World Health Organization

REGIONAL OFFICE FOR Europe

HEALTH EFFECTS OF PARTICULATE MATTER

Policy implications for countries in eastern Europe, Caucasus and central Asia

Abstract

This paper summarizes the evidence about the health effects of air pollution from particulate matter and their implications for policy-makers, with the aim of stimulating the development of more effective strategies to reduce air pollution and its health effects in the countries of eastern Europe, the Caucasus and central Asia.

Keywords
AIR POLLUTION - adverse effects
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POLICY MAKING

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Convention on Long-Range Transboundary Air Pollution

Abbreviations

AQG	air quality guidelines
EECCA	eastern Europe, the Caucasus and central Asia
PAH	polycyclic aromatic hydrocarbon
PM	particulate matter
UNECE	United Nations Economic Commission for Europe

Introduction and context

In most countries in the region covered by the United Nations Economic Commission for Europe (UNECE), ambient air quality has improved considerably in the last few decades. This has been achieved by a range of measures to reduce harmful air emissions, including those stipulated by the various protocols under the Convention on Long-range Transboundary Air Pollution *(1)*. There is, however, convincing evidence that current levels of air pollution still pose a considerable risk to the environment and to human health.

Recently, the Executive Body of the Convention has adopted amendments to the Convention's 1999 Gothenburg Protocol to Abate Acidification, Eutrophication and Ground-level Ozone. Following years of negotiations, the approved revised text of the Protocol now specifies national emission reduction commitments for main air pollutants to be achieved by the UNECE Parties by 2020 and beyond. The revised Protocol includes, for the first time, commitments to reduce the emission of fine particulate matter ($PM_{2.5}$). Furthermore, black carbon or soot is now included in the revision as an important component of $PM_{2.5}$. Black carbon is an air pollutant which both affects health and contributes to climate change *(2)*.

What is particulate matter?

PM is a widespread air pollutant, consisting of a mixture of solid and liquid particles suspended in the air.

Commonly used indicators describing PM that are relevant to health refer to the mass concentration of particles with a diameter of less than 10 µm (PM_{10}) and of particles with a diameter of less than 2.5 µm ($PM_{2.5}$). $PM_{2.5}$, often called fine PM, also comprises ultrafine particles having a diameter of less than 0.1 µm. In most locations in Europe, $PM_{2.5}$ constitutes 50–70% of PM_{10}.

PM between 0.1 µm and 1 µm in diameter can remain in the atmosphere for days or weeks and thus be subject to long-range transboundary transport in the air.

PM is a mixture with physical and chemical characteristics varying by location. Common chemical constituents of PM include sulfates, nitrates, ammonium, other inorganic ions such as ions of sodium, potassium, calcium, magnesium and chloride, organic and elemental carbon, crustal material, particle-bound water, metals (including cadmium, copper, nickel, vanadium and zinc) and polycyclic aromatic hydrocarbons (PAH). In addition, biological components such as allergens and microbial compounds are found in PM.

Where does PM come from?

Particles can either be directly emitted into the air (primary PM) or be formed in the atmosphere from gaseous precursors such as sulfur dioxide, oxides of nitrogen, ammonia and non-methane volatile organic compounds (secondary particles).

Primary PM and the precursor gases can have both man-made (anthropogenic) and natural (non-anthropogenic) sources.

Anthropogenic sources include combustion engines (both diesel and petrol), solid-fuel (coal, lignite, heavy oil and biomass) combustion for energy production in households and industry, other industrial activities (building, mining, manufacture of cement, ceramic and bricks, and smelting), and erosion of the pavement by road traffic and abrasion of brakes and tyres. Agriculture is the main source of ammonium.

Secondary particles are formed in the air through chemical reactions of gaseous pollutants. They are products of atmospheric transformation of nitrogen oxides (mainly emitted by traffic and some industrial processes) and sulfur dioxide resulting from the combustion of sulfur-containing fuels. Secondary particles are mostly found in fine PM.

Soil and dust re-suspension is also a contributing source of PM, particularly in arid areas or during episodes of long-range transport of dust, for example from the Sahara to southern Europe.

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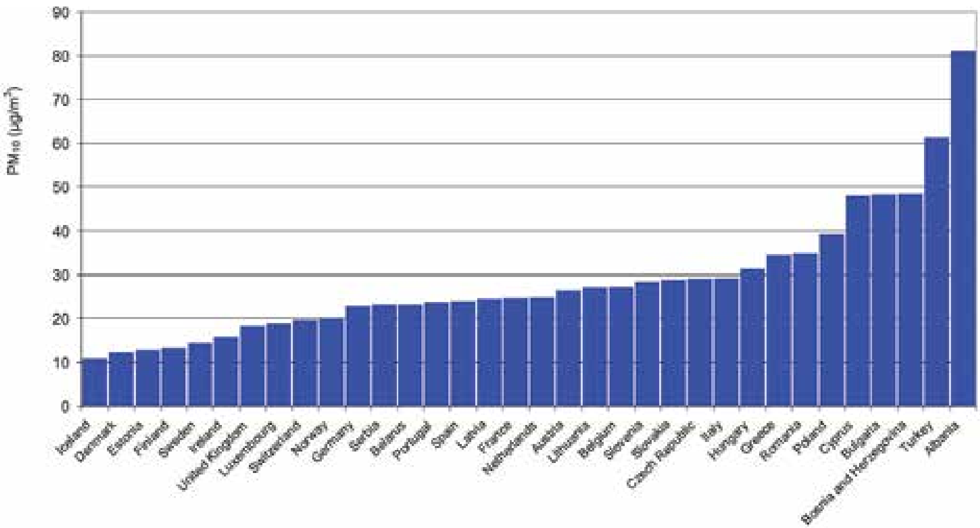
What are the levels of and trends in PM in the WHO European Region[1] ?

The WHO Environment and Health Information System (ENHIS), which is based to a large extent on data submitted by European Union (EU) member states to the European Environment Agency AirBase *(3)*, includes PM_{10} monitoring data from urban and suburban background locations. Fig. 1 presents the population exposure, expressed as annual mean concentration of PM_{10}, weighted by the population in cities with data, in 403 cities in 34 WHO European Member States for 2010. In only 9 of these 34 Member States, PM_{10} levels in at least some cities are below the annual WHO air quality guideline (AQG) level of 20 µg/m^3. Almost 83% of the population of the cities for which PM data exist is exposed to, PM_{10} levels exceeding the AQG levels. Although this proportion remains high, it is an improvement compared to previous years, with average PM_{10} levels slowly decreasing in most countries in the last decade.

Fig. 1.
Population-weighted annual mean PM_{10} in cities by WHO European Member State, 2010



Source: WHO Regional Office for Europe *(4)*.

On the other hand, monitoring of PM_{10} and $PM_{2.5}$ is very limited in countries in eastern Europe, the Caucasus and central Asia (EECCA), with only a small number of monitoring

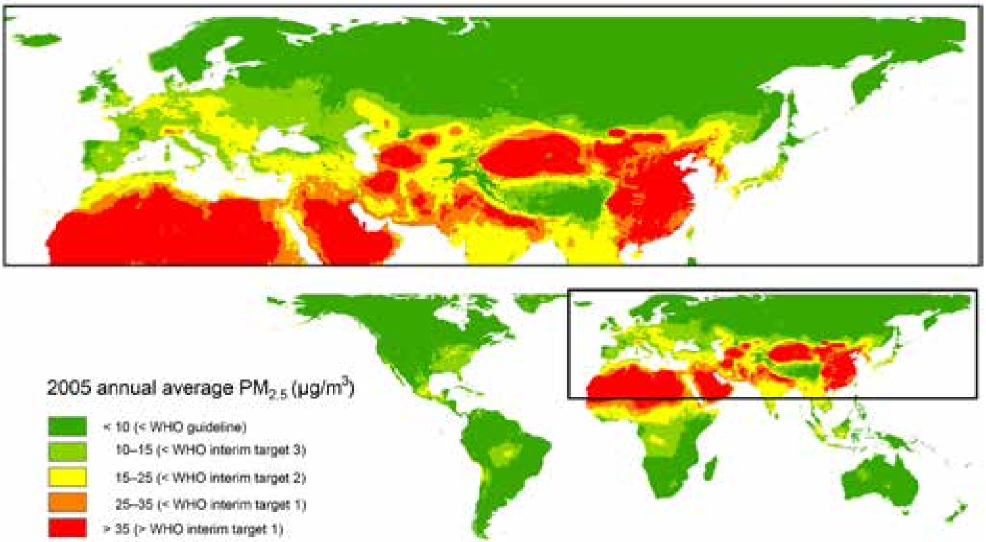
1 The WHO European Region includes 53 countries stretching from the Atlantic Ocean to the Pacific Ocean, with a population of almost 900 million people.

stations in Belarus, the Russian Federation (Moscow) and Uzbekistan (one in Tashkent and one in Nukus). Initial data from the two Uzbek cities indicate that PM_{10} and $PM_{2.5}$ levels are high in comparison with most of the other cities with PM monitoring in the Region. While the levels in Nukus may be affected by dust storms (which are frequent in that area), various combustion sources may be predominant in Tashkent.

The proper assessment of levels of and trends in PM in EECCA countries requires PM_{10} and/or $PM_{2.5}$ monitoring in more locations in those countries. The assessment of PM concentrations requires continuous monitoring conducted for 24 hours daily for 365 days a year, with standardized methods or methods equivalent to the standard. Quantitative knowledge about sources and levels of and trends in emissions of primary particles and precursor gases plays an important role in finding the best control strategy for reducing risks.

In view of the scarcity of ground-level data for PM, remote (satellite) sensing combined with modelling and existing surface measurements has recently been used for the assessment of population exposure at country level. Recent estimates have been published for $PM_{2.5}$ concentrations using this technology as part of the Global Burden of Diseases, Injuries and Risk Factors Project *(5)* (see Fig. 2). Further development of these methods and their precision depends to a large extent on the availability of surface measurements in all regions of the world.

Fig. 2.
Estimated 2005 annual average $PM_{2.5}$ concentrations (µg/m^3), presented according to the WHO AQG and interim target values



Source: Michael Brauer, personal communication based on *(5)*.

What are the health effects of PM?

PM_{10} and $PM_{2.5}$ include inhalable particles that are small enough to penetrate the thoracic region of the respiratory system. The health effects of inhalable PM are well documented. They are due to exposure over both the short term (hours, days) and long term (months, years) and include:

- respiratory and cardiovascular morbidity, such as aggravation of asthma, respiratory symptoms and an increase in hospital admissions;
- mortality from cardiovascular and respiratory diseases and from lung cancer.

There is good evidence of the effects of short-term exposure to PM_{10} on respiratory health, but for mortality, and especially as a consequence of long-term exposure, $PM_{2.5}$ is a stronger risk factor than the coarse part of PM_{10} (particles in the 2.5–10 µm range). All-cause daily mortality is estimated to increase by 0.2–0.6% per 10 $\mu g/m^3$ of PM_{10} *(6,7)*. Long-term exposure to $PM_{2.5}$ is associated with an increase in the long-term risk of cardiopulmonary mortality by 6–13% per 10 $\mu g/m^3$ of $PM_{2.5}$ *(8–10)*.

Susceptible groups with pre-existing lung or heart disease, as well as elderly people and children, are particularly vulnerable. For example, exposure to PM affects lung development in children, including reversible deficits in lung function as well as chronically reduced lung growth rate and a deficit in long-term lung function *(4)*. There is no evidence of a safe level of exposure or a threshold below which no adverse health effects occur. The exposure is ubiquitous and involuntary, increasing the significance of this determinant of health.

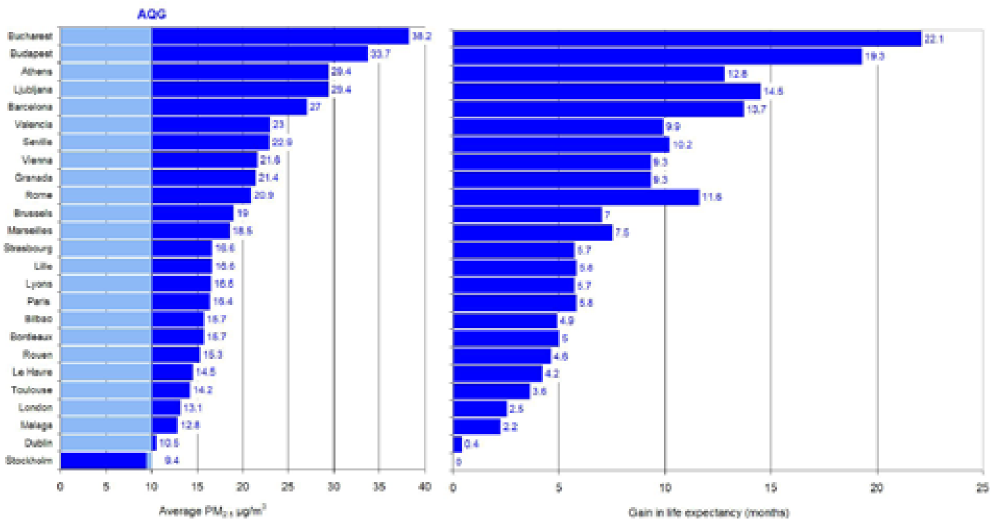
At present, at the population level, there is not enough evidence to identify differences in the effects of particles with different chemical compositions or emanating from various sources *(11)*. It should be noted, however, that the evidence for the hazardous nature of combustion-related PM (from both mobile and stationary sources) is more consistent than that for PM from other sources *(12)*. The black carbon part of $PM_{2.5}$, which results from incomplete combustion, has attracted the attention of the air quality community owing to the evidence for its contribution to detrimental effects on health as well as on climate. Many components of PM attached to black carbon are currently seen as responsible for health effects, for instance organics such as PAHs that are known carcinogens and directly toxic to the cells, as well as metals and inorganic salts. Recently, the exhaust from diesel engines (consisting mostly of particles) was classified by the International Agency for Research on Cancer as carcinogenic (Group 1) to humans *(13)*. This list also includes some PAHs and related exposures, as well as the household use of solid fuels *(14,15)*.

What is the burden of disease related to exposure to PM?

It is estimated that approximately 3% of cardiopulmonary and 5% of lung cancer deaths are attributable to PM globally. In the European Region, this proportion is 1–3% and 2–5%, respectively, in various subregions *(16)*. Results emerging from a recent study indicate that the burden of disease related to ambient air pollution may be even higher. This study estimates that in 2010, ambient air pollution, as annual $PM_{2.5}$, accounted for 3.1 million deaths and around 3.1% of global disability-adjusted life years *(17)*.

Exposure to $PM_{2.5}$ reduces the life expectancy of the population of the Region by about 8.6 months on average. Results from the scientific project Improving Knowledge and Communication for Decision-making on Air Pollution and Health in Europe (Aphekom), which uses traditional health impact assessment methods, indicate that average life expectancy in the most polluted cities could be increased by approximately 20 months if the long-term $PM_{2.5}$ concentration was reduced to the WHO (AQG) annual level (Fig. 3).

Fig. 3.
Predicted average gain in life expectancy (months) for people aged 30 years for a reduction in average annual levels of $PM_{2.5}$ down to the WHO AQG annual mean level of $10 \mu g/m^3$ in 25 European cities participating in the Aphekom project



Source: based on Medina *(18)*.

WHO AQGs

WHO last revised its AQG values for PM in 2005, as follows:

- for $PM_{2.5}$: 10 μg/m^3 for the annual average and 25 μg/m^3 for the 24-hour mean (not to be exceeded for more than 3 days/year);
- for PM_{10}: 20 μg/m^3 for the annual average and 50 μg/m^3 for the 24-hour mean.

In addition to these guideline values, the AQGs provide interim targets for each air pollutant, aimed at promoting a gradual shift to lower concentrations in highly polluted locations. If these targets were to be achieved, significant reductions in risks for acute and chronic health effects from air pollution could be expected. Progress towards the guideline values should, however, be the ultimate objective. As no threshold for PM has been identified below which no damage to health is observed, the recommended values should be regarded as representing acceptable and achievable objectives to minimize health effects in the context of local constraints, capabilities and public health priorities.

WHO is currently developing indoor air guidelines for household combustion of fuels for cooking, heating and lighting. These will provide recommendations for household fuels and technologies that will enable progress towards the AQGs.

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Evidence on effects of air quality improvements

There is consistent evidence that lower air pollution levels following a sustained, long-term intervention result in health benefits for the population, with improvements in population health occurring soon (a few years) after the reduction in pollution. Several successful interventions and accountability studies have been evaluated *(19,20)*. A few examples are summarized below.

Follow-up to the Harvard Six Cities Study, United States

A group of adults living in six cities in the United States was followed from 1974 to 2009 in order to estimate the effects of air pollution on mortality. Overall, $PM_{2.5}$ concentrations had decreased to below 15 µg/m^3 by 2000 (except in one city where levels were below 18 µg/m^3). The main finding was that a 2.5 µg/m^3 decrease in the annual average level of $PM_{2.5}$ was associated with a 3.5% reduction in all-cause mortality *(21–23)*. Results show associations between chronic exposure to $PM_{2.5}$ and all-cause, cardiovascular and lung cancer mortality, with health effects seen at any PM concentration. Results suggest that the critical period of exposure to $PM_{2.5}$ for the associated health effects is one year for all-cause mortality, implying that health improvements can be expected to start almost immediately after a reduction in air pollution. In a related study, but using different data, it was demonstrated that the reduction in fine particulate air pollution in the United States in the 1980s and 1990s accounted for as much as 15% of the 2.7-year overall increase in life expectancy that had occurred in that period *(24)*.

Short-term decrease in industrial emissions, United States

A copper smelter strike in 1967–1968 in four states, and the closure and reopening of a steel mill in Utah Valley in 1986–1987, are two examples of unplanned events which had a positive impact on health by decreasing air pollution concentrations in specific areas. The copper smelter strike led to a 60% drop in regional sulfur dioxide concentrations over eight months and was associated with a 2.5% decrease in mortality *(25)*. In the Utah Valley, the closure of the steel mill, which was the primary source of PM_{10} in the area, lasted for 13 months and led to a decrease in PM_{10} levels of approximately 50% during the closure in winter compared to the previous winter when the mill was operating. Hospital admissions for children were approximately three times lower and bronchitis and asthma admissions were halved when the mill was closed *(26)*. Furthermore, the reported 3.2% drop in daily numbers of deaths was associated with a simultaneous fall in PM_{10} levels of approximately 15 µg/m^3 while the steel mill was closed, the strongest association being with respiratory deaths *(27)*.

Respiratory health studies and air pollution abatement measures, Switzerland

The Swiss Study on Air Pollution and Lung Diseases in Adults assessed lung diseases in adults from eight Swiss communities in 1991 and again in 2002. Overall exposure to outdoor PM_{10} estimated at each individual's residence fell by an average of 6.2 μg/m^3 over the study period, to reach a range of approximately 5 μg/m^3 to 35 μg/m^3 in 2002, depending on the community. This reduction in particle levels was associated with attenuated age-related annual declines in various lung function parameters. The falling PM_{10} levels were also associated with fewer reports of respiratory symptoms such as regular cough, chronic cough or phlegm, and wheezing and breathlessness *(28,29)*. As part of a separate investigation, children from nine Swiss communities were followed between 1992 and 2001 as part of the Swiss Study on Childhood Allergy and Respiratory Symptoms with respect to Air Pollution, Climate and Pollen. Falling levels of regional PM_{10} were associated with a declining prevalence of various respiratory symptoms, including chronic cough, bronchitis, common cold, nocturnal dry cough and conjunctivitis symptoms *(30)*. These findings suggest that modest as well as drastic improvements in ambient air quality are beneficial for respiratory health in both children and adults.

These examples of successful interventions show that decreased levels of particulate air pollution can substantially diminish total, respiratory and cardiovascular death rates. Benefits can be expected at almost any reduction in levels of air pollution, which suggests that further policy efforts that reduce fine PM air pollution are likely to have continuing favourable effects on public health.

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Air quality management and policy

Up to 80% of particulate air pollution in EECCA countries can be reduced with currently available technologies *(31)*. The reduction of outdoor air pollutants in general, and PM in particular, requires concerted action by public authorities, industry and individuals at national, regional and even international levels. Responsible authorities with a vested interest in air pollution management include the environment, transport, land planning, public health, housing and energy sectors. Since the burden of air pollution on health is significant at even relatively low concentrations, the effective management of air quality is necessary to reduce health risks to a minimum.

The development and exchange of information on policies, strategies and technical measures to reduce emissions are part of the fundamental principles of the Convention on Long-range Transboundary Air Pollution. The Working Group on Strategies and Reviews of the Convention, and in particular its Expert Group on Techno-economic Issues *(32)*, maintains the database of information on control technologies for air pollution abatement and their costs. An example of its work is provided by the Group's 2010 report summarizing progress in work to reduce dust emissions from small combustion installations *(33)*.

There are co-benefits to addressing particulate air pollution that go beyond just the positive impact on health. For example, reductions in black carbon emissions from the strategic mitigation of combustion sources will also simultaneously reduce global warming *(34)*.

Finally, integrated policies on urban planning and transport can encourage the use of cleaner modes of transport and lead to changes in individual behaviour by promoting walking, cycling and increased commuting by public transport. These policies contribute to cleaner air while promoting physical activity and largely benefiting public health.

Conclusions

PM is a widespread air pollutant, present wherever people live.

The health effects of PM_{10} and $PM_{2.5}$ are well documented. There is no evidence of a safe level of exposure or a threshold below which no adverse health effects occur.

Since even at relatively low concentrations the burden of air pollution on health is significant, effective management of air quality aiming to achieve WHO AQG levels is necessary to reduce health risks to a minimum.

Monitoring of PM_{10} and/or $PM_{2.5}$ needs to be improved in many countries to assess population exposure and to assist local authorities in establishing plans for improving air quality.

There is evidence that decreased levels of particulate air pollution following a sustained intervention result in health benefits for the population assessed. These benefits can be seen with almost any decrease in level of PM. The health and economic impacts of inaction should be assessed.

Particulate air pollution can be reduced using current technologies.

Interventions resulting in a reduction in the health effects of air pollution range from regulatory measures (stricter air quality standards, limits for emissions from various sources), structural changes (such as reducing energy consumption, especially that based on combustion sources, changing modes of transport, land use planning) as well as behavioural changes by individuals by, for example, using cleaner modes of transport or household energy sources.

There are important potential co-benefits of integrating climate change and air pollution management strategies, as evidenced by the importance of the PM indicator and climate change contributor black carbon.

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