

ICOH Statement: Global Asbestos Ban and the Elimination of Asbestos-Related Diseases

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The International Commission on Occupational Health (ICOH) calls for a global ban on the mining, sale and use of all forms of asbestos and for the elimination of asbestos-related diseases. To accomplish the elimination of asbestos-related diseases, we urge each and every individual country to implement a total ban on production and use of asbestos. We also urge complementary efforts aimed at primary, secondary and tertiary prevention of asbestos-related diseases through country-specific “National Programmes for Elimination of Asbestos-Related Diseases” in line with ILO and WHO guidelines.

There is sufficient evidence in humans for the carcinogenicity of all forms of asbestos (chrysotile, crocidolite, amosite, tremolite, actinolite and anthophyllite). Malignant asbestos-related diseases include lung cancer, mesothelioma and cancers of the ovary and larynx.¹⁾ Non-malignant asbestos-related diseases include asbestosis and pleural abnormalities such as pleural thickening, pleural calcification and pleural effusion.²⁾

International consensus has recommended that a total ban on production and use of all forms of asbestos is the best way to eliminate the occurrence of asbestos-related diseases. In 2006 WHO stated that the most efficient way to eliminate asbestos-related diseases is to stop using all types of asbestos.³⁾ The ILO Resolution on Asbestos, 2006, calls for eliminating the use of asbestos and identifying and properly managing asbestos currently in place as the most effective means to protect workers from asbestos and to prevent future asbestos-related diseases and deaths.⁴⁾ By government decision, a number of countries have already adopted a universal ban on all types of asbestos based on recognition of the substantial human and economic burden of diseases caused by asbestos. Some other countries have banned the use of amphibole asbestos, predominantly crocidolite, but have not banned the use of chrysotile. As there is sufficient evidence by the International Agency on Research on Cancer (IARC 2012) of the carcinogenicity in humans for all forms of asbestos, amphibole-only bans are inadequate; asbestos bans need to include chrysotile as well.

Some countries have banned the production and/or use of asbestos-containing industrial products, but have continued to mine, sell and export asbestos. This is an unacceptable policy and should be reconsidered by those countries. In order to be effective, a total ban on production, use and export of all forms of asbestos should be achieved in every country.

Even after a total ban on production and use of asbestos is achieved, occupational exposure to asbestos will persist due to the continued presence of asbestos from prior use in building materials and durable machinery/equipment. Workers who carry out maintenance, demolition and removal of asbestos-containing materials will thus continue to be at risk. Therefore a set of protective measures must be implemented to optimize effective prevention. The adoption of a total ban on all use of asbestos and products, equipment and materials containing asbestos implies a need to follow up the implementation of the ban with supplementary regulations and national programmes for ensuring the elimination of all use of asbestos and the required protection from exposure to asbestos. This includes, as appropriate, the review of legislation and regulatory systems regarding trade and the protection of consumers and the external environment.

Primary prevention involves ensuring control of exposures to airborne asbestos fibres, monitoring concentrations according to established standards and reporting exposure levels to appropriate

authorities. There is no exposure level below which asbestos-related disease risk can be totally eliminated. A global ban represents the best form of primary prevention. Additionally, for those countries that have already adopted a ban on the production and use of asbestos, environmental decontamination required for buildings, industrial facilities and infrastructures can represent a further form of primary prevention with beneficial impacts both on the people working in contaminated sites and on the general population. To minimize asbestos exposure, reference exposure limits (i.e., occupational exposure limits) should adhere to international standards. Complying with these limits will reduce, but not totally eliminate, the risk of asbestos-related diseases. Exposed workers should be informed about their working conditions and associated hazards, and provided with appropriate respirators. While respirators should not be relied upon as the sole means of routinely limiting exposure to asbestos fibres, workers provided with them should be trained for their proper use, and encouraged to wear them when warranted. Adequate fitting, changing of filters, sanitary storage and maintenance of respirators are also required for optimal protection. Licensing or authorization procedures need to be considered to ensure safe handling, repair, maintenance and demolishing operations. Ambient air levels at the boundary of demolition sites adjacent to residential areas should be strictly monitored and kept below exposure limits. Proper and safe handling of asbestos-contaminated waste is essential. Finally, in view of the synergistic effect of smoking and asbestos exposure on lung cancer risk, access to smoking cessation programmes is essential for all workers currently and previously exposed to asbestos.

Secondary prevention includes medical monitoring of exposed workers, early diagnosis and individual case management to prevent disease progression. Secondary prevention is not effective for mesothelioma and is not yet proven to be effective for lung cancer among asbestos exposed individuals, but individuals identified with early asbestosis can be transferred away or protected from further exposure with the intent of slowing progression of their disease. Malignant and non-malignant asbestos-related diseases can be diagnosed according to established guidelines.^{2, 5)}

Tertiary prevention includes medical intervention and public health services to limit disease-related disability and help workers affected by asbestos-related diseases to cope with chronic effects of their disease. Appropriate medical care and rehabilitation for the diseases and their potential complications, including immunization against pulmonary infections, should be provided. After disability and impairment evaluation, just compensation and disability benefits should also be provided, as warranted.

Individuals with asbestos-related diseases should be reported to authorities and public health registries. Public health surveillance of asbestos-related diseases, in particular malignant mesothelioma, asbestosis and pleural abnormalities, can help track progress towards eliminating asbestos-related diseases and may identify where further primary prevention efforts are needed. Public health surveillance of reported exposure levels can also be used to target enhanced primary prevention.

Achieving a worldwide ban on the mining, sale and use of all forms of asbestos and the elimination of asbestos-related diseases will require that physicians and occupational health personnel responsibly and persistently express their concerns, raise awareness and take necessary action regarding the need to prevent asbestos-related diseases. Recognizing the urgent need for coordinated actions, ICOH will continue to foster global and national collaboration in this endeavour, promoting the engagement of ICOH members in training occupational medicine and health professionals in competencies needed to support comprehensive national efforts to eliminate asbestos-related diseases.

References

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