Specific needs of the newly independent states and the countries of south-eastern Europe
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Key points

Previous steps in the European environment and health process have called for the strengthening of collaboration with and within the newly independent states of the former Soviet Union (NIS) and the countries of south-eastern Europe (SEE). Although there is substantial variability between the two regions, as well as between the countries within them, they still have a common set of health and environment priorities that call for action.

- The main problems include limited accessibility to safe water and sanitation (especially in rural areas), road traffic mortality, and mortality resulting from unintentional injuries, as well as the morbidity and mortality associated with exposure to air pollution. In some locations, environmental contamination by lead remains a problem.

- Most of the NIS and the SEE countries have recently modified legislation in the area of environment and health. In many of them, the changes are motivated by preparations for accession to the European Union. Implementation of these new laws and regulations will require new skills and resources.

- Intersectoral policy integration is less advanced in the NIS than in other parts of the WHO European Region.

- Most of the SEE countries have already developed national children’s environment and health plans; such plans are still under development in the NIS. The implementation level is lower in the NIS and the SEE countries than in other parts of the WHO European Region. To a large extent, this is because of insufficient human and financial resources, as well as a lack of intersectoral collaboration.

- Substantial progress has been made in the SEE countries in monitoring and assessment of environment and health but accessibility of information is still limited in the NIS.

- Common outstanding needs in all the NIS and the SEE countries include: clearly identified priorities and objectives, a stronger focus on implementation, improved institutional framework and professional capacities, and increased financing for environment and health. The dissemination of information to the public needs to be improved and the evidence bases for policies strengthened. A more supportive international cooperative framework is also needed.
Introduction

The Budapest Declaration of the Fourth Ministerial Conference on Environment and Health noted a concern relating to insufficient progress in controlling and containing health hazards arising from the environment in the newly independent states of the former Soviet Union (NIS) and the countries of south-eastern Europe (SEE). The signatory countries expressed a commitment to further strengthen collaboration in order to support actions aimed at improving the environment and health situation in that part of the European Region of WHO. The Declaration invited international organizations to establish effective mechanisms for coordinating technical and financial assistance to the Member States, in order to stimulate legislative and institutional reforms, strengthen countries’ capacities and effectively reduce exposures to environmental hazards and their health impacts. The Declaration also invited the WHO Regional Office for Europe to support the initiative of some of the countries to reform and upgrade their sanitary/epidemiological services and to establish public health systems.

The Intergovernmental Midterm Review of the implementation of the Budapest Declaration (Vienna, June 2007) concluded that the special needs of the NIS and SEE countries had to be better addressed in the future; assistance with priority setting and standardization mechanisms were seen as possible ways forward. The Review also noted that it was important to promote subregional cooperation as a way of ensuring an increased implementation rate.

The environment and health situation and policies in the NIS and SEE countries were further discussed both at the high-level preparatory meetings (in Milan and Madrid) and at subregional meetings (in Bishkek, in November 2008 and in Dushanbe, in October 2009 for the NIS, and in Belgrade, in September 2009 for the SEE countries).

The definitions of country groupings used in the process have not been formally established but correspond broadly to the countries’ recent history and current political situation. For the purposes of the present paper, the NIS include the countries of the former Soviet Union, with the exception of the Baltic states (i.e., Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan). The SEE countries are more diverse, with different histories and different current political plans. Some have the status of candidate countries for membership of the European Union (EU), while some others are potential EU candidate countries. For the purpose of this analysis, this group includes: Albania, Bosnia and Herzegovina, Croatia, Israel, Montenegro, Serbia, the former Yugoslav Republic of Macedonia, and Turkey.

Seven NIS and four SEE countries replied to the WHO policy survey, allowing an assessment of national policies and their relevance in addressing environment and health issues. This assessment, together with the analysis of the progress achieved in health and environment, based on European environment and health information system (ENHIS) indicators, are presented in the background document Health and the environment in Europe – progress assessment and provided input for the present paper. Additional information was collected through an on-line survey on national children’s environment and health action plans (CEHAPs) conducted in November 2009 (with
seven NIS and seven SEE countries responding), environmental health performance reviews of Belarus, Montenegro and Serbia, and input from WHO meetings and consultations.

**Environment and health priorities in the NIS and SEE countries**

The overview of the health and environment situation based on the ENHIS assessment\(^1\) and presented in the paper *Health and environment in Europe. Progress assessment*, prepared for the Fifth Ministerial Conference on Environment and Health (EUR/55934/BD/1) indicates a number of common health and environment priorities for action in the SEE region and the NIS.

- Health risks resulting from limited access to safe water and sanitation remain an important public health problem in the region, particularly in rural areas. In 10 of the NIS, 45–85% of the rural population lived in houses not connected to improved water sources in 2006. The situation was relatively better in SEE, with 13–35% of rural houses not connected to water. Although significant progress has been made over the past decade in most of the WHO European Region, access to improved water sources deteriorated between 1990 and 2006 in some NIS and SEE countries (Fig. 1).

- The incidence of road traffic injuries is relatively low in many of the NIS, but the rates of injuries among young people per motor vehicle are among the highest in the Region, at between three and seven times higher than the incidence in the countries with the lowest rates per vehicle. Also road traffic mortality in the NIS is approximately 45% higher than the regional average and has increased over the past decade, in contrast to the declining overall regional trend.

- Mortality rates due to unintentional injuries are more than 10 times higher in many of the NIS than the lowest national averages in the European Region.

- According to the limited data available from air quality monitoring, the impacts of air pollution on health in SEE are among the highest in the European Region, with more than 95% of the urban population living in cities with PM10 concentrations that are two to three times higher than the WHO air quality guideline level. Indirect and incomplete information from the NIS suggests that health is also significantly affected by urban air pollution in this part of the Region.

- Health risks resulting from indoor air pollution caused by the use of solid fuels and environmental tobacco smoke (ETS) are also of concern. More than 60% of children in most NIS and SEE countries are exposed to ETS both inside and outside of homes, and more than one third of houses in several of those countries use solid fuel for cooking and heating.

- The phasing out of leaded fuel in most of the NIS and SEE countries has resulted in a significant decrease in exposure to lead but leaded fuel is still used in some of them. Lead exposure around large industrial sources of pollution is still causing health problems and concerns, as suggested by data available from Ukraine, the Russian Federation, Serbia and the former Yugoslav Republic of Macedonia.

\(^{1}\) For detailed data, see ENHIS fact sheets on: http://www.euro.who.int/ENHIS.
A special survey conducted by WHO of environment and health focal points in the SEE countries indicates that the highest priority issues perceived in that part of the Region are chemicals and heavy metals, together with insufficient access to safe water and sanitation. These leading priorities are followed by food safety, and risks resulting from housing environment and waste management. Interestingly, in spite of the high health burden from ambient air pollution documented by ENHIS data, this has not been selected as one of the leading priorities.

**Progress in policies and actions**

**Policy development**

Most NIS and SEE countries report intensive regulatory activity in the area of environment and health. In SEE, this is determined, to a large extent, by preparations for EU accession, which requires the transposition of EU legislation into national legislation. However, the results of the policy survey indicate that, in the NIS too, around 50% of environmental health policy documents have been created or updated since 2004, and many of those updates were stimulated by EU legal instruments. Institutional reforms have been implemented, or are planned, in several NIS. The sanitary-epidemiological systems that existed in the past are being upgraded and adjusted to the current political and economic situation, as well as to the modern requirements of health systems.
The emphasis of policies differs between the various parts of the European Region. For example, penalties for infringements of regulatory instruments related to drinking water safety are used more frequently in the NIS than in other countries, while action plans and remedial measures to minimize the risk of non-compliance are less common. Action plans addressing bathing water quality are also less common in SEE and the NIS than in EU countries, reflecting a more comprehensive water basin protection approach in the western part of the Region.

The health sector reports a more intensive involvement in sustainable safe water policies in the NIS and SEE countries than in other parts of the Region. This may be partially explained by the higher health risk posed by shortcomings in access to safe water and adequate sanitation but also by the traditional scope of the responsibilities and structures of the sanitary-epidemiological services. However, this involvement is not supported by monitoring of the situation or of the impact of activities, as only one SEE country of all those surveyed could provide data on water-related disease outbreaks. A review of current national capacity undertaken by the Task Force on Water-related Disease Surveillance indicates that relevant information may be available at the local and national levels but may be not easily accessible. The work in the framework of implementation of the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes and the guidelines it proposes can improve this situation, especially if the collaboration mechanisms provided for in the Protocol are used to support NIS and SEE countries effectively.

Policy development and implementation are markedly less intensive in relation to unintentional injuries than those related to safe water and sanitation in all parts of the Region, including the NIS and SEE. To some extent, this is explained by the fact that, in many of these countries, the responsibility for injury prevention, particularly road traffic injuries, lies primarily with other ministries, such as the ministry of the interior, while the role of the health sector is often restricted to the provision of trauma care and emergency services. Actions plans and governmental regulations or guidelines are more common than legally binding instruments. Some policy measures, such as safety regulations related to playgrounds or building codes requiring emergency fire exits are common in the NIS but not in SEE. On the other hand, policies focusing on prevention of injuries during leisure activities or on product-related injuries were rarely reported from the NIS in the WHO policy survey. Health sector involvement is higher in the NIS than in other parts of the Region, although this may indicate a greater focus on the response to rather than the prevention of injuries.

Policies related to prevention of health risks resulting from ambient air pollution in SEE are gradually being adjusted to the approaches of the EU, while most of the NIS still do not address the pollutants with the most pronounced impacts on population health: respirable particulate matter (PM10 and PM2.5) and ozone. Some NIS have only recently included these pollutants in their policies, and only one (Belarus) has begun regular monitoring of PM10 in cities. The modalities of implementation of existing policies differ between the groups of countries, with penalties seen more frequently and remedial action plans less common in the NIS and SEE than in EU countries. In the NIS, the health sector is more commonly responsible for policy formulation, implementation and enforcement than in other parts of the Region (EU and SEE). On the other hand, public information relating to air quality and its health risk is less readily
available in the NIS than elsewhere. As observed by the United Nations Economic Commission for Europe (UNECE) Working Group on Environmental Monitoring and Assessment, the NIS need to revise their air quality monitoring programmes to help make monitoring a practical tool for environmental policy, especially for: target-setting; developing pollution abatement strategies; assessing progress in achieving policy targets; and addressing the effectiveness of abatement measures. The Group recognizes that the main policy objective is to minimize the health and environmental effects of air pollution. Relevant guidelines were prepared and considered by the UNECE Committee on Environmental Policy in October 2009 (UNECE, 2009). The recommendations are fully in line with the conclusions of a WHO meeting on the health basis for air quality management in the countries of eastern Europe, the Caucasus and central Asia (WHO, 2005).

Most of the NIS and SEE countries have limited policies addressing the prevention of health risks related to poor indoor air quality, especially microbial pollution resulting from dampness and mould. These are mainly expressed in regulations and guidelines on building maintenance, heating and ventilation. Policies addressing ETS are more developed, though progress in establishing a smoking ban in public places is markedly slower in SEE countries and the NIS than in EU countries. The health sector in the NIS and SEE countries is involved in ETS-related policy formulation, but only to a lesser extent in its implementation, evaluation and enforcement.

The national laws and regulations on chemicals in the NIS were generally inherited from the Soviet system and are therefore not necessarily harmonized with present international requirements. A WHO meeting on chemical safety in the NIS concluded that, although most countries have laws regarding the safe production, transportation and trade of chemicals, those laws are often neither harmonized nor enforced, as they fall under the authority of different ministries (for example, ministries of the interior, transport, trade, health, environment, labour, customs, and agriculture) (WHO, 2008). Unfortunately, communication between the ministries responsible is often insufficient for the effective management of chemical risks. Law enforcement is reliant on existing skills for inspection (for example: sanitary, veterinary, environmental and ecological) and therefore there is high variability in the level of inspection, law enforcement and compliance. Some sub-laws and other legal acts contain varying standards for pollutants in different media. However, many of the newer emerging pollutants are not identified and there are often no standards for their monitoring and evaluation.

There are also important gaps in policies related to chemical safety in some SEE countries where leaded gasoline is still in use, and other regulatory approaches to assessing and managing the risks related to heavy metals are weak.

The development, implementation and enforcement of policies addressing environmental noise are markedly less intensive, with a lower level of health system involvement, in SEE countries than in the other parts of the Region. The NIS report that they assess and evaluate the health risks related to noise but rarely use specific indicators or measurable targets to measure the progress of their policies and actions. In this group of countries, the health sector is often involved in all elements of the policy development and implementation cycle.
**Intersectoral collaboration**

The implementation of many actions to ensure that environments support health and prevent risks from environmental determinants of health is usually the responsibility of a wide range of economic and government sectors. This means that environmental health policies must be shared by various government sectors. Such policy integration is less advanced in the NIS than in other parts of the European Region. There are only rare examples of either intersectoral collaborative structures with clear mandates (e.g. multisectoral working groups) or informal structures (Fig. 2). At the same time, dedicated units within the ministry of health responsible for the organization and development of health-related intersectoral programmes exist in two thirds of the NIS that responded to the WHO policy survey. Interdepartmental collaboration is common, although there is rarely a clear mandate for it. Formal or informal meetings of various sectors are less common in the NIS and, as in most other countries, there is no special budget allocated for such collaboration.

**Fig. 2. Structures for intersectoral collaboration on environment and health in country groups**

(EurG-A = EU before 1 May 2004, Andorra and EFTA; EurG-B= other EU member countries, EurG-C = SEE, EurG-D = NIS)

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**Children’s Environment and Health Action Plan for Europe and its impact on policies in the NIS and SEE countries**

According to the results of the Children’s Environment and Health Action Plan for Europe (CEHAPE) survey, enhanced intersectoral collaboration has been one of the main positive impacts of the CEHAPE. However, the survey shows that, while the CEHAPE has strongly influenced countries in the EU and western Europe in developing their national CEHAPs, this has been less the case in the NIS and especially in SEE countries. The development of national plans has been completed in most (24 out of 33
responding) countries in the western part of the Region and in SEE, while the plans are still under development in 5 out of the 7 NIS that responded to the survey. In those NIS and SEE countries where national CEHAPs have been developed, the implementation level is lower than in the other parts of the Region. To a large extent, slower progress with CEHAP development and implementation in the eastern parts of the Region is the result of insufficient human and financial resources (Fig. 3). Respondents also indicated that insufficient intersectoral collaboration was a hindering factor. These problems have resulted in many actions being one-off events with low sustainability (in particular in SEE).

![Fig. 3. Challenges in implementing CEHAP at national level](image)

**Monitoring and assessment**

SEE countries have made significant progress since the Budapest Ministerial Conference in the use of ENHIS indicators and related reporting. Country information is available in international databases mostly as a result of the ongoing harmonization with EU legislation and the ratification of international conventions. Nevertheless, urgent action should be taken to improve data availability, increase their relevance for environmental health issues and intensify their use both within countries and on a regional scale. For example, chemical safety is a priority health and environment issue of concern but the information on the relevant indicators, such as blood lead levels in children, is available in only a very few countries.

In the NIS, the data necessary to calculate ENHIS indicators, and thus allow intercountry comparison of health issues related to the environment, as well as environmental exposures affecting health, are available in most countries for 7 out of 22 indicators. However, these data are not always accessible, further limiting the feasibility of assessments. In some countries, access to monitoring data is subject to the payment...
of fees, which restricts data exchange, comparison and analysis. Some countries reported decreasing capacities for health and environment monitoring, which further reduces their ability to assess the situation and trends in environmental risks. With the notable exception of Belarus, health-relevant air pollution (particulate matter, PM10) is not monitored in the NIS, making the assessment and management of that risk factor very difficult.

Recommended actions to address common outstanding problems and needs

Although there are many differences between environment and health problems and policies in the different NIS and SEE countries, there are a number of common key areas of action that can accelerate the improvement of environmental conditions to support health in these parts of the European Region. To a large extent, they are in line with the recommendations for action on environmental policies in countries of eastern Europe, the Caucasus and central Asia (OECD, 2007). Many countries have already made substantial progress in developing their national action plans (national environmental and health action plans or CEHAPs). In those countries, efforts should focus on implementation of the plans, through the gradual achievement of realistic targets according to realistically set time schedules. Where plans are not completed, multisectoral efforts should be consolidated to finalize the plans, and link them to the current policy agenda and national development programmes. The following are necessary for implementation of the plans.

1. **Improvement of the institutional framework**
   Implementation of the plans will require institutional stability and clarification of responsibilities at national and subnational levels. Active involvement of subnational authorities and other stakeholders will be essential. The health system should take the lead in advocacy for priority health actions, supporting other sectors implementing projects and programmes in their area of responsibility. This institutional framework should be supported by more efficient international cooperation, with the work of various international organizations, donors and their national collaborators being better harmonized, with a view to maximizing the health and environment profiles of projects. In particular, collaboration between WHO, the United Nations Development Programme and the United Nations Environment Programme projects would increase the efficiency of international support.

2. **Strengthening of financial and human resources**
   This should be done through a comprehensive approach to the financing of environmental health and strategic investment in skills. The recognition of health as an important target in pollution abatement and investment in clean development is essential. Assuring the budgetary resources necessary to support actions required by national legislation is a priority. Health issues should be more prominently addressed in international donor agreements, particularly those concerning environmental projects. This will require a more strategic approach to fundraising, and the creation of intersectoral alliances and projects. Human resources are equally important. Professional capacity building is necessary for the improved design and efficient implementation of policies and projects.
addressing environmental determinants of health. In particular, the capacities in the health sector should be improved, to allow the effective combination of internationally generated knowledge with local information. This would assist in the identification of priorities for actions, thereby maximizing their health gain and pointing to the most efficient actions. The education of both health and environmental professionals in the area of environmental health should be broadened and deepened through the inclusion of environmental health subjects in the educational curriculum and continuing education programmes. Such training should also be provided for nurses and doctors in the primary health services, increasing their contribution to disease prevention. Research capacities should be increased to support the generation of local knowledge and the ability to address emerging problems, as well as to ensure the sustainability of the professional education system.

3. **Improving monitoring and evaluation**

An effective information system can produce reliable, timely information, which is essential, both to win greater attention from policy-makers to the priority issues requiring action and to communicate the results of their policies and actions. Timely and reliable information on the impact of internationally-supported projects is also essential for generating further resources and assistance. The system should facilitate the sharing of information gathered by various sectors and institutions, and include essential health and environmental parameters relevant for planning and monitoring of actions addressing environmental determinants of health. It should facilitate the efficient use of the available resources and, through the specialization and competence of participating institutions, increase the quality and relevance of the information generated by the system. The experience acquired through ENHIS provides a focus for activities to upgrade national information systems. The information should be available to both government and nongovernmental stakeholders, as well as international partners. Public access to this information should be facilitated by skilled communicators, to increase the impact of the information in preventing hazardous exposures, promoting environment- and health-supporting behaviours, and increasing the health benefit of actions.
References


The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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