safer would also reduce interpersonal violence, while child injury prevention in the home would also benefit the elderly and disabled. In any case, it was easier to measure the cost–effectiveness of injury prevention on the population as a whole.

Conclusions and recommendations

24. Participants recommended that the following key messages should be included in the Conference Declaration.

Indoor air quality

- Institutional leadership capacity to address IAQ in countries needed to be clearly identified, with the involvement of many different partners and sectors.
- IAQ had to be tackled in a balanced way, taking account of other factors such as ambient air, urban development and climate change. The legislative approach had proved its worth.
- Specific mention should be made of ETS, as well as of the effects of paints and biocides, and reference should be made to chemicals assessed in REACH and the updating of WHO guidelines on IAQ.
Physical activity

- Active modes of transport (walking and cycling) were beneficial not only in fostering physical activity and countering obesity but also as a response to climate change and the current economic crisis.
- The environmental component of child-friendly measures to encourage physical activity (not only walking and cycling but also green areas in cities) should be further strengthened, and children and young people should be involved in spatial planning mechanisms.
- Equitable solutions should be found in order to provide access to sports facilities and active modes of transport for all citizens.

Injuries

- Commitments related to prevention of injuries in children should be included under the section of the Declaration referring to CEHAPE regional priority goal (RPG) 2.
- Reference should be made to existing policy instruments such as the Transport, Health and Environment Pan-European Programme (THE-PEP) and relevant resolutions of the WHO Regional Committee for Europe.
- Given the large socioeconomic inequalities in injuries, countries should be urged to adopt policies aimed at ensuring safety for all.
- Further research was needed in order to fill the gaps in data on morbidity related to injuries among children and adolescents.

Draft Declaration for the Fifth Ministerial Conference on Environment and Health

25. Dr Leen Meulenbergs, Chairperson, Declaration Drafting Group recalled that the Drafting Group had met for the first time in Brussels, Belgium in June 2008; general discussion with all Member States had taken place at the Second High-level Preparatory Meeting in Madrid, Spain in October 2008; and most recently the Drafting Group had held its second meeting in Paris on 3 and 4 December 2008. The Group consisted of representatives of 19 Member States, the European Commission, United Nations bodies and NGOs, as well as young people.

26. At its Paris meeting, the Drafting Group had reviewed a draft of the Declaration and recommended that its structure should be reorganized with the following main sections: Preamble; Environment and health challenges in a globalized world; Commitment to act; and The way forward. The Declaration itself should also be short (not more than 2-3 double-sided pages), clear and easy to read; it should be “youth friendly”; it should not give examples of individual risk factors (such as specific chemicals); and the commitments under each RPG in the CEHAPE section should be revised and sharpened (perhaps with the inclusion of a limited number of quantified targets), while avoiding repetition of material in the existing text of the CEHAPE. The Drafting Group did not consider the section on the specific needs of the NIS and SEE countries (pending the outcomes of meetings to be held with those groups of countries) or the concluding section on The way forward (pending the outcome of discussions at the Third High-level Preparatory Meeting in Bonn in April 2009).
27. At its meeting the previous day, the European Environment and Health Committee (EEHC) had endorsed the framework and structure of the Declaration. It believed, however, that the text was still long and repetitive, especially with regard to climate change, and that one or two tangible desired outcomes should be specified in each part of the Commitments section. Lastly, the EEHC had urged Member States not to add any more detail to the Declaration, but rather to concentrate on identifying priorities.

Structure

28. Representatives of Member States also endorsed the framework and structure of the Declaration.

Preamble

29. The preamble should be shortened to one paragraph, avoiding repetition with the content of the rest of the Declaration. Reference should be made to the Budapest Declaration, adopted at the Fourth European Ministerial Conference on Environment and Health, and to the changed situation since then, notably the current economic crisis. Mention should be made of the need for solidarity in the face of differences between the eastern and western parts of the WHO European Region. The format of the Preamble could perhaps be modelled on that of the Amsterdam Declaration recently adopted by countries in the context of the THE-PEP.

Challenges

30. The Challenges section, too, should be shortened to two or three paragraphs, although links should be retained between the new challenges identified in that section and the commitments expressed later in the Declaration. Mention should accordingly be made of problems of urban development and spatial planning, of children’s exposure to toxic chemicals from increased trade in toys, clothes, etc. in the context of the global economy, and of social, economic and gender equity. The time frame should be narrowed to refer to progress made since the start of the European environment and health process in 1989. The paragraph on intersectoral action should include a reference to the education sector or, more generally, to the need to adopt an “Environment and health in all policies” approach. Overall, the section should be presented in a positive way, emphasizing the fact that challenges could present opportunities for effective action.

Commitments

Involvement of children, young people and other stakeholders

31. The title of the section should be amended to refer to cooperation or participation, rather than involvement, building on the provisions of the United Nations Declaration of the Rights of the Child. The paragraph referring to capacity-building should be expanded to cover all stakeholders, not just medical and paramedical professionals, and moved to the subsection on Knowledge and tools for policy-making and implementation.

Children’s Environment and Health Action Plan for Europe

32. An introductory text should be added to the subsection as a whole, taking in aspects that were common to all RPGs, such as the Tallinn Charter on Health Systems, Health and Wealth (paragraph 12 in the current draft), multisectorality and “environment and health in all policies” (paragraph 15) and coordination with established political processes (paragraph 16).
33. The subparagraphs related to RPGs should each have the same structure, beginning with a statement of existing international commitments or policy instruments (such as the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes for RPG1, THE-PEP Declaration for RPG2, or WHO’s IAQ guidelines for RPG3), before going on to refer to other concrete outcomes that Member States would commit themselves to achieving. Each RPG should make specific reference to the need for all sectors (including local government authorities) to work towards its attainment in schools/educational establishments and day care centres.

34. In RPG1, for instance, a commitment could be included to ensuring safe water supplies and sanitation in schools by 2015, and possibly to homes, too. Questions were raised about the appropriateness of including references to climate change under this RPG. Equally, RPG2 should refer not only to spatial planning but also to housing. The relationship between walking/cycling and spatial planning should be explicitly mentioned, together with the need for environments that both were safe and promoted physical activity (see above, paragraphs 16 and 24).

35. Indoor air pollution and healthy indoor environments, including ETS, should be subject of the first new commitments under RPG3, to be followed by outdoor air pollution. The first subparagraph in RPG4 should be deleted, since spatial planning would now be covered under RPG2. Similarly, the second subparagraph, in injury prevention, should also be moved to RPG2. In the sub-paragraph on research, the wording should be amended from “… as soon as sufficient knowledge is available …” to “… if such evidence becomes available”. The commitment on asbestos should be expanded to cover the health impacts of that material in women and children, not just working children. Reference should be made to early exposure and product safety, especially in the context of pesticides and mixtures of chemicals. Noise should be generally included as a physical agent, without specification of the source.

Climate change

36. Dr Bettina Menne, Medical Officer, Global Change and Health, WHO Regional Office for Europe noted that, following the Second High-level Preparatory Meeting in Madrid in October 2008 and the previous session of the EEHC and the Declaration Drafting Group meeting in Paris in December 2008, representatives of nine countries and of the European Commission, the Health and Environment Alliance and the Regional Environment Centre had met in Rome on 14 and 15 January 2009 to review an initial draft of a European strategy for protecting health in an environment challenged by climate change. The current draft of that strategy was organized into a number of major sections: Challenges, Principles, Aim, Objectives and Framework for action. Of the six objectives, three were singled out for in-depth action: intersectoral cooperation and health in all policies; raising awareness among citizens and other stakeholders; and targeting the protection of vulnerable groups and subregions. Negotiations were ongoing and would take account of discussions at the recent session of the Executive Board and the forthcoming World Health Assembly.

37. Dr Lucianne Licari, Regional Adviser, Environment and Health Coordination and Partnerships, WHO Regional Office for Europe reported that, at its session two days earlier, the EEHC had been of the opinion that the outcome of the discussion on climate change at the Conference should be reflected in a number of commitments in the Declaration. Two objectives in the draft strategy lent themselves to such an approach: the establishment of a European clearing house for sharing best practices, research data, information technology and tools, and the promotion of measures targeting the protection of vulnerable groups and subregions. The strategy itself should not be a “committal document”; instead, it should indicate the multiple linkages between environmental protection and health protection and describe ways of tackling all the problems being faced. In so doing, it might give specific examples of the links between
climate change mitigation and adaptation measures, thereby helping to differentiate the WHO Conference from COP15 while responding to World Health Assembly resolution WHA61.19 on climate change and health.

38. Dr Nata Menabde, WHO Deputy Regional Director for Europe, observed that, resolutions adopted by the World Health Assembly were binding on the Organization as a whole, and therefore there was no automatic requirement to make separate regional strategies on issues covered by global resolutions. The agenda of the fifty-ninth session of the WHO Regional Committee for Europe in September 2009 (which did not currently include climate change and health) had already been established by the Standing Committee of the Regional Committee at its session in Oslo in November 2008. The views of participants in the present meeting would no doubt be conveyed to the Standing Committee at its next session in March 2009, in terms of including the topic on the agenda of the 2009 Regional Committee session. In any case, the topic would figure prominently on the agenda of the Conference and in its Declaration.

39. Participants recognized that the key advantage of the European environment and health process was that it bridged the divide between purely environmental matters, as covered by the United Nations Framework Convention on Climate Change, and purely health matters, as taken up by the World Health Assembly. Nonetheless, they endorsed the position taken by the EEHC, namely that clear commitments to concrete outcomes with regard to climate change and health should be included in the Conference Declaration and not be the subject of a separate negotiated document. Those commitments should focus on the establishment of a clearing house and the protection of vulnerable groups and subregions. Such an approach would, however, require strong supporting material in the form of a policy brief. It would be a challenging task for the group of countries and stakeholders concerned, led by the United Kingdom and Serbia, to prepare such a policy brief and work up the corresponding section of the Declaration in the time available.

Knowledge and tools

40. Participants suggested that reference should be made, in the first paragraph of this subsection, to the “further development of the Environment and Health Information System (ENHIS).” The wording of the paragraph on human biomonitoring would need to be reviewed: it was perhaps unrealistic to expect it to be a tool for integrating all routes and sources of exposure with adverse health effects.

Next steps in drafting process

41. The Chairperson of the Declaration Drafting Group called for any further comments on the current draft (based on interventions at the present meeting) to be submitted to the Secretariat in writing by 10 February 2009. The next meeting of the group working on the climate change section of the Declaration and the corresponding policy brief would be held in London, United Kingdom in March 2009. A revised draft of the Declaration would be prepared after that meeting and distributed to Member States for consideration at the Third High-level Preparatory Meeting (Bonn, Germany, April 2009).

Closure

42. The WHO Deputy Regional Director for Europe thanked the Ministry of Health of Luxembourg and the EC Directorate-General for Health and Consumers for jointly hosting the meeting, and commended the Chairperson of the Declaration Drafting Group on helping participants to elaborate a position on which they could agree by consensus.
Annex 1

List of participants

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