

Quantification of health effects related to SO₂ and NO₂ pollutants using Air quality model

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ABSTRACT

In the past few decades, the results of epidemiological studies have shown that there is a significant relationship between human health and air pollution. The aim of this study was to quantify the health effects, the estimated number of cases of death, cardiovascular and respiratory deaths attributed to NO₂ and SO₂ pollutants in Bukan city by Air Quality software. Bukan city has a population of 224,628 persons and an area of 2541.306 square kilometer. Raw data of SO₂ and NO₂ concentrations were received from the Department of Environment of Bukan city. To analyze the data, the Excel and Air quality 2.2.3 softwares were employed. The annual average of SO₂ concentration was 85.61 µg m⁻³ which is higher than the WHO AQGs and Iranian National Standard. Air Quality model predicted that with every 10 µg m⁻³ increase in gaseous SO₂, total, respiratory and cardiovascular mortality related to SO₂ was 36.2, 7.8 and 29.9 deaths, respectively. The average concentration of NO₂ was almost constant throughout the year. NO₂ concentration in summer and winter seasons was 25.23 and 25.95 µg m⁻³, respectively. Consequently, 0.64 and 0.36% of the total and cardiovascular mortality was due to NO₂, respectively. In conclusion, Air Quality software can be used for health risk assessment of SO₂ and NO₂ pollutants.

Keywords: Air pollution, Bukan, Nitrogen dioxide, Sulfur dioxide, Air Quality software.

Introduction

Today, air pollution is one of the most important environmental problems in world cities.¹ In the past few decades, the findings of epidemiological studies have shown that there is a significant relationship between human health and air pollution.^{2, 3} Air pollution is a serious challenge for human health which causes various diseases and deaths globally each year.^{4, 5}

The health effects of air pollution is divided into short-term and long-term effects.⁶ According to the estimate of World Health Organization (WHO), 800,000 persons have encountered premature death worldwide each year due to cardiovascular, respiratory diseases and lung cancer. Approximately, 150,000 deaths occur in South Asia.⁷ Also, it is estimated that 1.4% deaths in the world is attributed to air pollution.⁸ According to WHO Air Quality Guidelines (AQGs), criteria pollutants are nitrogen dioxide (NO₂), ozone (O₃), particulate matter (PM₁₀ and PM_{2.5}), sulfur dioxide (SO₂), carbon monoxide (CO) and lead (Pb).⁹ The results to estimate the disease burden by WHO show that 89% of all

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air pollution has been associated with cardiovascular and respiratory diseases.^{10, 11} Therefore, because each person inhales 10 m³ of air every day, investigating the effects of air pollutants on human health is very crucial. Nitrogen compounds are chemically different, but the most important form from the perspective of health is NO₂.¹² NO₂ is one of the criteria pollutants that has various effects on human health. The health effects of NO₂ is divided into short-term and long-term effects. Health effects include hospital admissions, upper and lower respiratory illness, bronchitis, chronic cough, and increasing infant mortality.¹³ In addition to health effects on humans, NO₂ can adsorb sunlight and reduce visibility.¹⁴ According to studies, the main effects of NO₂ occur as pulmonary and Chronic Obstructive Pulmonary Disease (COPD).¹ The WHO AQGs value is 40 µg m⁻³ (annual mean) that is set to protect the public from the health effects of NO₂[9]. NO₂ has natural and anthropological sources. Natural sources include lightning, volcanic activity, bacterial activity and oxidation of NO to NO₂ in the atmosphere.⁹ Anthropological sources include combustion processes, power stations, transportation systems, heating plants and industries. The main sources of NO₂ in urban air include motor vehicles (transportation system) and the combustion of fossil fuels that are responsible for the production of more than 70% of NO₂.^{9, 15} Health effects of NO₂ can occur at high and low concentrations. Epidemiological studies have shown that 5-7% of lung cancer in smoker and non-smoker can attributed to the existence of NO₂ in the atmosphere.^{16, 17} Some studies have shown that short-term exposure to NO₂ can cause cardiovascular death of exposed people.²¹⁸ SO₂ is one of the criteria pollutants of the atmosphere. Natural resources emitting SO₂ into the atmosphere are volcanic eruptions and forest fires. Anthropological sources of SO₂ include motor vehicles, burning of oil and coal at power stations. Health effects of SO₂ on human can be associated with these cases: constriction of airways, bronchitis, irritation of the eyes, nose, throat and airways, low depth of breathing, cardiovascular complications, breathing problems and COPD.^{17, 19} Studies have shown that there is a significant relationship between

SO₂ concentration and increasing hospital admissions due to asthma and other respiratory problems.²⁰ The findings of an epidemiological studies in Europe show that low concentration of SO₂ (less than 10 ppb) was related to increased mortality due to heart and respiratory illnesses. In other words, for every 10 ppb increase in SO₂ concentration, the risk of death increased by 0.2-2%.²¹ Therefore, as earlier mentioned, the aim of this study was to quantify the health effects, the estimated number of cases of death, cardiovascular and respiratory death attributed to NO₂ and SO₂ in Bukan city by Air Quality (Air Q) software.

Materials and Methods

Location data

West Azerbaijan province is located in northwestern Iran. Also, Bukan is located to the south of this province (36°32'N, 46°13'E). Based on the latest population census, Bukan has a population of 224,628 persons. Its height is 1370 meters above sea level with an area of 2541.306 square kilometer. The location of the Bukan city and its air quality monitoring station is shown in Fig.1. As shown in Fig.1, at present, Bukan city has only an air quality monitoring station which is located almost at the center of the town.

Data collection and processing

In this study, raw data of SO₂ and NO₂ concentrations were received from the Department of Environment of Bukan city. Data processing steps are shown in Fig.2. As shown in Fig.2, data processing is divided into four stages. In stage 1 (SO₂ and NO₂), concentration data were received from Department of Environment of Bukan city as Microsoft office excel spread sheet format. SO₂ and NO₂ concentrations (hourly) data were received from 2015 to 2016. Also, temperature and pressure data (for unit conversion) were received from the Meteorological Agency of Bukan city. In stage 2, SO₂ and NO₂ data were processed by MS excel 2013 software. SO₂ and NO₂ data in excel software were processed according to the following stages: Primary processing (removing, sheeting, integration time, corrections for temperature and pressure), secondary processing (code writing in excel, the calculation of SO₂ and NO₂ means, primary and

secondary filtering of data). For data analysis on short-term health impact assessment, interval of $10 \mu\text{g m}^{-3}$ was selected. Therefore, it is necessary to know the number of days the daily average falls within: Interval of $10 \mu\text{g m}^{-3}$: <10, 10-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80-89, 90-99, 100-109, 110-119, 120-129, 130-139, 140-149, 150-159, 160-169, 170-179, 180-189, 190-199, 200-249, 250-299, 300-349, 350-399, >400. Finally, after data classification according to interval of $10 \mu\text{g m}^{-3}$, the results were entered into Air Q software.

WHO criteria for quality health assessment

The received data of SO₂ and NO₂ should have the following criteria: I. data related to one year (1 January to 31 December), II. The data are divided into two seasons (winter: from January to March and from October to December inclusive and summer: from April to September inclusive), also, the ratio between the number of valid data for the two seasons of the year considered cannot be greater than 2. III. To obtain one-hour average values from data with a smaller averaging time, at least 75% of valid data should be used. IV. To obtain average values of 8-hour 'moving' from hourly measures, the number of hours where valid measures have been performed must be for at least 18 hours (75%). V. To obtain 24-hour average values from data, at least 50% of time should be available. VI. To obtain seasonal and annual average values, at least 50% of valid data for the reported period should be used.¹

Air Quality software

For data analysis, Air Q software version 2.2.3 was used. To use the Air Q software, the following information were required: latitude and longitude, city population, mean and maximum concentration (annual, winter and summer) of SO₂ and NO₂, annual 98 percentile, baseline incidence (BI) per 100,000 per year, relative risk (RR). In this study, BI and RR values were selected based on similar studies.^{19, 22}

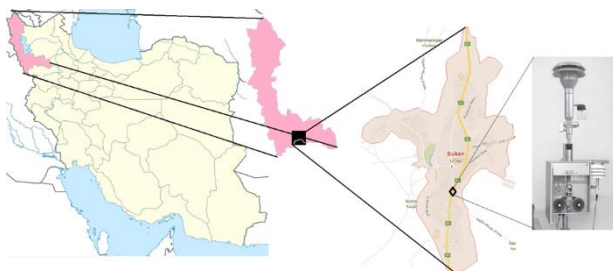


Fig.1 Location of the study area in Bukan city, West Azerbaijan, Iran.



Fig.2 Data processing with use of Air Q 2.2.3 software

Results and Discussion

This study investigated the health effects of SO₂ and NO₂ pollutants onto inhabitants in Bukan city by WHO approach. Table 1 shows descriptive analysis of SO₂ and NO₂ concentrations in various seasons of 2015-2106. WHO AQGs and Iranian National Standard have recommended an average concentration of $20 \mu\text{g m}^{-3}$ for SO₂.⁹ According to Table 1, the annual-average concentration of SO₂ was $85.61 \mu\text{g m}^{-3}$ which was higher than the WHO AQGs and Iranian National Standard. The average concentration of SO₂ was more in winter than in summer. SO₂ concentration in summer and winter was 79.51 and $92.35 \mu\text{g m}^{-3}$, respectively. Table 2 shows hourly-average concentration of SO₂ from 2014 to 2015. WHO AQGs for SO₂ was recommended as $20 \mu\text{g m}^{-3}$ (24-hour mean).⁹ In all months of the year, 24-hour concentration of SO₂ is higher than the WHO AQGs and Iranian National Standard. Table 3 presents RR with 95% CI which was used for estimating the health effects of SO₂ and NO₂. The values of Table 3 have been extracted from previous studies.²³ As shown in Table 3, health effects of SO₂ can be used to calculate mortality such as total mortality (except for deaths from traffic accidents), cardiovascular, respiratory mortality and morbidity such as Hospital Admissions (H.A), COPD disease and acute myocardial infarction. Table 4 shows the relationship between SO₂ concentration and the percentage of estimated AP % (attributed proportion), RR and estimated number of excess cases (persons). As shown in Table 4, Air Q model predicted that with $10 \mu\text{g m}^{-3}$ increase in every gaseous SO₂, total, respiratory and cardiovascular mortality in relation to SO₂ was 36.2, 7.8 and 29.9 deaths (mean), respectively. From 2015-2016 in Bukan city, there had been 935 deaths, and 57 deaths were attributed to driving accidents. In other words, 878 persons encountered non-accidental deaths. Consequently, 4.12, 0.889 and 3.4% of the total,

Table 1 SO₂ and NO₂ concentrations in different seasons

Average			SO ₂ (µg m ⁻³)			Percentile of 98%
			Maximum			
Annual	Summer	Winter	Annual	Summer	Winter	
85.61	79.51	92.35	365	199.62	365	189.88
Average			NO ₂ (µg m ⁻³)			Percentile of 98 %
			Maximum			
Annual	Summer	Winter	Annual	Summer	Winter	
25.58	25.23	25.95	42.09	32	42.09	33.9

respiratory and cardiovascular mortality were due to SO₂, respectively. The findings of Mohammadi et al showed that the number of deaths related to total and respiratory mortality with SO₂ was 157 (3.25%) and 26 (4.03%) persons, respectively, at Ahvaz in 2010.²⁴

WHO AQGs has recommended a concentration of 40 µg m⁻³ to protect the public from the health effects of gaseous NO₂.⁹ 15 Iranian National Standard also recommended 40 µg m⁻³.

According to Table 1, the annual-average concentration of NO₂ was 25.58 µg m⁻³ which was less than the WHO AQGs and Iranian National Standard. The average concentration of NO₂ was almost constant throughout the year. NO₂ concentration in summer and winter was 25.23 and 25.95 µg m⁻³, respectively. Table 2 shows hourly-average concentration of NO₂ from 2014 to 2015. WHO AQGs for NO₂ was recommended as 40 µg m⁻³ (1-hour mean).⁹ In all months of the year,

Table 2 SO₂ and NO₂ hourly-average concentrations (µg m⁻³) at Bukan city from 2014 to 2015.

		Maximum	Minimum	Mean
January	SO ₂	174.98	17.33	118.04
	NO ₂	31.93	22.09	25.24
February	SO ₂	155.91	26.1	63.68
	NO ₂	29.75	22.81	25.32
March	SO ₂	161.19	14.21	113.14
	NO ₂	42.09	23.33	26.73
April	SO ₂	155.07	22.99	84.4
	NO ₂	27.52	22.35	24.57
May	SO ₂	132.11	20.25	91.36
	NO ₂	28.16	22.35	24.83
June	SO ₂	138.46	13.68	95.02
	NO ₂	29.22	22.10	25.35
July	SO ₂	110.82	0.26	36.54
	NO ₂	28.59	18.65	24.82
August	SO ₂	104.07	15.12	72.09
	NO ₂	32	22.28	26.03
September	SO ₂	199.62	10.02	70.57
	NO ₂	29.42	20.5	25.78
October	SO ₂	237.27	6.4	149.17
	NO ₂	29.29	19.07	25
November	SO ₂	202.81	0.07	51.93
	NO ₂	25.55	21.09	23.44
December	SO ₂	136.43	0.02	43.87
	NO ₂	32.87	21.04	27.93

Table 3 Relative risk with 95% CI and corresponding reference, implemented by Air quality software and used for the estimate of health effects of SO₂ and NO₂

Health effects		Baseline Incidence	Relative risk per 10 µg m ⁻³			
			Low	Medium	High	
SO ₂	Total	543.5	1.003	1.008	1.0048	
	Mortality	Cardiovascular	231	1.002	1.008	1.012
		Respiratory	48.8	1.006	1.01	1.014
	Morbidity	H.A. COPD	101.4	1	1.0044	1.011
		Acute myocardial infraction	132	1.0026	1.0064	1.0101
NO ₂	Total	543.5	1.002	1.003	1.004	
	Cardiovascular	231	1.003	1.004	1.005	
	Morbidity	H.A. COPD	101.4	1.0006	1.0026	1.0044

hourly-NO₂ concentration was lower than the WHO AQGs.

The findings of Kermani et al revealed that the average-annual concentration of ozone and nitrogen dioxide was 130 and 64 µg/m³ in Tehran, respectively.¹ In addition, Naddafi et al study showed that annual-average concentration

of PM₁₀, SO₂, NO₂ and O₃ were 90.58, 89.16, 85 and 68.82 µg/m³ in Tehran, respectively.²² Table 3 presents RR with 95% CI which was used to estimate the health effects of NO₂. The values of Table 3 have been extracted from similar studies in Iran.^{15, 17, 25} As shown in Table 3, health effects of NO₂ can be used to calculate mortality

Table 4. Health effects, relative risks, estimated AP % and estimated number of excess case due to short term exposure to SO₂ concentration above 10 µg m⁻³

Health effects	RR (Medium)	Estimated AP (%)	Estimated number of excess cases (Persons)
Total mortality	Central	2.9606	36.2
	Lower	2.237	27.3
	Upper	3.5318	43.1
Cardiovascular mortality	Central	5.7509	29.9
	Lower	1.5025	7.8
	Upper	8.3853	43.6
Respiratory mortality	Central	7.0868	7.8
	Lower	4.3761	4.8
	Upper	9.648	10.6
H.A. COPD	Central	3.2471	7.4
	Lower	0	9
	Upper	7.7406	17.7
Acute myocardial infarction	Central	4.6543	13.8
	Lower	1.9445	5.8
	Upper	7.1526	21.2

such as total mortality (except for deaths from traffic accidents), cardiovascular mortality and morbidity such as H.A. COPD. Table 5 shows the relationship between NO₂ concentration with the percentage of estimated AP % (attributed proportion), RR and estimated number of excess cases (persons). According to Table 5, Air Q model predicted that with every 10 µg m⁻³ increase in gaseous NO₂, total and cardiovascular mortality was 5.6 and 3.2 deaths (mean), respectively. From 2015-2016 in Bukan city, there had been 935 deaths, and 57 deaths were attributed to driving accidents. In other words, 878 persons encountered non-driving-accidental deaths. Consequently, 0.64 and 0.36 % of the total and cardiovascular mortality was due to NO₂, respectively. Motalleby et al showed the number of deaths due to NO₂, SO₂,

and O₃ as 22, 82 and 54 persons, respectively, and that the highest health effect was due to SO₂.²⁶ The findings of Omidi et al showed that for every 10 µg/m³ increase in the NO₂ level, the risk of CM, MI, and HACOPD increased to about 0.2, 0.36, and 0.38%, respectively.¹⁷ The modeling results of Zallaghi et al showed that in 2011, 13 cases of respiratory deaths in Tabriz city were due to SO₂. Also, the cumulative number of COPD related to SO₂ was 9.¹⁸ Jeong study showed that among studied pollutants, PM₁₀ had the highest health effect on the 1118000 persons of Suwon city, causing an excess of total mortality of 105 out of 4254 in a year and SO₂ had the least health effect. Also, O₃ and NO₂ each caused 42.7 and 81.3 excess cases of total mortality in a year, respectively.²⁷ The results of Ghozikali et al at

Table 5. Health effects, relative risks, estimated AP % and estimated number of excess case due to short term exposure to NO₂ concentration above 10 µg m⁻³

Health effects	RR (Medium)	Estimated AP (%)	Estimated number of excess cases (Persons)
Total mortality	Central	0.46	5.6
	Lower	0.3072	3.8
	Upper	0.6124	7.4
Cardiovascular mortality	Central	0.6124	3.2
	Lower	0.46	2.4
	Upper	0.7644	4
H.A. COPD	Central	0.3989	0.9
	Lower	0.0923	0.2
	Upper	0.6733	1.5

Tabriz in 2014 showed that 0.9 and 0.4% of H.A. COPD were related to SO₂ and NO₂ at a

concentration of over 10 µg/m³, respectively.²⁸ In another study by Ghozikali et al, the findings

showed that 0.5 and 0.7% of H.A. COPD were related to SO₂ and NO₂ at a concentration of over 10 µg/m³, respectively.²⁹ For monitoring of public health, continuous survey of criteria pollutants in air pollution, modeling and simulation can be very useful.

Conclusion

The findings of this study showed that concentration of gaseous SO₂ and NO₂ were higher and less than WHO AQGs and Iranian National Standard, respectively. Annual-average concentration of SO₂ and NO₂ were 85.61 and 25.58 µg m⁻³, respectively. Quantification of the health effects of nitrogen dioxide and sulfur dioxide pollutants were performed with Air Quality software. The use of this software for health-risk assessment is very simple and it can give useful information on the field.

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