1722d ASBESTOS RELATED DISEASES IN EUROPE: TRENDS AND PERSPECTIVES

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Situation To date Europe has consumed about 50% of the cumulative world asbestos production. Although 38 out of 53 European countries (72%) have banned asbestos, 300 million Europeans still live with a potential risk of exposure.

Use and health outcomes Europe's takes 65% share of the yearly world asbestos production and 30.7% share of consumption. A total of 30 000 to 47000 ARD fatalities are estimated to occur in Europe including about 50% of all occupational cancer deaths. In the asbestos banning countries the ARDs increase; the non-banning countries record lower ARD rates.

Policies and practices Many European countries prohibited crocidolite and asbestos spraying in the early 1970s. Total bans were launched in 9 countries in the 1980s and the 1990s. The EU launched in 1983 protective and in 1999 preventive policies against asbestos. The EU asbestos ban came into force in 2005. The banning terminated the use of new asbestos, but protection of asbestos demolition workers is still a great challenge for which the EU has provided stringent regulations and guides. Policies from the WHO Regional Office for Europe and ILO cover all the 53 countries, including the 15 non-banning countries. The ILO and WHO Euro have called all countries to draw up national asbestos profiles, national programmes for elimination of ARDs and their better registration.

Proposals for further actions International Organisations, Global Coalition, EU and countries could jointly work for:

- Pan-European ban of asbestos
- Implementing the 'Freeing the EU from asbestos by 2030' initiative
- Information and support for safe alternatives
- Registration and labelling of sources, surveillance and registration of exposures and exposed workers
- Guidance in diagnosis and recognition of ARDs
- National programmes for:
 - Elimination of exposures and for demolition
 - Elimination of ARDs
 - Capacity building, information, awareness raising.

1722e ASBESTOS IN LATIN AMERICA: PRESENT TRENDS IN PRODUCTION, CONSUMPTION AND POLICIES

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Situation Since asbestos has been banned in most industrialised countries, production and consumption have shifted to low and middle-income countries. At present, asbestos consumption in Latin America (LA) amounts to 10% of yearly global production. Brazil, the only LA producer, mined more than 7,000,000 tons of chrysotile between 1980 and 2013. Argentina, Chile, Honduras and Uruguay are the only LA countries where asbestos is banned and Brazil, Colombia and Mexico,

the main consumers. The bulk of consumption is concentrated in asbestos-cement products.

Use and health outcomes In 2012 mortality from mesothelioma was in 5.6 and 1.0/1,000,000 in Argentina and Brazil, respectively. The few epidemiological studies available show clear evidences of clusters of mesothelioma in municipalities with a long history of asbestos consumption in Brazil and a forecast of rising incidence of mesotheliomas in Argentina and Brazil for the next decade. Employing a population attributable fraction method, a sizeable number of asbestos-related cancers was estimated for Argentina, Brazil, Colombia and Mexico.

Policies and practices The flawed arguments used by the industry to maintain its market, both to the public and in courtrooms, strongly rely on the lack of local evidences of ill effects and the invisibility of asbestos-related diseases in LA, due to limited number of studies and a difficult access of exposed workers to good quality health services. An inquiry made in Argentina, Brazil and Colombia disclosed only one internationally accredited laboratory for quantitative fibre analysis, doing only phase contrast microscopy.

Proposals for future actions In Brazil, non-governmental organisations of asbestos workers were pivotal to counter balance misinformation and inequities, ending recently in a Supreme Court decision to support eleven asbestos related state laws of prohibition, which, in practice, is curtailing asbestos mining. In parallel, continuous efforts should be made to stimulate the growth of competent and ethical researchers to convey adequate information to the scientific community and to the general public.

1722f ASBESTOS RELATED DISEASES IN THE UNITED STATES: HISTORICAL TRENDS AND CURRENT SITUATION

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Asbestos use Asbestos was first discovered in the USA in 1825. Importation began in the mid-1800s and domestic mining in the 1890s. The industry grew in the 20th century and by the 1970s, over 7 00 000 tons were consumed annually. Then, because of environmental and occupational restrictions coupled with vigorous efforts to seek legal compensation for injured workers, use declined. By 2000 annual consumption had fallen to 14 600 tons, and most manufacturers had ceased production. However, the USA has never banned asbestos and still imports over 300 tons per year. Importation has recently increased. The chloralkali industry is the principal consumer.

Asbestos-related disease Asbestos has caused over 2 00 000 deaths in the USA. Multiple studies published between 1918 and 2000, most notably those of Irving Selikoff, documented the American ARD epidemic and linked asbestos to multiple cancers, mesothelioma in particular. The epidemic continues to the present, and in 2016 there were 2597 mesothelioma deaths, many in persons <55 years.

Prevention policies The first non-binding guidance on occupational asbestos exposure was proposed in the USA in 1938. The first regulation was established in 1972. In 1975, OSHA declared asbestos a human carcinogen. In 1979, OSHA and NIOSH declared that there is no safe level of exposure to asbestos. In 1989, EPA issued a rule banning most asbestos-containing products, but this ban was overturned by the

courts in 1991, and asbestos-containing products are therefore allowed currently in US markets.

Proposal for eliminating ARDs A complete ban on all manufacture and use of asbestos worldwide is the only strategy to end the global pandemic of ARDs. The possibility of securing an asbestos ban in the USA was rekindled in 2016 with passage of new chemical safety legislation. Asbestos is listed under this law as a priority chemical. Responsibility for enforcement rests with the Trump Administration.

1719 PRACTICE OF OCCUPATIONAL HEALTH SERVICES (IMPLEMENTATION OF SEOUL STATEMENT ON THE DEVELOPMENT OF OCCUPATIONAL HEALTH SERVICES FOR ALL)

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Aim of special session The Seoul Statement has announced during ICOH Congress 2015, which contains the recommendation on development of occupational health services for all. In this session, representative of each continent or region will speak about the progress of occupational health services in their continents or regions.

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1719a OCCUPATIONAL HEALTH SERVICES IN BELGIUM AND OHS STRATEGY 2020 IN THE EU

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In Belgium the support to the internal service in well-being at work and occupational medicine is typically delivered by multidisciplinary external services. Due to the extent of services delivered, the number of services decreased and most of the Belgian working population is served by a small number of large services that have 400–800 own personnel. Half of the personnel is delivering occupational health services, the other half is advising and supporting in occupational safety, psychosocial factors at work, ergonomics and industrial hygiene.

Some recent changes in activity and newer tendencies in the field of occupational medicine and well-being at work in general will be discussed.

The EU has developed an OHS strategy 2020: Healthy Workplaces for all ages, promoting a sustainable working life. This strategy was translated in The Healthy Workplaces Campaign 2016–2017. The Occupational Medicine Section of UEMS (European Union of Medical Specialists) was a partner in this strategy and campaign. The main issues and key objectives of this campaign will be shown. Important themes were prevention throughout working life, the workability concept, a diversity-sensitive risk analysis, workplace adaptation and disability prevention, rehabilitation and return to work. There was also attention to newer issues like cooperation between Human Resources and OSH management and workplace health promotion. Besides of improving the health and well-being of all employees, this shall also improve productivity and cost-effectiveness at organisational level.

1719b EVALUATION OF EDUCATION OF SPECIALIST OCCUPATIONAL HEALTH PHYSICIANS IN THE PERIOD 2009–2013 IN FINLAND

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A nationwide external quality evaluation was carried to identify strengths, good practices and areas in need of development. The enhancement-led evaluation process included a self-evaluation report by the universities; evaluation interviews and visits by the evaluators; an evaluation report; a feed-back seminar. The evaluation focused on the management and planning of education, the learning philosophy and defining evaluating outcomes; the education resources and pedagogical training; the constructive alignment of education; the continuous development of education.

Key strengths included good cooperation between units, pedagogical training of the trainers, investment in web-based learning and the repetitive evaluations. Areas needing development included clarifying of the learning philosophy, broadening the learning outcomes to cover competences, achieving higher visibility, diversifying practices for learning assessment and feedback. Also, evaluators suggested more reflection practices to support professional growth; advancing pedagogical training of trainers; increasing the throughput of students and promoting the specialty to medical students. Genuinely interactive virtual learning was emphasised. Scientific research on and international approach of developing education were encouraged.

After the report the learning philosophy was clarified in the new curriculum, reflection was included in the logbook and a project started to develop evaluation of the learning outcomes as competencies and EPAs. A pedagogical web-based course and a guidebook for trainers were published. The universities have worked also on the external challenges: the changes in working life, the upcoming national reform of specialist medical education and the continuity of funding. High quality in medical education is essential. An external evaluation may substantially help to meet this challenge.