



Workshop report Shaping the message: “Towards a WHO European Region free of asbestos–related diseases”

**Report of a meeting in Bonn, Germany
10-11 June 2014**



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

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ABSTRACT

In June 2014, the WHO Regional Office for Europe conducted a workshop to assess progress achieved in selected countries of the WHO European Region in implementing the commitment of the *Parma Declaration on Environment and Health* (2010) towards the development of national programmes for the elimination of asbestos-related diseases in the WHO European Region by 2015. Challenges experienced in the countries in this respect and the future involvement of WHO in dealing with these were discussed.

KEYWORDS

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Acknowledgments

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Introduction

Asbestos is one of the most severe and widespread environmental and occupational health hazards in the WHO European Region. Responsible for half of all lethal cancers linked to exposure at work, it has been estimated, despite underreporting (1), that more than 107 000 people worldwide die every year from asbestos exposure at work (2). According to Volume 100C of the International Agency for Research on Cancer (IARC) monographs (2012), this insidious killer causes fatal diseases, such as lung, ovarian and laryngeal cancer, mesothelioma and asbestosis, several decades after exposure (3).¹

Since there is no safe level of exposure to asbestos, the only way to eliminate asbestos-related diseases (ARDs) is to stop the use of asbestos in any form. All forms of asbestos are carcinogenic to humans – even very low levels of exposure to it increase the risk for cancer – and asbestos can be substituted with safer materials.

WHO and International Labour Organization (ILO) recommend that all forms of asbestos should be banned in order to eliminate ARDs (4). In the WHO European Region, 37 of the 53 Member States have banned the use of all forms of asbestos. Nevertheless, some countries are still producing, trading, and using asbestos, and an estimated 300 million people are still exposed to asbestos both in and outside the work place.

In endorsing the *Global plan of action on workers' health for 2008–2017* at the Sixtieth World Health Assembly in 2007, the Member States requested WHO to conduct a global campaign for the elimination of ARDs, "bearing in mind a differentiated approach to regulating its various forms – in line with the relevant international legal instruments and the latest evidence for effective interventions" (5). This formulation does not signify that WHO endorses the use of asbestos in any way.

In 2010, the Member States adopted the *Parma Declaration on Environment and Health* (6), committing themselves to taking action on a range of environmental issues affecting health, including the use of asbestos, and to developing national programmes for the elimination of ARDs by 2015, in collaboration with ILO and WHO.

The WHO Regional Office for Europe has been actively supporting the Member States in this endeavour and has provided technical assistance through a series of meetings on: the development of national programmes for the elimination of ARDs (2011); assessment of the human and financial burden of asbestos in the WHO European Region (2012); and an evidence review and policy implications related to multiple exposures and risks (2013).

¹ See written comments of the representative of Kazakhstan (submitted after the meeting during the final consultation on the text of the report) in Annex 1.

With the aim of providing technical support in the development of national programmes and profiles on asbestos, and of discussing progress in selected countries of the WHO European Region towards meeting the commitments of the Parma Declaration (6), the WHO European Centre for Environment and Health of the WHO Regional Office for Europe organized a workshop for representatives of these countries in Bonn, Federal Republic of Germany, on 10–11 June 2014.

Organization of the workshop

In preparation for the European Environment and Health Task Force high-level mid-term review meeting, all WHO European Member States were invited to participate in a survey to assess the development of environment and health policies and progress made towards meeting the commitments of the Parma Declaration (6), including the development of national programmes for the elimination of ARDs by 2015. The results of this survey formed the basis of the discussions at the workshop, the programme of which is attached as Annex 2.

Representatives of 15 Member States and the European Commission, nine WHO temporary advisers, and staff members of the WHO European Centre for Environment and Health participated in the workshop (Annex 3).

Petar Bulat was elected as Chairperson and Jeongim Park as Rapporteur. All comments and suggestions made during the meeting and submitted after finalization of the draft report (Annex 1) have been addressed in the report.

Asbestos policy in Member States: progress made

In early 2014, the WHO European Centre for Environment and Health carried out a survey to assess the progress made by Member States towards the implementation of the time-bound targets of the Parma Declaration (6).

The survey questionnaire comprised six sections covering different targets, one of which included 17 questions regarding national programmes for the elimination of ARDs. Within the three-month deadline for response, WHO received the completed questionnaire from 31 of the 53 Member States; responses received after the deadline were not included in the analysis. Twice as many responses were received from countries with policies banning the use of all forms of asbestos (70%: 26 out of 37) as from those without such policies (30%: 5 out of 16).

The survey analysis indicated a need for urgent action to achieve the goals of the Parma Declaration (6) to protect people from asbestos-related risks.

The need to develop national programmes for the elimination of ARDs (NPEAD) in Member States needs to be emphasized, especially where asbestos was banned at an early stage, and to adhere to the requirements of ILO/WHO regarding periodic updates, issued in 2007 (4). At the moment, 47% of the responding countries have such programmes. This approach would enable a

more comprehensive approach to protection against asbestos risks and the monitoring of achievements in the Member States.

More needs to be done in countries where chrysotile-containing products are still being produced and traded. While the most efficient way to eliminate ARDs is to ban the use and trade of all forms of asbestos, the adoption of regulations on providing health-hazard warning signs or labels is strongly encouraged. In this context, the inclusion of chrysotile asbestos in the list of chemicals for which there is a need for informed prior consent by the importing countries was proposed by the majority of the Parties to the Rotterdam Convention, promoting the sharing of responsibilities to protect human health and the environment from potential harm caused by hazardous chemicals (7). However, no political consensus was achieved on this proposal by the seventh Conference of the Parties (COP) to the Rotterdam Convention, which took place in Geneva in May 2015, and the decision was deferred to the eighth COP.

There is also a need to make an inventory of existing asbestos-containing materials to define the baseline and targets, and to review progress made on a regular basis. The inclusion of the clinical and epidemiological aspects of asbestosis, lung cancer and mesothelioma in further-education programmes related to asbestos is recommended for primary-care physicians and specialists in respiratory tract and occupational health working in countries where asbestos is used.

Policies on incentives for the safe removal and disposal of asbestos from buildings, including the safe transport of asbestos-containing materials to landfills, need to be promoted; the survey revealed that these procedures were in place in only 50% of the responding Member States. It is also noteworthy that countries without policies on banning the use of all forms of asbestos indicated that they did not have legally binding policies on safe removal of asbestos and depositing asbestos-containing waste as hazardous.

All policies relating to the elimination of ARDs should stipulate that serious consideration must be given to children as a vulnerable group. In many countries, even policies implemented after the endorsement of the Parma Declaration (6) do not address the presence of asbestos in schools or kindergartens.

Surveillance of occupational diseases, including asbestos-related diseases

The key elements required for the better surveillance of occupational diseases, including ARDs, and the experience gained in the Member States in developing such registries, were presented during this session.

Monitoring of exposure

Timo Tuomi, Finnish Institute of Occupational Health, Helsinki, reported on asbestos exposure in Finland. He stressed that in spite of a decline in exposure to asbestos, the total number of ARDs had not decreased after the introduction of the ban on all forms of asbestos in Finland in 1994. This was mostly due to the long latency period between exposure and manifestation of disease. About half of the asbestos that has ever been used in the construction industry in Finland is still in place. Before the ban, workers were exposed to asbestos during construction activities, but nowadays the main occupational exposure occurs during activities related to asbestos removal, waste handling, and the repair and maintenance of premises with asbestos-containing

materials. Environmental and domestic exposure may occur during the renovation of buildings with asbestos-containing materials or because of poor dust control during the removal of the materials and waste handling. According to Timo Tuomi, ARD epidemics will continue to happen unless the use and production of new asbestos and the occupational exposure of workers to asbestos are stopped.

The current limit values in the European Union (EU) are 0.1 f/cm³ for fibres longer than 5 µm, thinner than 3 µm and with a length:breadth ratio greater than 3:1 in workplace air and 0.01 f/cm³ elsewhere. In measuring and analysing asbestos, a distinction should be made between airborne fibres, settled dust on surfaces, and asbestos as a constituent. To measure the concentration of asbestos fibres in the air, an energy-dispersive x-ray analysis (EDS) is carried out, which also determines the asbestos-fibre concentration in respirators (less than 0.01 f/cm³) during asbestos removal when air concentrations are between 50 f/cm³ and as much as 200 f/cm³ (sprayed asbestos). Autopsies have shown a mean chrysotile-fibre concentration of between 8.0 f/g and 11.6 million f/g in the lung tissue of workers employed in the mining, milling or manufacturing of chrysotile asbestos (8).

In evaluating asbestos exposure from work history records, interviews and employment records are used, as well as a differentiation of the probabilities of exposure by workplace or occupation, or the so-called fibre-years approach, which counts the cumulative dose of an individual by multiplying the number of workdays per year with the mean fibre concentration in the air during a workday.

Timo Tuomi concluded by highlighting the need to ensure that asbestos removal and waste management were safe and to develop reliable, low-cost methods of identifying asbestos.

Occupational-diseases registries

For practical reasons, presentations on occupational-diseases reporting, including occupational injuries systems were limited to two Member States (Italy and Serbia). Some of the countries undergoing the EU accession process have revised and integrated their legislative regulations.

Italy

The relevant Italian experience was presented, bearing in mind that the country had been a major producer and user of asbestos until it was banned in 1992 (Law 257/1992) and that – given the long latency of the disease – the spread of mesothelioma, which is directly connected with exposure to asbestos, was likely to continue to an estimated peak of about 800 mesothelioma deaths annually in the period 2012–2024 (9).

The Lombardy Mesothelioma Registry (RML) was established in 2000 in the most populated and industrialized region of Italy. RML is part of the National Mesothelioma Registry (ReNaM), which represents the best source of data on mesothelioma cases. According to ReNaM, more than 1500 cases of mesothelioma of all sites were registered in 2011. Carolina Mensi, WHO Collaborating Centre for Occupational Health, Clinica del Lavoro “Luigi Devoto”, Milan, Italy, explained that diagnosis is ascertained through an examination of the clinical records, including histology reports in accordance with the ReNaM guidelines. A standardized questionnaire is completed for confirmed cases. A panel of industrial hygienists and occupational-health physicians evaluates asbestos exposure in workplaces and environmental settings. The

completeness of case ascertainment is routinely verified using other sources, such as hospital discharge records (coded as 163 (International Classification of Diseases (ICD) IX)) and death certificates (coded as C45 (ICD X)). Asbestos-exposure profiles are evaluated as "occupational", "non-occupational", "unlikely" or "unknown".

In the period 2000–2011, RML identified 4000 cases of mesothelioma in Lombardy, which has 10 million inhabitants; this is equivalent to about one-fourth of all Italian cases. Asbestos exposure is mainly occupational and more frequent among men, with little variation of exposure profiles over time. The experience gathered by RML over the years has led to the establishment of an efficient information network of different institutions and health services. In addition, practical skills in processing epidemiological data have been acquired, which are useful in addressing new scientific hypotheses and planning ad hoc research. RML is a useful epidemiological surveillance model that is transferrable to different occupational tumours (for example, sinonasal cancers).

Dario Consonni, WHO Collaborating Centre for Occupational Health, Clinica del Lavoro "Luigi Devoto", Milan, Italy, added that it is compulsory to report the exposure of workers to occupational carcinogens and suspected occupational cancers to the Italian Workers' Compensation Authority (INAIL). However, apart from mesothelioma, the underreporting of occupational cancers is a very serious issue (10). In addition, most patients with occupational diseases (including mesothelioma) do not seek or receive adequate compensation (11,12).

Serbia

Petar Bulat, Vice-Dean, University of Belgrade School of Medicine, Belgrade, Serbia, introduced the Health Insurance Act, which came into effect in 2011, defining occupational injuries and diseases. The Act requires that any case of injury at the workplace be recorded by a medical doctor working in the field of occupational injury and confirmed by the employer and the labour inspector. He highlighted that this concept not only provides accurate, timely information on occupational injuries to all the entities concerned, but it also brings questions about the functions of the labour inspectors and the education of doctors and inspectors into focus, leading to periodic updates of the national regulations on occupational injuries. An e-registry of occupational diseases was in place as a result of wide discussions among the stakeholders, including experts, employers, occupational-health specialists and general practitioners.

In Serbia, 56 diseases are included in the occupational-diseases registry. The limitations of the system are that the list is not open for eventual new diseases, so a full approval process should be performed in case of adding to it. General practitioners (GPs) are not sufficiently trained in the area of occupational diseases. Furthermore, it is not clear where responsibility for the diagnosis and reporting of occupational diseases lies, and what the diagnostic criteria are. In the past, this has led to serious underreporting. The country also has a national cancer registry, which is not yet linked with other registries; it is a good source of data on mesothelioma although these are only indicative of data on asbestos-related lung cancer.

Overall, the coordination of and collaboration between the different ministries to establish reliable disease registries is a challenge. As already mentioned, the education of GPs in occupational-diseases diagnostics is insufficient, and the agency responsible for covering expenses related to diagnostic procedures has yet to be identified. It is believed that the harmonization of diagnostic criteria for occupational diseases would enable the comparison of data between countries.

Cancer registration, including occupational cancers and asbestos-related occupational cancers

Stefano Rosso, European Network of Cancer Registries, presented a brief history of the population-based cancer registries (PBCR) established in countries before 1955 for either voluntary or compulsory notification. The main document regulating the functionality of mesothelioma and occupational-cancer registries in EU is Directive 83/477/EEC, particularly Article 17 (13). The main purposes of establishing PBCR are to assess the cancer burden and measure the impact of interventions in cancer prevention and control. Since 2011, WHO has estimated cancer to be the leading cause of death worldwide and, according to its latest data, the highest incidences of mesothelioma are found in Italy, Australia, and the United Kingdom, while the highest mortality rates are registered in the United Kingdom, the Netherlands and Australia, notably affecting men.

It is generally acknowledged that the quality of cancer registers must be improved, especially as regards completeness of data on a regular basis, and that measures should be more quantitative to provide the opportunity for better comparability and clustering (14). In addition, countries that have not yet implemented cancer registration should consider doing so soon, especially in areas where exposure to asbestos, both occupational and environmental, has occurred. In this context, in relation to the registration of mesothelioma cases, experience suggests that exposure should be measured by reconstructing its history. Stefano Rosso stressed that this should be done by collecting and analysing documents, comparing records, and retrospectively assessing industrial processes and environmental exposure, complemented by personal interviews.

Criteria for diagnosis and attribution of ARDs

Although many countries have banned the use of all forms of asbestos, the adverse health effects of past exposure continue for decades.

Thomas Kraus, Aachen University, Germany, presented the diagnostic criteria of four major ARDs: asbestosis, pleural thickening, lung cancer, and mesothelioma. Exposure history, latency, symptoms, clinical findings, radiological findings based on ILO classification, and the International Classification System for Occupational and Environmental Respiratory Diseases (ICOERD) in relation to each ARD were discussed. The application of high-resolution computed tomography (HRCT) can improve the sensitivity of ARD diagnosis and could serve as a basis for the reporting criteria in the Germany. HRCT is also recommended in the consensus report published by the Finnish Institute of Occupational Health, *Asbestos, asbestosis, and cancer: Helsinki criteria for diagnosis and attribution 2014* (15), which is an update of the version published in 1997.

Dr Timo Tuomi provided a brief summary of the report, which summarizes current information on methods for the management and elimination of ARDs, mainly in the following four areas.

1. Computed tomography (CT) screening for asbestos-related lung cancer

Low-dose CT is recommended for workers exposed to asbestos who meet the minimum criteria of the National Lung Screening Trial (NLST) based on asbestos exposure and smoking history.

2. Follow-up and diagnosis of non-malignant ARDs

Stratified and risk-based approaches are recommended for the follow-up of workers exposed to asbestos. Chest radiography is still the dominant method used for medical, legal and compensation purposes. ICOERD, using HRCT, is recommended to diagnose non-malignant effects. Spirometry and questionnaires including detailed exposure history and smoking habits are still recommended. Influenza and pneumococcal vaccination is recommended for patients with asbestosis.

3. New asbestos-related-disease entities

Six entities were evaluated in addition to those included in the original version of the Helsinki criteria (1997). The results indicated that: laryngeal cancer and ovarian cancer can be viewed as asbestos-caused diseases; colorectal cancer and stomach cancer cannot currently be viewed as asbestos-caused diseases as the evidence is limited; retroperitoneal fibrosis can be caused by asbestos; and ventilatory impairment and chronic airway obstruction may be considered asbestos-caused if asbestos exposure and the presence of asbestos-related radiographic changes are involved.

4. Pathology and biomarkers

Based on the evidence, recommendations were made by an international group of experts on histological types of lung cancer associated with asbestos exposure, histological criteria for asbestosis diagnosis, biomarkers for the histopathological diagnosis of mesothelioma, screening for early diagnosis of mesothelioma, and markers for asbestos attribution in lung cancer.

Consolidated action to eliminate ARDs

Information on the different approaches taken to address the wider involvement of stakeholders in decision-making related to, and the implementation of, national policies was presented by the representatives of two WHO collaborating centers on occupational health.

Jovanka Karadzinska-Bislimovska, Institute of Occupational Health, Skopje, The former Yugoslav Republic of Macedonia, outlined the major steps taken in implementing public health action to eliminate ARDs based on the national experience. Enhanced public awareness about hazards facilitates setting up preventive measures, reducing risks and avoiding costly activities to protect the population. This is summarized in the "situation awareness model", which provides information to all stakeholders (namely, the general public, state and non-governmental workers, the media, the community and employers) on relevant factors in the environment. This exercise triggers decision-making at the local and national levels.

Eun-Kee Park, Associate Professor, Kosin University College of Medicine, Busan, Republic of Korea, presented the user-friendly web-based "Toolkit for the elimination of asbestos-related diseases" (16) developed jointly by the University of Occupational and Environmental Health Japan, and the Occupational Safety and Health Research Institute (Republic of Korea). He noted that the most effective way to combat ARDs is to stop the use of all forms of asbestos in

accordance with the ILO/WHO recommendations (4). All existing legislation on asbestos, as well as evidence and best practices, had been incorporated in the toolkit to enforce scientifically based policy development in countries. It provides scientific references on key issues: assessment of asbestos exposure; risk identification and substitutes; asbestos-related legislation and regulations; tools for diagnosing ARDs; economic cost and burden incurred by asbestos exposure and ARDs; and risk communication.

International approach to universal health coverage of workers

Jorge Costa-David, representing the European Commission Directorate-General for Employment, Social Affairs and Inclusion (DG EMPL) provided information on: (i) EU's legal basis for the protection of workers reflected in Directive 2009/148/EC on exposure to asbestos at work (17), describing some of its main provisions; (ii) the meeting of EU Member States held in June 2013 to review the effectiveness of measures taken within the current asbestos-related framework at EU level; (iii) the European Parliament resolution on asbestos-related occupational health threats and prospects for abolishing all existing asbestos (2013) (18); (iv) some initiatives taken under the auspices of EC, including the publication of two guidance documents for workers by DG EMPL and the Occupational Safety and Health Agency (OSHA) (19,20); and (v) other OSHA activities in this area.

The EU Member States are taking the methodology outlined in *European Occupational Diseases Statistics (EODS). Phase I: methodology* (2000) into consideration in processes related to ARDs (21). However, the diversity of their systems has raised difficulties in responding to the changing landscape of occupational diseases as a result of the emergence of new risk factors and the transformation of work patterns. Therefore, the Commission carried out an evaluation of the measures taken in the EU, the results of which were revealed in the report, *Occupational Diseases in the EU* (22). This issue was also addressed at a conference organized by the European Commission in December 2013 to discuss the magnitude of occupational diseases in the EU (23). The conference also dealt with the role of science in the current approaches to the administration and management of, as well as policy on, occupational diseases, including an analysis of some of the main national and international systems (23).

In sharing WHO's vision of universal health coverage for all workers through basic occupational health services, Ivan Ivanov, Scientist, Interventions for Healthy Environments, WHO headquarters, outlined the legal framework related to Resolution WHA60.26 – Workers' health: global plan of action – adopted at the Sixtieth World Health Assembly (2007) (24). He addressed the fact that occupational risks have an important health and financial impact and referred to the United Nations resolution on universal health coverage (2012) (25), which emphasizes the necessity for health-promotion and disease-prevention services over and above curative measures. The resolution focuses on poor, vulnerable and marginalized groups, workers in the informal sector, and migrant workers.

There is, therefore, a need to expand the health-care coverage of workers, by taking action in three major areas, namely to:

1. increase financial allocations and ensure (through insurance schemes) that workers do not have to pay for the prevention, diagnosis, treatment and rehabilitation related to occupational diseases and injuries;

2. increase the number of interventions aimed at the primary prevention of occupational risks and promote capacity-building at the workplace; and
3. improve access to essential health services of workers in the informal sector and small enterprises, as well as farmers and migrant workers, to include:
 - (a) primary prevention of occupational risks – provision of advice on how to improve working conditions through workplace visits, information materials and workers' training);
 - (b) secondary prevention – early detection and eventual treatment of work-related diseases and injuries); and
 - (c) tertiary prevention – promotion of working capacity and fitness for work and reduction of absence due to illness).

As part of the UN InterAgency Working Group on Costing (IAWG-Costing),² WHO provided technical oversight in the development of OneHealth (26), a software costing tool designed to inform national strategic health planning in low- and middle-income countries. A special module on workers' health within the OneHealth tool is under finalization. It will enable countries to integrate the above-mentioned interventions in their national health accounts and mobilize additional resources, for example, through social security and the pooling of private funds. The focus will be on building health-system capacity and delivering interventions incorporating the largest possible number of workers, particularly those in the informal sector and small-scale work settings, as well as migrant workers. Health systems should help people to keep their jobs and earning potential.

Conclusions and recommendations

Discussions at the workshop contributed to identifying the following challenges in Member States.

- In some countries, health registries are administered at the regional level, which results in segregated, incomparable health data at the national level.
- Some Member States emphasized the necessity of gathering data before taking required measures; others preferred not to wait for the establishment of national registers and had already started to take action based on published scientific evidence and the experiences of other countries.
- The introduction of incentives to encourage GPs to report on occupational diseases, including ARDs, was considered useful. Existing incentives for the removal of asbestos-containing materials were limited and the procurement of new materials was becoming unaffordable in some rural areas.
- Sometimes asbestos-containing materials that are removed from buildings are not safely deposited due to the lack or insufficient enforcement of legislation on toxic waste. At times, these materials are even sold on the black market.

² Recognizing the need to peer review costing and budgeting tools and their application in countries, the Inter-Agency Working Group on Costing for Health Systems (UNAIDS, UNDP, UNFPA, UNICEF, the World Bank and WHO) works to harmonize costing tools and processes to improve efficiency at the country level, achieve interoperability, and coordinate the provision of technical assistance.

- Conveying the message to policy-makers to facilitate decision-making is sometimes difficult; even asbestos focal points can experience obstacles in reaching high-level officials.

In the light of the encouraging discussions and the progress already made, WHO agreed to meet the requests of the Member States for technical support in the following areas.

1. Prevention of ARDs

- provision of information on asbestos substitutes and the organization of a workshop on this topic;
- awareness-raising of the general public and policy-makers about the health effects of all forms of asbestos, based on scientific evidence.

2. Early diagnosis of ARDs

- provision of a training module for, and capacity-building of, medical doctors (occupational-health specialists, pulmonologists, etc.) in performing diagnostic procedures for the early detection of ARDs (particularly highlighted by countries initiating activities on the elimination of ARDs);
- provision of educational materials for general practitioners, including those providing services outside the health-care system, to alert them about ARDs.

3. Policy development

- support in justifying the need for the development of strategies for the management of asbestos waste;
- support in making an inventory of existing asbestos-containing materials in construction sectors (both private and public premises);
- support in establishing national registers on occupational diseases including ARDs, as well as national cancer registers, and in the organization of a workshop on these two topics.

The participants in the workshop underlined the need to extend the 2015 deadline of the Parma Declaration (6) for the development of a framework for and policy on the elimination of ARDs.

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ANNEX 1. Written comments of the representative of Kazakhstan (submitted after closure of the meeting during the final consultation on the text of the draft report)

Comment 1

К сожалению, ВОЗ в своих оценках не предоставляет информации о вкладе влияния различных видов асбеста в асбестообусловленную заболеваемость и смертность. При этом существует широкий консенсус относительно того, что способность вызывать заболеваемость у различных видов асбеста существенно отличается. Так, сами авторы оценок смертности в своих работах признают различие во вкладе типов волокон в общую смертность, например, когда два типа минерала – хризотил и амфиболы рассматриваются отдельно в работе Concha-Barrientos и Дрисколл и другие *The global burden of disease due to occupational carcinogens, 2005 (1)*.

Считаем крайне необходимым указывать в таких оценках смертности оценивать и указывать вклад различных видов асбеста в общую смертность и заболеваемость.

Translation of comment 1

Unfortunately, WHO, in its assessments, does not provide information about the contribution of different types of asbestos to asbestos-related morbidity and mortality. At the same time, there is broad consensus that the ability of the various forms of asbestos to cause disease varies significantly. Thus, in the work of Concha-Barrientos, Driscoll, et al: *The global burden of disease due to occupational carcinogens (2005)*, the authors, estimated mortality acknowledging the difference of fiber types in the contribution in total mortality, for example, when two types of mineral – chrysotile and amphibole – are dealt with separately..

We consider it essential to specify the different types of asbestos in such mortality assessments and to point to their contribution to overall mortality and morbidity.

Comment 2

Касательно самого существования порога, пока не имеется единого мнения по поводу уровня, на котором он установлен, и научное общество признает, что этот порог существует, однако он еще не был определен. Именно так это трактуется в документе Международной программы по химической безопасности, Environment Health Criteria 203, от 1998 г где в заключительной части указано:

10. CONCLUSIONS AND RECOMMENDATIONS FOR PROTECTION OF HUMAN HEALTH

- a) Exposure to chrysotile asbestos poses increased risks for asbestosis, lung cancer and mesothelioma in a dose-dependent manner. No threshold has been identified for carcinogenic risks.*

Именно подход о пороговости воздействия хризотила используется в нашей стране и во многих других, в том числе развитых странах при регулировании использования данного вещества, где установлены предельно допустимые концентрации вещества в воздухе рабочей зоны и атмосферном воздухе.

В связи с вышеизложенным просим скорректировать трактование отсутствия безопасного воздействия в соответствии с документом ЕНС 203 и международной регуляторной практикой.

Translation of comment 2

As regards the very existence of a threshold, while there is no consensus about the level at which it should be established, the scientific community recognizes that it does exist but has not yet been determined. This is how it is interpreted in the document of the International Programme on Chemical Safety, *Environment Health Criteria 203* (1998) (2), which states:

10. CONCLUSIONS AND RECOMMENDATIONS FOR PROTECTION OF HUMAN HEALTH

(a) Exposure to chrysotile asbestos poses increased risks for asbestosis, lung cancer and mesothelioma in a dose-dependent manner. No threshold has been identified for carcinogenic risks.

This is the approach to threshold for chrysotile exposure in our country and in many others, including developed countries, in regulating the use of the substance by setting the maximum allowable concentration of the substance in the working area and the air.

In view of the above, please correct the interpretation of the lack of safe exposure in accordance with document EHC 203 (2) and international regulatory practices.

Comment 3

По мнению нашей страны, дифференцированный подход к регулированию различных форм асбеста является важнейшим элементом решения Ассамблеи ВОЗ, который необходимо внедрять при реализации программ по элиминации асбестообусловленных заболеваний. К сожалению, в настоящее время этот подход не находит отражение в работе.

Translation of comment 3

In our country's opinion, a differentiated approach to the regulation of the various forms of asbestos is the most important element of the World Health Assembly resolution, which should be introduced in the implementation of programmes for the elimination of ARDs. Unfortunately, at present, this approach is not reflected in the work.

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ANNEX 2. Programme

10 June 2014

- 08:30 Registration
- 09:00 Welcome address by Head of WHO European Centre for Environment and Health (*Elizabet Paunovic*)
- 09:10 Introduction of participants, appointment of chairperson and rapporteurs, adoption of provisional agenda and provisional programme
- 09:20 Presentation of preliminary results reported by Member States regarding the development of national plans for the elimination of asbestos-related diseases (*Elizabet Paunovic and Aliya Kosbayeva*)
- 09:50 EU Commission current activities on workplace-related asbestos issues (*Jorge Costa-David*)
- 10:15 Exposure to asbestos and its monitoring in Finland: epidemiology of asbestos-related diseases (*Timo Tuomi*)
- 11:00 *Coffee break*
- 11:30 Asbestos-related diseases in Italy: occurrence and new criteria for etiologic evaluation (*Silvia Fustinoni, Carolina Mensi and Dario Consonni*)
- 12:15 Lombardy Mesothelioma Registry, Italy: organizational aspects and main results 2000-2012 (*Silvia Fustinoni, Carolina Mensi and Dario Consonni*)
- 13:00 *Lunch*
- 14:00 Towards universal health coverage of workers (*Ivan Ivanov*)
- 14:45 Occupational disease surveillance system as a basis for workers' health protection and role of national and subnational health-care services:
Electronic surveillance and occupational-diseases registry development in Serbia, including ARDs - challenges and the way forward (*Petar Bulat*)

Electronic occupational-injuries registry - practical software demonstration (*Petar Bulat*)
- 15:30 *Coffee break*
- 16:00 Cancer registration including occupational cancers and asbestos-caused occupational cancers (*Stefano Rosso, European Network of Cancer Registries*)
- 16:30 Diagnostic criteria for occupational ARDs (*Thomas Kraus*)
- 17:00 Asbestos, asbestosis, and cancer: the Helsinki criteria for diagnosis and attribution (*Timo Tuomi*)
- 17:30 Discussion
- 17:45 Closure of the day

18:30 *Reception at UniClub Bonn (courtesy of WHO)*

11 June 2014

- 9:00 Awareness raising activities and consolidated approach towards the elimination of ARDs among professionals of different sectors, nongovernmental organizations and the community
(Jovanka Karadzinska-Bislimovska)
- 9:45 Implementation of Toolkit for Elimination of ARDs *(Eun-Kee Park)*
- 10:30 Discussions and suggestions
- 11:00 *Coffee break*
- 11:30 Practical exercise in small groups, identifying further activities and required WHO involvement
- 13:00 *Lunch*
- 14:00 Definition of next steps, activities and agreement for a follow-up process
- 15:30 *Coffee break*
- 16:00 Discussions and closure of the meeting

ANNEX 3. Participants

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**The WHO Regional
Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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In June 2014, the WHO Regional Office for Europe conducted a workshop to assess progress achieved in selected countries of the WHO European Region in implementing the commitment of the *Parma Declaration on Environment and Health* (2010) towards the development of national programmes for the elimination of asbestos-related diseases in the WHO European Region by 2015. Challenges experienced in the countries in this respect and the future involvement of WHO in dealing with these were discussed.

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