



**22nd Meeting of the
European Environment and Health Committee
(EEHC)**

**27 – 28 November 2006,
Szentendre, Hungary**

with a focus on

CEHAPE Regional Priority Goal 1: *"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".*

Report

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(EEHC)
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**Regional Environmental Centre for Central and Eastern Europe,
(REC)
Szentendre, Hungary.**



EEHC decisions

- The IMR would go ahead as outlined by WHO
- Children, health and environment should continue to be the main focus, along with health in all policies.
- WHO would prepare an indicator-based report, including those for child labour, and an inventory of actions, as well as a “business report”.
- The cost of inaction on children’s environment and health issues could be a major topic
- The question of a Convention for 2009 was still on the table
- WHO would commission a working paper on tools such as the ISO
- Next meeting: 27-28 February 2007 in Brussels.

The presentations during the first part of the meeting focused on:

- The major public health benefits that ensue from improving the deteriorating water and sanitation infrastructure in the Region.
- Concern that the total number of people in the Region without safe water and sanitation had remained the same over the same for the last ten years
- The importance of all children having access to clean toilets and safe water
- Planned re-use of water which can deliver high public health protection
- How wastewater systems and dry toilets are a simple, effective and inexpensive measure for rural areas
- The key role of consultants in communicable disease control in fighting water related disease
- WHO guidelines and how they could better take account of risk exposure in early life
- Implementation of the Protocol on Water and Health, including reports from Switzerland and Hungary
- Outbreaks of Hepatitis A, report from Bulgaria
- Climate change and its implications for water management

1. Opening session

Professor William Dab, Chair of the EEHC, welcomed participants and thanked Marta Bonnifert from REC for hosting the meeting.

Dr Miklos Persanyi, Hungarian Minister for Environment and Water, noted that the signing of the Children's Environment and Health Action Plan (CEHAPE) in Budapest in 2004 had been a memorable occasion, and had encouraged synergies across organizations and sectors. Pressing demands from populations had led to degradation of resources. Hungary had been rich in thermal and mineral waters for over two thousand years. However, 96% of the surface water came from other countries, which meant that ensuring both quality and quantity of water involved delicate international relations. Drinking water relied on the strategic protection of groundwater resources. Social and economic development was reflected by the percentage of the population served by clean water and sewage systems: in Hungary, 98% of apartments had water but only 66% had a sewage system. By the end of 2015 it was hoped to fully serve all settlements. It was important too to be prepared for floods, droughts, and industrial accidents. The future for our children was the highest priority issue for all parents.

Ms Katalin Rapi, from the Ministry of Health in Hungary, said that Hungary had played a major role in the Water and Health Protocol and carried a special responsibility for its implementation. The Hungarian public health programme sought to reduce non communicable diseases, reduce inequalities and promote environmental and social economic conditions conducive to a healthy way of life. Urgent measures had to be taken to promote a healthy environment, through local and national environmental health programmes. A detailed, interdisciplinary and cross sectoral survey had been conducted to support this. The ministerial conferences had helped to support political commitment.

Dr Marta Bonifert from REC thanked the Italian Ministry of Environment and Land and Sea for its support. REC was now located in 17 countries, including Turkey. They ran over 300 projects, with a budget of 100 million euros. REC was a non partisan project for the improvement of the environment, focusing on sustainable development and post accession support, building bridges between business and NGOs. The projects ranged from health and environment to training and capacity building, to policy development and public participation.

2. Review of scientific evidence related to CEHAPE Regional Priority Goal 1 on water and sanitation.

Please note that the powerpoint presentations made at the meeting are available on the EEHC password protected web site to which the committee members and environment and health focal points have access. Access for others can be provided by the secretariat on application.

Dr Stephen Pedley from the United Kingdom used *Cryptosporidium*, an emerging waterborne pathogen, as a model with which to illustrate the surveillance systems that had evolved in the United Kingdom for the recognition and control of emerging waterborne pathogens. Cryptosporidiosis was a significant cause of waterborne outbreaks of diarrhoeal diseases, for example in 2005 there were 4527 isolations of *Cryptosporidium*, of which 47.5% were from children below the age of 10 years. Surveillance was essential to public health, but was only of value if it

led to improvement in health of those who were surveyed. It should be used for determining causes of illness, determining vulnerable groups and detecting outbreaks. He described the surveillance system, which since the early 1990s had included medical practitioners in the role of Consultant in Communicable Disease Control (CCDC) within each district health authority. The CCDC played a key role in two parallel surveillance systems, one which required water companies to carry out risk assessments and notify the relevant authorities in case of risk of contamination, and the other whereby general practitioners sent samples to laboratories who also then reported to the local CCDC, and the Centre for Disease Surveillance and Control which compiled national statistics. The knowledge and resources were thus available in a coordinated way to mount an appropriate response to a potential or actual outbreak of disease. At the European level, international networks were also becoming important.

Dr Michael Waring from the United Kingdom pointed out that in the light of children's vulnerability to chemical exposure, with different absorption, distribution, metabolism and excretion, it was important to consider whether and how the standards and guidance from WHO could be improved and made more appropriate. The WHO Guidelines for drinking water quality made recommendations based on and driven by concerns for early life exposure in only eight chemicals (boron, DDT, Di (2-ethylhexyl) adipate, fluoride, lead, methoxychlor, nitrate and nitrite) the first four on animal data, the other four on human data. In some cases, lead and DDT, the guidelines value was based on a bodyweight appropriate for a one year old, but not others. There were other chemicals however whose health impacts were not proven but were a cause of concern in terms of reduced neonatal survival, brain damage etc, such as 245T, iodine, manganese, sodium, sulphate, and chlorinate by products. Why were so few WHO recommendations based on risk exposure in early life? Of 30 guideline values for pesticide, only two or three were driven by children's sensitivity. Even for high product chemicals, the OECD had identified reproductive toxicity as a common data gap, and had developed knowledge on developmental neuro-toxicity in animals, linked to endocrine disruptors, and cancer.

Professor Rafael Mujeriego from Spain talked about augmenting water resources in the Mediterranean region where 28 million people (7% of the population) in the Mediterranean area only had access to less than 500 m³ of water per year, and 115 million (29% of the population) had access to less than 1 000 m³. 80-93% of the water was used for agriculture. These flows were not stable and the population was expected to rise to 340 million by 2020. There was increasing awareness that not only did available sources have to be more efficiently managed, but less conventional resources had to be found: reclamation and re-use. Up to now, re-use had been held back by concerns about water quality and the need to distribute it over long distances from reclamation plants. However by 2010 it was thought that water re-use would provide up to 36% of the water devoted to irrigation. Advancing its use required an integrated water resources management framework.

Direct or planned re-use did not involve discharge or dilution into a natural stream. It was being applied not only in Spain but also California and Florida, to expand their water supplies. The beauty of re-use was that it was local and reliable, and provided not only a new local water source but also a way to meet high standards for wastewater discharges. Other benefits included energy savings, reduced pollution in the environment and more reliable water flow. Planned re-use required a reclamation process and a dual distribution system, as well as a new mentality and political will. He also explained the terminology: water reclamation, water re-use, incidental/direct re-use, potable and non potable re-use, recycled (waste) water, and newater. This term was used in Singapore and citizens were more comfortable with it. Often "recycled" was a more popular term than "re-use". He listed different types of re-use, from irrigation in rural areas, to use in toilets, fire fighting, street cleansing, car washing in urban areas, as well as industrial use in cooling towers, and process water, and recreational use in lakes and ornamental

ponds. It could be used in groundwater recharge, through infiltration and injection. Seven million dollars had been spent in Monterey in the United States of America on irrigation using reclaimed water, and it was not controversial. Pink was used for the pipes carrying re-used water. It was used for cooling towers in many parts of the world.

Two sets of guidelines had been an inspiration for this: those on the safe use of wastewaters (WHO) and those on water re-use from the United States Environmental Protection Agency. In the Mediterranean, public perception was a critical issue. He listed the comparative costs, including the energy costs of re-use, to illustrate its cost effectiveness. Investment costs to produce reclaimed water for unrestricted irrigation was about 0,30 euros/m³, as compared to 1,8 euros/m³ for storage, and 3,0-4,0 euros/m³ for desalination. The energy consumption of water reclamation varied from 0,001 to 0,73 kWh/m³, similar to water purification/wastewater treatment. The key conclusion was that water agencies should be responsible for the whole water cycle. High quality reclaimed water delivered a public health and environmental protection level similar to conventional water supplies.

In subsequent discussion, there was a focus on cryptosporidiosis, which in Poland was thought to provoke from 50% -70% of the 2500 cases per 100 000 of childhood diarrhoea annually. It seemed to cause more cases among young girls, and in older boys. Cryptosporidiosis was a zoonotic disease from farm animals, so surface waters were risk factors. It was difficult to disinfect, was resistant to chlorine, and efficient filtration systems were needed to take it out. The standard was based on technical grounds not health grounds. In most outbreaks, the pathogen was detected afterwards. Swimming pool outbreaks were not uncommon. In response to questions about fluoridization, the United Kingdom said that a statutory limit of fluoride was recognized, 1 mg per litre, and some supplies contained more, from naturally occurring fluoride. Dental caries were very low, with little fluorosis. About 10% of population received 1 mg per litre, but this came under local agreements. There was also discussion about the public resisting having anything less pure than drinking water. Bulgaria highlighted problems with toilets in schools. Over 30% of its population, including schools, did not have a constant water supply.

Dr Roger Aertgeerts drew participants' attention to the 3rd edition of the *WHO Guidelines for drinking-water quality* which highlighted the development of water safety plans, and had been followed by a new publication, *Water safety plans, managing drinking-water quality from catchment to consumer*. WHO had also just published *Fluoride in drinking-water*. He pointed out that the data on water and health was patchy in many countries. The meeting of the Parties of the Water and Health Protocol, which had met early that month, had felt that even those countries with a database sometimes found it difficult to develop an instrument for policymaking, moving from hard copy to online data.

3. International and national policy response to CEHAPE Regional Priority Goal 1 challenges, progress, opportunities and constraints

a) International responses

Robert Visser from the Organisation for Economic Co-operation and Development (OECD) said that in parts of the European Region, the water and sanitation infrastructure was in a critical condition and deteriorating, and this crisis impacted on public health. However, official data disguised this fact. An analysis of performance information in more than 400 water utilities in 8 countries in Eastern Europe, Caucasus and Central Asia (EECCA), using the World Bank Benchmarking Start-up Kit, revealed similarities: the continuity of services was very varied, often only a few hours per service a day, which created health problems. Sewerage and wastewater treatment facilities were often the first service items to be shut down, resulting in increased environmental and health impacts. The most alarming situation of water infrastructure

existed in small and medium cities. The water lost to leakage/theft etc. meant that systems were open and therefore at risk. This was much higher than the 16-20% European norm at over 70% in some countries. This data contrasted with the United Nations data whose figures show progress towards the Millennium Development Goals (MDGs). This was because the MDG indicators looked at improved water and sanitation, but did not take into account whether water that comes out of the tap actually is safe to drink, available, and whether access is sustainable in the future. The OECD however looked at the water coming out of the tap, quality and supply, so the picture was clearer. The United Nations data could be complemented with water services quality data to overcome this problem, and the Joint Monitoring Programme was working on this. Infant mortality figures showed improvement, but were still much higher than the western countries. Some health indicators had been improving, such as the infant mortality rate, while others are deteriorating, such as infections with viral hepatitis A: anecdotal evidence of outbreaks of water related diseases were numerous. Globally 41% of world population did not have access to improved water and sanitation. The OECD had done some work in the importance of investing in safe water, and everywhere the benefit cost ratio was over 1, and in some case it was enormous. Investing in improved water supply and sanitation services could yield potentially large benefits for public health, the environment, and economic development.

Margriet Samwel from the European EcoForum and Women in Europe for a Common Future (WECF), presented some examples and graphic photographs of NGO projects that aim to reduce the diarrhoea which is one of the causes of children in the EECCA countries having a higher probability of dying before the age of five. The area of rural Romania where one of their projects was based, had no water supply or sewage. People relied on 400 wells, and pit latrines in their yards. No wells there were found to have safe drinking water: they had very high levels of nitrates, and of faecal bacteria. There were pit latrines, animals grazing near wells, pesticide tips, dead animals, and no solid waste control, little public awareness, and people could not pay for public services. There was no budget for monitoring the wells and no alternatives offered if the well was closed. Generally the options considered for rural sanitation involved only pit latrines which were polluting and smelly, septic tanks which were usually not serviced and leaked causing pollution, and centralized sewage and a waste water treatment plant, which were very expensive. About 90% of wastewater was not treated.

WECF, in cooperation with local communities, had sanitation projects in 10 countries for 25 000 people. Sophisticated wastewater treatments were too expensive for rural areas so wastewater systems were the answer. The pilot projects underway included some on wastewater treatment, and the use of dry toilets with urine diversion, which was being piloted for schools; they did not need water for flushing. Some used ash for storage and disposal of urine and faeces, with the products, particularly urine, being re-used for agriculture. The urine in these rural areas had been found to be purer than the drinking water!

Dr Dorota Jarosinska summarised the work on the European Environment Agency (EEA) in this area. The EEA did not collect health outcome information, but did collect data on water including the presence of organisms in it. The Water Information System for Europe (WISE) was expected to capture comprehensive data and provide an information management system for water, including river basins. The agency was preparing an assessment report, for the Belgrade Conference in October 2007, looking at progress since 2003. It would be guided by the 6th EU action programme and the EECCA Environment Strategy. There would be a water stress chapter in the Belgrade report. It is difficult to get recent data, but it was clear that there was high leakage from the distribution network in many EECCA, southern and south eastern European countries, for example, in Armenia and Kyrgyzstan this ran at between 50-60%, in Georgia and Moldova it had increased from 30% to 40% and in Italy and Spain around a third of the water supplied was lost before delivery. Such leaks allowed cross contamination between water and

sanitation networks. Switching the network on and off allowed microbiological and other pollutants to contaminate the network, and diminished the quality of the water. In many EECCA and south eastern European countries there had been a significant decline in the level of water quality monitoring over the last 15 years. Total water abstraction had decreased by more than 20 % during the last 15 years, mostly in the EECCA countries and the new EU Member States, as a result of the decline in abstraction in most economic sectors. The quality of river water was improving but this was mostly due to declining industrial activities.

In discussion, participants confirmed that many countries did not have a management system for water, and there was a big gap between urban and rural areas. WHO pointed out that comparing data from WHO in 1984 with the last assessment of the Joint Monitoring Programme showed that the total number of people in the Region without safe water and sanitation had remained the same over the same for the last ten years. It was unethical that people should not have access to water. It might be because long term investment was long term and too big or because the message was just not attractive for the public, or perhaps because politicians move on too quickly. Toilets were not charming. However the opportunity should not be missed to send a strong message. It was pointed out that in some countries water had been privatized and water was not seen as politicians' business although it was a human right.

In discussion, participants confirmed that the situation in the Region with water and sanitation was much worse than was commonly appreciated. Ecological sanitation systems were useful, being simpler and inexpensive, along with handwashing initiatives; one third of consumption in households went on flushing. The key point was that all children should have access to flush toilets and clean water, whether this was achieved through conventional wastewater systems or re-use and ecological systems.

A further concern was mentioned which was that even in the European Union, the condition of toilets in schools was a problem and children were afraid of going to the toilets or refused to use them all day because they were disgusting. Proper sanitation was also a gender issue since its lack could prevent girls from going to school in Muslim countries, and collecting water was usually a burden on the women.

b) national responses

Dr Pierre Studer from Switzerland reported on the implementation of the Protocol on Water and health. There was no shortage of water in Switzerland, however the Protocol had been ratified. Switzerland was made up of 23 cantons and 26 local governments, all with a large amount of autonomy, including on water. It had taken seven years to get it ratified by both chambers of the parliament. The item had to be described, the consequences for cantons and federal government outlined, finance identified and legislation developed. A water policy was outlined at a federal level, but had to be sensitive to political considerations. Three ministries had to be involved and the water suppliers; there were 2,700 different water suppliers, including many small suppliers. Twenty different reports had to be consulted to get the full picture of water and sanitation and to set goals properly. Consumers wanted to know about quality of their drinking water and a lot of water was also provided to other countries. Switzerland was organizing a national data bank and information for the public, which was directly linked to the Protocol. There was some opposition to the database from the parliament, and the chemical industry who did not welcome stricter parameters that would cost them a lot, but it was explained to them that industry would be part of the negotiation. The consequences of implementing the Protocol were that goals had to be set, water monitoring managed at national level, and water related activities coordinated. National reports had to be published periodically and Swiss drinking water legislation revised. The cost would be approximately 300 000 dollars per year for the next three years. More information could be found in English, French, German and Italian at: <http://www.waterinfo.ch>.

Dr Gyula Dura reported on Protocol implementation in Hungary. It was not an isolated process, for Hungary, accession had been an important factor. Now, over 92% of the population had access to safe drinking water. It was the responsibility of local governments and the public health institutes. Progress could be seen: in 1989, bacteriological failure was running at 8.4%, whereas by 2005, it had been reduced to 2.5%. The implementation of the Protocol had assisted reform, and provided health benefits. However, there were still challenges: over three million people had to use water that fails the parameters both of chemicals and bacteria, and there were over 30 000 contaminated industrial sites. Now the law required risk assessment, and clean ups. Hungary had a problem with arsenic, and in the 1980s research had shown that high arsenic levels significantly increased the risk of spontaneous abortion, as well as skin, cancer, and kidney cancer. Lung cancer increased with long-term intake. In the last five years, deaths of children from diarrhoea have been reduced. So the Protocol has proved to be a useful tool – a number of investigations had been carried out on for example, secondary contamination of distribution networks, detection in cyanobacteria in source water, and on wells. It had proved to be a supportive tool and brings the issue of water higher onto the political agenda. Hungary had now set up a drinking water inspectorate, developed water safety plans for waterworks, water suppliers, public buildings and good producers, and increased its communication with the public.

Dr Roger Aertgeerts from WHO/Europe said that the issue of water was in danger of being overlooked. The Protocol had been ratified quite quickly, with 21 countries so far ratified, rising to an expected 25 by January 2007. He outlined the main water-related diseases, on which targets would be set by the ratifying countries. There was a lot to do, with problems of diagnosis and reporting, but the emphasis would be on improving outbreak detection, and developing contingency plans. The Parties would agree a plan of work for 2007-2009. Water safety plans are in harmony with EU programmes. Access was the first question: 40 million people in the EU alone were without access. A significant amount of work remained to be done on ensuring access in the regions known as Euro B and Euro C: improvements had been made but the quality of access had deteriorated, and there was discontinuity of supply. The situation was worst in small cities and rural areas. (Euro B had seen an increase in access from 66% to 72% in urban areas, while rural areas stagnated at 48%; Euro C had had a small improvement in urban areas with coverage moving from 36% to 40%, but stagnation in rural areas at 48%. On sanitation, Euro B had stagnated at 92% in urban areas and 67% in rural areas; Euro C had also stagnated at 94% in urban areas, and 73% in rural areas. The priorities had to be outbreak detection and contingency plans, equitable access, prevention and remediation of contamination of distribution system, financially sustainable services, in-house measures and hygiene education. In Euro A, coverage was nearly complete (100% of urban and 97% of rural population had access to safe water, and in sanitation near universal coverage was available to 96% urban and 99% of rural areas.) but neither quality nor operational performance were covered by the data. It was not yet known what proportion of the Region's population was affected by non-compliance with water quality standards. A zero tolerance approach towards unsafe water and sanitation was good for safety. It was a question of human rights.

4. Future challenges in addressing CEHAPE Regional Priority Goal 1

Dr Hrstina Mileva focused on the increasing prevalence of Hepatitis A, and reported on the outbreak of viral hepatitis which occurred in Svoge, Bulgaria, in July and August 2006. 194 people had been affected in Svoge itself, and 94 more from other villages. 42 school children were among them. A chocolate factory was involved, whose water supply came from worn out pipes. The ministry of health set up a commission, including the ministries of environment, agriculture, and home affairs. The population was informed and bottled water recommended. Residual chlorine levels were measured daily. Action was also taken towards preventing secondary outbreaks in child facilities and schools, such as repairs in washrooms and lavatories,

provision of washing and disinfection products, medical examination of pupils, and immunoglobulin prophylaxis, as well as improved control of compliance with sanitary and hygiene requirements in these facilities. Dr Mileva outlined the measures that were taken in full and drew participants attention in particular to the immediate population alert system in the event of water transfer network damage, the approval of higher potable water chlorination values in epidemic situations for more efficient decontamination, building internal supplementary installation for water decontamination in food factories and re-examination of the Hazard Analysis and Critical Control point system in large foodstuff factories.

Dr Bettina Menne from WHO/Europe outlined the challenges presented by climate change in the next 50 – 100 years, with extreme weather events such as storms and droughts. Increasing long term droughts had already been observed, along with raised sea and lake levels, and an increase in ocean acidification which contributed to more rapid CO₂ level. Glaciers were in retreat, This would be accompanied by changes in vector borne diseases and more outbreaks of infectious disease, including diarrhoea, and increased risk of dying in floods and high temperatures. There was increasing run-off and pollution of lakes. Climate change related water and health related impacts included increased winter floods and flash floods, coastal flooding, and the percentage of areas under high water stress were likely to increase from 19% to 35% by the 2070s. The most vulnerable regions were southern Europe and some parts of central and eastern Europe, where summer flows could be reduced by up to 80%. The hydropower potential of Europe was expected to decline on the average by 6%, and by 20 to 50% around the Mediterranean by the 2070s. At the same time, a projected rise in surface temperature and shifts in rainfall in most countries of Asia would induce substantial declines in agricultural productivity as a consequence of thermal stress and more severe droughts and floods; accelerated glacier melt was likely to result in a decrease in river flows as the glaciers disappeared. For every degree C temperature increase, there would be between 10-30% increase in notified cases of food poisoning and diarrhoeal diseases, and a four to eight fold increase in heat-related mortality. The increased number of drought events would be associated with malnutrition periods and consequent disorders, including those of child growth and development. The Stern Report in the United Kingdom had said that with an increase of 3 degrees by the end of the century, glaciers would be retreating entirely and Mediterranean countries and some Asian countries would be experiencing water stress.

The implications of this for water management were that programmes should be augmented to increase resilience to climate variability, particularly in relation to flood prevention and management, flood proofing, public education, and the inclusion of climate changes into water safety programmes. The cost of inaction were high: the costs of extreme weather alone could reach 0.5 - 1% of world gross domestic product (GDP) per annum by the middle of the century, and would continue to rise if the world continued to warm. Following the 2003 heatwave, it was important to look again at public health programmes, doctor training, structure of hospitals, and real time surveillance systems. If nothing was done, Stern had estimated a 5% reduction in per capita consumption. If the environment and health costs were included, this figure would rise to 11%.

Some discussion followed. The Chairman reported on his recent speech to WHO Regional Committee, where he had stressed the progress being made with CEHAPE implementation, the importance of standardized reporting between countries and of inter-sectoral cooperation. This made it easier to be evidence-based, and link science to the field.

He went on to ask the European Commission for clarification on remarks that had been reported in the media to the effect that health impacts on children from environmental factors had been exaggerated. Michael Huebel from the Commission said that the remarks had come from an

unnamed official and were erroneous. A staff document on environmental health information, on further development of Commissioners' environment and health work, had contained an unfortunate statement; it would be discussed at the consultative group that week and the document should not be interpreted as a political departure. The Commission had produced two Communications, one on strategy and one on the plan, and had formally committed itself to the outcome of the Budapest conference. These commitments had come from the College of Commissioners. The intention was to review the effectiveness of the action plan. Participants welcomed this clarification.

Participants shared their challenges in implementing Regional Priority Goal 1. It was suggested that if the stress was put on the needs of isolated villages and mountains, particularly in tourism areas, progress could be made. A youth delegate reported on a survey that had been conducted among children, and found that 42-70% of them never visited school toilets because they were so disgusting. At the water youth parliament held earlier in 2006, in which 15 countries had taken part, it had been clear that children in the more eastern countries had even worse toilets. Such issues had to be taken seriously. It was also noted that CEHAPE and the Budapest commitments should be raised at the forthcoming meeting of the Parties to the Water and Health Protocol.

5. The Intergovernmental Mid-term Review (IMR)

Dr Roberto Bertolini introduced a draft agenda of the IMR, to participants. It consisted of four blocks: firstly, a review of evidence, including an indicator -based report, and new data on the burden of disease. In the second block, countries were invited to report on what they had done, in the four parallel sessions on each Regional Priority Goal, constituting 12 hours of presentation in all. Member States were encouraged to bring written material and documentation if they wished. They would also report on implementation of the other issues in the Budapest Declaration. The third block of the IMR would involve reflection on lessons learnt, including by NGOs, and on the value of policy instruments used by Member States. Young delegates would have the opportunity to question ministers at a roundtable. The approach of health in all policies would be very much to the forefront. Finally the focus would go to the ministerial conference in 2009, in Italy, as well as a report back on the youth event.

In discussion, participants welcomed the focus on young people and NGOs, and also involving some ministers. There should be a focus on either success stories or areas where progress needs to be made. Finding political solutions was important on particular issues in the working groups.

Robert Thaler, Co-chair of the CEHAPE Task Force, said that Austria looked forward to welcoming everyone in Vienna in June 2007. The youth and the NGOs would gather the day before. His wish was that it would not be a technical conference but with high political participation, including state secretaries and deputy ministers. Other participants emphasized that Member States should not only report on their individual countries, focus on lessons learnt, and identify priorities for action, but look at the region overall, the gap between countries, and how they can be helped.

Hanna Hammari and Lina Tislevoid, the youth delegates, reported that the youth network needed fresh blood and new thoughts and more interesting people from more countries. A workshop was taking place in February or March 2007 with 100 – 150 youth participants, hosted by the European Commission, and they wanted the youth to value the youth participation process and review the Budapest youth declaration, bringing NGOs together around the EU action plan and CEHAPE process. This strong youth network would link to the national focal points. The Commission would fund a good number of participants, plus involve Tunza and the European Youth Forum.

Genon Jenson from the Health and Environment and Alliance reported on NGO involvement in the IMR – working with the International Society of Doctors for the Environment, Ecoforum, Women of Europe for a Common Future. There would be three stages: an NGO preparatory meeting in Brussels in February in conjunction with the Environment for Europe Belgrade process, to develop involvement with both processes, and an NGO event in Vienna, followed by participation in the IMR itself. People coming to the meeting would come with a written report on their countries. The scientific community was also organising a meeting in Vienna from 11-13 June 2007 (run by INCHEM). Governments could help with travel grants, disseminating information and sharing experience of involving NGOs in CEHAPE implementation. EEHC member countries should involve their own youth. It was pointed out that young people in central Asia would not be able to afford to come and would need support. Serbia reported that they had held a youth workshop just last week, harnessing enthusiasm of young people, but also roping in local governments, medical high schools, and schools doing environment and health.

The next EEHC meeting would be kindly hosted by Belgium and would take place in Brussels from 27-28 Feb 2007, then 1 March CEHAPE meeting, back to back.

Tuesday 28 November 2006, second day of the meeting, for EEHC member and observers only.

6 The Intergovernmental Mid-term Review (IMR)

After WHO summarized the plan for the IMR, the EEHC Chair, Professor Dab, outlined the need to develop operational tools at national and local level to improve practice. Moving from knowledge to policies was the problem. It was important to systematize the knowledge, and organize partnership between private and public sectors. Civil servants switched topics every three years, so the tools should be carefully prepared for continuity on what precise actions to take. He suggested that international standards such as the IS 14 000 provided a model that could well be used in public health and was being used by the United State Environment Protection Agency. If WHO had the mandate to develop and pilot some practical tools for the 2009, they could deliver the first one in 2009, for some key sectors such as water. Other contributors added that it was not only the health or environment sectors that needed to act: it was important to reach policy integration, and start a process, not just tell policymakers what to do. Countries needed to be presented with alternatives as country situations were very different: flexibility was key.

Participants mentioned other aspects that merited attention including looking at the effects of windows of exposure, tiny exposures to chemicals or radiation, and linked to this, the impact of the economic strategy on the developing child. The message should be that the environmental burden of disease tended to be underestimated, not exaggerated. What was the real cost of each risk factor? A team had made a synthesis of public health research in Europe and it showed that during the last 10 years the research in basic disciplines such as epidemiology, toxicology, risk assessment had been increasing and overall the quantity of scientific work was good, but research on risk management was lacking: less than 3% of scientific work was devoted to risk management.

A key issue for the IMR in Vienna would be to get the discussion back to the political level. Health in all policies was the way to go, with a framework of integration with other departments, each looking at their particular aspect of one issue such as air. It took time but it worked. Perhaps people from each sector could be invited to Vienna? At the moment, the health sector was too far downstream, feeling the effects of policies decided in other sectors. There was also a risk of

drowning in complexity. Short, medium and long-term targets would be helpful and a management framework would work in that context. It was suggested that all decision-makers should do an environmental health impact assessment for all decisions.

Some countries would welcome a greater emphasis on regional cooperation: political conflict should not be a barrier for cooperation. Armenia, Azerbaijan and Georgia had recently signed an agreement with the EU and this was a good basis for cooperation.

Some participants considered that ministers and other politicians needed to be involved only in 2009, others that they should be involved at the IMR to keep political pressure high. The main purpose of the IMR was to provide a review of the process (paragraph 21b of the Declaration) and to assess implementation, therefore if politicians attended, they should be those who were involved in implementation. The point was made – and discussed - that only legislation could provide continuity, financial obligations, and the power to force other sectors to act. For example, emission standards had provided the catalytic converter not voluntary agreements. Developing legislation forced policymakers to think about common issues that needed to be solved. Some delegates supported a Convention for 2009, particularly concerned about the effects of neurotoxic chemicals on children. Others said that existing legislation was often not implemented or enforced, and that industry needed a level playing field.

Achievements, comparisons, data and economic indicators were important. There were other stakeholders in the health sector, local authorities, mayors and European parliamentarians. The benefits of action and cost of inaction needed to be shown, they were useful for industry, who have long term plans as they have to invest in the future. Industry would welcome a gap analysis, and a long term plan with reliable goals, to aid prioritizing. The OECD reported on their recent environment ministerial meeting on climate change, and another planned for March 2008 with a focus on globalisation. The cost of inaction could be a major topic.

WHO summed up the discussion and it was agreed that children, health and environment should continue to be the main focus, along with health in all policies. WHO would take the points raised on board and would commission a working paper on tools such as the ISO.

7. CEHAPE task force report.

Dr Hilary Walker from the United Kingdom, Co-chair of the CEHAPE Task Force, reported on its 4th meeting which had taken place in Cyprus in October 2006. The full report can be found at http://www.euro.who.int/Document/EEHC/CEHAPE_Cyprus_4th_Mtg.pdf

The following countries had reported at last once on all four Regional Priority Goals for the web map of implementation: Albania, Bulgaria, Cyprus, Denmark Estonia, Greece, Finland, France, Lithuania, Malta, Montenegro, Romania, Serbia, Slovenia, and Sweden. Reporting generally was good but patchy: eleven countries had not responded at all. Member States had been invited to complete and return the web map templates on the Goals as soon as possible.

Robert Thaler, Co-chair of the task force, outlined the views of the task force on the IMR, already discussed, and emphasized the need for involvement by youth at a local level. The question of a legal instrument was still an open one and was still on the table. The possibility of the environment and health process becoming global had been raised, and countries had raised some concerns about the loss of European focus and risk of slowing down implementation in Europe, if this was to happen. Austria was looking forward to hosting the IMR in Vienna.

Various points were raised in discussion, from the need to find money to bring NGOs to Vienna, to the need to call the youth and NGO events something other than “side events”, which

marginalized them. WHO noted that several ideas had been mooted for inclusion in the ministerial conference in 2009, such as nanotechnologies (an ideal opportunity for the precautionary principle to be exercised), global change, and partnership with sectors such as industry, and the link between the health system – including physicians and nurses - and public health. OECD reported that they had seven working groups examining safety issues of nanotechnology, and would be happy to provide input. It was pointed out that anti-smoking had made huge progress in recent years and this was partly because huge resources had been devoted to it. This was also needed for environment and health.

Viv Taylor Gee from WHO/Europe reported on the progress of the communication strategy and the web map. She would be moving to become web manager for WHO/Europe in January 2007, and thanked participants for the close work she had enjoyed with them over the ten years she had spent in the secretariat as communication officer.

Dr Michal Krzyzanowski reported that the WHO European Centre for Health and Environment was preparing both an indicator-based report, and an inventory of actions, for the IMR, using the web map information. There would also be a “business report” from WHO, for accountability purposes. A request was made for child labour to be included in the indicators.

8. Financial report

Dr Lucianne Licari from WHO presented the paper on the financial situation and requirements. The estimated annual operational expenses in the paper were based on 2007 costs and calculations. Four EEHC member countries had received a request but these had been based on 2002 figures. It incorporated the cost of back to back meetings, replacing Elaine Price. (The CEHAPE information officer was doing that on top of her normal job, funded by Austria, and a communications/web manager would replace Viv Taylor Gee. She added that as well as contributions in money and kind, secondments to WHO would also be welcome: there were currently three vacancies. She thanked the host countries for the meetings, including Austria for the IMR.

Norway and Finland confirmed that they were happy to continue to support the work of the EEHC. Belgium was pleased to host the next EEHC/CEHAPE Task Force meeting.

9. Reporting by EEHC members

Participants gave details of some upcoming events or developments of interest to participants: UNECE acknowledged the request to report to the Environment for Europe’s Belgrade Conference: a slot had not so far been found but would be further investigated. There were many synergies, and it was agreed it was important not to duplicate efforts. Events included:

- The next Committee on Environmental Policy (CEP), 29 May 2007
- The next ad hoc Preparatory Working Group of Senior Officials (WGSO), Environment for Europe Executive Committee, (EXCOM), 14-15 February 2007, and 29 May – 1 June 2007.
- THE PEP Steering Committee, 16 – 17 April 2007
- High level steering committee on transport environment and health, now in 2008.

The Health and Environment Alliance reported on their activities such as:

- Producing fact sheets on lung health and the environment in 10 languages, for respiratory doctors;

- New publication on hospitals and indoor air quality, prepared with the NGO, Health Care Without Harm;
- An upcoming workshop on 1 February 2007 on pesticides and children's health, part of activities connected to the revision of the Pesticides Directive;
- Launch of a campaign on mercury and children's health, February 2007;
- An environmental health workshop in Poland to be held in March 2007

Ecoforum reported that they were producing four fact sheets and two briefing papers on European Union economic strategy, and in February 2007 were holding a meeting in the Republic of Moldova on rural water and sanitation. The European Environment Agency reported on a joint workshop with WHO, and the Joint Research Centre on the environmental burden of disease. The presentations were on the password protected web site of the EEHC.

10. Closure

The next EEHC meeting would be in Brussels on 27-28 February 2007, followed by a CEHAPE Task Force meeting on 1 March 2007. The details would be on the EEHC web site (<http://www.euro.who.int/eehc>) The Chair thanked participants for their valuable contributions to the discussions of the past two days on Regional Priority Goal One and on the IMR and associated issues, and thanked REC for hosting the meeting.

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