



## European Environment and Health Committee

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### **Report on the 21st meeting of the European Environment and Health Committee Oslo, Norway, 15-16 May 2006**

**with a focus on:**

#### **CEHAPE Regional Priority Goal II:**

“to prevent and reduce the health consequences from accidents and injuries and pursue a decrease in morbidity from lack of adequate physical activity, by promoting safe, secure and supportive human settlements for all children.”

#### **Dates to remember**

Next meeting CEHAPE Task Force, Limassol, Cyprus, 16 – 17 October 2006.

WHO European Ministerial Conference on Counteracting Obesity, Istanbul, Turkey, 15 – 17 November 2006.

Next meeting EEHC, Szentendre, Hungary, 27 – 28 November 2006.

First United Nations Global Road Safety Week, 23 – 29 April 2007.

Intergovernmental Mid-term Review (IMR), Vienna, Austria, 13 – 15 June 2007.



**Summary of recommendations of the EEHC on the IMR  
(see report text for details)**

- The IMR should be a high-level meeting and include ministers.
- The “brand”, that is the theme of, “the future for our children”, should be retained.
- Further focus could be added by one main objective similar to the ‘zero vision’.
- The IMR should be dedicated to reporting back on CEHAPE commitments.
- This should be done using a similar format to the CEHAPE Task Force meetings.
- Challenges and constraints should be examined as well as achievements.
- The gap between western and eastern countries should be better addressed.
- It was agreed that short concise working papers would be appreciated.
- There should be a report on progress compiled by WHO.
- A short paper should also be developed on the fifth ministerial conference.
- New stakeholders such as scientific institutes and local authorities, to be involved.
- Youth involvement should be maintained and promoted.
- Other major related events and processes should be taken into account.
- Economic tools were a key issue: the cost of inaction.
- The IMR should also allow for emerging or recent issues to be addressed.
- Side-events and exhibitions should be avoided or kept to a minimum.
- A CEHAPE award for good practice should be made.
- A “certification/reference level” should be investigated.



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## **1. Introduction**

The 21<sup>st</sup> session of the European Environment and Health Committee (EEHC) convened in Oslo, Norway, from 15 – 16 May 2006. It was divided into two parts. The sessions on 15 May 2006, to which all 52 Member States of the WHO European Region were invited, focused on aspects of evidence on accidents, injuries and physical activity among children, followed by a review of the national and international policy response to CEHAPE Regional Priority Goal II. The next day was an operational session of the EEHC, to which non-member countries were welcome to attend as observers. The list of participants is given in Annex 1.

## **2. Opening remarks**

Dr Bjørn-Inge Larsen, Director, Norwegian Directorate for Health and Social Affairs, welcomed participants, particularly the new youth delegates. Norway had a long tradition of public health dating from 1848, which emphasized local authority involvement. In relation to accidents and physical activity, it was important to find the balance between promotion and protection: children should not be overprotected.

Mrs Helen Bjørnøy, Norwegian Minister of Environment, also welcomed participants, noting that people had a right to a healthy life and a clean environment: it was important to prevent disease, not only cure it. Although childhood lasted only a short time, it laid the foundations for a healthy adult life. Children needed cycle tracks, safe trails playgrounds and physical skills, and they needed to have their say. WHO and CEHAPE had shown the way to go, with all sectors involved. Mrs Rigmor Aasrud, State Secretary of the Ministry of Health and Care Services, said that Norway was developing an action plan that was being developed by the end of 2006. Young people would be involved in developing it. There were challenges in reducing the number of overweight and obese children who did little exercise and had a poor diet: this was linked to social inequalities. Injuries were the main cause of death among children. A new national surveillance system was to be started in 2007. Targets needed to be adopted within the flexible framework, to give children a better deal in life.

The Chair of the EEHC, Professor William Dab, also welcomed participants and the newly-elected youth delegates, and opened the meeting.

### **3. Review of scientific evidence related to Regional Priority Goal II (RPG II)**

#### **Latest evidence on unintentional child injuries**

Dr Dinesh Sethi, WHO Regional Office for Europe, presented some of the latest evidence on unintentional injuries, which formed the leading cause of death and disability in the Region for children aged between 1 and 14 years, accounting for 36% of all deaths in that age group. There were an estimated 27 900 deaths per year for children under 15 years in the Region of which 11% (3 200), were due to intentional injuries. There were great inequalities across the Region. In countries of low incomes and in political and economic transition, children were at 4.3 times the risk of dying of injuries than children in high income countries. The gap had not narrowed for the last 20 years and it was not narrowing now. Deaths were only the tip of the iceberg. Despite inadequate data, it was estimated that for every death from injuries there were 150 children hospitalized, 2 700 attending emergency rooms, and 4 914 visits to family doctors. Many long-term sequelae such as psychological and chronic physiological damage were not captured in these figures. Road accidents were the first cause of death for 5 – 14 year olds in Euro A and Euro C, and the 2<sup>nd</sup> in Euro B (WHO categories). The high income countries are among the safest in the world. However in the most deprived areas even within them, road traffic accidents are 3.5 times higher than in the least deprived, falls are 6 times higher, and fires are 18 times higher.

The official figures alone indicated that every year an average of 19 950 children from 1 to 14 years died from injuries, which was a rate of over two an hour. There was a tenfold difference between the countries with the highest rates (Kazakhstan, the Russian Federation and Turkmenistan) and the lowest (Italy, Sweden and the United Kingdom) These were avoidable deaths. If the whole Region had the same rate as Sweden, which had adopted specific policies for many years, then over 15 000 child deaths from injury could be saved – that is, 75%.

There were many international policy initiatives on injuries, from the United Nations including WHO, and the European Commission. There was now a WHO European network of focal points on violence and injury prevention, a WHO global strategy, regional consultations from UNICEF, and nongovernmental organizations such as the Europeans Child Safety Alliance and the development of child safety action plans in countries. The health sector could play a greater role beyond treating the victims: European Member States agreed, at WHO Regional Committee 55 in 2005, to develop national plans, improve surveillance, strengthen capacity, prioritize research, promote good practice, support the focal points and report back on their progress in 2008.

There was a huge potential to save lives, but also to save money since injuries were costing countries dear. Every Euro spent on smoke alarms saved €69 in overall costs, on child safety seats €32, and on bicycle helmets €29. What was needed was for policy-

makers to undertake injury prevention as a societal responsibility, not an individual problem, and tackle key risk factors. Efforts could be coordinated to create a hazard-free environment. It was time to go from data to action.

(More details were available in the forthcoming WHO publication, *Injuries and violence in Europe, why they matter and what can be done*. See <http://www.euro.who.int/violenceinjury>.)

In subsequent discussion, the point was made that some question prioritizing the use of helmets and safety seats: the number of children killed in the United Kingdom increased when compulsory seatbelts were introduced, as people drove with less care. The use of bicycles fell when it became compulsory to wear helmets. Were we withdrawing the threat from children, or vice versa? Children needed to cope with risk and not be over-protected. They were not being allowed out of doors, while society continued to function in a hazardous manner. Crossing a 12 lane highway to get to school or sitting in cars in traffic jams were not healthy options. It was complex: the death rate per vehicle dropped as the level of motorization increases. In some countries there were more accidents in rural areas. The lack of data to underpin societal interventions was discussed: this reflected the tendency in the past to look on injuries as unavoidable and the individual's responsibility. The data was not always comparable – in some countries (e.g. the Russian Federation), a death from injuries is a death that occurs within seven days of the injury, but the international standard is 30 days.

## **An eastern European perspective**

Dr Samat Toimatov, Ministry of Health, Kyrgyzstan, described his largely rural country, where 31% of the population is under 14 years of age. Official statistics showed that of the 21 837 children injured in 2005, most injuries were at home: 13 920 at home compared to 5 115 on the streets and 913 in road traffic accidents. However, the total number of traffic accidents increased in 2005 by 12.5%, and 42% of those who went to hospital as a result were driven to hospital without medical care. 6.3% of children injured in road accidents died. Family conflicts were also a problem: every year over 500 children were hospitalized as a result of child abuse, and this was just the tip of the iceberg. 58% of women are estimated to suffer violence at home and 18% of children. To tackle this, a law had been adopted on family violence, and another on road traffic. They were developing better coordination with NGOs and had held an intersectoral conference with WHO in 2004. They had a TV spot “obey traffic rules” and guides for children on injury prevention. They had increased training among professionals, first aid training, and had better data collection and standardization. However despite the growing problems of injuries, including the increased trafficking of vulnerable young girls, there was no government strategy as yet on the prevention of violence and injuries among children, a lack of data and a lack of money.

Dr Vadim Donchenko, from the Ministry of Transport, Russian Federation, explained that his country had the highest level of road deaths in the whole Region: 24.59 per

100 000 populations. The number of deaths caused by road accidents had grown by 25% in 1998-2004 and mortality and morbidity among children from road accidents was now 10% higher than in 1990. Country's car use was expanding rapidly with some 260% more cars on the road than in the 1990s. The transport strategy endorsed by the Government, expected to double the population's mobility by 2012. 50% of cars, 61% of trucks and 46% of buses were over 10 years old. Most accidents took place in towns and cities, but most of those who died were from rural areas. The annual socioeconomic cost of road accidents was officially estimated at 2.5% of Gross Domestic Product.

The government requested the European Conference of Ministers of Transport to carry out a review, which was done with the aid of an expert group, the World Bank and WHO. Its main recommendations were to ensure government leadership to increase awareness of the threats posed by road traffic crashes to societal well-being and the economy, and to establish multi-sectoral cooperation at the highest level to set up a federal programme. Laws were being developed on infrastructure, seat belt use, drink driving, headlight use, emergency vehicles, speeding, etc. and penalties and sanctions were being increased tenfold. There were major problems to overcome, including police corruption, and the improvement of education of young people.

## **Home injuries**

Ms Mathilde Sengölge, Austrian Safety Board, outlined the situation in Europe. 51% of injuries among children occurred at home or in leisure time. They were the leading cause of death of children between the ages of 1 and 4 years in the EU, but little data existed on them, and preventive interventions which were known to be effective were not being used. Home injuries were a priority for the professionals in the European Child Safety Alliance. The main sources of data were the WHO Mortality Database, the EU Injury Database and national statistics, and they did not all cover standardized information (e.g. where the injury took place, whether it was unintentional or intentional) 43% of injuries were the result of falls: the most common part of the body injured was the head, and the poor were most often the victims of severe falls and scalding. There were disparities between countries, and the reasons were not clear, for example, there was a 72-fold difference in drowning. If Austria, Denmark and Netherlands were compared, it was found that for every death there were 1 350, 1 851 and 131 hospitalized respectively, and 6 650, 5 561 and 1 531 visits to emergency rooms, respectively. There was much information about home injuries that was still to be understood.

In discussion it was pointed out that the European Commission was producing a report on injuries later in 2006. It was important to get the data and to target actions: harmonizing the definitions used for the data was difficult but essential. Even after many years of a system in place, hospitals often failed to record events accurately. In some countries, no data meant no action, but political will was also a sine qua non. There was some concern that adults were continuing to take responsibility for children for longer, and children had less independence. In the United Kingdom in 1970, 80% of children went to school on their own, but 20 years later, only 9% did. Parents were denying their children freedom to

roam out of concern for their safety and they were kept indoors or in back gardens. Children that were over-protected were more vulnerable later.

In Sweden “Vision Zero” drove the agenda on traffic-related deaths. Municipal councils had responsibility under the law for “health protection” safety measures in housing: there was a long tradition of preventive measures. It was not always possible to transfer policies between countries but it was clear from the evidence that child resistant packaging worked, as did capacity building for injury prevention.

## **Linking environment, injuries and physical activity**

Dr Harry Rutter, United Kingdom, examined the problem: road traffic injuries were an enormous problem in the WHO Region - road traffic injuries were the leading cause of death for children (5-14 years: 4 691 deaths annually) and young people (15-29 years: 37 994 deaths annually). At the same time, in the EU, overweight children were expected to rise by 1.3 million a year, with more than 300 000 of them becoming obese each year. By 2010 it was estimated 26 million children in EU countries would be overweight, including 6.4 million who would be obese, with serious health effects. Too few children met the moderate-to-vigorous physical activity guidelines: only one in three were sufficiently active. Sport in school was promoted but is being increasingly squeezed out by academic pressures. New partnerships had to be built across the sectors. Where there was more cycling there were fewer overweight children, but the trends were currently in the wrong direction, as car travel to school was increasing significantly. His view was that children had been marginalized, and the people who drove were killing those who did not.

Mr Peter Lyndon Jacobsen, United States of America, said that fear was not well understood. Parents were fearful: surveys showed that 89% of parents worried about traffic, 50% of parents believe a child will be hit. 25% of parents believe their child will be hit. The decreases seen in injury rates may be linked to removing children from the roads. The volume and speed of traffic has increased, and acts as a barrier: well recognized by traffic engineering literature. People only crossed at crossings. Thus asking people to allow their child to be more active would not work if the fear was still real. If more bicycle lanes were provided then people cycle more: at the moment men cycle more than women where cycling is perceived as dangerous. Some countries had put successful measures in place such as traffic calming and bicycle lanes.

In Finland, the net benefits of doubling cycling had been estimated to exceed the costs by €100-200 million/year through reductions in injuries and others health effects. Installing bike lanes increased bicycling and decreased injuries: 35% reduction was seen in deaths among cyclists in Denmark following segregated bicycle lanes alongside urban roads.

In London the congestion charge had reduced traffic by 18%, increased bicycle use by a third and reduced cyclists’ injuries. There was safety in numbers: as more people walked

and cycled it became safer, therefore increasing physical activity would not increase injuries.

The economic costs should not be forgotten: it had been calculated that physical inactivity cost €650 per Californian citizen, €315 per English citizen and €146 to €200 per Swiss citizen. Traffic crashes costs (per year): €660 per USA citizen and €580 per EU citizen (approx. 2 % of GDP). Physical activity had to be part of daily life: cost-effective measures were available to remove the barriers to it. Professionals should publish on this, and learn from successes and failures. This was a major challenge to the status quo.

## **Building partnerships**

Mr Bjørn-Are Melvik, Nordland County, northern part of Norway, which had many very small municipalities, emphasized the importance of the education sector, which could reach all children and parents in the local community. Nordland County's target was to work in partnership, to increase physical activity and create a good framework for school meals, using existing knowledge, developing models and giving guidance. Local solutions were important and political will essential. It was hoped to offer school meals and for every teacher to take part in an hour a day of physical exercise. The most important group were the children who were inactive, they were often forgotten as they were not good at sport. Sports could be combined into other subjects particularly maths and science. Teachers usually stayed in from October to May but many physical activities could be appealing and challenging: using ropes, waterproof cameras, ice activities - a wide variety. The timetable should reflect the patchwork of recess, activities, etc. Some schools had local networks involving the school nurse, local landowners, farmers, athletic club, caving enthusiasts, etc. The civil servants in the county also had free fruit and two hours free time at a fitness centre, to keep them healthy.

Mr Joel Valmain, European Commission, DG of Energy and Transport, described recent developments in reducing accidents and injuries among children under the slogan "Road safety is a shared responsibility". The EU White Paper on transport policy of 2001 aimed to fight congestion and increase road safety. The goal was to halve road deaths by 2010. The slogan was "It was up to the Member States not the European Commission", since road safety is subject to subsidiarity unless there is added value. Therefore, political will was vital. There was a Road Safety Charter where countries committed to report on their progress in concrete and measurable actions. Deaths had fallen from 70 900 in 1990, to 50 400 in 2001 to 40 000 in 2005, but more was needed to reach the target. The main causes of deaths were speeding, alcohol and not using seat belts, but Member States were also concerned about young drivers – 2 000 deaths per year occurred at weekends among 18 – 25 year olds. A third driving licence directive was proposed with anti-fraud measures, harmonization of categories, stronger medical checks and a special moped category (high casualties from 14 – 17 years). One in four accidents were related to alcohol and a special four year €19 million research project, DRUID (Driving under the

Influence of Drugs, Alcohol and Medicine), was currently analyzing the influence of consumption of psychoactive substances on fitness to drive.

There was no harmonization of speed limits in Europe, but generally, urban areas limits were set at 50 kph, and motorways at 110 – 130 kph, apart from certain roads in Germany. There were three different types of driver: those who respect the speed limits (3 – 4%), those who drive very fast (2 – 3%) and the vast majority who drive 10 – 25 km over the speed limit and think they are respecting the law. A cross-border enforcement directive was in preparation.

Some useful websites for further follow-up included:

- Commission transport: [http://europa.eu.int/comm/transport/index\\_en.html](http://europa.eu.int/comm/transport/index_en.html).
- Road transport section: [http://europa.eu.int/comm/transport/road/index\\_en.htm](http://europa.eu.int/comm/transport/road/index_en.htm).
- Community database on Accidents in Europe (CARE): [http://europa.eu.int/comm/transport/home/care/index\\_en.htm](http://europa.eu.int/comm/transport/home/care/index_en.htm).
- Driving licences: [http://europa.eu.int/comm/transport/home/drivinglicence/index\\_en.htm](http://europa.eu.int/comm/transport/home/drivinglicence/index_en.htm).

In the ensuing discussion, France reported on how it had halved its road deaths in two years: speed cameras had proved particularly effective, being responsible for 30% of this reduction. Some countries did not allow advertising that emphasized speed. Saving the lives of children might be the only argument which worked. Jail penalties were rarely given for speeding, and in some countries the police or the victims' families were just bought off with money. Speeding at 40 – 50 km was the boundary in terms of making a difference to public health, so tackling the average driver would have a big impact. It was stressed that the cost of injuries is high and the lack of physical activity increases cardiovascular disease, a major killer, so that should be included when costing inaction. The roads should be seen as the route to physical activity, but as car use increases and city centres become giant car parks, the roads are seen as being only for cars and dangerous for everyone else.

Projects that helped to prevent young people having to use their cars on a Saturday night were useful, for example the bus in Oslo that picks up young people from bars. However in some areas of suburban sprawl, the car is the only means of transport if people have to travel a long way. This combines with the fear of the streets in societies where people do not know each other, and there is a loss of trust.

#### **4. National and international policy response to CEHAPE Regional Priority Goal II – Progress, opportunities and constraints**

##### **Social dimensions of transport policy**

Professor John Adams, United Kingdom, outlined the increase of “hyper mobility” whereby people travelled on average 20 miles a day, compared to 1950 when it was 5 miles a day. This was seen as progress but gradually the disbenefits were outweighing the benefits, such as more dispersed population in suburban sprawl, social polarization, less culturally distinctive communities, anonymity, less child friendliness and more obesity.

Many cities had barriers across roads to direct pedestrians and cut them off from cars. Another solution was that of Hans Monderman (Dutch road traffic engineer) with his idea of “naked streets”, where signage was removed and uncertainty was deliberately injected, which had the effect of slowing everyone down, and enabling pedestrians to cross the road with ease.

##### **Environment and health indicators**

Dr Michal Krzyzanowski, WHO Regional Office for Europe, described the development of this tool that had been asked for at the Budapest Conference. The methodology was nearly finalized and it was starting to be applied, with the work focused on CEHAPE. Countries did not want new reporting obligations so efforts were made to use existing data; 30 core indicators had been developed, and an extended set of 8 more. Work was also being done on methods to assess the information needs of policies. It would all be integrated into the Health for All database. The policy indicators did not need countries to report, the methods had been tested and could be applied. Of the Regional Priority Goals (RPGs), RPG IV was the most difficult to get data for; 15 countries in the eastern part of the Region had met to discuss joining the network that had been set up, and contributing data. The web site reflected some of the information already available; the database was planned to go live in November 2006.

Ms Ingrida Zurlyte, Lithuania, had been involved in the information system development since 2000. National involvement benefited from comparisons between countries, which acted as a stimulus to look for more efficient solutions. It also reduced work load because of data retrieval from international databases and the expertise that was generated on different issues. It supported the development of a national environmental health information system.

Discussion focused on how useful data was for decision-making. Causal links could be made between determinants and health effects, and comparability was a useful spur. However, a judgment still had to be made e.g. whether to shift children or shift traffic.

Ms Joanne Vincenten, EuroSafe/European Child Safety Alliance, reported on the development of child safety action plans by 18 countries. The focus was on raising the political agenda of child injuries, increasing standardized data and reporting, and on capacity building. The network were publishing a good practice guide in June 2006 (see launch 27 June 2006, [www.childsafetyeurope.org](http://www.childsafetyeurope.org)). A survey on infrastructure, who does what and budgets, would also be produced, in autumn 2006. It was committed people who made the difference, and the political will in CEHAPE helped.

Austria reported on how they had stressed the Thematic Strategy on the Urban Environment during their Presidency of the EU: there was a synergy between it and CEHAPE. Austria had school mobility management plans extended to all schools, using consultants and training for tailor-made plans. They had also started to develop a master plan on cycling, also as part of CEHAPE. Injuries, and physical activity were both pillars of a major health promotion campaign in Austria where 170 000 out of 800 000 injuries annually were children, half of them at home, and 40 children died from injuries a year - mostly from road traffic. Their child safety plan would be completed by the end of 2006.

Ms Francesca Racioppi, WHO European Centre for Environment and Health, Rome, Italy, reported on the Transport, Health and Environment Pan European Programme (The PEP) which had a project promoting walking and cycling in urban areas. The PEPs's multi-sectoral task force was taking stock of what is already developed, and assessing costs and benefits. They were looking at pioneer projects in Norway with the help of the Karolinska Institute, Sweden. They had documented 70 case studies, which would be made available. The project was in collaboration with the European network for the promotion of health-enhancing physical activity (HEPA Europe). The third high-level meeting would be held in April 2008.

Member States reported back on developments, including Slovakia which was prioritizing tackling injuries and accidents to children, and had set up a national register. A CEHAPE workshop had been held with WHO involving many colleagues from many sectors and that had proved very inspirational. Norway was using taxis as mini-buses to bring young people home. This €50 000 project was due to start in June 2006. The ICFTU (International Confederation of Trade Unions) representative emphasized the problem of young workers exposed to risk and injuries at the workplace, including during summer jobs. The 2006 European Week for Safety and Health at Work was to be dedicated to young people to ensure a safe and healthy start to their working lives (see <http://ew2006.osha.europa.eu/>). Sweden was drawing up an action plan with proposals for healthy dietary habit and physical activity, and Stockholm was trialling a congestion charge in August 2006, which would be evaluated.

## **5. Youth involvement in international and national policy-making in environment and health**

Ms Bente Moe, Norway, reported back on the workshop on youth participation that had been held in Norway in March 2006. It had been supported by the Nordic Council of Ministers, the Nordic Working Group for Environment and Medicine, and the Norwegian Directorate for Health and Social Affairs. 17 youth delegates, aged between 16 and 20 years, came from 8 countries. They discussed the issues in RPG II, how youth representation would work in the environment and health process, and the challenges they faced. They agreed it was important that the adults used courtesy, understandable language, responded to youth input and that visible results could be achieved. Young people were more likely to see opportunities than barriers and they had a lot of energy. Recommendations were made to follow up, share information, cooperation and networking national and international level. Next steps were identified as supporting an electronic network, developing youth input to the Intergovernmental Mid-term Review in 2007 and evaluating this participation.

The youth delegates underlined their concern about lack of physical activity, and overweight. Young people and children should do more and not necessarily sports as such. In one area of Finland 9 000 pupils in 22 schools were involved in an "On the Move" project, with materials and buddies and NGOs helping. School and family meals were important: in some countries such as Estonia and Lithuania, only girls learned to cook. Safe mobility and transport were also key factors. More traffic education was needed, traffic clubs, walking licenses, and better public transport. There was an international youth traffic patrol which could be extended. If only planners asked children what they needed and how they needed it, a lot more could be done to help them be active in their daily lives. Youth councils should be in every area as they could help fight for this.

The discussion reflected how countries were starting to involve young people in decision-making. Austria mentioned a workshop to be held in October 2006 to train young people to train others in CEHAPE RPGs. It was stressed that it was not appropriate to expect young people to take this issue on as a personal issue of individual behaviour. Governments had to play their part.

## **6. WHO work on implementation of Budapest Conference commitments**

Dr Lucianne Licari, WHO Regional Office for Europe, reported on WHO's new project supported by DG Sanco. It aimed to support EU Member States and EPTA countries (Expanded Programme of Technical Assistance) in developing/incorporating children's health and environment into national policies and action plans. It would do this by

conducting in the new EU Member States, national profiles on children's health and environment priorities (health and environment performance reviews). This would also help to support the development and implementation of national policies and help to assess the health impact of European Community actions in different sectors. The project would produce guidelines, health risk reduction policies, training modules and case studies to assist Member States as they developed policies on environment and health aiming at a high level of protection of children. The health and environment performance reviews would apply a uniform methodology, enabling comparison between countries and sharing of experiences and good practice.

Environmental Performance Reviews were first done by UNECE and OECD between 1998 and 2002, at the invitation of countries. Not all had included health. They had been found to be invaluable. These reviews could only be done in the EU so although some other Member States had requested them they could not be done until funds were found.

This project was welcomed by the participants. There was concern to make sure the gap between the Commonwealth of Independent States (CIS) and the rest did not widen, as the rest of the Region was not eligible to participate. In CIS countries the institutional framework was a crucial area, and multisectoral activity was essential. The World Business Council for Sustainable Development had issued some relevant reports, for example on sustainable transport, and would like to be involved.

## **7. CEHAPE Task Force report**

Mr Robert Thaler, Chair of the CEHAPE Task Force, reported that participation at the meetings was very good. At the last meeting in Ireland, 44 Member States had registered to attend, and 72 participants came. There were now 79 environment and health focal points. Most countries had intersectoral committees and were preparing or implementing their NEHAPS (National Environmental Health Action Plan), revising their NEHAPs, or preparing stand-alone CEHAPs.

Support had been received from Austria, Cyprus, Ireland, Norway and the United Kingdom: Austria was providing financial support for staff to strengthen the CEHAPE secretariat, Cyprus was hosting the next CEHAPE meeting on 16 – 17 October 2006 and there was interest for hosting the fourth meeting of the Task Force in 2007.

The WHO secretariat had run some country workshops on CEHAPE and would be running more. The CEHAPE Action Pack now included 70 case studies, sharing scientific knowledge and good practice. The CEHAPE web map was facilitating reporting by countries and the legislation project was developing.

The epidemic of obesity in Europe started in childhood: in some countries one in four young boys/girls were overweight; there was an increase of fast and fat food and decrease of physical activity. Some countries were taking action: progress was uneven.

The importance of involving other sectors and local authorities was paramount in relation to RPG I. Interventions were needed on healthy food and consumer purchasing behaviour, promotion of human powered mobility in particular in planning and infrastructure policies: cycling-friendly, walking-friendly, child friendly urban environment and settlements; and on school policies, education and public awareness raising campaigning and product advertising.

The economic costs of “inaction” - physical inactivity, obesity and injuries - should be calculated and incorporated in policy making and tools, as should the cost of action. The Intergovernmental mid-term Review (IMR) was to be held in Vienna, Austria, from 13 – 15 June 2007 and it was to be hoped that a youth conference would be held the day before.

## **8. Intergovernmental mid-term review (IMR) meeting in 2007 – scope and agenda**

Dr Hilary Walker, United Kingdom, outlined the reporting possibilities for the IMR. (Vienna, Austria, 13 – 15 June 2007) WHO could prepare a compact overview from countries, to include standardized comparable information, from EHIS (Environment and Health Information System) , the web map and a template on issues from the Declaration. There could also be individual reports from Member States. A template for a core set of child-specific indicators had been sent to Member States in May 2006, based on Regional Priority Goals and including policy indicators to be filled in by Member States and other indicators which were mostly to be retrieved from existing international databases. The indicators for RPG II for example, were:

- child mortality from traffic accidents
- child mortality from other external causes
- percentage of physically active children
- prevalence of childhood overweight and obesity
- policies to promote safe mobility and transport for children
- policies to reduce child injury
- policies to prevent childhood obesity.

Discussion on the Conference emphasized that it should be a political conference as well as a technical one. CEHAPE was a successful “strong brand” and should be maintained and developed. However for the IMR the reporting back was central: there would have to be clear guidance for reports from Member States.

Dr Lucianne Licari, WHO Regional Office for Europe, reminded participants that the role of the IMR was to ensure reporting back on implementation since the Budapest Conference, evaluating the progress made, including identification of difficulties and outstanding issues, and to set a provisional agenda for the Fifth Ministerial Conference to be held in Italy in 2009. Detailed proposals should be presented to the 57<sup>th</sup> session of the WHO Regional Committee for Europe, Serbia, and the UNECE Committee for Environmental Policy in the autumn of 2007.

The IMR could be structured into three major parts. The first one could be on reporting, with a maximum of five or six presentations summarizing progress achieved since Budapest. This could develop into discussion of lessons learnt and outstanding issues to be addressed. This session could perhaps use working groups.

The second session could take as its subject the next steps, to take stock of what the environment and health process should now be doing, and how to better serve countries. The third session should focus mainly on planning the Fifth Ministerial Conference, its theme and agenda, to ensure continuity and add extra value to the work going on. For example, should the principle of thinking globally and acting locally have a new emphasis?

There were some obvious challenges: from attracting the participation of policy-makers, media and wide stakeholders to ensuring intersectoral involvement and providing ministries with economic arguments for action for prevention. There was to be a WHO ministerial conference in 2008, on health systems, and it was important to ensure that prevention as a basic principle of public health was not neglected.

Various ideas were mooted in discussion and the following recommendations made:

- The IMR should be a high-level meeting which would issue invitations to Ministers and include some ministerial presence.
- The “brand” that is “the future for our children”, should be retained, but further focus could be added by selling one main objective similar to the ‘zero vision’ promoted by Sweden (for example, why are **any** children dying of water-related disease in the Region?).
- IMR should be dedicated to reporting back on CEHAPE commitments. This should include enough time for discussion and evaluation. However, reporting should be done on a country experience basis using a similar model to that used in Task Force meetings. This would ensure that a country-by-country verbal report on a list of country activities would not take place in plenary.
- It was important that countries examine not only achievements but also challenged and constraints in implementation and priority areas for action
- There should be a thorough representation of all countries of the region, with particular emphasis on the EECCA (Eastern Europe, Caucasus and Central Asia) countries: the gap between western and eastern countries should be better addressed. Sufficient resources should be found to ensure adequate representation of the countries in transition. What had to be avoided was ‘unification by exclusion’.
- It was agreed that short concise **working papers** would be appreciated. The reporting should aim to provide a clear analysis of what had happened since 2004, what was still to be done and whether countries were going in the right direction.
- There should be a report on progress compiled by WHO on the basis of the EH indicators and the web site reports.

- A short, concise and policy-oriented paper should also be developed by the secretariat on the provisional agenda and programme of the Fifth Ministerial Conference, for discussion at the IMR.
- New stakeholders should be involved, such as scientific institutes and local authorities, who are central to implementation.
- Youth involvement should be maintained and promoted both within the countries and in international meetings. Member States attending the IMR should be encouraged to include youth representatives as part of their official delegation. The European Commission would explore the possibility of a youth consultation.
- Other major related events and processes should be taken into account, for example, the WHO European Ministerial Conference on Counteracting Obesity in November 2006, the Belgrade 'Environment for Europe Process' in September 2007 and the WHO Health Systems Conference in 2008.
- Economics was a central area to include: the cost of inaction. How much was being spent on prevention rather than cure? Happiness or well-being could be examined as an area of interest and, for example, the Daly-Cobb index of sustainable economic welfare which supplements the GDP. Such new tools and incentives for policy makers should be promoted and applied, thereby changing the focus of the evidence base used to 'sell the product' and ensure better implementation rates. Closer links should be sought with the World Bank. It was important to promote financial institutions incorporating health impacts on children into their criteria.
- The IMR should allow for emerging or recent issues to be addressed such as avian flu or progress with REACH (Registration, Evaluation and Authorisation of Chemicals).
- Side-events and exhibitions should be avoided or kept to a minimum.
- A CEHAPE award for good practice should be made.
- A 'certification/reference level' should be investigated whereby practice within Member States, IGOs or NGOs would be rated against a widely promoted standard created specifically for this purpose (e.g. as is the case with ISO (International Organization for Standardization) certification).
- Since the evidence base was so important to Member States to underpin policymaking, it should be subject to evaluation. An important tool was the environmental burden of disease, the methodology of which should be elaborated in more detail and presented to the IMR meeting. (A meeting on this was taking place in September 2006.)

Dr Michal Krzyzanowski, WHO European Centre for Environment and Health, Bonn, Germany, reported on a meeting on information systems held in Germany in April 2006, attended by experts from 28 Member States, where there was a concern to ensure the participation of non-participating countries. All Member States were invited to participate in the network. Proposals had been made for the products for the IMR, including a report which would be indicator-based and on the web, and for case studies. A presentable system would be presented to the EEHC in February 2007. Data for the CIS countries would have to be collected manually. REC (Regional Environmental Center for Central and Eastern Europe, Hungary) had offered its assistance. 16 countries participated in their

network within the environmental health topic area, they had projects on air quality in schools, sustainable transport and upcoming projects on, for example, research and impact assessment. The European Environment Agency (EEA) was working on several environment and health messages in the report being prepared for the Fifth Environment for Europe Conference to be held in Belgrade. A TACIS (EU body – Technical Assistance to countries of Eastern Europe and Central Asia) project started recently would increase capacities on air, water and climate change.

On youth involvement, countries were urged to send youth delegates to the CEHAPE Task Force meetings, and participants looked forward to seeing a youth-friendly CEHAPE being written: UNEP would be happy to assist.

All participants were invited to send any further comments and suggestions on the IMR to Dr Licari at WHO by 30 June 2006.

## **9. Reporting by EHC members on implementation of Regional Priority Goals III and IV**

European Eco-Forum and Women in Europe for a Common Future, reported on their “Nesting” project concerned the impact of pollution on pregnant women and their babies and avoiding chemicals in the home. Norway was preparing a new green paper on chemicals. WHO was appointing a technical officer on chemical safety, and later on occupational health. Strategic Approach to International Chemicals Management (SAICM) and RPG IV were interlinked. The World Business Council for Sustainable Development reported that much work was going on in industry on REACH, also some on SAICM (Strategic Approach to International Chemical Management) and Johannesburg commitments. EPHA was involved in the “Stop mercury, stay healthy” campaign. Awards had been given for good and bad practice by VOICE (Vulnerable Road Users Association). REC, Hungary, were holding a conference on chemical safety, with a special focus on children. In Budapest, 25 – 29 September 2006, there was to be a special meeting on mercury and heavy metals. UNEP was involved in an environmental diplomacy programme, partly on health and chemicals. The EEA and WHO were to hold a meeting on the Environmental Burden of Disease from 25 – 27 September 2006.

The European Commission was preparing a Green Paper on physical activity – they had received many replies to their consultation. On the platform on diet and physical activity, the EC had held a big meeting with the United States of America to exchange best practice. A communication on injury prevention was coming out, and also a Council recommendation on injury prevention. As part of the EU Action Plan, a consultation had been held on bio-monitoring. Also an expert group was to be set up on indoor air quality.

Austria was involved with the EU’s Thematic Strategy on the Urban Environment, on which a key meeting was to be held on 28 –29 June 2006, where a progress report on the next generation of standards for cars in Europe (EURO 5), would be delivered, and new levels of particulates should be finalized: particulate filters would be required by 2010.

Now EURO 6 (WHO categories) was being developed, which would focus on nitrogen oxide (NOX) emissions particularly.

Some specific areas of progress were reported on: Georgia had recently registered all radiation sources and tightening up safety procedures for radiation equipment, as part of emergency planning. A draft document was being consulted upon. Italy reported on an obesity prevention plan that was being developed. Armenia was undertaking a study on road traffic accidents and had a new law on traffic regulation that increased penalties dramatically, with a new monitoring system for motor was. They were also investing in gymnasia, pools, etc. in schools, and had a new law on sport for adults and youths. Finland reported on its national chemical strategy, and the preparation of its child safety action plans, its home injuries campaign, its road traffic programme, and new safety instructions for daycare. The Russian Federation was concerned about its levels of air pollution, of which over 50% was provided by road traffic in big cities.

## **10. Final comments, conclusions and wrap-up**

Norway was thanked for hosting the meeting, and thanks were extended to Elaine Price, from the Secretariat of the EEHC, with best wishes for her retirement.

## **11. Date and venue of next meeting**

The next meeting is to be held in Szentendre, Hungary, 27-28 November 2006.

## **Annex 1**

### **List of participants**

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