Report of the First High-Level
EEHC Preparatory Meeting for the
WHO Fifth Ministerial Conference
on Environment and Health

Milan, Italy, 10–12 March 2008
The Fifth Ministerial Conference on Environment and Health should continue to focus on children’s health and environment issues. The impact of globalization on the European Region was relevant and had to be a relevant part of the discussions.

There had been a lot of effort and resources by countries, IGOs and NGOs in investing in the CEHAPE and its regional priority goals. These should continue to direct the work after the next ministerial conference, with an emphasis on implementation.

There was the need to appreciate the richness of twenty years of the European Environment and Health Process, and also to create bridges to established political processes that may require better implementation or that may themselves benefit from the increased political attention awarded to them by the conference.

The issue of Climate Change was very topical and also relevant to the conference and its preparations. There were many actors in this field of work and it was important that the EEHP clearly addressed this issue by providing added value. All agreed that it should be a major pillar of the conference and the preparations. The cross sectoral nature of climate change should be the cornerstone of this work thus promoting increased collaboration across sectors in addressing environment and health issues. From the health point, preparedness of health systems in the countries was key.

**Keywords**

ENVIRONMENTAL HEALTH CONGRESSES – organization and administration
EUROPE
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Monday 10 March

Opening session

Dr Jon Hilmar Iversen, Chairperson of the European Environment and Health Committee, welcomed participants to the First High-Level Preparatory Meeting leading to the Fifth Ministerial Conference on Environment and Health in 2009. He invited Dr Alberto Mantovani, Director of the Humanitas Hospital, Milan, who had kindly offered to host the meeting, to make the opening address. Dr Mantovani spoke about the work of the Hospital and warmly welcomed all the participants to the venue, hoping that everyone would find it easy to work in such surroundings in preparation for the Ministerial Conference.

Dr Iversen then invited Dr Marc Danzon, WHO Regional Director for Europe, to make his opening address. The Regional Director spoke about the importance to Europe of both the European Environment and Health Process (EEHP) and the upcoming Ministerial Conference. He explained that WHO was currently preparing for the European Ministerial Conference on Health Systems, to be held in Estonia in June 2008; it was very important for the Ministerial Conference on Environment and Health in 2009 to make links to the 2008 Conference. The value of the environment and health conference was that it ensured good collaboration between the two sectors, and that resulted in consistent policies in both. However, linking the conferences through their discussion of intersectoral policies would also make it possible to better address health systems. Dr Danzon spoke of the importance of looking at the burden of disease of vulnerable populations arising from environmental risk factors; avoidable deaths were a good indicator of the changes achieved by policies. He wished all those present two good days of work and negotiations with fruitful results.

The two chairpersons of European Environment and Health Committee, Dr Corrado Clini and Dr Jon Hilmar Iversen, also welcomed the participants to the first preparatory meeting. Dr Clini then called on Professor Lucio Luzzato to make the keynote address.

Session 1 – Renewing political commitment to the Children’s Environment and Health Action Plan for Europe (CEHAPE)

In his keynote address on “Health impacts of environmental risk factors”, Professor Luzzato spoke about clinical symptoms that were becoming more common and how they were linked to environmental risk factors. It was impossible to deny the strong influence of the environment on clinical manifestations but the question was not whether the disease resulted from the environment or other factors. The most relevant issue to the manifestation of disease was the relative weights of one to the other, and the resulting manner in which the outcome of disease could be influenced. There were several genes that influenced disease or disorders and how they emerged but, given that 7.6 million people died of cancer in 2005 and that 84 million were expected to die by 2015, the links between environment and health could not be ignored. Only 70% of manifested symptoms occurred in low and middle income countries, with the result that cancer was thought of as a disease of developed countries. That was not necessarily the case. Some cancers were also more strongly dependent on the environment, and the impact of cancer made it too complex to explain or to dissect the environmental factors from the genetic role. Overweight and obesity, low levels of fruit and vegetables in the diet, lack of physical exercise, cigarette smoking, excessive use of alcohol, unprotected sexual activity, urban air pollution,
solid fuel wastes, use of contaminated syringes and needles, and excessive exposure to sun all played a part in the development and eventual outcome of the disease. Only the intelligent use of statistics would allow a better understanding of the magnitude of the effect of the environment.

Professor Luzzato focused his keynote address on key environmental risk factors, including tobacco and environmental tobacco smoke, chemicals and chemical incidents such as Seveso and Chernobyl, with the incredible resulting increase in breast cancer arising from the fallout, and the impact of urban air pollution on cancer risk. Diesel fuels were currently listed as class 2B carcinogens and an increase of 10 micrograms of particulate matter 2.5 could also cause a significant rise in cancers. Extremely low frequency magnetic fields had led to debates and serious discussion on the site of, and use of electric plants, even though the increased risk was probably quite small. Cancers could also be caused by infectious diseases such as hepatitis B (liver cancer), human papilloma (cervical cancer), helicobacter pylori (gastric cancer) and HIV (lymphoma and Kaposi’s sarcoma). However, gene interaction was also a factor and family clustering was important.

Dr Lucianne Licari, representative of the WHO Regional Office for Europe and responsible for the organization of the Fifth Ministerial Conference on Environment and Health, gave a brief overview of the planned preparations for the Conference, the decisions taken by the last meeting of the EEHC and the series of meetings leading up to the Conference itself, to be held in Italy in 2009. She also explained the first ideas about a possible agenda for the Ministerial Conference.

A number of interventions followed this presentation:

The youth group expressed concern that, although the Intergovernmental Midterm Review (IMR) had confirmed that the Youth Network should be strengthened, as an integral part of the process, very little support was being received from the Member States. The Network was supposed to meet once a year but had not yet been able to do so. Young people were able, through their enthusiasm, to strengthen participation across countries. However, the Network needed to hold meetings to ensure its proper preparation for the Conference; it was reliant on the kind offers of countries to host them. There was also a need for greater youth representation within the countries. The Youth Network should ideally include one or two officially recognized young people from each Member State, to ensure a strong network able to work with Environment and Health focal points within their own countries.

Cyprus stated that the Conference theme should clearly reflect its focus. While agreeing with the inclusion of other vulnerable groups into the work around the CEHAPE, it was important that the title of the Conference should be clear and understandable and should continue to refer to children. She reminded those present that many countries were currently implementing their children’s environment and health action plans. For this reason, Member States felt that there was a need to strengthen efforts and political commitment at national level. Perhaps it was time to consider at least one soft quantitative target that would help to evaluate the status of the European Environment and Health Process. She further encouraged Member States to support some European cohort studies in the form of long-term studies following children through different life stages.

Austria reported on implementation of the national children’s action plan and the difficulties involved. The delegate agreed with Cyprus that children should continue to be the focus of the Conference. Youth participation was very important for Austria and because of this, they were educating youth facilitators so as to implement projects with them. It was very important to have
youth involvement at the Ministerial Conference in 2009 and to have the support of WHO to ensure youth involvement on a national level too.

Regarding the Conference theme, Denmark considered the issue of children to be extremely important. “Environment and health in a globalized world” could be as a possible title, as it would send an important message about the movement of goods, including harmful substances, across borders and it would also cover exposures, waste and the impact of increased transport and CO₂ production on climate change, as well as linking easily to the relevance of environmentally friendly transport. The question of lifestyle, including physical activity and health nutrition, and its impact on health was important. For Denmark, which was to host the international climate change convention in December 2009, energy need and energy production was key to the issue of climate change. Other items that could be addressed by the Conference included endocrine disruptors and occupational health, with exposure to several chemicals, including pesticides, as being of importance not only to workers but also to the general population. Exposure to several chemicals at one time, known as the “cocktail effect”, needed to be addressed. Allergies, noise and air pollution were other possible topics. The Conference preparatory process, which enabled all countries to play an active part in the preparations and in setting the agenda, was very welcome. Denmark also volunteered to be part of the drafting group for the Conference declaration and the future of the process.

Tajikistan had done a lot since its national children’s environment and health action plan (CEHAP) was developed. However, a number of national documents were already obsolete, as they did not correspond to current priorities or to the current national situation. They included the national action plan on environment, which did not reflect the current environmental situation. New plans were needed to meet the current requirements. Tajikistan proposed that, as the CEHAPE regional priority goals (RPGs) were reviewed and further prioritized, it would help to rank them in order of priority.

Kyrgyzstan welcomed the fact that both the IMR held in Vienna the previous year and the first high-level preparatory meeting highlighted new priorities. The delegate thanked the secretariat for taking the proposals of Member States into consideration and for addressing new priorities such as the special needs of the newly independent states (NIS), social inequities, and cooperation with new stakeholders (including local authorities and youth participation), all of which needed more attention. Kyrgyzstan was facing problems nationally and needed to focus more on particular problems arising from water (waterborne diseases), children’s accidents and some additional items, such as micronutrient and iron deficiencies. There was also a need for an assessment of the role of health services in addressing and tackling the priority areas. This would give them more importance and reinforce them as national priorities in a wider context with other sectors, as well as highlighting them as priorities for the public health sector.

Norway agreed that the focus on environment and health issues of children must be continued into the future. It was important that commitments made earlier in the European Environment and Health Process (EEHP) should be evaluated at national and international level. At the current stage of the Process, there were new ministers and new governments who needed to take ownership of the actions and make the commitments their own. However, it was also important to commit to tackling new challenges, and to look at other processes going on in WHO to see how the EEHP could be linked to them. Youth participation and child-friendly perspectives were important and should be incorporated into those processes as well.
Like Austria, Belgium was in the process of developing a new national environment and health action plan (NEHAP), to commence in 2009. For that reason, a long-term approach in the European Environment and Health Process (EEHP) was important and therefore the theme should remain one of “healthy environments for children” (also considering other vulnerable groups). The EEHP had facilitated the integration of the two sectors but there was still need for more collaboration. It had also helped to raise awareness of environment and health issues and therefore it was important to consider linking to established processes, including those of the European Union (EU) and of the United Nations Economic Commission for Europe (UNECE), so as not reinvent the wheel. It was important to focus on the added value of the EEHP and how it could ensure further implementation of environment and health commitments already made. Climate change needed more attention but all the working tools for policy-making available to evaluate the implementation process should not be forgotten. Belgium asked for the EEHP to produce a broader range of scientific advice. The International Public Health Symposium to be held in Spain in October 2008 was a good step in the right direction. Also, more technical advice, possibly through an economic tool, could provide more guidance on both national and international levels, especially on the cost of action versus inaction.

Armenia agreed with Denmark on the health issues of main concern, and emphasized the importance of continuing to focus on children. That did not exclude other vulnerable populations, or the general population; it should be clearly stated that the EEHP addressed environment and health issues affecting all the population. The ministerial conferences had made a difference in addressing the environmental risk factors of health and should be continued. Without them, there would be problems at national level. With regard to revisiting established commitments, it would be good if the EEHP referred back to other political commitments but that would require coordination by the WHO Regional Office for Europe. Other international processes were taking place but they did not all include health issues. That was the added value of the WHO series of conferences and thus coordination of the EEHP by WHO was key to the impact of the process. Climate change was a good topic to address at the Conference, but food safety issues and movement of goods were also important.

Germany stressed the importance of climate change, as well as its mitigation and adaptation to it. There should be more emphasis on the health effects of climate change, which were very important and called for more national attention. CEHAPE implementation should continue but it could also be positive to include other vulnerable populations such as the elderly, and link those issues to climate change (for instance the impacts of heat-waves on elderly populations or other vulnerable populations). The Ministerial Conference should also address social equity, keeping in mind that it was not only children from low-income countries who were affected but, in certain situations, those from high-income countries too, as in the case of exposure to chemicals, an issue that did need more attention. Germany agreed with the secretariat’s suggestion of “A better world for better health” as the theme for the Ministerial Conference but, to ensure reference to both health and environment, also suggested “Better environment for better health”.

The EEHC Chairperson, Dr Iversen, agreed with all the speakers that the environment was a risk factor. He explained that children were an important indicator group and give early information on what the general population is being exposed to.

Sweden stated that the EEHP was very important and endorsed the idea that the focus should stay on children. Indoor environments, air pollutants and chemicals, as mentioned by Denmark, needed more attention. With regard to preparatory work for the Conference, Sweden felt that the
agenda proposed by the secretariat was in line with what they believed needed to be addressed. However, on climate change, Sweden expressed concern that it should be the high priority for the Conference. They agreed in principle that it was important to understand how to address this issue but there were many other important issues for Sweden and they believed that the exchange of good examples among countries should be further discussed at the Conference in 2009.

Italy agreed with the structure for the Conference preparation as it was cost-effective. As a preliminary thought, Italy could agree with the second and third titles suggested or maybe the fourth title with amendments suggested by Germany, but it was important that both environment and health should be addressed with equal importance in the title. Other issues such as renegotiating the CEHAPE were also important but the climate change discussion due to take place the following day was key for Italy in addressing new issues and new priorities towards the Rome Conference and beyond. The Belgrade “Environment for Europe” Ministerial Conference in 2007 had focused on delivery, as it was expected to be more concrete and to ensure results. It was therefore important to adopt the same approach in the EEHP. Enough was known about what needed to be done but it was still necessary to narrow the gap between science and policy and to take action to achieve real results. That could be made possible by increasing bilateral and multilateral cooperation between countries providing and requiring assistance. Italy, as a member of the EU, reminded those present that the EU had adopted Council conclusions in 2003 and 2007 committing Member States to ensuring coordination between the two processes; it was therefore important to link the EEHP to the EU processes.

Azerbaijan explained that, although different countries had different priorities, the EEHC should develop the criteria/targets for measuring environment and population health. It was very important to establish criteria to adequately assess the status of implementation as that could help to establish priorities to be included when new action plans on environment and children’s health were being developed.

The Netherlands felt, that after 20 years of the EEHP, it was a good idea to stand still, take stock and be proud of what had been achieved over the past years, and not only identify the gaps that still needed to be addressed. To be able to do that, it was important to have information and data, and to establish mechanisms to that end. At the moment, not all Member States were able to provide the right data to allow that and the EEHP should continue to that end. The Ministerial Conference should consider reaching out to other vulnerable groups, like ethnic groups and migrant groups but also elderly populations. Integration of all activities of all sectors should be the main objective of the next Ministerial Conference. The idea of “healthy settings” could be quite useful in implementing interventions and reaching out to more diverse sectors, encouraging them to take action, intervene and implement as required. A suggestion for the Conference title could be “Growing up/Growing older under healthy living environments”. The Netherlands also agreed that it was good to have tools for policy-making and one of the things to be proud of was that those tools had been developed. However, it was also important to make good use of them and stimulate their further use. The delegate from Netherlands referred to a previous intervention that had called for more political attention. Political attention was important and ministerial conferences were a way of attracting attention to environment and health priorities. Finally, the Netherlands expressed the desire to join the drafting group for the Conference Declaration and the future of the process.

UNECE referred to the established political processes mentioned by previous speakers for which it was responsible and emphasized the need to link to those results-oriented existing processes such as the Transport, Health and Environment Pan European Process (THE PEP), with
Particular attention on what still needed to be done and what had not yet been adequately addressed. The PEP high-level meeting to be held in January 2009 would present a number of assessment reports on transport-related issues but would also deal with the Water and Health Protocol of the Convention on the protection and use of transboundary watercourses and international lakes which would be 10 years old in 2009. UNECE recommended that the Rome Ministerial Conference should look at the Protocol more closely to see what needed further prioritization. One should not underestimate the ministerial attention at the Conference and the opportunity that it would provide to streamline and further implement all the existing priorities.

Greece thanked the secretariat for the presentation and supported the proposed procedures and scheme of events for the Ministerial Conference. It shared the view that the focus of the EEHP should continue to be on children, without excluding other vulnerable groups. Secondly, there were still big gaps in implementation and the level of work still necessary required ongoing international cooperation, which would further stimulate implementation at the national level. The focus should be on strengthening implementation by sustaining political efforts through to completion to try to achieve more positive results. Thirdly, one of the gaps in implementation was the result of the weak links with other relevant policy sectors that many countries had still not managed to improve or coordinate efficiently. It was therefore important to look into the tools for policy-making and ways of ensuring better work with other sectors. Fourthly, with regard to quantitative targets, it might be necessary to have several because of the different RPGs. However, there were so many differences among the countries of the European Region, even geographically, that it was difficult to suggest what those targets should be. In principle though, Greece would be happy to consider different quantitative targets for different end points on an international level. As a fifth point, Greece asked that the title of the Conference should carry a positive message. Greece agreed with something along the lines suggested by Germany, (“Better environment for better health”) but also with the Danish proposal with slight modifications such as “Strengthening environment and health links in a globalized world” as that will allow the Conference to deal with global issues. Finally, Greece felt that the process had to avoid negative connections to environment as a risk factor for health and fully agreed with Italy, that the work in the future should be result-oriented.

The Republic of Moldova thanked the Italian government for hosting the first preparatory event, as well as WHO for organizing it. The Republic of Moldova agreed with the key messages explained by the WHO secretariat for the next two years – mainly that the CEHAPE had to remain firmly at the top of the agenda. There was still a need to continue to evaluate the countries’ ability to address children’s health but also to show how much progress had been achieved in improving the general environment as well as children’s health. The Republic of Moldova encouraged the process to continue to insist that countries remain responsible for reporting back on their activities in addressing the RPGs, as many countries had very serious problems affecting not only children but also all society. It was therefore helpful to include other vulnerable groups into the picture. In the past decade, nutrition, food safety and food security had been unfairly neglected in political discussions and it was important to add those topics to the list of items to be addressed by the Fifth Ministerial Conference. The Republic of Moldova also agreed with emphasizing THE PEP implementation, as, in many countries, there was no political support for it outside the ministries of environment. The Fifth Ministerial Conference would help to emphasize its importance to other ministries or sectors. Climate change and health should be added to the agenda as the most discussed topic of the moment; without addressing climate change, there could be no future for the children. The Republic of Moldova felt it would be difficult to express all the needs and requirements in the Conference title but did support the
idea proposed by Denmark to emphasize the dynamic and changing world arising from globalization.

The International Trade Union Confederation (ITUC) thanked the secretariat for the work done and agreed that children should remain the priority focus group of the Conference, with CEHAPE as the main initiative, although much more could still be done. When speaking about children, child labour was still an important issue even in the European Region, especially in the agriculture sector, which was usually the sector least covered by legislation. Hence the focus should be not only on children, but on the most vulnerable among children, such as children of immigrants. Such children were particularly vulnerable as they tended to move around with their parents and lose all social contacts and stability from school and friends, resulting in problems. Other groups such as women, and especially immigrant women, were not allowed to take part in the labour market because of their own culture and that had an impact on the children too. The elderly were very important in providing a socially stable environment. They played a very positive role but sometimes their contributions were minimized by changes in society which kept the generations apart; that gave even more reason for taking young people seriously. It would cost little to involve young people or other stakeholders at national level and it was important to ensure more involvement of sectors such as business and trade unions and to increase the momentum around the process of youth networking.

Ireland joined other speakers in thanking the hosts and the secretariat for all the work done. The meeting presented a very good opportunity to reflect on the current situation. The environment was complex, with national and regional priorities and goals, as well as global priorities and goals. Against that background, the focus of the EEHP should be on adding value – what could the process bring to the table that had not yet been done? Youth participation and the focus on children were particularly important. The youth participants had already reminded the meeting that the Member States had promised youth involvement; Ireland would continue to support that process. Another focus should be on cross-sectoral work, already highlighted by Greece, as it was critical to the achievement of results. There were still some difficulties in a number of countries in ensuring the joint involvement of both environment and health sectors. That needed to be promoted further. Also, a stronger focus on civil society involvement was very relevant as governments could only take the process to a certain stage; the more active engagement of that sector would be helpful. The economic arguments, especially the cost of inaction and the burden of death from preventable disorders, were also a priority, as its cost was rising. A focus on communication was also very important. Professor Luzzato had emphasized four key causes of cancer: diet, exercise, smoking and exposure to sun, all of which were within the control of every individual; those were therefore the issues that Ireland would like to see emphasized.

Serbia thanked Italy and the secretariat for the presentation emphasizing the challenges faced at international and even national levels. With regard to the specific needs of the NIS and the south-eastern European (SEE) countries, Serbia explained that a special network of indicators was required to ensure that all the policies that had been drawn up could be monitored and adjusted, and to address all the challenges being mentioned. Many delegates had already highlighted that implementation of the Budapest Declaration was on-going and should be continued to ensure follow-up. It was important for Serbia to continue to address children as one of the vulnerable groups but it needed to put more emphasis on children from Roma populations. Serbia also expressed the wish to participate in the drafting group for the Conference declaration and future of the process.
Albania emphasized that a few key words, “environment, health and children”, needed to be included in the title of the Conference to remind politicians of the current policies but also to clarify that, by addressing children’s health sustainable changes had been achieved for the whole population. The “globalized” world was also very important. Albania told those present that ministers had changed since the beginning of the process but so had the world and it was therefore important to tackle all the challenges of globalization.

Finland reminded those present that the Member States had spent many agonizing hours negotiating the RPGs. RPG 1 had received remarkably little attention in the discussion even though it was the cornerstone of public health policy and the daily experience of the poorest of the poor. In agreement with Ireland’s statement, Finland felt that it was important to add value to existing processes, and it was unacceptable that there were still millions of people without water and sanitation. Member States should focus more on those issues, rather than on issues that might be less relevant. Finland also agreed that the achievements of the past years should be cherished, as environment and health protection had improved dramatically in the most affluent regions, even though there were still some who required further assistance.

Andorra explained that it was still very difficult for the health and environment sectors to work together at national level. It was therefore important to provide all the relevant arguments to demonstrate the importance of such collaboration for the future, by emphasizing the socioeconomic aspects and the costs of inaction but mainly by demonstrating how it would affect other policies and the health of the population.

In her reply, Dr Licari clarified the youth involvement process and made an appeal for countries to come forward to help young people to meet and prepare on an international, as well as a national, level for the upcoming Conference. She explained that the EEHP was not letting go of the CEHAPE but only changing approach to it by looking at the RPGs with the aim of prioritizing further. The three high-level preparatory meetings were therefore planned to address RPGs 1 and 2 at the first meeting, RPGs 3 and 4 at the second meeting and all the remaining key issues at the third preparatory meeting. However, the meetings would discuss the RPGs in a cross-cutting manner, as recommended by the IMR. With regard to climate change, it was important to recognize and respect what was happening but it was also important to identify the added value involved. In health, climate change presented a very small niche for policy work and commitment, although it was much wider for the environment sector. The host country had expressed the desire to give more political attention to the Ministerial Conference by linking it to the G8, as Italy was to hold the G8 presidency at the same time as the Conference. It was important to identify how to make the best use of such a unique opportunity. Ensuring the evidence base for the Conference was very important and that was the main reason for organizing the International Public Health Symposium in October. The Symposium would look into all environment and health research and try to ensure continuity in providing evidence for policy as a tool. How that could be done still needed to be explored and, in the meantime, the outcomes of the Symposium would help to influence the framework programme of the European Commissions Directorate-General for Research and where it should provide funding in the area of environment and health. Dr Licari agreed that the EEHP was very relevant when ensuring political impetus and hence national funds for environment and health work. However, she asked those present to be open to discussing other ways of creating political momentum that went beyond the series of ministerial conferences. That could include using ongoing political processes such as THE PEP, or established political gatherings such as the UNECE Committee on Environmental Policy and WHO Regional Committee for Europe to win the same political attention. Instead of five-yearly ministerial conferences, it might be possible to have multiple
country gatherings or even intergovernmental meetings. Data remained very important to all the work, especially in the NIS and SEE countries where there was a need for appropriate and comparable data gathering. Only that could ensure the establishment of the information systems and indicators that were more easily provided by the wealthier neighbouring countries. With regard to stakeholders, Dr Licari explained that each preparatory event would deal with working with different stakeholders. Under RPG1, water was still a very important issue for the European Region, and the Water and Health Protocol did require further attention at the Conference. Finally, the secretariat thanked all the participants for the constructive discussion and called for written comments by the end of the month.

Addressing new priorities in RPG 1

The first presentation was by Dr Roger Aertgeerts, a representative of the WHO Regional Office for Europe responsible for water and sanitation issues. He summarized the current situation in relation to the Water and Health Protocol and RPG 1 (i.e. to prevent and significantly reduce the morbidity and mortality arising from gastrointestinal disorders and other health effects, by ensuring that adequate measures are taken to improve access to safe and affordable water and adequate sanitation for all children). The Region would meet the Millennium Development Goal on access to water but not on sanitation. That was worth noting, especially as it was the International Year of Water and Sanitation. Even in the western part of the European Region, there were still problems with regard to minor microbial contamination of water and other newly emerging pathogens. There were still problems with nitrates, heavy metals and chemicals in water and 50% of the population still did not have access to water all the time. It was also remarkable that populations in some countries had the perception that the water delivered was not safe. It was also important to highlight the issues of inequalities in water and sanitation as there were notable differences between rural and urban populations. The supply was markedly less good for rural populations. When looking at gender inequities in relation to water, women were the main users as they were responsible for cooking and cleaning and were thus mainly exposed. The use of the household budget, and decisions on its allocation to water and sanitation issues, were made by the woman of the house and determined the different exposures of the family members. When looking at climate change, issues related to migrants and the fact that the Region was already water-stressed meant that water management was going to be very important. Weather events were also likely to become a very challenging issue.

International instruments played a very important role in the issue of water and sanitation. The oldest instrument was the Barcelona Convention but there was also the Water and Health Protocol which currently had 21 partners, including 6 countries that had already ratified it. The work done under the Protocol covered five main areas: surveillance and outbreak detection; equity in access; progress targets and indicators; water supply under extreme weather events; and project facilitation. There was a number of barriers to action, including national policy-making, human behaviour, the issue of perception and factual understanding of the problem, poverty and economic barriers which needed to be overcome, Geographic location and gender issues. The ratification process helped to open up policy-makers to a number of arguments such as the decrease in the global burden of disease. With regard to national stability, integrated water management was important as ensuring a healthy life in urban areas meant increased stability in those areas. Economic instruments also showed that it was advantageous for a country to invest in water. For every dollar invested, nine dollars were saved. A tremendous amount could be done by working together with local actors.
In conclusion, Dr Aertgeerts explained that, while the international instruments were important, there was still a need for national policies to address the barriers mentioned and resources had to be found to ensure the continuation of the work in that important area.

Dr Enzo Funari, from the National Institute of Health of Italy (a WHO collaborating centre on water and sanitation) was then invited to talk about gastroenteritis in relation to water contamination, and water scarcity in relation to extreme weather events. There was no dedicated database on gastroenteritis but there was national reporting on communicable diseases including, importantly, information on the vehicle of transmission. Between 1995 and 2005, there had been 32,000 cases of gastroenteritis in the country and it had been possible to conclude that around 2,500 of those were waterborne, related to the consumption of shell fish and other products linked to contaminated water. The geographical distribution demonstrated that such cases mainly occurred in northern Italy. In the three northern regions of the country, just 6 municipalities had notified 75% of the cases, clearly demonstrating that inequities existed. The reporting of diseases was not representative of the Italian situation, unfortunately, as underreporting resulted in lack of preventive action to address the issue. As with hepatitis A, some regions did not notify at all and hence no action was taken. When looking at drinking water alone, it was still not possible to identify the causes but analysis was ongoing and would be reported on at a later date. Data besides that on health impacts also existed for flooding. Dr Funari concluded that it was important to strengthen health systems in the area of water-related disease surveillance, to identify critical areas for disease surveillance in order to better allocate economic resources, and to make better use of the Water and Health Protocol as a tool to strengthen national health systems.

In the discussion that followed, Dr Licari explained that it had taken a long time for the Water and Health Protocol to move ahead. Healthy environments and settings, i.e. tourism, hospitals, etc., were important. The epidemiological statistics coming from health systems helped to demonstrate the burden of disease related to the environment and it was important to continue to make those links. However, more political momentum needed to be created around water and health issues and the secretariat asked for comments and discussion on how to ensure that for the next Conference.

The Chairperson invited comments from the floor.

Italy referred to the Task Force on extreme weather events and health set up under the Water and Health Protocol. It was a first exercise in environment and health integration. Many health determinants were outside the control of governmental departments and the Task Force had decided to work in a joint manner to draft joint guidelines and recommendations for strategies with the Water and Climate Task Force under the UNECE water convention. Although the Task Force was primarily a national activity, it was still an exercise in promoting integration between different sectors.

Norway supported the intervention by Finland on the importance of clean water and sanitation for all. In 2009, 10 years would have passed since the signing of the Protocol on Water and Health at the Third Ministerial Conference on Environment and Health in London in 1999. The Protocol had so far been endorsed by a number of countries and was closely linked to the CEHAPE through RPG 1. However, there were still big challenges to deal with before safe access and sanitation were achieved. Vulnerable groups bore most of the burden of lack of access to water. It was important to promote the Protocol as an example of making use of an international instrument to achieve change; Norway believed it was a successful instrument and
tool for safe water and sanitation. Water was a necessity for life but safe water was necessary for health. Norway would like to have the item and the Protocol on Water and Health included on the agenda of the Fifth Ministerial Conference in 2009 in order to raise political attention to it as a legal instrument and to celebrate its tenth anniversary.

The Organization for Economic Co-operation and Development (OECD) pointed out that 70% of water was used in agriculture and that water was heavily subsidized; the proper pricing of water would help to promote that key issue. It was therefore important to integrate the two sectors in addressing this problem.

The ITUC referred to the presentation made by OECD at the IMR and explained that, unfortunately, little interest was shown in water and sanitation issues. There was a lot of political discussion on the issue but there was little public investment in the area, as privatization was being considered in many countries, especially by municipalities. Governments and local authorities should consider water and sanitation as a human right and put it as such on the political agenda. The existing data were not reliable; perhaps new surveillance projects were needed to estimate the real cost of unsafe drinking water. One suggestion would be that governments and local municipalities should take ownership of the problem. While fully appreciating the Italian project presented by the speaker, ITUC doubted whether the statistics were complete in relation to occupational exposures. It was important to have a project that carried out real observations in relation to smaller groups of society, to help observe what was really happening in different parts of the Region.

ECO-Forum expressed concern that, in the International Year of Sanitation, sanitation was the area where least progress had been made. One of the problems was that solutions were costly. In some countries, the infrastructure was breaking down. In Turkmenistan for example, many of the sewage pipes had broken down and that might have severe health effects. Where no centralized sewage could be provided, other alternative solutions needed to be sought. It was important to discuss how the Water and Health Protocol could be used to address the issue. The WHO Regional Office for Europe had developed very good tools for that purpose. For RPG1, ECO-Forum proposed looking at existing experience to see what needed to be changed. Guidelines on the safe reuse of water were needed and it would be helpful to share experience that already existed. ECO-Forum had translated the guidelines into Russian and Romanian. It also called for changes to be made to funding programmes to allow the issue to be addressed more intensely.

The youth group also appealed for the issue to be addressed more appropriately. Some countries still had no access to water and sanitation. In Lithuania, water was drawn from deep wells and, since the main source of pollution was over fertilization of fields, that water was unsafe. Stricter regulations were required.

ITUC asked for gender issues to be better addressed. Proper sanitation needed to be ensured for girls at school as, in some countries that were a prerequisite for them to attend school and improve their level of education.

The Republic of Moldova stated that RPG 1 was the most important for Europe. Even the CEHAPE only covered some aspects of safe water and sanitation. It did not address recreational waters, water used for irrigation, sewage water quality, water management and other issues. The Water and Health Protocol should be a very important instrument in the environment and health process to improve water supply and sanitation. In the Republic of Moldova, the issue was being addressed through a decade of action to run until 2015. The main improvements required were in
sanitation and achieving universal access to safe water. The ad hoc project on implementation of the water programme, launched with the support of Norway, would achieve a lot and, although was not possible to solve all the serious problems over the coming few years, it was very important to maintain it on the agenda of the Ministerial Conference.

The European Commission’s Directorate-General for Health and Consumers (DG Sanco) expressed concern that, in discussions on environment and health, the health angle was still missing, despite the fact that the RPG itself addressed morbidity and mortality from gastrointestinal disorders. The Italian presentation showed clearly that there was not enough data to help push the issue forward; data was an important tool towards achieving full ownership and implementation of the Water and Health Protocol.

The Chairperson then invited Dr Aertgeerts to reply. He explained that recognition of access to safe water was a recent change and welcomed the intervention from Italy on the recent developments on the Task Force on extreme weather events and health. Sanitation had been forgotten in the past, especially when referring to gender issues. As indicated by the previous speaker, data on priority water-related diseases was still lacking. The Water and Health Protocol did recognize that emerging diseases were still being underreported by western countries and even more so in the eastern part of the Region. Dr Enzo Funari and his team had begun to address the problem, studying health systems individually and requesting all available data to check how they could be strengthened to provide information as a valid tool. Dr Funari added that it was important to keep collecting information on and to better define water-related diseases. The vulnerable groups should be defined, together with different detrimental environments that could be critical to health. Prioritization within different scenarios would help to resolve issues linked to the often limited economic resources.

In reply to the suggestion from Norway, Dr Licari replied that it might be more useful to have a side event on the Water and Health Protocol at the Conference to create the necessary political focus, rather than to put it on the main Conference agenda since the intention was not to address specific environmental risk factors such as water in the plenary session. Water was also one of the themes that would be addressed in a crosscutting manner e.g. through climate change.

Finland called for more attention to be paid to under nutrition from lack of water and sanitation as that was increasing the burden of disease.

**Addressing new priorities in RPG 2**

The Chairperson invited Dr Dinesh Sethi, the officer responsible for injuries in the WHO Regional Office for Europe, to talk about “Inequalities and child injuries in the WHO European Region”. Dr Sethi explained that unintentional injuries were the leading cause of death in children aged 1 to 14 years and accounted for 36% of all deaths. There were 28 000 deaths in children under 15 every year, representing 3 deaths every hour; of those, 1 in 10 were intentional. There was clustering by geographical region, with the lowest rates in the Nordic areas and the highest in the NIS countries. For all ages, the risks in lower-income countries were far higher than in high-income countries, at 1.3 times higher for falls and 16.8 times higher for poisoning. If all the countries of the Region had the same mortality rate as Sweden, then over 15 000 deaths (3 out of 4 deaths) could be averted. Inequalities also existed within the countries; comparing children of low economic class to those of higher economic class, the risk for death from injury was 3.5 times higher for road traffic accidents and 18 times higher for poisoning in
the lower income group. Pedestrian and bicycle mortality was higher in children of unemployed people compared to children of professionals. For housewives, it was 38 times higher. However, those statistics could only be reproduced and studied if that type of data were collected. As deprivation increased, injuries in pedestrians rose. That may be owing to differences in access to and use of health care, in exposure to different environments and in social support networks dealing with aftermath of injuries. Action could be taken to decrease the inequities by improving health care, improving the environment and reducing social stratification. In November, a world report and European report on child injury prevention were to be published. In 2009, a child-friendly version was also to be brought out. WHO was working with a number of countries, and 13 had expressly asked for assistance in that area for the 2008–2009 biennium. There were various instruments in addition to the CEHAPE that called for reporting back; web-based tools were being developed, including an inventory of policy documents, an integrated presentation and a reporting template. Over 20 Member States had hosted events and the First European Road Safety Day had been held the previous year in collaboration with the European Commission. In conclusion, Dr Sethi emphasized that there was the potential to avoid 3 out of 4 childhood injuries through a number of cost-effective interventions. Although there were a number of international instruments to do that, addressing inequalities was a key factor to the successful outcome. The need for more documents and evidence on what worked needed to be addressed.

The Chairperson then invited Dr Sheila Goldman from Israel to give her country example on “Variability in childhood patterns of injury by nationality”. The project was intended to compare Jewish children to other high-risk groups living in Israel, to identify and promote targeted policies. The presentation looked at data gathered from two different nationalities and compared injuries from burns, road traffic accidents and falls. In her conclusions, Dr Goldman explained that childhood injuries required more attention in Israel, falls accounted for 50% of related injuries and all three types of injury were responsible for a heavy economic burden on the Israeli health care system and society. She explained that all the data had been shared with all policy-makers to ensure targeted policies.

Dr Corrado Clini chaired the afternoon session on the first day and invited Dr Irina Kupeeva to speak about her country experience, with a presentation on “Road traffic injuries in the Russian Federation”. She presented data showing that children had special needs and required special policies and the attention of different ministries and agencies. Coordinated action was relevant at federal, regional and municipal levels. Advocacy programmes were highly relevant because, although children began life as pedestrians, they were the vehicle drivers of the future. Sharing of international experiences had helped the country to enhance federal commitments and intersectoral approaches to road traffic accidents. Legislation was also important for active and passive controls. Implementation of prevention strategies made it possible to use the resources available to address such injuries more effectively.

The chairperson then invited Dr Sonja Kahlmeier from the WHO Regional Office of Europe to talk about “Promoting health through physical activity”. Her presentation highlighted the socioeconomic differences in the Region and the impacts of the lack of physical activity. The data presented compared low-income to high-income countries and demonstrated the socioeconomic difference. The picture was complex: on the one hand, there was an obvious trend towards high levels of physical activity in high-income groups; that, because of the lack of access to transport, there was a tendency to walk more in low-income countries. Dr Kahlmeier explained that there was little data on regular physical activity and most of the data collected was therefore leisure-related. There was, however, an indication that the less supportive the environment, the lower the levels of physical activity. Gender differences were also highlighted,
with males being more physically active than females, a trend that remained largely the same across various age groups. The high level of physical inactivity in the Region led to high level of burden of disease; 600 000 deaths per year were attributable to lack of physical activity. That was also related to economic costs and could be translated into between €100 and €300 per person per year. Evidence from Switzerland showed that savings from increased physical activity were in the region of €2.5 billion per year. The level of physical inactivity was so high that it could only be changed through intersectoral collaboration and partnerships with sectors that could assist and promote such collaboration. Inequalities in access to more leisure physical activity must also be addressed for a substantial change to be made. Solutions needed to be easily accessible, as the most sedentary part of the population needed to be targeted without losing those who had already made some effort. Simple but cost-effective solutions such as cycling, walking and climbing stairs produced the best results. WHO had launched a guidance document and new tools on how to take into account the benefits from cycling. Physical activity was not only an individual responsibility but also a societal responsibility. Dr Kahlmeier then referred to the Ministerial Conference on obesity and explained its main conclusions and recommended actions. The emphasis was on the collection of case studies that could be shared by countries across the Region to help them learn from each other how best to address the problem. It would help if specific groups were targeted and specific resources addressed to the specific issues of physical activity.

The Chairperson invited the next two speakers to share their country experiences.

Dr Rimma Potemkina presented the country example of the Russian Federation in respect of physical activity. Various statistics showed that over 60% of the population were overweight while less than one quarter of the population had the recommended level of physical activity at leisure time. To address the situation, there was an acute need for an action plan on physical activity at the national and regional levels.

Dr Alfred Rutten presented the “BIG” project, which looked at “Promoting physical activity among women in difficult life situations”. It was a small case study on how to reach difficult target groups and help them improve their level of physical activity. The project mainly addressed changes in health behaviour and structural changes, and provided an insight into the importance of participatory processes. Dr Rutten explained how intersectoral collaboration had been developed to ensure more physical activity in a group of the population that usually exercised very little.

The Chairperson then opened the floor for comments on violence and injury prevention and on physical activity.

Latvia commented on the importance of active lifestyle as well as the importance of injury prevention. A new task was to provide the link between these two.

The Netherlands thanked the secretariat for putting the item on the agenda and also for the paper produced by Dr Kahlmeier, which highlighted that the environment was a determinant of the level of physical activity and that sport could never compensate for the influence of the urban environment on physical activity. Sport was very important in the contemporary world, and the German country example highlighted the need to tailor activities to specific target populations. Even the sports sector could benefit from organizing activities in a different way, ensuring the participation and involvement of all at as early an age as possible. All the discussions in the health sector were about supporting other sectors; health ministries must also tell others how the
health sector could contribute to their work and not only vice versa. The two presentations highlighted the fact that most discussions around political charters concerned support. However, the public health sector thought on a very individual basis with the emphasis on individual responsibility, promoting healthy lifestyles by influencing people to change their own living. Hence, if environment planning were to be made i.e. city designs and street plans, the key factor in achieving more physical activity, that could make a difference and be more productive than promoting only individual responsibility. It was a highly political issue and intersectoral approaches were therefore important to achieve that goal. Many ministries talked about health in other policies and how difficult it was to involve other sectors. However it should also be recognized that it was the health sector that was reluctant to cooperate and had to be persuaded to work intersectorally. In the case of physical activity, it was clear that the environment and other sectors were willing to work together but health tended to hold back. The Ministerial Conference needed to address the issue.

Austria spoke about the new programme of activities launched by the Ministry of Environment in 2004 that involved the collection of quantitative data. The programme included mobility management in schools, linking injury prevention and physical activity and teaching both teachers and pupils about their behaviour. The programme was a big success and 50 schools had already consulted the Ministry, while many others were still subscribed to the programme. Car trips in Austria covered 1 300 000 kilometres; evaluating such statistics helped to drive the message home. The programme involved teachers and pupils in a very active manner.

Dr Clini commented on the place of road traffic accidents and physical activity in the sustainable strategies of Member States. They should consider suggesting to the parties to the European Environment and Health Strategy how to include some objectives related to reducing road traffic accidents, and some indicators based on time frames and organization to support physical activity, linking health protection and sustainable development through those indicators.

Denmark agreed with the Netherlands that lack of physical activity was a political issue, and that a supportive environment was very important. One of the main concerns was that most of the health-promoting and physical activity-promoting interventions had not been evaluated. There was no data on the length of their effectiveness and very little information targeted certain vulnerable groups such as the elderly, one of those that had least access to physical activity.

The ITUC stated that the subjects of physical activity, nutrition, obesity and children were highly political but unfortunately politicians were not taking up the responsibility for them. The politicians could actually ensure change, for example, by integrating physical activity and nutrition education into school curricula. The means were therefore available; what was lacking was political priority being given to the issue. The only way to achieve change for children was to invite the ministries of education and, in some countries, ministries of culture to become more involved, and to better understand how to ensure that children become physically active early on in life. The emphasis should therefore clearly be on schools.

The youth group delegates agreed with what had been said; young people themselves were involved in teaching others about road safety and physical activity. They felt that there was a need for safer crossing routes, more bicycle lanes and better urban planning.

Dr Kahlmeier reacted to a point made by several speakers concerning the link between road traffic injuries and physical activity. Issues related to road safety included the promotion of safe physical activity. Hence, cycling and walking could be increased dramatically without negative
consequences in terms of road fatalities. In fact, it was known that, in countries with more cyclists and walkers, it was safer to cycle and walk. It was important to establish the infrastructure, and the most difficult period was the first transition period, when care needed to be taken to avoid people being put in dangerous situations.

Dr Rutten added that it was important to consider other vulnerable populations. The context therefore needed to be studied carefully so that, in adopting a more holistic approach by involving mothers in the health promotion campaign, a positive impact on children’s health would be achieved.

Dr Peecheva emphasized that each country had different vulnerable groups and different priorities, and general goals and international examples should therefore be adapted to each particular context.

**Tuesday 11 March**

**Session 2 - Climate change**

Dr Iversen, Chairperson for the day, thanked the Italian hosts for the evening event and welcomed the participants back to the meeting. He invited Dr Nata Menabde, Deputy Regional Director of the WHO Regional Office for Europe to make an opening address. Dr Menabde expressed the Regional Director’s satisfaction with the events of the first day of the meeting. More clarity had been achieved through the discussions that had taken place. She made reference to the aspects of globalization that the Member States wanted to bring to the Ministerial Conference, and in relation climate change. It was the theme for World Health Day 2008 and, for WHO, it was important not only to think beyond damage to the natural environment but also to reach out to all sectors that influence it, as well as ensuring that health systems were prepared to address those challenges brought by climate change. Entrepreneurial skills were necessary for this, as well as an understanding of what needed to be dealt with and the human resources required. The meeting was therefore providing an opportunity to discuss this further, especially on the second day. Dr Menabde thanked everyone for their enthusiasm and direct involvement. She appealed for more emphasis to be put on tools, such as economic tools, that help to promote the viewpoint of health.

The Chairperson invited Dr Corrado Clini to deliver a keynote address on “Integration of environment and health policies for climate change mitigation and adaptation”. Dr Clini spoke of how water stress, increasing energy demand, and socioeconomic disparity were all placing an increasing burden on healthy living. Current trends were towards an increase in temperatures. According to a projection by the Intergovernmental Panel on Climate Change (IPCC), the present trend was actually higher than expected. It was possible that, in the coming 50 years, there would be a commensurate increase in the temperate regions, with the European Region affected by an increase of more than five degrees. In Europe, looking at the historical trend from the end of the eighteenth century up to 2003 and extrapolating into the future, it was possible to predict the climate scenario for the next 40 years. The increase in temperature and resulting drought were relevant for all temperate regions but especially for Europe as they would lead to economic vulnerability owing to changes in agricultural production. One of the global effects of the increase in CO₂ concentration was the acidification of the oceans, resulting in endangerment of ocean organisms because of a devastating increase in phytoplankton. Accelerated meltdown of
the glaciers was already being seen in Greenland; globally, the effect of increased temperatures in Europe would drive many other interrelated effects. Water stress would increase, as would the number of people living in river basins under water stress, natural extreme climatic events would become more frequent and many ecosystems in the European Region would be at risk. The socioeconomic effects of such events would be very relevant, especially with human migration from the southern African region towards northern Europe. There would also be problems with agricultural productivity in the central and eastern European region, and that would have socioeconomic effects. Effects on health protection from water stress, from immigration and from reduced food production could not be ignored; health protection was a key component in the strategies for adaptation to climate change, to help make the changes required in the coming 20 to 25 years.

The context of climate change in Europe was an additional consideration. Adaptation required radical change in the organization of public health protection but mitigation, for instance, of emissions was also needed. There was a conflict of interest between energy security and climate security. Reductions in global emissions of 30% to 50% should be achieved by between 2030 and 2050. In the World Energy Outlook 2005, world energy consumption had been predicted to increase. Trends in world energy consumption of fossil fuels would result in a 60% increase in CO₂ emissions. The trend in global emissions was the A2 scenario (the worst scenario on global warming). The mitigation gap was very large. The challenge of energy security was a challenge for health protection, as only a reduction in the use of fossil fuels could help protect health from the impact of pollution. Greater use of nuclear energy would be required to reduce carbon emissions, a technological challenge that entailed identifying alternative means of energy, which might, in their own right, prove to be a challenge to health. Health was therefore a cross-sectoral issue in addressing climate change. Dr Clini recommended considering health protection as a pillar in a global strategy for addressing the challenge of energy security. Increased energy consumption was an unavoidable trend, especially in the developing countries.

Dr Bettina Menne from the WHO Regional Office for Europe spoke about “Protecting Health from Climate Change – Opportunities for environment and health policies and health systems”. She explained the work that had taken place in a number of Member States in the European Region, including country assessments, collaboration on climate events and the setting-up of a working group to deal with such events. Health impacts of heat-waves continued to be the main issue, although energy developments were also considered. Climate change was an issue of public health security and could slow down health, economic and social development. She challenged those present to think of forms of joint action towards climate change adaptation and mitigation as a cross-cutting dimension in the RPGs of the CEHAPE.

Public health security was under threat – rising temperatures, rising sea levels, more extreme weather events, hotter days and nights, and heavier precipitation were to be expected, accompanied by increases in infectious diseases resulting from warmer temperatures. Health effects would therefore gradually increase over time, as would the increased burden of malnutrition from diarrhoeal disease, cardio respiratory and respiratory disorders. That would result in increased inequity and a threat to nutrition because of lack of food security. Decreased crop productivity could increase problems with nutrition for central Asian countries. Economic growth might also be impeded.

Dr Menne went on to explain that climate change touched on all the RPGs and hence it would be a good idea for Member States to consider adaptation to and mitigation of climate change across all RPGs in their national action plans. She explained how health systems should protect health
in the context of a changing climate and help to ensure further equity and security responsiveness, and that resources for populations remained available. She concluded with a summary of events planned around World Health Day 2008 on 7 April and appealed to Member States to use the event to attract more political attention to the issue.

The Chairperson then invited Dr Hilary Walker of the United Kingdom and Dr Tanya Li of Uzbekistan to share their experiences in preventing public health impacts of climate change.

Dr Walker explained that, over the years, the environment in the United Kingdom was changing markedly. Summer rainfall was decreasing, while autumn and winter rainfall was increasing. Predictions included hotter drier summers and changes in mean annual temperatures; the country had also registered a change in the longest period with maximum temperatures. Heat-waves were expected to become more common, mean temperatures would increase by two degrees and winter temperatures by four degrees, and the number of hot spells would also increase. Warmer wetter winters would result in a change in annual rainfall and more floods in autumn, as well as winter sea floods. Very cold spells would become rarer as would high winds.

Dr Walker went on to explain the impacts on health. More frequent heat-waves and flooding, as well as an increase in tick-borne, waterborne and foodborne diseases, were impacting on the health of the population and, while a decline in winter deaths had been noted, a change in air pollution and a change in the incidence of cancers, as well as global migration, were relevant. Although malaria was not endemic, it could become so in the future. So far, the United Kingdom had only had to deal with Lyme disease arising from changes in land use. However, the incidence of foodborne diseases, especially *Salmonella* and *Campylobacter*, would continue to rise, as would the incidence of skin cancers. Direct effects included cold- and hot-weather deaths and heat-wave deaths, as well as their cardiovascular effects such as viscosity, clotting and respiratory infections. Psychiatric disorders, including depression, and drugs that affect the ability to thermo-regulate would become more common. There was a possibility that the population was adapting, as mortality rates had not risen as much as expected. The mean annual mortality rate had not risen between 1971 and 2003, and the cold-related mortality rate had fallen by more than 33%. Nevertheless, mortality was expected to increase as temperatures rose above 27 degrees. Other cross-cutting effects from climate change included health inequalities, differing vulnerabilities and global migration, as people moved to deal with the rising temperatures. That would all impinge on health services and their capacity to respond. There would be interagency dependency within health services as well as with other sectors.

To deal with all that in the United Kingdom, various responsibilities had been allocated within the health department, as well as other government departments, with strong internal coordination led by the Department for Environment. The various policy teams for mitigation and adaptation worked together, and also dealt with the heat-wave plan, the emergency preparedness plan and National Health Service facilities. Every government department had a minister responsible for climate change, mitigation and adaptation, as well as other officials responsible for climate change. Efforts were being made to work across policies to ensure that they did not conflict. An analysis was being made of how climate change would impact on the different roles and a climate change policy framework had been drawn up. Policies included the adaptation of social and health care, support for the development of local heat action plans, awareness-raising to show people what they could do to adapt, and preparedness for extreme events, as well as policies for reducing air pollution and both sun awareness and energy awareness campaigns. The key aim was to study adaptation to climate change without
minimizing the relevance and role of mitigation. Dr Walker’s final message was that all four RPGs were relevant to climate change and Member States should be prepared.

Dr Tanya Li presented the example of Uzbekistan. Work on climate change had been going on for a long time, but the health sector had not been involved in the first report. The second had included intersectoral collaboration; the results presented were from 2005 and 2006. An assessment was made of the results obtained over the recent decade. The indirect impacts of climate change on health, including morbidity and mortality, were also analysed. Thanks to the valid work done by the health sector, the second report was expected to be issued shortly. Various environmental indices had been measured, as had meteorological changes. Mathematical modelling had been applied. Different measures had been introduced for cardiovascular disease under different conditions and the conclusion was that, although the whole population was quite vulnerable to changes in temperature, the rural population was more vulnerable because of heat-wave islets and different patterns of disease. Dust storms and their distribution patterns in deserts and mountains were highly relevant; they could last up to 30 days, impacting on people with cardiovascular disease who were known to be sensitive to them. In different territories in Uzbekistan, there was some relationship between temperature fluctuations in spring time and increased cardiovascular mortality in October. Further research was needed.

With regard to acute conditions, there had been a steady rise over previous months. The correlation between air temperature rise and acute intestinal infections was analysed, showing the latter to be 13% higher than usual. In assessing the situation and relevant interventions, Leishmaniasis of both urban and rural types was an important factor. Lack of data had been a challenge, especially mortality data which was only available to health specialists. Infectious diseases and cardiovascular diseases had been studied for annual trends. An update of the databases and more cohort studies were required to allow further studies related to Geographic distribution. However, in order to ensure adequate adaptation to climate change, it would be even more useful to establish joint intersectoral specialized databases readily available to all involved to allow them to check the health impacts of heat-waves.

In conclusion, the main lesson learnt by Uzbekistan was the need to harmonize the surveillance systems for infectious diseases and environmental data. Climate factors also needed to be included. More attention should also be paid to transboundary events to ensure a timely multisectoral and national response to different extreme events.

The Chairperson opened the floor for comments.

Finland had been one of the first countries to write adaptation strategies using IPCC forecasts. Malaria had been highly endemic for hundreds of years during the cold period in Finland; it had then vanished because of the disintegration of agriculture society. Studies had determined that it was not likely to re-emerge. However, it did reappear during the Second World War as a result of the movement of troops. Finland felt that, as in the United Kingdom, the main tasks of the health ministry concerned adaptation, which was the strategic choice of WHO. The recommendations were only to strengthen public health structures, rather than anything more elaborate or distinct.

Greece stated that the issues raised by Dr Menne were well known to the technical community but, although the figures were convincing, the decision-makers were reluctant to take immediate action, possibly to avoid creating panic. It was important to provide them with good arguments, good country examples or case studies with easy solutions and easy practices so that Member
States could choose efficient responses with regard to health effects. Good arguments, especially economic arguments, would be more effective in raising awareness to avoid future panic.

The European Commission commented that the direction of the Conference was unclear. Using the argument of climate change to boost the CEHAPE RPGs was one thing but to focus the Conference completely on climate change was another. Looking at the Goals, water was relevant but did not clearly involve health services; injuries, under RPG 2, would show no added value if climate change were included. Air quality did have a connection with climate change, and a package had recently been approved because the European Environment Agency had stated that there would be substantial savings on air quality measures related to climate change. However, health services would not be much involved at that stage. It must be remembered that the Conference was dealing with people; hence, to ensure health service involvement, it would be useful to define intentions clearly, to work beyond the RPGs and, if necessary, to tackle climate change as a separate priority.

Dr Corrado Clini, co-chairperson of the EEHC, considered it important to involve health in climate change by considering how climate change was connected with water, injuries or indoor air quality. However, in addition to the relationship between climate change and other factors, thought should also be given to how climate change could change health policies. In the case of injuries, flooding was related, as were shortage of water or of electricity because of extreme events. If climate change would impact on health, it was important to consider how health policies should be adapted to climate change. Dr Clini’s impression was that Member States were still looking at climate change as a risk factor, whereas, in actual fact, it was the overall situation and required an integrated new approach to ensure multisectoral collaboration in addressing the issue. In the beginning, the environmental sector had attempted to approach climate change on its own without any cross-sectoral approach or involvement. Nothing much had been achieved in that way and hence an integrated approach involving the health sector was the only way to deal with the issues. Even public activities needed to be designed with that in mind, with health as a tool for changing public policies towards climate change.

Dr Menne mentioned the failure of the United Nation’s Framework Convention on Climate Change and insisted that key to the success was by putting health at the centre of the climate change arguments. Whether that was done as a separate priority goal or in a cross-cutting manner throughout the existing RPGs was up to the Member States to decide; Dr Menne preferred a separate RPG.

The ITUC stated that the matter was simpler at sectoral level than at policy level. To what extent human and financial resources should be directed into mitigation of climate change was a difficult policy decision that was not relevant at the sectoral level. The existing mitigation examples did not ignore the impacts caused by climate change. Policies should be planned on the basis of how surroundings were expected to change as a result of the climate; for example, where water would be available or where houses were safest. Once again, the vulnerable did not have a choice, and equity therefore became an issue. Adaptation should take into account the needs of people on low incomes, and hence the social effects of climate change should be much higher on the agenda.

The youth group commented that the argument of climate change provided a good opportunity for multiple stakeholders, including the business sector, to contribute to mitigation and adaptation. Young people themselves could help to educate other young people and children on the issue and to promote adaptation and mitigation of climate change.
The Netherlands cautioned that the presentations had clearly demonstrated how large and acute the problems linked to climate change were. The issue of climate change was already crowded with a number of players who were struggling to deal with the problems. It was therefore important to look carefully at the role of the Member States and of the EEHP, as otherwise it would not be an efficient or effective way of dealing with the issue. Many adaptation programmes were already under way; it would help to look more intensely at the health perspective in existing programmes, especially where that had not been done or had not been done comprehensively enough.

Cyprus agreed with the Netherlands that the focus should be on strengthening or adapting the health system to cope with the effects of climate change. Those were different in different sectors and hence, while a coordinated intersectoral approach was important, attention should also be paid to the individual fragmented issues. It would therefore help if the process tied together all the different specific approaches, pulling together all information, materials and policies in an integrated and coordinated fashion. Mitigation was one problem dealt by many other organizations while adaptation was the way forward for the process.

ECO-Forum gave a number of examples from the central eastern region of health impacts of climate change, specifying the need for funds. According to the IPCC, 120 million people would be displaced yearly as a result of climate change, while only 2% of funds were being devoted to adaptation measures under the Kyoto Protocol to the United Nations Framework Convention on Climate Change. The present meeting, and especially the ministers of health, should prepare a recommendation on the funding necessary for adaptation measures and ensure that it reached those most in need.

Dr Menabde remarked climate change was such a complex issue that the needs went far beyond the capacity of those present. It was therefore important to understand the individual roles of the players and the added value that they contributed to the overall picture. WHO was very clear on its position and was determined to have health firmly placed on the agenda of climate change. It was currently discussing with governments how to make health more prominent on national as well as international agendas. A number of studies had been carried out and, although there were strong arguments, it was only the beginning of the work of adaptation required. While acknowledging the importance of prevention, the experience of WHO was that behavioural change policies did not work or had limited results. One of the recommendations was therefore to focus priorities elsewhere. Hence, while continuing to advocate prevention, it was important to make sure that the sector dealt with those issues that only it could deal with. In the case of health, that meant understanding how to build hospitals, what people to train and in what areas, as well as which information and data was needed. Realistically, it would be an achievement to make the necessary changes to the national health systems to prepare them to protect health from the effects of climate change. During the forthcoming session of the Regional Committee, WHO would discuss behavioural change measures and policies but more emphasis would be placed on planning and adapting health systems to deal with climate change. That was the role of the health sector and it was important to fulfil it within the broader picture of intersectoral collaboration.

Austria referred to Dr Menne’s comment on how to integrate climate change into the RPGs. Climate change was not primarily an issue of environment and health but one of health systems; it should not necessarily be integrated into the RPGs but should perhaps be included in a separate goal in the CEHAPE.
The World Business Council for Sustainable Development (WBCSD) agreed that the immediate job needed to be done first and that health systems needed to be strengthened to respond; however, a more proactive role was also important. Future solutions required investment and the business community needed advice from the health sector on what those solutions translated into. In addition to the current RPGs, it would be important, after the Ministerial Conference, for the EEHP to play an advisory role in respect of all the activities, which were mainly energy-related and not based on the Health in all Policies approach.

Tajikistan noted that not only heat-waves were of concern, but also cold-waves, the experience of the country during the current year. Since the country relied on hydro-electric power, the cold had caused an energy crisis. It was important to understand better how to stimulate the health system, what the challenges and drawbacks were and what intersectoral action was required or should be proposed. A joint working group could help to analyse the situation towards a better understanding.

Poland agreed on the need for mitigation of climate change effects but considered it important to discuss the reduction of greenhouse gas emissions. WHO was asked whether it would use its strong political voice to push for such reductions and implementation of the Kyoto Protocol. Without the latter, mitigation efforts would fail, leaving only adaptation. Health was a strong tool that could demonstrate the ethical issue involved and its dimension. Those that would suffer most were least responsible for climate change, while those most responsible were the most comfortable.

Tajikistan explained how climate change resulted in different manifestations, including increased exposure to carcinogenic substances. A variety of regulations applied to such substances; they could usefully be taken up by different WHO collaborating centres or national research centres and a new regulatory framework towards climate change drafted. Older regulations did not take the carcinogenic impact of climate change into consideration; revisions to maximum acceptable concentrations were therefore important. To clarify the role of climate change and carcinogenic substances, Tajikistan explained that glaciers were responsible for 90% of the fresh water supply in central Asia but that there were no monitoring systems. Barrels of radioactive waste could be found very close to water production areas and the lack of a monitoring programme could result in health repercussions, especially as a result of the effect of climate change on the glaciers.

Dr Jon Hilmar Iversen said that climate change was actually having a negative effect on the health promotion campaigns focused on healthy lifestyles. In Norway, despite long-standing attempts to urge school children to walk to school, parents were increasingly driving their children to school because of the effects of climate change.

Sweden expressed support for the work of the WHO Executive Board and looked forward to the adoption of a resolution. In discussing how to broaden the work around climate change, Member States should focus on the Ministerial Conference. It would be interesting to see how a resolution could be integrated into the four CEHAPE goals without broadening the issue. Sweden supported the viewpoint of Ireland and Cyprus.

Armenia noted that the climate change issue could be reflected more strongly in the Conference Declaration rather than the CEHAPE goals, in addition to the cross-cutting approach of the RPGs.
Denmark said that it had set up a new ministry of climate change and energy, as climate change was very high on the agenda in Denmark because of the upcoming meeting in 2009. There were many ongoing processes related to climate change. The process should focus on key areas, and that led Denmark to associate its position with those of Ireland, Cyprus and Sweden.

In reply to the comments of Ireland, Sweden, Denmark and Cyprus, Dr Menne explained that World Health Assembly resolution WHA61.19 of 2008 did not include issues set out within the CEHAPE goals but simply called for a WHO work plan, pilot projects on adaptation and national action plans. The WHO Regional Office for Europe’s meeting on climate change to be held in Bonn in April 2008 would therefore be useful in identifying what needed to be delivered to the Health Assembly. The resolution would put emphasis on health systems but Dr Menne understood that the environment sector needed to hear more about health impacts and benefits. Tajikistan’s idea of setting up a working group could be very useful and could be further discussed at the Bonn meeting.

Dr Menabde concluded the session on climate change by summarizing the main points made. Stronger advocacy efforts were required to put health high on the agenda of the discussion on climate change. WHO would continue to exert political pressure for the reduction of emissions and the endorsement of the Kyoto Protocol, with its preventive implications. It would also continue speaking on behalf of vulnerable populations and the countries most in need – the actual victims of climate change – as all possible measures needed to be used to ensure their protection. Adaptation measures were extremely important and depended on the existing knowledge base, which needed to be extended but also modified to the cultural context and health system designs that had proved useful at national level. Finally, it was important to be proactive, as the time to act was now, especially in taking measures for individual care and for the population at large. Such measures should be translated into a practical action plan with the role of each stakeholder and player clearly elaborated; such actions were beyond the limitations of the CEHAPE RPGs, as the driving force was the objective and not the tool.

**Session 3 - Addressing the priorities identified by the Intergovernmental Midterm Review**

The Chairperson invited Dr Dafina Dalbokova, the representative of the WHO Regional Office for Europe responsible for the indicator system, to talk about “Ensuring renewed commitment to Regional Priority Goals 1 and 2”.

Dr Dalbokova gave an assessment of the situation in the European Region in implementation of RPGs 1 and 2, using the available information and data provided by countries to the Environment and Health Information System (ENHIS) aggregated into 26 core indicators on children’s health and environment data.

The outbreak of waterborne diseases was a key issue. Currently, there was a lack of harmonized reporting and no child-specific data, with the exceptions of Croatia and Finland, where there had been compulsory reporting on water and sanitation since 1997.

Water-related health determinants and inequities were highlighted; despite progress, access to water resources remained low, particularly in the eastern part of the Region. In 11 Member States, less than 40% of the rural population had access to improved water sources. Furthermore, for every person without improved drinking water in urban areas, there were four to five people...
not served in rural areas. Such disparities increased towards the east, in particular in the NIS, where the difference between urban and rural dwellings was 45% to 50%. There was also a clear east-west pattern in terms of connection to sanitation facilities. Less than 50% of the rural population in 16 Member States had in-house sanitation and the disparities increased towards the east up to a difference of more than 50 percentage points between urban and rural dwellers. In the case of urban waste water treatment, significant progress in population connected to waste water facilities had been achieved between 1980 and 2003. The proportions of treated waste water were higher in the northern countries and had risen in the south and south-east of the Region from 40% to 60%. Further improvement was expected in the east but there was a need for more reporting, and that was currently hindering monitoring of the changes. Waste water discharges were linked to the quality of bathing water, with a clear relationship between bathing water quality and infectious diseases. No bathing water quality data were available for 43% of the population in the European Region. In summary, the health inequalities in water-related health risks were greater towards the east, and access to safe waste water disposal facilities remained low in many of the NIS countries and still lower in rural areas. Continuing urban growth was bringing important challenges, with a need to strengthen implementation and reporting in respect of the Water and Health Protocol, the only such instrument available. Strengthening surveillance and data collection was therefore important.

The mortality data on RPG 2 (injuries, and physical activity and mobility) showed that, for children aged 0 to 4 years in 2002, injuries from drowning, falls, burns and poisoning accounted for 75 000 deaths. Rates were especially high in the NIS and the Baltic countries. Such information helped to focus risk reduction strategies. The socioeconomic determinants showed a clear relationship between mortality and gross domestic product (GDP), with highest mortality in central and Eastern Europe. Differences between countries with the same GDP showed that there was room for health preventive actions. It was shown that policies could reduce the risk as well as contribute to economic savings. The assessment also showed that policy implementation differed among countries. A study in 2006 of 12 national policies for the prevention of unintentional injuries, covering issues such as child-resistant packaging and the banning of sales of fireworks to children, showed substantial results. There were also considerable variations between countries for physical activity, although there was no clear geographic division. Boys tended to be more active than girls. The information on physical activity gave an indirect indication of policy responses in place, including green areas and cyclist, pedestrian and recreational areas, and showed that they were indeed linked to activity levels in the population. A shift in paradigm to health mobility had the potential to bring large health gains. In summary progress had been achieved in reducing health injuries but major inequities still existed. Prevention of unintentional injuries remained important and highly relevant.

With regard to next steps and the development of ENHIS, Dr Dalbokova pointed out the importance of maintaining the system and enlarging the number of Member States involved. The system needed to be enhanced at national level, particularly with country-specific indicators, and the European instrument must continue to be useful. The thematic scope should be expanded to address emerging issues such as climate change. Member States were asked to comment on the usefulness of ENHIS to Member States, what they would like to see in its future development, the perspectives for subnational and national analyses, and what could be done to improve monitoring in all Member States.

The Chairperson opened the floor for comments.
ITUC noted that, since child labour continued to be an issue, its occurrence in different countries should be included in the indicators.

Bulgaria welcomed the strong presentation and considered the data very relevant for politicians. Member States knew what needed to be achieved but still wanted answers on how it could be done. It was important to define and assess what had been achieved and the actions being implemented, taking into account the availability, quality and comparability of the data. In response to commitments made in Budapest, Bulgaria had developed the indicators but that had been a difficult and challenging task. The next challenge was to ensure the sustainability of ENHIS; it had been agreed at the Budapest Conference that environment and health indicators were necessary but it was still not clear how they were being used in practice. It would be helpful to use data for reporting within countries as well as in health impact assessments, in response to new emerging needs and issues, and in the preparation and reporting based on indicators.

For Serbia, the set of environment and health indicators was one of the strongest tools in developing evidence-based policy-making. The system had not yet been developed in Serbia and was needed in the SEE countries and the NIS. Serbia requested assistance in developing and using the system in the country.

Uzbekistan called for more attention to be paid to problems related to water quality, especially water treatment and sewage water. In urban settings, only 70% to 75% of water was properly treated, and, in rural areas, only 36% of the population had access to proper purification, with systems either not available or not working properly. Waste water was therefore dumped into rivers, to the detriment of those who lived downstream. Another problem was purification facilities in rural areas. ENHIS was important and there was a general need for more information in Russian on WHO sites to ensure better exchange of information, especially with western European countries; the Regional Environmental Center could contribute to that.

Tajikistan considered that waterborne diseases were very important in the NIS and called for increased surveillance and international cooperation, not only for infections but also to ensure access to clean drinking water.

The Russian Federation stated that ENHIS was being developed properly in the country and the Russian government supported its continuing development.

Dr Dalbokova replied that ENHIS did include a child labour indicator but there was no data for more than 40% of the region; it came under RPG 4 and thus would be presented at the next EEHC meeting. She thanked the Member States for their support in the continued development of ENHIS.

Session 4 - Working in partnership with new stakeholders

Dr Clini chaired the afternoon session and invited Dr Donato Greco, Head of the Department of Prevention and Communication in the Ministry of Health, Italy to talk about the Health in All Policies (HiAP) Declaration endorsed at a meeting in Rome in December 2007.

Dr Greco explained that the meeting in Rome was the result of an Italian initiative. The Declaration had four main objectives: it encouraged the implementation of projects promoting HiAP; it served to strengthen multisectoral approaches; it promoted intersectoral collaboration,
including with international governmental organizations such as WHO; and it promoted the use of health impact assessments. The HiAP Declaration was a result of recognition of the epidemiological status and burden of disease in the European Region. Despite the emphasis on some acute diseases such as chikungunya and avian flu, the real burden of disease resulted from chronic illnesses such as cancers, myocardial infarcts and osteoarthritis. The main determinants and risk factors were smoking, alcohol, lack of physical activity, inappropriate diet and environmental factors. The health sector was not the main sector responsible for such determinants and did not have the power to make policies affecting them. The financial sector, as well as the environment, transport, and agriculture sectors, all played a significant part in such health determinants. Health was only a small player on the preventive side. Over the years, there had been substantial improvements in population health and survival rates related to certain diseases. However, that had resulted in more years of life with more chronic disease, requiring more diagnostic procedures and longer and more frequent episodes of treatment, which were costlier and a larger burden on the health sector. Hence, no system would be sustainable in twenty years’ time if the chronic disease trend were to continue. The only solution was prevention and health promotion, which must be intersectoral, inter-institutional and multidisciplinary for all ages and must begin before conception and continue right through life. The alternative was the current situation, where the health sector was paying the costs of determinants that were in the hands of other sectors to control and address through effective policies. Health services continued to pay for the ineffective policies and actions of other sectors and that was why health had to be in all policies. Italy had drawn up a major plan called “Guadagnarе Salute” (Achieving Health); with all the ministries in the country working together, an official act had been signed on 22 May 2007 on multisectoral collaboration. There were two exceptions: the first was the law on passive smoking, which had initially not been well accepted by Italian society. Three years later, the effect of such a public health decision had been a decrease in admissions for heart attacks of more than 10%. The second exception was that in Florence, Tuscany where the death rate from cardiovascular disease was markedly different from the rest of Italy. That was because the bread in Florence contained no salt, while the rest of Italy ate 11 grams of salt a day in bread. The result was an agreement with bakers to be signed in the coming weeks to decrease the salt content in bread to try to achieve a similar result in the rest of the Italian population. In conclusion, that was an example of working with other sectors to achieve health gains.

The Chairperson then invited Dr Franklin Apfel to facilitate the panel discussion with: Dr Angelo Stefanini from Emilia-Romagna region and Dr Franco Picco from Lombardy region, Italy, Dr Fernando Carreras-Vaques from Spain and Dr Helmut Brand from North Rhine-Westphalia, Germany.

Dr Apfel explained that the aim of the panel discussion was to demonstrate how policies made at national level were translated at regional and local levels. The panellists came from the national, regional and local levels of government and had been invited to explain how the ensured they implementation of environment and health actions.

Dr Picco from Lombardi region explained that environment and health had to work very closely together. There was a difficult balance to reach between the two but there was a feeling, especially from the media, that the environment sector was deteriorating. However, there were yearly improvements in the region, despite it having 10 million residents (3% higher population density than other regions of Italy) and 800 000 industrial, commercial and agricultural firms, as well as tourism and high levels of energy consumption. Like many other industrial regions, Lombardy was facing many pollution problems, especially in the agricultural areas. Health
officials, however, still said that life expectancy in Milan was six months more than in other areas of Italy. That was the result of the quality of the regional health care system but also of the investments in improving the environment, which involved cooperation between the stakeholders and civil society. The basic strategy was to establish agreements with sectors concerned and ensure that every top-down measure was preceded by a full environmental evaluation of the balance between benefits and costs. Law enforcement always followed agreements, and research and innovation were supported as much as possible, as it was recognized that new technologies were used to solve the problems, along with education, economic incentives, enforcement and control. The main environmental problem in the region was air pollution, despite the fact that all pollutants were below EU limits, and there had even been marked improvements over the past year. Another problem was soil contamination resulting from the high level of industrial activity in the region. Many sites were under local authority monitoring and clean-up was continuing through public-private partnerships. Although Lombardy was very rich in underground and surface waters, it also had water management problems. There was improved water collection and treatment, and pumping from underground was under control. The current problem was the overuse of fertilisers. Rules on chemicals were very strict and hence there was very little risk to health. Only a small amount of waste went to landfill and energy production from waste accounted for about 43% of total production. Despite the large number of incineration plants, policies and actions were being introduced to address the issue. With regard to increasing green areas, there was a regional policy to improve parks and green areas to provide a better quality of life for the Lombardy population.

On behalf of the Regional Minister of Health and Social Care of the Emilia-Romagna region, Dr Angelo Stefanini spoke about the three-year plan that addressed social and health care issues at regional level. Over the previous six to seven years, there had been a lot of enthusiastic planning that had resulted in the plan called “A Covenant of Solidarity for Health”. Its intention was to ensure that not only the health sector but all other sectors too could work together to address health. That was something very new to most of the policy-makers in the region, although it was not necessarily different from the 1978 Alma Ata Declaration, which called for that approach by recommending health as a human right, and specifying the duty of the Member States to provide adequate health care. The regional plan had resulted in a call for intersectoral cooperation, now known as “Health in All Policies”. In 1999, the regional health plan had been drafted in line with the national health plan and followed the same policy guidelines. It also called for the identification of local tools to make the vision possible. The result was guidelines known as community health plans, Piani per la salute. The regional plan was formalized as a decree and coordinated by local government, with resources committed by multiple sectors. It involved the whole of one province in the region (there were 13 other provinces in the region with their own plans). That was quite a change, from a health care perspective to “planning for health”; it ensured the involvement of communities, and highlighted the need to make bridges with other sectors. That led to a stronger role for the local actors who coordinated the plan. The reality of planning at the local level was therefore the need to address the concerns of a number of social actors, in order to take better account of the social determinants of health and, more importantly, to address health inequalities.

In reply to a request for a more specific example, Dr Stefanini explained that it had been realized at the time that community health was the responsibility of all components of society and while it was natural for everyone to feel the duty to cooperate, the ways in which people actually did so were entirely different since everyone had their own perspective. Hence regional policies supported the local government in the implementation of the three-year plan by maintaining a framework. One of the priorities identified by the local community was road safety. There was a
large scope for collaboration between sectors, and the actors were mainly the municipalities, the schools, voluntary associations, police media, non-profit organizations and trade unions. The actors all participated in the process, which started with their training to ensure that they all had the same knowledge of what they were dealing with. Every stakeholder tried as far as possible to provide resources and time for the joint community plan, which was successfully implemented. Each sector selected different priorities and actions, mainly those more related to the sector’s specific field, but it was all integrated together. Emilia-Romagna was the strategic centre for transportation in Italy, and therefore road safety was one of the main objectives chosen by the stakeholders. However, other priorities were also important, for example the health risks of care givers: the Emilia-Romagna region had one of the largest aging populations in Italy and hence the provision of care was very important for the community, as was the health of the carers.

Dr Stefanini explained how the local government ensured the actors worked together. There were indeed differences between local plans in terms of priorities chosen and methods of implementation used. For example, there were differences in how priorities were identified, how implementation was initiated, whether focus groups or top-down approaches were used, how experts were integrated into the decision-making and planning process and how all that was discussed with the general population. Being part of such an experience, as diverse as it was, was fascinating and very rewarding.

Dr Apfel explained that Dr Stefanini had shown that there was a large number of techniques to ensure multisectoral approaches, and invited Dr Helmut Brand to talk about the experience of the Regional Network and especially the experience of North Rhine-Westphalia (NRW). Dr Brand explained that there were 18 million people in NRW, where he was head of the Regional Public Health Institute and a member of the Regional Network of Local Authorities. The role of the network was to discuss how to implement policies at regional level. NRW was heavily industrialized and it was very difficult to ensure that environmental factors were addressed. However, environment and health issues were not the only problems addressed by the Network; there was also the problem of social inequity that had existed since the Second World War. The health care system was based on social insurance and, since Germany was a federal republic, each state would find its own solution. Thus, each group in society had its own representatives and all welcomed the opportunity to sit together and talk until solutions were found. Dr Brand explained that, in implementing local plans, NRW, like other local authorities, found it was difficult to bring the different actors in the health system together. However, 10 years previously, the Institute had organized local conferences to discuss the setting up and implementation of local environment and health action plans. Evaluation of the process had already taken place twice and would be conducted a third time at the end of 2008. It showed that there was a key role to be played by the regional authorities who provided back-up when the discussion at local level could not continue further. That had led to a system where discussions between different groups, including patients and others most at need, took place at local level, integrating other sectors when necessary. These discussions continued until consensus was reached without any real voting taking place. That system was currently used by regional governments as well as local districts. The local districts prepared the discussion and discussed at regional level, and vice versa. Although the issues originally discussed focused on health and health care, other cross-cutting issues, of interest to all sectors, were being integrated into the regular discussions.

Dr Apfel asked for clarification on which sector was the driving force behind such collaboration and how the other sectors were involved. Dr Brand explained that, at the beginning, the initiative had been started by the regional government, which had even put money into the approach. It had since been taken up by the public health institute, which was working constantly to support
discussions through the collection of data and dissemination of information as evidence for supporting the discussions.

Dr Stefanini intervened to clarify that that experience was different to that of Emilia-Romagna, where it was the health sector at the local level that had started the process. That was a disadvantage, as many other sectors felt that the discussions were a health care initiative and that slowed down the introduction of a Health in All Policies approach.

Dr Apfel reminded the participants that, frequently the health sector blamed other sectors for not doing their part but one had to also consider that the health sector might actually be the problem. The health sector still tended to monopolize rather than share the problem. It was important that doctors should learn to share problems and overcome the difficult part of providing local government with technical tools and training people within local government who could help to lead the way, as a sector that was integrated rather than apart. The health sector needed to shift towards a facilitative approach rather than be in command and control, and to provide common platforms for the exchange of information and decision-making. It was important to engage actors and support them.

Dr Fernando Carreras-Vaques from Spain then explained in his presentation that environment and health was one of the main challenges in Spain, especially because of climate change. Spain was organized into three administrative levels: local, regional and state, each with different responsibilities. The state set up lines of action related to health and environment, established the legislative framework and played a coordinating role at national level. The regions and autonomous communities implemented and expanded on the state laws, and were responsible for their direct implementation. The local authorities took primary control of health and environment in relation to protecting the health of citizens. Promoting a framework for joint action on climate change with all stakeholders was important and all measures were taken at all three levels. By way of example of the measures taken, Dr Carreras-Vaques mentioned the National strategy for air quality, the Quality plan on national health systems, the National strategy on sustainable development, the National strategy on health at work and the Spanish strategy on urban environment, the main proposal of which was to move towards sustainable scenarios and to improve the health of citizens. At state level, it was also important to highlight research and innovation on health and environment issues. At the autonomous regional level, activities were supported through the development of regional plans. Regions were currently working to integrate different areas, including water and air quality, chemical and biological security, action on climate change, environment and health training, and risk communication. Those actions were in line with the CEHAPE RPGs. The local councils were the last link in the administrative chain and, at that level, all measures were taken, along with specific action such as waste management, street cleaning, creation of green areas, drinking water supply, mobility urban planning, drinking water and health education activities. Local authorities were responsible for providing health settings and guiding citizens in their behaviour. Local Agenda 21 was also relevant and was still referred to. Spain was developing a national plan for climate change, which would have a general framework to ensure collaboration between all actors. All initiatives related to health and environment, and especially on climate change, would be used to ensure integration between all the sectors. The effective coordination of all the initiatives through the state administration included an advisory committee. All the administrative levels were efficiently coordinated to work together.

Dr Clini made two additional comments on the Italian situation. He explained that all environmental regulations that were designed and adopted at national level and at regional level
were driven by health protection objectives. The objective was primarily the health of the population, which was the driving force for all protection of the environment. In addition to the local structure and the national health system, there was also the technical body for implementation of the plans. At local level, the two administrations were integrated or overlapped. However, public participation at local level on environmental protection was driven by health objectives and the experience of Italy was important as public participation through associations and voluntary actions had always been very positive and had always identified the best option for protection of both health and environment. However, frequently, public participation caused conflict between the local communities (sometimes small groups of local communities) and the national authorities because of the health impacts of the decisions being discussed. The participation process in Italy had generated a call for a “zero risk” option, and that was a big challenge for the local and national authorities, who had to decide on various issues such as the authorization of industrial plans or the building of incinerators or waste water plants and those would frequently conflict with the zero risk option. Hence local authorities would not agree with plans because of public pressure. The conflict of opinion was an emerging issue that affected the ability of local authorities to make a reasonable decision even though it might concern an integrated programme activity between environment and health. Learning from that experience, guidance should be drawn up on ways of communicating a real picture of the risks involved to make it possible to manage such decisions adequately. Given the importance of the role of local communities in environment and health, it was an issue that needed to be addressed.

Dr Greco also agreed that, for the next Ministerial Conference, the discussion needed to be diversified further. There was an enormous gap between population perception and the actual risk involved. The community needed to be mobilized but the level of communication had hitherto been disregarded. As indicated by Dr Picco earlier in the session, health in Emilia-Romagna was improving, as was the environment, but the perception of the person on the street was the opposite and hence decisions made at the local level were not necessarily correct if taken on the basis of public perception. It was therefore very important to address perception to enable more productive public participation. In addition, health risks should dictate where resources were used, but that was not necessarily the case. Passing laws without public education would not work and hence it was important to improve communication to the public.

Dr Stefanini explained that conflict was inevitable when a group of people gathered together to make decisions in a truly democratic manner. It was difficult to reach common agreement, perhaps because of two main problems. One was the lack of information-sharing (even of scientific information); information was still not shared democratically and usually only in little amounts when the scientist or doctor chose to do so. To address that issue, it had to be accepted that the public was mature enough to deal with information disseminated in the right way. However another problem in decision-making also highlighted a need for maturity. Decision-makers tended to change their minds about implementing decisions as a result of the impact of public opinion. It was important to “decide how to decide” and then to ensure that decisions were not reversed.

Dr Helmut Brand also spoke about the importance of public statements and risk sharing and ways of communicating the risks. All factors were relevant and should be taken into consideration; that was why risk communication was very important. It was one thing to set up regulations but another to implement them. There was a lot of talk about public participation, which was important but had to be ensured in a transparent manner. In the end, the rule of law applied and the perception that zero risk was achievable was a real problem. There would always
be disagreement on the outcomes and decisions, but it could help to minimize the legal battles and protests.

ECO-Forum agreed with the previous speaker and explained that children were at the heart of its own work. In the Netherlands, increasing numbers of children had difficulties in learning and scientists believed that that could be a result of neuro-toxic chemicals introduced into the bodies of newborn babies. They were usually pesticides which did not necessarily harm adults but which, in the long term, did affect their children. It was therefore important to keep in mind the long-term effects of decisions and not only to consider the immediate outcomes. ECO-Forum called upon the panel, as local, regional and national policy-makers, to draft standards, norms and legislation taking the long-term impacts into account.

Belgium declared its support for the work of the WHO Regional Office for Europe in finding ways of working in partnership with new stakeholders. With regard to public participation and the role of local councils, Belgium felt that public participation was a real challenge and a fundamental right, as indicated clearly in the Århus Convention. Good public information was essential to deal with environment and health problems. It was also important to integrate policies and the Health in All Policies approach. The subnational authorities in Belgium had legislative powers and therefore integration was important at that level and also because of the increasing level of globalization in the world. The interplay between all the levels was important in ensuring that citizens were protected at the local level from effects from the global level.

DG Sanco expressed concern that members of the panel felt that environment and health issues were doing well in their regions. That was not the message that needed to be communicated to the public. The public was a stakeholder, and it was important to learn what to tell them to encourage them to reinforce the process. Awareness-raising and information on ways in which they could contribute were very important.

Austria also emphasized the need to improve communication with the public. It was important to translate scientific language into normal language that could be understood by the public. Employing public relations and communication officers experienced in risk communication was very important.

Kyrgyzstan thanked all the panellists and agreed that all the experience shared was very useful and should be taken into account. In Kyrgyzstan, the creation of rural committees to catalyse the decisions about rural development and their impacts on health was working well. Together with the Swiss Red Cross, a project called “Jungal’s scare model” had been developed. In the model, the population at large was faced with problems that they could expect to encounter in everyday life. The involvement of all stakeholders in solving problems at regional and municipal levels and the involvement of nongovernmental organizations (NGOs) and different population groups was very important, as was experience-sharing.

The youth group explained how their network operated at national level to contribute to the implementation of projects at local level. Projects initiated by young people were then picked up and expanded on by others, including NGOs and other stakeholders. That was why the EEHP needed not only to consider ways of working with new stakeholders but also to consolidate ways of working with established ones, such as young people themselves. There was still no proper structure for young people to work together and that was why a call was being made for the issue to be addressed.
Sweden’s youth delegate highlighted the importance of young people as stakeholders and explained how she had begun as an official youth delegate on the Swedish delegation. A lot of work had already been done by youth participants, but there was still a problem of funding and commitment from Member States. There was a plan of work towards the Conference for young people to follow but it required support from the Member States. Young people were effective in advocating change, as they could create a ripple effect and raise awareness among those in a position to carry through the changes required into the future. Without a youth network, there would be less impact in the future.

Dr Apfel wrapped up the session by asking the panellists to reflect on the discussion and how it could be taken forward to the Ministerial Conference. A clear interest in participation and involvement of the public, including young people had been expressed. At local level, communicating and engaging people in the process helped to ensure a sense of ownership. Despite the values of Alma Ata and other WHO principles that had been established so long ago, Member States were still challenged by the task and it was important to make use of the growing momentum to further the agenda.

Dr Clini replied that the public should be a stakeholder in the process as they had the power to block the main decisions to be taken. Public participation should involve all aspects. It was the same population that asked for clean air while demanding freedom to use their cars. It was also the same public asking for free access to commercial services that protested against building incinerators. Therefore, a comprehensive approach was required and communication with the public needed to be ensured. Ways had to be found to consider, in the same framework, all the different needs and often contradictory requests of the public. The Ministerial Conference in Rome could help to ensure an exchange of experiences, and that would contribute to integrated risk communication in addressing the different and contradictory requests from the public, and thus to manage the public participation process without conflict, if at all possible.

Dr Stefanini felt that the real challenge was to translate scientific knowledge into public knowledge, as it was one way of ensuring the participation of the public as well as of policy-makers. Evidence-based policy-making was possible, as scientific knowledge existed in abundance and its implementation would already take a very long time. As a public health physician, Dr Stefanini expressed concern that researchers lived in ivory towers, concentrating on publishing their work in esteemed journals rather than promoting its use in policy-making. To be able to achieve change, it was important to become communicators and to pass on the knowledge, so that policy-makers and the public could understand it.

Dr Greco said that the responsibility of decision-makers in the environment sector was transferred to the local level. Very frequently, the local level influenced the decisions made, which were thus indirectly influenced by the public, since it was the public who elected the local council, including the mayor. It was important that someone should take responsibility for the decisions, especially so that commitments such as those made at ministerial conferences could be implemented.

Dr Brand agreed that it was all true for both environment and health. He referred to the problem of global warming where it was not clear exactly what would happen and yet decisions had to be taken. The fact had to be faced that some decisions had to be made without the evidence. “No decision” was also a decision and hence training was very important for decision-makers.
Dr Apfel summarized integrated risk strategies and risk management strategies dealing with contradictions between groups. That should be part of each RPG, to assist in the implementation of each objective. On climate change, there was a great need to elaborate mechanisms for dealing with uncertainty; the WHO guidelines could help in that. The importance of uncertainty was that it could create panic in the public but the reality was that, being honest and being able to communicate the process helped to find answers and reinforced trust and public understanding.

Dr Menabde concluded the discussion by touching on the role of local government, which was an issue of territoriality. There was a need for collaboration. However, that was not always genuine. That was the reality of human nature and it had to be recognized that humans sometimes did not want to engage. When intersectoral collaboration did not work, it could be because people could not see the benefits of collaboration or did not really want to collaborate. It was important to face up the problem and to really believe that all stakeholders were necessary. That was governance, in all its complexity. It was important to create an atmosphere that promoted evidence-based decisions, but that had to be backed up by acknowledging who was really accountable for the end results. Within governments, health ministries were responsible for health but not for making sure that other sectors did their part in protecting health. It was important that health authorities should exercise their stewardship role, collect the necessary evidence, promote and advocate health-related issues to other sectors, and then let them take their own decisions. But the health authorities had to be accountable for that. Currently, no minister of health was assessed on the basis of their influence on other sectors to improve health, but rather on their tangible achievements. The ministers must clearly understand that they were stewards and had to be accountable for the information flow to all the stakeholders and hence the adequate involvement of those stakeholders. Another point to consider in the debate was values in life. There was talk of changing habits, but values were different for different populations and cultures. Some societies were more aware of environmental values than others. Hence, environment and health was not a priority on the agenda of some governments. Irrespective of the evidence provided, that would always be the case and it was important to make allowances for such cultures and work around the trade-offs that such countries were ready to make. It was straightforward to convince countries that thought in the same way, but more difficult to learn how to address different values in different parts of the Region. Generating targeted intelligent information on what mattered could therefore help. That was the core of the matter and could not be done by looking at individual factors. Everyone would be collectively responsible for its failure; equally, together, everyone could make it work.

At the end of the panel discussion, the Chairperson decided to return to an agenda item from day one, “ensuring change at national level”, on which the discussions had not been completed.

Session 1 – Ensuring change at national level (continued)

Dr Jon Hilmar Iversen explained that that session had been organized to promote evidence-based policy-making in the Member States and invited Dr Lucianne Licari to explain further.

Dr Licari explained that the Environment and Health Performance Review (EHPR) was a way of ensuring cross-sectoral collaboration on a national level. Through that process, sectors would come together to discuss issues and problems, identify existing policies across sectors and also discuss how to draw up policies and plans in common at national level. There were 16 EHPRs scheduled for the coming months before the Ministerial Conference and the overall report would be presented at the Conference. Slovakia was one of the first countries to finalize its EHPR and
would present the experience as an example of planning environment and health policies and actions at national level with cross-sectoral collaboration between a number of ministries.

Dr Clini then invited Dr Katarina Hazlova of Slovakia to present the EHPR of her country as a demonstration of achieving change at national level. Dr Hazlova explained that the project on the implementation of the Budapest commitments was funded by DG Sanco and centred on EHPRs. The objectives were planned as a way of providing assistance to Member States in planning and implementing environment and health policies at national level as a follow-up to the commitments undertaken at the Fourth Ministerial Conference. A detailed EHPR should be one of the main ways of ensuring that evidence-based actions addressed children’s environment and health issues. Other countries participating in the project or requesting EHPRs included Belarus, the Czech Republic, Estonia, Finland, Kyrgyzstan, Lithuania, Malta, Montenegro, Poland, Serbia, Spain and the Former Yugoslav Republic of Macedonia. The final report of the project, with recommendations for action, would be collated into one environment and health situation analysis and presented to the Ministerial Conference in 2009. The DG Sanco project aimed to further strengthen the European Environment and Health Process, to better understand the role and responsibilities of all stakeholders in the process and to underline the need for effective measures, including the utilization of proper international instruments to reduce environment and health risks. The EHPR examined the policy and relative institutional frameworks within a country and then provided guidance on better planning of intersectoral interventions required to address existing environment and health priorities. That would be done through interviews with all sectors, key stakeholders and policy-makers responsible for environmental health determinants that made possible an extensive assessment of baseline conditions, trends, policy commitments and institutional arrangements in the country.

The main objectives for Slovakia were to find out how well health policies were designed to address environmental determinants and whether they were in a position to respond to the challenges. Slovakia also wanted to know how well its environment and health policies were already integrated into existing national plans, what principles and policies existed around environment and health issues, and how well they were being addressed or implemented. It wanted to compare the environment and health situation prior to the first NEHAP to the current situation to see if there had been any change within the country and to identify if health policies had, indeed, been integrated into policies of other sectors. The project group consisted of three teams: the WHO team, a team from the public health authority of the Slovak Republic, and a third team of stakeholders and professionals from other sectors. The EHPR involved interviewing 30 individuals from 17 institutions including 8 ministries. There were three key steps: the preparation phase, the implementation phase and the evaluation phase, which resulted in a report that was endorsed by the Slovak side. The main outcomes were the identification of existing legal and institutional frameworks and the human capacity required for the implementation of environment and health policy, a tailor-made assessment of the principles, measures, methods and instruments in environment and health, and a critical review of the openings in the existing system for implementation of environment and health policies. Suggestions for adjustments in view of effective environment and health performance were very useful.

The main conclusions of the Slovak report were that the current government programme stressed health care rather than public health. There was not enough reliable data in the institutions and the data that did exist came mainly from monitoring programmes led by other institutions. Moreover, there was no linking of data between environmental factors and health effects. Health impact assessments needed to be strengthened further. That was exacerbated by the lack of
awareness of environment and health issues within the country that then led to lack of commitment of financial and human resources to those issues. Also, all actions by different sectors were fragmented and not transparent. Dr Hazlova explained that the NEHAP was a governmental programme well recognized and approved by all ministries, with all sectors well represented. It was therefore an important platform for addressing environment and health. The findings of the EHPR were strong arguments that could influence the policy-makers’ perceptions to bring about changes required in both the health sector and other areas. Dr Hazlova also shared her personal experience of organizing the EHPR in the country, arranging the interviews and collecting the materials required. Most documents and policies were available in Slovak but, despite that, there still was a marked lack of materials for both the public and the government. The EHPR had therefore helped to win recognition of the existence of those problems and to ensure the enforcement of existing policies, which required increased information flow and dissemination. The next steps included a national workshop for decision-makers where the report would be presented and discussed to achieve agreement on implementation of its recommendations. In order of priority, a strong national information system was needed to provide the data required for decision- and policy-making. Secondly, health impact assessments needed to be developed and used. Another priority was to improve capacity for environment and health and to make space for new stakeholders in providing the services required.

The Chairperson invited comments from the floor.

ITUC requested clarification on the policy advice received in the context of the EHPR. Dr Hazlova explained that the review highlighted the gaps in policy; representatives of WHO were to speak with high-level officials in the ministry in that regard. That was important, as it was ministry officials who could make such changes. The State Secretary and other important figures were involved, and WHO had managed to convince them of the need for the changes. The EHPR was therefore instrumental in ensuring some effective action at the key level of government.

Belgium referred to a similar process under UNECE – the Environmental Performance Reviews (EPRs) – and asked WHO to take them into consideration, especially since the EPRs had been so successful in influencing the development of National Environmental Action Plans.

The secretariat explained that the EHPRs were a further development of the EPRs; WHO had broadened the scope of the EPRs to ensure that public health was properly assessed.

**Session 5 - Specific needs of newly independent states and south-east European countries**

The Chairperson invited Dr Maria Haralanova, the representative of WHO Regional Office for Europe responsible for public health policy, to present the ongoing work with the NIS and SEE countries.

Dr Haralanova explained that her focus was to show the needs of the countries’ health systems, and that they were highly relevant to ensuring the implementation of environment and health policies. The NIS and SEE countries had first asked for specific attention and support at the Fourth Ministerial Conference in Budapest in 2004. The assistance requested was specifically related to the issue of the sanitary and epidemiological services “SANEPID”, which were equivalent to the public health systems in western states. WHO recognized the need to support those countries and was encouraging the wealthier countries to assist through financial and
technical assistance. Over the two days of presentations, Dr Haralanova had heard the call for implementation at national or subnational level, evaluation of what was being done, strong information systems, and reliable information for decision-making, as well as, the need for continuous political will and commitment to vulnerable populations. The discussions had all been related to how health systems performed and, indirectly, to the further economic development of those countries. To achieve health gain, a health system needed to produce a variety of health services - personal, community or population-based services. It also needed to work closely with other sectors to ensure that they produced health impacting interventions. Only that could lead to good health gains. Hence, a health system went beyond the perception of health care, and the Ministerial Conference would emphasize that aspect. The NIS and SEE countries had inherited health systems from the past; they needed to be further developed as they were old and inappropriately financed, and skills and human capacity had been neglected. Intersectoral approaches were inexistent and environment and health did not work together. The countries needed to upgrade their laboratories and human resources, to be taught new approaches and to formulate new monitoring programmes. WHO was therefore proposing that the countries in need should work together to share experiences and learn from each other, eventually to ensure that all the necessary environment and health reforms were carried out. WHO was already assisting with the assessments and was documenting and sharing information from other parties. However, there was a need to strengthen cooperation with other external players towards better operational models and financial and technical advice. The presentation from Kyrgyzstan would show that it had been done and it was possible. Multi-country initiatives on a subregional level were very helpful, especially around specific areas of reform; that was the objective of the meeting to be held in Kyrgyzstan so that the countries could come together to address the issue together.

The Chairperson invited Dr Sabyrjan Abdikerimov, Deputy Minister of Health of Kyrgyzstan to share his experiences and describe the challenges encountered by his country in trying to modernize the environment and health monitoring system. In Kyrgyzstan, water was an acute problem even though the country was rich in water resources. Many pipelines supplying water were worn out, many water purification systems were out-of-date, and 20% of the equipment was not of an acceptable quality. Fifteen per cent of the population did not have access to the centralized system. The economic difficulties had led to the collapse of the system and there was currently no unified system for supplying rural areas. Rural supplies were currently run by rural consumer services, with the consumers responsible for water distribution. That resulted in lack of water quality controls and hence many people were exposed to contaminated water, and outbreaks of typhoid, as well as other waterborne diseases, including viral hepatitis and dysentery had been registered. There was a correlation between the incidence of infectious diseases and water consumption. There was also a problem of chemical contamination of water, resulting in a correlated increase in kidney problems in children, there being a 7–8 times higher incidence in south than in north. High levels of fluorides were resulting in tooth decay: up to 84% of children had problems with tooth decay, and fluorides in water had to be addressed. From 2002 to 2007, the Asian Development Bank and the World Bank had allocated funds for the construction of water pipelines in rural areas. The funds totalled US$ 8 million but that was insufficient. The sanitary and epidemiological service was primarily responsible for quality control, and water was often below the accepted standards in terms of contamination. Four different tests were conducted for microbiological indicators, and 30% of results were below the acceptable standards. One of the priorities was to ensure high standards for drinking water, but there was a need for an efficient system of monitoring. Staff needed to be trained, and an additional US$ 30 billion was to be awarded for that. It was important to reduce the number of outbreaks, and information dissemination and health promotion were priorities. Dr Abdikarimov
also spoke about injuries and mortality from road traffic accidents in the country. Disability was increasing, with more than 4000 children in 2006 and 4300 in 2007. Violence and injury had been addressed at several conferences such as one in Bishkek on safety on roads. Many people had been trained to deal with personal and family violence, and a number of centres had been set up to ensure adequate support. Gender equality was an important issue in the country and equal access to trades, goods and services was strongly promoted. The public health system used the interdisciplinary approach and was evidence-based. In follow-up to Dr Haralanova’s presentation, Dr Abdikerimov stressed that reforms had begun in 1997, with structural changes starting in 2000. The country was currently building capacity and focusing on financing systems and improving rural health. Rural health committees, with the involvement of NGOs and agencies, were instrumental in that. He urged all his colleagues to take courage and reform their SANEPID services as he who climbed the mountain would master the road. He encouraged the move away from the rigid regimes inherited from the Soviet era towards one of partnership and collaboration. As a member of the World Trade Organization (WTO), Kyrgyzstan was driven by WTO regulations and it was important to use the modern system of monitoring and surveillance of communicable and noncommunicable diseases. There was need for more support in the form of equipment and for a review of some of the internal functions.

The Chairperson then opened the floor for comments.

The former Yugoslav Republic of Macedonia expressed concern that the agenda item was being discussed at the end of a long day, as the subjects of discussion were driving forces for everyone. The political systems influenced the achievements of public health and WHO was championing the area in trying to establish linkages between the NIS and SEE countries and the rest of the Region through the network of nine countries (Albania, Bosnia, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia) who were working together on the WHO project to evaluate public health processes. The project required financial and technical support. He also suggested that the other countries could learn from the lessons of the subregion, especially since the old system was not entirely wrong, and a lot of environment and health programmes were attached to it. A number of countries had mentioned work at the local level but, in the SEE countries, it was the public health services that were relevant to monitoring environment and health issues, and that emphasized the relevance and importance of the work.

Finland praised the two presentations especially in relation to non personal health services. The recommendations would be forwarded to colleagues in the World Bank as an example of how WHO was leading the way in reforming public health systems in the subregion.

Italy appreciated all the initiatives to bring forward such changes in the subregion. However, it would be pointed out that the main objective was to improve health policies in order to address environmental determinants, but also to prevent environmental effects that could backfire on health. Said collaboration was important, and the two objectives should be discussed at the same time. The countries should have common responsibilities and the EEHP should take that message back to them. That focus should ensure collaboration, shape the environment and health reform and identify specific cooperation activities that would address both the public health systems and the environmental challenges. There were huge interactions between the two, for example, all the problems around the Aral Sea. Bulgaria noted that a review by the SEE Network of public health services had identified areas for improvements such as multisectorality and primary health services. Although it was a new
member of the EU, Bulgaria still needed assistance in providing such services. It supported the WHO initiative to strengthen the capacity of environmental health services.

Serbia supported the discussion and the statement by the former Yugoslav Republic of Macedonia about public health institutions in NIS and SEE countries. The main point was how to apply a public and preventive approach rather than a patient-oriented approach in the old network of public health systems. The network also needed to be modernized and positive experiences, especially in the environment and health area, shared. That was the real challenge for this subregion: not to destroy but to improve and take forward what worked well, and then improve upon it. Serbia thanked Kyrgyzstan for the encouragement expressed. The SANEPID system used an old-fashioned approach on environment and health monitoring that was common to the subregion. The existing network could help to improve monitoring systems to meet the needs of the modern environment and health approach.

**Wednesday 12th March**

**Session 5 - Specific needs of the newly independent states and south-east European countries (continued)**

Dr Jon Hilmar Iversen, the Chairperson, opened the morning session with an item left from the previous day. He invited Albania to speak.

Albania expressed full agreement with suggestions made the previous day related to the restructuring of public health services. Albania’s sanitation and hygiene service had existed for many years; there was now a need for more experience from western countries. Technical and financial resources were necessary for countries to reform their services, so Albania was pleased that WHO had put the topic on the agenda. Some assistance had been provided under the Biennial Collaborative agreement, but more was needed, especially to promote the multi-country collaboration that was proving so successful.

The Republic of Moldova expressed gratitude Dr Haralanova for the presentation and for raising awareness of the need to reform the epidemiological system, as well as for the provision of materials and funds for the service. It was important that WHO was ready to provide assistance for the reform. Over the past 17 years, the Republic of Moldova had tried to preserve the existing system but improvements were being made. There was a need for drastic steps to be taken. The Ministry of Health had set up a special directorate of preventive medicine, the intention being to reform the service. The presentation by Kyrgyzstan, with its experience of reforms, was particularly interesting. The Republic of Moldova would like to hear more about what Kyrgyzstan had done and the problems encountered in carrying out reforms.

Armenia stated that the need for reform was a result of the overall situation; private industry was changing the way it was working and that was driving the changes in the country, including, to a certain extent, the changes in legislation. Since the most recent developments, there was a problem in that all those with a diploma expected to be treated as public health specialists, even if they were not fully specialized. It was therefore important to ensure capacity-building, especially of specialists, as that would help to promote and deliver the changes for the reform. Training in new ways of risk assessment and burden of disease was an extremely important tool.
in helping countries to communicate the risks arising from environmental factors. Reform was necessary but had to be accompanied by capacity-building.

ITUC thanked the speakers and focused on two points. The Kyrgyzstan example showed that the concern about the widening gap was justified and, if the countries were to view themselves as a region, there was a need for western countries to consider the cost–effectiveness of investing in the NIS and SEE countries. It was very important to bridge the gap between the different parts of the Region. The second point was that the example from Kyrgyzstan showed that the added value of combining environment and health issues and that it was more effective than looking at health alone. Preventive measures were more easily identified and, although more effective health systems were certainly needed, it was important to prioritize the health needs arising from environmental factors, and the combined efforts that would result in effective solutions. ITUC thanked the Polish delegation for raising the issue of the Kyoto Protocol the previous day.

Finland commented on the previous day’s discussion and stated that all the EU countries had prepared strategies for sustainable development in which the two issues of environment and health were addressed together. Such documents also existed in eastern countries such as Kazakhstan, which had an excellent action plan on how to address sustainable development. The documents were available at national level and could prove to be very useful.

Croatia referred to the intervention made by the delegate from the former Yugoslav Republic of Macedonia on the previous day, and agreed that the countries of south-eastern Europe had played a substantial role in developing public health in the previous century. Croatia had invested substantially in building up the network of public health institutes, during the current transition period, other players had taken up some responsibilities such as for legislation but not for its consequences. There were 2000 experts stretched between marketing services and working autonomously. Institutional, legislative and financial backing for the public health systems in the countries of south-eastern Europe was therefore necessary. The delegate made an appeal to the SEE coordination group to help Croatia in the reform of the public health system. Croatia also spoke about the accession and negotiation process with the European Union, convinced that it was a strong tool for capacity-building. It was unfortunate that there were no documents in the Acquis Communautaire on environment and health reform processes; more should be made available.

The Chairperson then invited the speakers to respond to the comments made.

Dr Sabyrjan Abdikerimov thanked the countries for their support for the reforms taking place in Kyrgyzstan. He explained that, although presidential endorsement of the reform was still pending, he was encouraged that the President had expressed commitment to the reform as a national priority. Dr Abdikerimov believed that there would be drastic changes in the public health system over the coming 20 years, and that was why his country had asked WHO for technical assistance in implementing the reform. There was already a plan of action and, before the Fifth Ministerial Conference Kyrgyzstan was to host a small meeting to discuss the issues raised by neighbouring countries. He was pleased that the neighbouring countries would be able to see the outcomes of the plan, as well as to share common problems and experiences. He concluded by encouraging other NIS to have no fear of embarking on such a reform process and not to delay the decision. Step by step, they would see the changes taking place and benefits appearing.

Dr Haralanova thanked all the NIS and SEE countries and the colleagues from Western Europe who had committed themselves to strengthening services in the Region. She agreed that the
widening gap was still worrying and the need for action was great. Appropriate time for discussion of the issue would be allocated at the Conference. Through a stepwise process, it would be possible to upgrade both skills and performance. Armenia was right that reform was stimulated by the changed socioeconomic and political situation in the countries. She agreed on the need for tremendous change and promised that WHO would do all it could to support such changes in the sub region. A package of services was needed and had to be ensured and delivered to a specific level of quality. The work being done in Kyrgyzstan, Estonia and all the SEE countries had tremendous potential, as the countries had played a major role in driving the public health agenda in the past, and that had resulted in enormous achievements in combating communicable diseases. Hence, it was very important to ensure that the environment and health sectors act together to ensure positive environments to support better health and to bring down the costs of health care. The countries of south-eastern Europe had a clear line of action through their Network, and WHO would continue to support them, not only through the Network but also on a country-by-country basis. WHO would continue to collect and share western experiences. In Kyrgyzstan, there was an excellent partnership between the Swiss, Red Cross, the United Kingdom Department for International Development and the German government that had enabled change. She thanked Kyrgyzstan for offering to host the coordination meeting for the NIS in the autumn and assured those present that WHO would do all it could to scale up actions in time for the Ministerial Conference.

The Chairperson then postponed Sessions 6 and 7, in order to open Session 8 immediately.

**Session 8 - Healthy environments - The future for our children**

In a presentation on “Creating bridges to established political processes”, Dr Licari pointed out that one of the objectives of the Conference was to look back at commitments already made. However, the Member States had expressed a desire to look back to the rich experiences of the previous ministerial conferences and see what still needed to be done. The idea had been that each preparatory event would deal with commitments related to the RPGs being addressed at that particular meeting. The present meeting was looking at commitments related to RPGs 1 and 2 while the following meeting in autumn 2008 would look at commitments related to RPGs 3 and 4. WHO was also attempting to tie together previous WHO ministerial conferences and, for the purposes of the secretariat, Member States were encouraged to highlight what still needed more attention.

The Chairperson then invited Ms Ana Drapa, Chairperson of the Protocol on Water and Health to the Convention on the Protection and Use of Transboundary Watercourses and International Lakes, to speak about the Protocol.

Ms Drapa explained that the objective of the Protocol was to achieve human health through the implementation of adequate measures, both environment- and health-related. The Protocol was the first legally binding instrument to protect water resources and health. The countries were called on to ratify the Protocol and apply measures to achieve an adequate drinking water supply, adequate sanitation, effective protection of water resources, prevention, control and reduction of water-related diseases, and effective systems for monitoring and reducing outbreaks linked to water-related diseases. An important provision of the Protocol was that countries had to set targets in a number of areas, including safe drinking-water, sanitation, bathing water, agriculture and publication of information. After ratification, countries had two years in which to establish and publish targets with dates for achieving them, and three years in which to introduce
surveillance and early warning systems, contingency plans and response capacities. The CEHAPE was an important policy document that helped governments to focus attention on such issues. RPG1 had thus helped to reduce morbidity and mortality by ensuring that adequate measures were taken to address safe and affordable water and adequate sanitation for children. That could be better achieved by ensuring that all children were provided with safe water and sanitation, through better infrastructures for water. The implementation of national action plans helped to ensure that more households were connected to direct water supplies. Education campaigns helped further. According to the Protocol, countries should establish target dates in legislation and then allocate the resources required. The positive impact would contribute to the sustainable development of the countries. Cooperation among different actors and an adequate information system using the results of research was the government’s responsibility. Ms Drapa concluded by presenting some data on Romania.

The Chairperson then invited Dr Francesco Branca and Dr Hilde Kruz, representatives of WHO Regional Office for Europe responsible for nutrition and obesity, and food safety, respectively, to talk about the WHO Ministerial Conference on Obesity from an environment and health perspective.

Dr Branca explained that the main result of the Conference was the European Charter on Counteracting Obesity, and that brought a change to the way that obesity was addressed. The concept was to change the social, physical and economic environment to ensure that healthy choices were available to everyone. That involved a whole portfolio of choices while advocating legislation and acknowledging the importance of public-private partnerships. Collaboration was particularly important and there was a focus on lower socioeconomic groups. The goal of the Conference had been to reverse the trend by 2015. The Conference had considered a lot of policy developments, including the European Commission white paper on nutrition, The World Health Assembly was also working on more resolutions related to the non communicable disease strategy. Colleagues in north America had seen that Europe was taking lead in the area; Sweden and France were starting to report a flattening of obesity graphs but only in higher socioeconomic groups. Italy, Croatia, Norway and Portugal had also begun policy revisions. Some countries had committed more resources and established more intersectoral collaboration. The second WHO action plan for food and nutrition policy dealt specifically with diet-related non communicable diseases, obesity in children and adolescents, micronutrient deficiencies and food borne diseases, in an intersectoral manner, suggesting different interventions for implementation by different stakeholders. Dr Branca explained a few of the actions and the roles of the different sectors. He emphasized the importance of relevant information, including adequate labelling and marketing practices that influenced children. The importance of physical activity and environmental influence was also well reflected in the action plan, as was data collection for the purpose of monitoring and evaluation. WHO was currently trying to guide international action after documenting which actions worked best. The issues were global and action networks were a tool currently being promoted. Countries were being encouraged to exchange experiences and share best practice in three areas; marketing of food to children; salt reduction; and childhood obesity surveillance. Dr Branca concluded with the links between the two conferences, mainly related to the impact climate change on food security, especially the availability of food and vegetables, which was expected to decrease. Food production costs and the globalization of the transport and consumption of food were also environmental-related issues. Water and food safety, as well as physical activity in relation to land use, were also linked. Dr Branca encouraged participants to share their intersectoral experience so that the nutrition movement could learn from the experience of environment and health collaboration.
Dr Kruse spoke about food safety, arguing that healthy environments were particularly important. Access to safe and nutritionally adequate food was a human right. Food borne diseases were still a challenge, with 1.8 million deaths per year and 30% of population suffering from food borne diseases each year. Current knowledge of food borne diseases was only the tip of the iceberg; the actual incidence was much higher since food surveillance was still very inefficient, especially in the eastern part of the Region. The food borne disease burden was linked to pathogens, chemicals and parasites. Many acute food borne diseases could have long-term complications with sequelae for patients. Of the total estimated deaths from diarrhoea and cancers, many were food borne; however, there was a need to establish exact figures, as many diseases and syndromes that were actually food borne were not registered as such. Currently there was a large initiative to gather more data from the Region. The food safety chain was very long and it was important to look at it holistically, from farm to fork. Food safety was dependent on the environment, and affected by, for instance, industrial emissions and effluents. Food could be affected at any stage, from production to consumption. Several environmental factors affected food safety: pollution of water, air, soil and feed. Some food production methods increased risk of exposure to illnesses and included industrialized food production, the move towards more organic farming, letting animals graze freely, etc. Food scares in Europe such as those linked to bovine spongiform encephalopathy (BSE) or dioxins in relation to animal feed, irrigation with contaminated water, and the use of fertilisers and pesticides could impact on the health of the population. The use of antibiotics in food production, especially the misuse of antibiotics in animals, needed to be addressed. Urbanization posed risks in relation to food borne disease, and the longer food chain of today made everyone more vulnerable. The centralization of food production resulted in larger outbreaks of food-related disease; the way food was handled in the modern world, e.g. salad bars and street vendors, allowed pathogens to survive. Ecological changes could cause high temperatures that increased the risks from Salmonella; storms and flooding increased algal blooms and resulted in water safety issues. Population displacement was also relevant, as were micro toxins and bio toxins from an increased variety of viruses and algal blooms. The main goal of the Action Plan was the reduction of food borne disease. National food safety action plans were important and problems were best dealt with at their root. Prevention and control of food safety hazards required integrated action, including environmental action and interdisciplinary action. Scientific risk assessments were important, with systems that could monitor contamination at various stages of the system. International collaboration, including the introduction of rapid alert systems and information sharing, as well as targeted and tailored risk communication, remained very relevant.

Mr François André, Chairperson of the Transport, Health and Environment Pan-European Process (THE PEP) was then invited to speak about the latest developments. Dr André explained that the second high-level meeting of THE PEP had decided to focus on the promotion of safe walking and cycling and the dissemination of experiences through THE PEP clearing house, which was implemented by a steering committee, a bureau of 12 Member States (4 per sector) and serviced jointly by WHO and UNECE. It had a special focus on the countries of the Eastern Europe, Caucasus and central Asia (EECCA) region as well as countries in transition and was funded through voluntary contributions. THE PEP was a unique framework for the work of health, transport and environment ministries. Its programme of work focused on developing tools, providing guidance and exchanging knowledge across the whole region. The first concrete project was the clearing house and the development of a tool box for policy-making. Various workshops had been held on sustainable health, transport and land use planning in Cyprus, Moscow, Tbilisi and Telč; one was expected in the Republic of Moldova. THE PEP had also developed instruments to provide guidance on health impacts and the related socioeconomic costs; as an institution, it looked at integrated policy- and decision-making and provided a forum
for exchange on good practice. The most recent product was the guidance and methodological assessment of the economics of walking and cycling, that was accompanied by a visual tool to help estimate the mean annual benefit for cyclists, and the total benefit in terms of decreased mortality attributable to cycling.

THE PEP was currently planning its Third High-Level Meeting in January 2009, hosted by the Netherlands. It would then provide feedback to the Fifth Ministerial Conference on Environment and Health. The sixth meeting of the steering committee was to take place in Geneva in April 2008 and, in June 2009, a sub regional workshop was to be held in the Republic of Moldova. There would possibly be an extended ad hoc bureau meeting in autumn 2008. The key objectives of the high-level meeting were: to strengthen Member State’s commitment to policy integration at national level; to reinforce THE PEP’s role as a regional platform for promoting national action; to take stock of developments during the first decade of collaboration between the three sectors, i.e. from 1997 to 2007; to focus on the challenges of the NIS and the EECCA; and to identify priorities for future work. Three key documents were planned for the high-level meeting: ‘Transport, Health and Environment: the trends and development for the first decade; an assessment report by UNECE with a proper assessment of THE PEP, including recommendations; and the Declaration of the high-level meeting that would highlight the remaining challenges, strengthen the role of THE PEP, further the political commitment to further integration, and widen the partnerships, especially in terms of financing solutions.

Dr Andre then explained the structure of the Declaration, which would include one section on the challenges, one on the achievements, and a third on making the link. Regarding the latter, he said that THE PEP bureau had been inspired by the CEHAPE RPGs and intended to have three main priorities listed in that section. The proposed goals were: a) to reduce emissions; b) to promote health and safety; and c) to manage sustainable mobility and promote a more efficient transport system. The final section of the Declaration would deal with commitments to implementation, which could include the development of integrated plans on transport, health and environment, strengthening THE PEP by ensuring policy development and developing national action plans to integrate the three dimensions of those policies, also following up on the successful example of WHO.

Dr Licari was invited to update the participants on the forthcoming WHO Ministerial Conference on Health Systems, Health and Wealth. She explained that the Conference aimed to achieve a better understanding of the impacts of health systems on people’s health and economic growth, as well as to take stock of recent evidence on effective strategies to improve the performance of health systems, given the increasing pressures on them to ensure sustainability and solidarity. Dr Licari cautioned that there was a difference between health systems and health care systems and the reason for discussing the Conference at the environment and health preparatory meeting was that environment and health was part of the broader definition of health systems. The intention was to link the two conferences. Dr Licari then presented all the documentation planned for the Ministerial Conference. The Estonian focal point was then invited to talk about the Conference. All the participants were warmly awaited in Estonia and expectations were high for the discussions, including those on environment and health.

The Chairperson invited comments from the floor.

Cyprus asked for clarification concerning the side event of the Ministerial Conference in Estonia. Cyprus also welcomed the presentation on food safety and stressed the need to consolidate the activities of the European Food Safety Authority (EFSA) under the umbrella of WHO; they
should be given more visibility, as a lot of action was duplicated. Cyprus asked for a stronger link and better coordination between EFSA and WHO.

Ireland thanked the speakers for their comprehensive presentations on a number of issues concerning food safety, there was going to be major pressure on food production because of the growing rising population and land use for bio fuels. There should be no compromise on food safety and the Codex Alimentarius should be protected to ensure the balance between trade and safety. In Ireland, there was a process that had weakened the hazard analysis and critical control points (HACCP) so that the system no longer applied to micro enterprises; however, such business were actually quite large. That was an issue for EU Member States and highlighted the future trends that they should be wary of.

DG Sanco welcomed the presentations, which had shown how the different processes, although directed in different ways, all tied together in environment and health. They adequately demonstrated that the EEHP was key to bringing the different elements together; the idea was to work towards a healthy environment setting, including mention of the health system Conference and further promotion of the obesity conference. The issue of health end points was also important and the focus of the discussion over the next year should continue to be on health.

The Chairperson invited Ms Ana Drapa to make final comments on the Water and Health Protocol, as she had to leave. Ms Drapa thanked the participants, who had emphasized the importance of the Water and Health Protocol and its use as a tool in implementing national actions. Such an instrument ensured that two ministries worked together and respected the targets of both the Protocol and CEHAPE RPG 1.

Finland spoke about maximizing opportunities between environment and health. The presentations had highlighted the need to find measures to promote better environment and better health, which was not always easy. There were often situations where there was conflict between the sectors and therefore an integrated assessment should be applied to any proposed measures to ensure that all the consequences had been considered. A case in point was obesity. In principle, solutions could be found to decreasing CO2 emissions as well as obesity; however, in most cases, solutions could increase the impact on the environment while addressing health, and therefore conflicts might arise.

WBCSD raised two issues; the role of hygiene in storing food had not been mentioned, and competition for resources.

Germany had drawn up an action plan to tackle obesity; that was also the priority of the three presidencies of Italy, Portugal and Germany. It would be very useful to share the experiences of the EU and WHO, so that they might learn from each other.

Italy welcomed the concise messages in the presentations, many of which had referred to policy tools such as the Water and Health Protocol and THE PEP. Those were excellent examples of how to implement national strategies and should therefore be used as preferred tools and instruments instead of inventing new ones. For example, it would help if the Water and Health Protocol monitored implementation of RPG 1. Under the Water and Health Protocol, there was a new task force on extreme events and health, looking at the impacts of climate change on health in relation to the water cycle and the effects on health systems. The food safety approach as a life cycle approach could also be very interesting, especially in order to understand all the implications and the differing impacts. It could help the two sectors to better understand the
effects of their actions. THE PEP was the most advanced tool available but it could be difficult to apply. Italy felt that the tools should be mainstreamed into the EEHP and not just linked indirectly.

Armenia noted that, since the previous ministerial conference, there had been a further deterioration in food safety in Armenia. More attention should be paid to trade globalization and the International Health Regulations in the area of food safety. Countries were having difficulties in implementing the International Health Regulations with regard to chemicals, etc. However, those in relation to food safety were important and assistance was required in understanding how to implement them. There were stricter safety norms for the use of the Codex Alimentarius. Armenia was surprised that it needed to reduce the norms and standards, whereas it had in the past simply followed the Codex Alimentarius, as recommended by the World Trade Organization (WTO). Public health services and public health safety were a similar issue. There had been changes in institutional structures which countries needed assistance to deal with.

Kyrgyzstan agreed with Armenia about the problems in adapting national systems to the Codex Alimentarius as it, too, was a member of WTO. For that reason, Kyrgyzstan requested documents on the Codex system itself, as well as on amendments to the Codex in Russian. Any technical assistance for the implementation of such policies would be welcome. It would take a lot of time and effort to organize the translations itself.

Norway welcomed the interesting presentation. In 2009, there would be the environment and health conference as well as the high-level meeting of THE PEP; hence, if there was to be a further ministerial conference in 2014, it might be a good idea to include the transport sector as they should have common aims.

Dr Branca agreed that there was a need for an environment impact analysis in nutrition; it was an interesting tool that would assist implementation. A common assessment would contribute to the evolution of the health system. As Germany had mentioned, the successful project on obesity showed that preliminary successes could be recorded but work still needed to be scaled up and taken across sectors. The joint work with the environment sector was certainly one of the requests and there was a possibility of a joint activity at the end of the year, to be promoted by Slovenia.

Dr Kruse replied to Cyprus that it was important to collaborate with EFSA and that there were discussions on how to harmonize the assessments. The importance of hygiene was central to the food safety issue. In reply to Armenia with regard to trade and globalization, and the challenges to the Codex Alimentarius in setting standards for food in international trade, there was still a focus on public health issues. All countries were encouraged to attend meetings of the Codex Alimentarius commission; there was a trust fund that provided support for attendance by developing countries. With regard to the availability of documents in Russian, there had been increased activity, as Russian was one of the official languages and more and more documents were becoming available in Russian. The importance of surveillance programmes for different diseases, including waterborne diseases, could not be underestimated.

Dr André thanked the participants for their comments and recognized that it was indeed very difficult to ensure collaboration between three sectors at a national level. That made THE PEP a more useful tool at national level, as it could be a facilitator.
Session 7 - Inequities in environment and health

The chairperson then invited Dr Paul Wilkinson from the London School of Hygiene and Tropical Medicine to deliver his presentation on “Addressing socioeconomic inequities within countries”. Dr Wilkinson explained that deprivation was related to illness but illness also gave rise to socioeconomic deprivation. The more deprived were also more exposed and, even starting with a level playing field, it could still lead to deprivation. Poorer people tended to be more exposed and it was a fact that richer people had a choice to live far away from the exposures. That was not the case with transport. In general, those with higher levels of deprivation tended to have slightly higher exposure. That was not very different from richer populations who chose to live in city centres. When looking at road traffic accidents in the higher professional workers as compared to ordinary workers, there was a mild gradient of risk which became more dramatic with more vulnerable populations, and even more with cyclists and pedestrians. That also held for air pollution exposures. When looking at the number of homes in the United Kingdom with access to cars, the central London area had modest car ownership, and traffic pollution was worse in urban areas with a resultant higher level of index. Hence, the owners of cars generated higher pollution in areas where the most vulnerable lived. There were also differences in who contributed to the risks. Black people tended to be poorer, to use the bus more and walk more, but they cycled less and hence tended to be more vulnerable. When looking at data from Greece, it could be seen that the vulnerable road users were cyclists and the pattern was different to that for car injuries. The people causing the problem were not the ones suffering more, who were really the very young and elderly. Looking at Greek data and testing for blood alcohol, it could be observed that, as the use of test went up, road injuries came down. As speed violations increased there was a small dip in injuries. It was impossible to make a direct relationship from that, but such things were difficult to interpret.

The priority should be on transport and encouragement of walking and cycling should be considered. The promotion of active transport could have beneficial effects on almost all of the issues being discussed. In the United Kingdom, there was particular concern with obesity resulting from lack of physical activity; less distance was being walked each year. Children were more physically active if there was no car. Car use was actually increasing in the country. The congestion charge scheme in London had led to a reduction in traffic entering the zone, although that had slightly increased because of increased bus use. There had also been a reported decrease in road injuries. Exposures to air pollution, especially to NO\textsubscript{2}, and the changes, albeit slight, in pollution were very impressive when translated into numbers of lives saved and quality of life gained. The change in physical activity was still to be measured but models extrapolated by the London School of Hygiene had shown that 15g of fat tissue per day could be lost and a decrease of more than 20% of all cancers and diabetes achieved. There were risks to pedestrians and cyclists when shifting activities. The preventable risk of cardiovascular disease was relevant for regular cyclists. At a young age, there was a net decrease in benefit because of exposure to an increased risk of road injuries. However, for a cyclist in the 40-year age group, there was a benefit related to cardiovascular prevention that was carried through to later life. Clearly, there needed to be imaginative schemes to continue to promote physical activity, and transport was one of the key elements to deal with environment as well as health. The congestion charge was not enough; bolder initiatives were required, with major routes for cyclists and walkers. Any economic gains were related to those benefits. There was direct and indirect evidence for a number of interventions and it was important to introduce population-wide measures, to ensure an overall gain. Some environmental measures should be top priorities for further action.
Dr Isabel Yordi was then invited to speak about “Gender inequities in environment and health”. Talking about gender and health meant talking about interactions between gender and health and what made men and women behave in different ways. That was not the same in all the countries of the Region. In considering inequalities, the different gender needs should be included in policy-making, as well as how outcomes related to social inequities and social determinants of health. The need to address gender inequities had been pointed out by the IMR and by the first meeting of the newly elected EEHC, when it recommended addressing them in a cross-cutting manner. That was very timely and in line with general WHO policies, as approved by the World Health Assembly in the gender strategy the previous year, with commitments for Member States. However, it was important to build national capacity to deal with gender issues, and the main tools for integrating gender issues into policies and plans need to be readily available. That required data from the Member States that would make it possible to see unfair or relevant differences between men and women. It would also help in allowing gender analysis and identifying gender discrimination. Gender needed to be integrated into management systems and, importantly, in ENHIS, to ensure accountability in all work done.

Looking at CEHAPE RPG 1, it was easy to see why gender issues were so important. Women and men had different roles in water provision and also different risks and vulnerability, as well as differences in terms of availability of water, as already described in the presentation on water and health. Studying RPG 2 highlighted huge differences in physical activity and, through a life-course approach, it could be seen that, while girls began physical activity around puberty and boys remained active, the genders made different use of their spare time, resulting in different health outcomes. Access to resources also differed, as women tended to be in a subordinate position in some countries. Boys were generally more active than girls and the expectations of society were such that 15-year-old girls had a different self-perception. That resulted in them worrying about obesity more than boys and hence, obesity was more prevalent in 15-year-old boys. Differences between boys and girls also depended on the location of the home, as it was usually the man’s occupation that dictated the location of the family home. There was also a difference in domestic violence, and boys were more prone to drowning. Road traffic accidents showed differences in mortality and morbidity between men and women, with men more likely to have road traffic accidents and injuries, since they were more likely to drive under the influence of alcohol. But, even in areas like climate change, gender and poverty were inter-related and, in most disasters, women were more affected, at a 3:1 ratio. That was not only because women were less strong but also because they were less encouraged to swim in certain societies and hence more prone to drowning in extreme events such as flooding. Heat-waves also affected women more as they reacted differently to extreme temperatures; the same was true for skin cancers, which were dependent on exposure to sun. In conclusion, gender issues interacted with other issues such as poverty and gender inequalities determined the impact that the environment had on the health of men versus that of women. Gender norms and behaviours determined the various risks and protective factors, as well as the response of the health system, while gender-based discrimination prevented women from equal participation in decision-making.

The main challenge was the lack of sex-disaggregated data. Unfortunately, even where such data was available, it was not used. It was important for countries to learn how to collect such data, how to use it and analyse it to understand better what needed to be done through appropriate recommendations. Most of the evidence came from developing countries but more data from other countries was needed. Gender as a cross-cutting issue could actually present a larger challenge as it could tend to become invisible if only dealt with in that way. Dr Yordi therefore
made an appeal to continue to work on gender-disaggregated presentations and maintain attention on that priority.

The Chairperson invited comments from the floor.

ECO-Forum applauded the initiative to work on gender issues; a working group would help to focus on gender in data collection. Gender economic analysis was the starting point for all ECO-Forum projects and it was not stereotyped in the European Region. There were quite a few differences in the sanitation area, and surveys showed that women put more priority on clean water and sanitation and suffered more when water was unavailable. Women also did not have access to investment funds required to ensure access to water and sanitation. It was thus important to check how investment and funding opportunities were geared. ECO-Forum reiterated the World Bank statement that if one invested in women, one invested in all.

ITUC also agreed that gender issues were very important. There was a strong link between the two presentations. As women were often paid less for doing the same work as men, very often they were victims not only of gender discrimination but also of economic discrimination.

Italy commented that the two presentations underlined how to address a good environment and health policy, especially in relation to cross-cutting issues. For example, with flooding and climate change, it was seen that women were the major victims. Hence, even in climate change, gender issues were important.

Austria added that following gender research in Austria on transportation and emission impacts, it had been found that women were the ones mostly affected. However, 96% of project managers of transportation in Austria were men, despite the fact that women were the victims.

Uzbekistan also commented on bans on motor vehicles entering a city as a means of addressing social inequities. That was not necessarily the best way to solve the problems. In the case of air pollution, installation of check points for vehicles entering the city and checking composition of exhaust fumes could be more productive than imposing a ban in general.

Dr Wilkinson replied to the comments and acknowledged that several people had identified the strong links between gender and inequities. He had not mentioned climate change, as the focus of his presentation was inequities inside countries rather than between countries. Those equity issues were one as part of the responsibility to take action against climate change. In response to Uzbekistan, Dr Wilkinson explained that he was not advocating a ban but, rather, the promotion of safe access to walking and cycling. Just tracking emissions was not going to promote walking and cycling, or to affect road injuries, noise or indeed the climate change agenda. Therefore, transport policy needed a balanced response but a broad overview.

Dr Yordi replied that the meeting would help to promote gender issues. She supported the idea of having a working group. It was important to consider the inequities issue, as pointed out by ITUC, and to look at women as agents of change. Women could make a difference if they became more involved, and a special message addressing women’s behaviour at the Ministerial Conference would be very good.
Session 6 - Understanding economic influence on policy-making

The chairperson then called on Dr Marco Martuzzi, a representative from WHO Regional Office for Europe responsible for health impact assessments, to speak about “Influencing environment and health decision-making through economic data”. Dr Martuzzi reminded those present that economic tools for evidence-based decision-making were mentioned in the Budapest Declaration and confirmed at the Intergovernmental Midterm Review in Vienna in June 2007. There was a very attractive argument in political terms for making the arguments for environment and health collaboration explicit in monetary terms. The methodology in various domains, including environment and health, had developed quite substantially in recent years. Many examples could be used, e.g. the work on clean air by the European Commission and that by OECD indicating that the cost of mortality attributable to PM in 25 countries of the EU had grown from 156 to 181 billion euros per year. On climate change, the recent report indicated a large cost of inaction, of between 5% and 20% of GDPs, as opposed to the cost of action, which was substantially less. On transport, it had already been stated that the health-related costs of current transport policies in Europe were in the range of 6% to 8% of GDP. That indicated the economic sense of adopting certain policies. The OECD was investing in web-based tools for cycling and walking in the framework of THE PEP; different actors could use the tools, attaching them as a supplementary argument to the traditional health impact assessment. Its application raised a number of issues: while there was overwhelming evidence that taking certain actions was of tremendous benefit to health, environment and the economy, there was as yet only a low response. Where there was a less clear picture, it could be questioned whether such assessments were always reliable. The issue of discounting in certain assessments (i.e. that benefits gained tomorrow were a little less valuable than those gained today) such as in the case of climate change could result in the issue being devalued. Other factors were the overall costs and benefits and the issue of whose costs and whose benefits were actually concerned with. It was also extremely important how the experience was related to the EECCA countries, where the setting was slightly different to where the applications had been tried. An expert workshop jointly organized with the EC and the European Environment Agency (EEA) had been held in December 2007, with a report to be published soon; some of the outcomes of the discussions indicated a need for refinement. However, it was important not to rely on the refinement alone; the need for data to feed the economic assessment as well as its evaluation was more critical. Such assessments could provide additional information for the process of decision-making without being the final word on whether a policy should be applied or not. The question of international comparability and the needs of EECCA countries was a priority, as was the need to invest in more work in the area. Its application in more practical examples was also very important.

The Chairperson then invited Dr Franck Ackermann to talk about “The use and misuse of economic tools”. Dr Ackerman focused on cost-benefit analysis and the fundamental assumptions and limits that existed for it, as well as other methods that could be used for economic assessments. He explained that cost-benefit analysis (CBA) quite suddenly became the most promoted way of evaluating a policy and had been used since the 1930s when it was mainly applied to the evaluation of building dams in the United States. Its use spread to the United Kingdom in the 1950s. CBA had some strength such as that it put everything into one metric measure and made them easy to compare, making it possible to screen out the things that cost too much. However, lots of tools were not right every job and, similarly, CBA was not applicable to every case. That was because it compared total costs to total gains, regardless of who paid. All costs and benefits had to be listed but there was no way to measure quality of life or other vague measures. Hence, economists tried to invent economic values just to be able to use the tool, and that could distort the picture. There was also the question of how to deal with uncertainty. CBA
was useful only when the assumptions made were acceptable but, if they were too simple, such a tool could not work. It was important to think more creatively about what might work other than simply CBA. First of all, one could choose to ignore equity and income distribution; or people tried to make up values for equity. There was no universally accepted way to include a value in CBA. To complicate the picture further, some actions and policies improved health but were detrimental to the environment and that conflict of costs was very difficult to show in CBA. Every benefit had to have a monetary price. Health and environmental prices were needed for health and environmental benefits but what was the price of a life or of an irreplaceable ecosystem? Through a number of examples, Dr Ackermann explained how CBA had been used in health and environment issues to reject applications or project proposals; that was not entirely right as there was no consideration of equity. There was also a problem when measuring benefits, as prices were not reliable as that involved making up prices for things that had no prices. Dr Ackerman spoke of the costs of removing arsenic from drinking-water as an example, explaining how engineers’ financial quotes were readily accepted but how there was a problem with calculating the benefits. Arsenic caused terrible cancers and death but how could one calculate the cost of such morbidity and mortality? Another example referred to the health impact assessment on building cooling towers on power plants which saved fish; however, it was difficult to define their worth as some fish were of recreational value and others of ecological value.

Dr Ackermann gave the example of climate change and rising sea levels and how insurance was applied in the case of rare events. He explained the fallibility of standards, extrapolated models and the costs attached to such disasters and health impacts, all inappropriately calculated. In conclusion, Dr Ackerman explained that there were multiple approaches to economic analysis of public policy. CBA, in simplifying assumptions, could be a powerful economic tool if used in an appropriate setting. Equity and income distribution, however, needed to be studied separately, while a holistic analysis of the benefits package avoided serious problems of valuation. Insurance against worst case risks was a valid basis for policy but it did not fit within the CBA framework. Cost–effectiveness analysis of meeting a fixed target was often appropriate and avoided many CBA limitations.

The chairperson opened the floor for comments.

Finland explained how they calculated the economic impact of environment and health problems using the assumption that 50% under nutrition killed over 5 million children per year and substantially expanded the environmental burden of disease. It questioned the statistics quoted that the impact of transport was really as high as 8% of GDP.

OECD said that the short life span of politicians affected the way they made decisions. OECD had published environment and health economic impacts that included the cost of inactions; it would be happy to collaborate with WHO on furthering that work.

The former Yugoslav Republic of Macedonia emphasized the need to convince politicians that it was time to take some important decisions. So far, disability adjusted life year (DALY) data had been used but it was unclear how to quantify that approach. The statistical systems were not yet in place so ways of ensuring that the economic data was presented needed to be developed. Changes to the education process should be considered, together with the type of people who could do the analysis until capacity was built up. A lot of countries in that part of the Region were only beginning to use economic data to persuade politicians; advice on how to proceed with such a tool would be very welcome.
ECO-Forum said that climate change was the main argument for returning to nuclear power, even in Italy, despite the fact that it presented no added advantages. Risks were still mentioned in the context of Chernobyl; with the economic approaches explained, it would be interesting to hear the recommendations with regard to the use of nuclear power.

ITUC pointed out that Professor Ackermann had not touched upon the cost–effectiveness analysis, and the outcomes of the calculations did not explain to politicians how the calculations had been made, or what assumptions had been used. Hence, there could be abuse of such a tool in that such analyses could shift the decision-making power from the politicians to the economic authorities. Politicians needed to understand the consequences of their decisions. In reply to Dr Martuzzi’s comments on why politicians were so slow, ITUC noted that they were elected for short periods and all changes had consequences for the people around them but there was very seldom the benefit of continuity; hence, the impact of a short-lived politician was like that of a pressure group.

Dr Clini spoke of the phasing out of nuclear power in Italy in 1987. The decision was currently being revised as an appropriate measure to address the problem of greenhouse gases. Italy imported 80% of its electricity from France, which produced electricity from nuclear power. Moreover, the price of electricity in Italy was much higher than in other European countries. Many other European countries such as Finland, the United Kingdom, and France were also considering investing again in nuclear power. Hence the discussion in Italy was in line with all the current discussions in the European Union about the role of nuclear power.

WBCSD thanked Professor Ackermann for an interesting presentation and commented that another approach was also in danger of misuse, like CBA. Hence, it was important to remember that different interpretations on the policy side could lead to very different decisions that would impact on the consumer.

Dr Martuzzi thanked everyone for their comments and explained that evidence-based policy would always be assisted by economic arguments, despite the fact that it was a tricky process. He acknowledged the contribution of OECD to the development of the economic tools and looked forward to more collaboration. The point raised by the former Yugoslav Republic of Macedonia was quite relevant and it was indeed important to use the tool critically. Expertise was required for its use and application. Hence it was important to strive for more knowledge and expertise to be more widely shared. The economic impact of transport was unbelievably large but that was linked to the very high mortality rates in road traffic accidents and hence the economic value given to life in Europe.

Professor Ackermann agreed that no system was politically safe from misuse or any objective tool that could take the decisions out of politicians’ hands. Economics did not provide an objective answer. The ITUC’s answer was that CBA should be used for prioritization but, unless complete information was available, there was no sense in comparing and prioritizing. DALYs and quality-adjusted life years helped to give a percentage value in comparison to a normal life year, and it was very unpopular to make economic decisions based on such measurements. Nuclear power was incredibly expensive because it was dangerous and it would not be logical to make it cheaper as that would mean cutting down on safety. Cooling water was very important and, in the light of heat-waves being experienced in Europe, it should be considered whether the electrical problem could be solved by using something that needed to be shut down in a heat-wave.
Dr Iversen called the session and meeting to a close with a reminder about the next major event in Spain in October. The Chairperson thanked the Italian hosts, especially Lombardy region, and all those who had contributed to the success of the meeting, including the WHO secretariat. On behalf of WHO, Dr Licari thanked the Italian hosts for holding the meeting, as well as the chairpersons of the meeting, and specifically acknowledged the WHO staff who had contributed to the success of the meeting, and the members of the Commission for their advice on preparations for the Conference. Dr Clini called the meeting to a close by thanking all those who had made the meeting successful, and looked forward to returning to Italy in October 2009.

Executive session of the European Environment and Health Committee (EEHC)

Dr Corrado Clini chaired the Executive session of the EEHC and invited Dr Michael Heubel of DG Sanco to talk about the priorities of the European Commission in the area of environment and health so that EEHC could discuss how the two processes could be aligned more closely.

Dr Michael Heubel spoke about the close interaction between the WHO EEHP and the EC’s Environment and Health Action Plan. He referred to the Intergovernmental Midterm Review, explaining that it had provided a first opportunity to examine the possibility of integrating both the research and the responsibilities of the two processes. Work on research and making research results available, as well as risk assessment methodologies, seemed to be common areas. In terms of policy-making, one area requiring more attention was that of raising awareness and involving health professionals. With regard to public awareness, indoor air quality was an issue gathering momentum, as were relatively newer priorities closely linked to the climate change agenda. There were also comparatively new areas such as links to nanotechnologies and themes around antimicrobial resistance that the Commission was interested in developing further. Dr Heubel spoke of the need to link old and forgotten concepts on healthy environments, where, by ensuring a safe and health-promoting environment, health could be preserved. The example of physical activity and better planning of recreational areas through land use planning was a case in point. It was important to ensure that the final objective was the achievement of health, as that was what drove the EEHP and made it unique over and above other processes. For that reason, it was important to ensure the further integration of health across other policies. The EEHP also needed to keep a focus on vulnerable groups, and it was important to mainstream outcomes of projects and continue the collaboration with the WHO Regional Office for Europe, creating more synergies for the future. The discussions that had taken place over the previous days were in line with the objectives of the European Commission and followed a similar direction. The Commission would support the next steps of the process.

Dr Clini referred to the link between climate change and international security. He explained that climate change could provide a strong framework for the integration of all policies and should thus provide the main impetus for the integration of environment and health.

Dr Michelidou-Canna of Cyprus hoped that the 2009 Conference would strengthen the commitment of Member States to implementation of the CEHAPE. Once again, Dr Michelidou requested that the title of the Conference should include the word “children” and proposed: “Healthy settings for children in a changing world”. Climate change was one of the issues that should be very strongly represented during the Ministerial Conference, and clearly linked with the objectives of the CEHAPE. With children as the main focus, there was reassurance in respect
of the sustainability of the process that started in Budapest. At the 2009 Ministerial Conference, the ministers would be new, and it was important to win their commitment at national as well as international levels. With regard to addressing vulnerable groups other than children, it was important that it be done in a focused way, and making use of the same objectives and activities as in protecting children’s health. Indoor air pollution was an important issue to be dealt with further.

Mr Bjorn Erikson of ITUC wanted to see a shift in focus from the health effects arising from the environment to the way that environmental changes were reducing health effects. One example could be the reduction in pollution as a result of environmental measures linked to transport and how it had resulted in a mitigation of health effects. He expressed concern that presentations frequently referred to vulnerable groups but without any definition of those groups; it needed to be clearly stated that the process was focusing on highly exposed groups, who were most likely to be exposed and thus required preventive measures.

Dr Lea Kauppi of Finland explained that, from an environmental point of view, the ultimate target was to contribute to the reduction of those problems. However, it was important to address both health and environmental problems together and the EEHP needed to focus on the measures that could be taken to mitigate as well as to adapt to climate change within the context of the preparations for the Conference. She emphasized the need for a more integrated approach, especially since the real challenge was to deal with several problems occurring together, all of which were highly complex. That would ensure that one problem was not made worse by improvements to another. The integrated approach was the real challenge and, since the changes occurring were complex, it was very important to put the different issues on the table at the same time. Climate change was a political issue but, when one sector planned mitigation actions to address certain health issues, it had to ensure that it was not making another situation worse.

Dr Clini, Chairperson of EEHC agreed it was important to set an agenda of equal interest to both sectors.

Dr Julie Tham of Netherlands spoke of the links with the EC Environment and Health Action Plan and the need for clearer ideas on how to elaborate the links further. One way was though the environment and health information system and it was therefore important to ensure support for a more sustainable system in the future. All parties involved should continue to work on a more manageable and sustainable system and continue to ensure the collection of data. Dr Tham also agreed that it was difficult to bring the environment and health sectors together and it was therefore important to set an agenda that appealed to both sectors.

Dr Michael Heubel, European Commission (DG Sanco) reminded the members that climate change was the political priority across all policy areas in the EEHP. However, it was important to see how it linked in with the overall work of the process. Referring to the EC Environment and Health Action Plan, which took into consideration how climate change related to overall environment policies, there was also a focus on disease and one on pollutants but it was the indicator system that would bind it together and Eurostat was helping to do that. There should also be specific deliverables, and it was important to avoid losing the focus on the disease aspect of climate change as had occurred in the past with the environmental focus.

Ms Bente Moe of Norway agreed that climate change should become the main issue but requested that the CEHAPE RPGs be reviewed to see what improvements could be made to integrate climate change rather than to create a new RPG.
Ms Cosima Pilz of Austria explained that most countries were now implementing the CEHAPE on a national level. Care had to be taken in integrating the new priorities of climate change and gender into the RPGs. The focus should remain clearly on children and the climate change issue should not compete with the CEHAPE objectives but, rather, be brought into it to allow Member States to continue with their implementation.

Ms Sasha Gabizon of ECO-Forum said that it would be interesting to understand whether actions implemented under the CEHAPE had any impact on climate change, as that could lead to some recommendations that could be integrated into the RPGs that specifically address the effects of and on climate change. The added value of the process was the burden of disease and it was important to continue to look at children as they developed and to ensure that precautionary action was taken.

Mr Sergey Samoylov of Uzbekistan also supported the continuing focus on the environment and health protection of children and asked for more focus on the Millennium Development Goal for water and sanitation.

Mr Massimo Cozzone of Italy responded to the comment made by Dr Kauppi. He noted the importance of the EEHP and the added value that it could provide in improving both health and environment policies. The policies should be made to converge and be synergistic; and the issue of climate change, as an environmental priority, should be the link between the two sectors and their policies.

Mr Gernot Klotz of WBCSD called for more emphasis on incentives. He referred to the EU where policies were already in place. It would help to understand where the gaps were and what value, if any, was added to the policies. He asked whether the process was intended to impact on the issue of climate change or to address the solutions currently proposed. If it were the latter, it was important to look at the usefulness of that and be sure that more was not being lost than was being gained. For example, indoor air quality and energy savings were conflicting targets. He called on WHO to be more ambitious in describing what was happening in other regions, looking at technologies and elaborating more on what could be done in those areas. The process needed to clearly advocate the right solutions.

Ms Heli Laarmann of ESTONIA expressed her support for the Conference title and theme suggested by Cyprus. She also hoped that the Conference would provide some practical solutions to the problems. It would help if the agenda of meetings were not overcrowded with issues. She also asked that any actions or solutions proposed by the Conference should be practical. The collection of reliable data was important and needed to be ensured.

Dr Lucianne Licari of the WHO Regional Office for Europe expressed concern that there were many players in climate change. It was important for the EEHP to be a part of the political debate but it was also important to identify the specific contribution that EEHP could make. Dr Licari was also concerned that the process of integration between the sectors had been difficult at international level, since the environment sector was sending clear messages that it was withdrawing from the process. She reminded the members of the EEHC how hard the previous Committee had tried to persuade the Environment for Europe Conference to integrate health into its programme but, despite repeated requests from the chairperson of the EEHC, Member States and other international organizations, health had not been placed on the programme of the 2007 Ministerial Conference and was only included in a side event at the kind invitation of the EEA.
Dr Licari also explained that, despite regular visits to the European Commission’s Environment Directorate General to try to ensure its continued collaboration in the process, the meetings had been unsuccessful. At the last meeting in Brussels, the Environment Directorate-General had sent a clear message that they were no longer interested in being part of the process or of the Ministerial Conference. If Member States felt that there was need for integration of the sectors, then they were the ones who could ensure that at national level and at international level, and, if it was really true that the environment sector preferred to retract back to purely environmental issues, then the EEHC had to recognize that the EEHP was going through a period of change.

Ms Francesca Racioppi of the WHO Regional Office for Europe referred to the discussion on integrating the two sectors and explained that the value added was in two main areas. It was important to see how it could be inserted into the Conference Declaration. She recommended identifying the joint benefits and which of them could best promote the climate change agenda, for example in the area of transport.

Dr David Stanners of the EEA clarified that the EEHP was important for all the work that was required around environment and health issues. The continuity of the process and the integration of the sectors are important and the key words were “continuity” and “integration”. Continuity of the process comes from: 1) the focus on children’s issues, maintaining that as a strategic position of the process; and 2) ensuring the indicators and information flows necessary for identifying problems and evaluating the process. The next step was to work on integration, including the integration of indicators. It would be helpful to draw attention to the shared information system and to try to use it to support integration of the work. The sectors needed each other. The EU’s policy on sharing information on environmental issues could help support other areas. However, another way of ensuring integration was by bringing some of the networks of different sectors together through a joint preparatory meeting in time for the Conference. It would be a good idea to integrate the sectors at a higher level to ensure support for the Conference together. It was also important to take into account the 15th Conference of parties in the Framework Convention on Climate Change to be held in Copenhagen in 2009, which was to look at decisions beyond Kyoto, and also to take into account the European debate around the preparations for the Copenhagen meeting.

Dr Lea Kauppi of Finland commented that, despite the difficult cooperation between the sectors, it was important to work together. She explained that contributions to the work of the EEHC from Finland came from the environment side and it was not important for her where the secretariat was located.

Dr Michael Heubel, European Commission (DG Sanco) appreciated the frank words of the secretariat. He explained that the commitment to the EEHP was contained in the policies approved by the Commission, against which it had to deliver. The Environment Directorate-General could only follow the instructions it was given from above on how to deliver against those policies and that may explain why it was more hesitant to be fully active in the EEHP. With regard to the EC Environment and Health Action Plan, DG Sanco were in internal discussions with the Environment Directorate-General to work out how it would be followed up in the coming months and to decide together on the role that the European Commission would play in the EEHP.

Dr Jon Hilmar Iversen, Chairperson of EEHC reminded the members that environmental issues were becoming increasingly important because of the climate change agenda. Since the EEHC was made up equally of the two sectors then both sectors needed to be addressed. He expressed
concern for the needs of the WHO secretariat and appealed to the members to help WHO, including through the secondment of staff from the environment sector to the secretariat, to ensure appropriate focus on environmental issues as well as health.

Dr Clini, Chairperson of EEHC explained that an integrated approach was needed for the new challenges emerging. Climate change was the context and framework within which such an integrated approach could be promoted. It was an issue that could be addressed by many sectors, since it was political, environmental, health-related, business-related and economic. There would be the Copenhagen Climate Conference in 2009 as well as the meeting of the G8, and environmental security was the theme of the day. As the effect of mitigation on health had not yet been evaluated, it would help if the EEHC could present a paper jointly with EEA on that subject. At the same time, the EEHP should continue to implement the work of the CEHAPE and its RPGs and should promote stronger integration between the environment and health sectors across the RPGs. Climate change meant addressing energy issues, costs/damages and extreme weather events, and the EEHP could help by highlighting the solutions from a technological point of view. EEA could also work with WHO to build integration between the two sectors. Member States could submit proposals on how to tie the framework of climate change, the CEHAPE and the RPGs together to prepare the background for the Conference. Madrid could provide an important first opportunity to ensure change in attitudes towards the EEHP. There was clearly a lack of contributions and proposals on health issues to other sectors’ work in the changing world. Dr Clini felt that this could be addressed by enhancing the positive aspects of integration of the two sectors. Dr Clini appealed to the members to send their comments by mid-April to the secretariat, who would then work with the EEA to prepare the background documentation.

Dr Clini also proposed holding another EEHC meeting for further discussions in Copenhagen before the second high-level meeting in October in Madrid. He thanked his co-chairperson and the secretariat and called the meeting to a close.