

Country Reports

Moderator: Apo Leung

The title of the presentation by Indian activist Madhumita Dutta, *Asbestos Kills! India in Denial!*, was indicative of the content of the first presentation of the morning [57]. The escalation of asbestos use in India – now the world’s largest importer of asbestos [58] – had taken place in circumstances created to maximize corporate profits and with no regard for occupational or public safety. Even as government agencies claimed the situation was under control, citing lack of epidemiological data, politicians reaped the profits from the asbestos factories and mines they owned; the state of Tamil Nadu owned a large asbestos factory. The growth of the asbestos industrial sector had been encouraged by government incentives such as the de-licensing of asbestos, which was nowadays no longer classed as a hazardous import, and the relatively high level of allowable industrial airborne asbestos concentration: 2 f/cc; there was virtually no enforcement of the few regulations which existed for minimizing hazardous exposures.

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There was some asbestos mining in India but the output was small and unable to satisfy national demand. There were illegal tremolite asbestos mines [59] in Rajasthan and chrysotile asbestos mines in Cuddapah, Andhra Pradesh. Miners, all of whom were unprotected, worked with their bare hands to extract the fiber. Mining operations had grossly contaminated communities such as the towns near a redundant asbestos mine in Roro, Chaibasa, Jharkhand. Twenty years ago mining operations ceased but there had been no attempt to remediate the area and children played amidst the contamination.

More than 100,000 people worked in India’s asbestos sectors. In addition, there were the thousands employed in the ship-breaking industry who were also routinely exposed to the asbestos hazard, not to mention the members of the public exposed to asbestos waste dumped by the shipyards, and the millions of consumers, especially in rural areas and urban slums, exposed to asbestos-cement roofing materials; over 90% of asbestos used in India went into the production of roofing materials. There were no publicly accessible government data on the number of workers at risk from asbestos, the scale of asbestos dumping, the incidence of asbestos-related disease or the threat to consumers. Independent studies had found a prevalence of asbestos-related diseases, e.g. the Tata Cancer Memorial Hospital admitted to treating 107 cases of mesothelioma

from 1985-2005. Government agencies were largely incompetent.

Organizing the victims was not easy. Most of the at-risk workers were from the unorganized sector: contract workers, day workers, migrant workers, all of whom were difficult to locate and identify. Other problems included difficulties in getting medical diagnoses (asbestos diseases were often misdiagnosed, sometimes as TB), obtaining occupational histories and filing for compensation; because of the complexities of India’s labor laws, it was difficult to hold companies liable for occupational illnesses. Despite these challenges, small victims’ groups were now being formed.

In his capacity as the Director of the National Institute of Occupational Safety and Health of Sri Lanka’s Ministry of Labor, Dr. Hemantha Wickramatillake discussed: *Asbestos Use and Related Health Status in Sri Lanka*. Common asbestos exposures included those which took place in manufacturing plants, during building demolition or roof removals, during tsunami clean-up work, in the use of asbestos brake pads and other consumer products, and via environmental exposure. The regulations which pertained to occupational asbestos exposures at Sri Lanka’s six asbestos manufacturing plants were weak and old, dating back to the 1950s; there was a reluctance by industry stakeholders to engage in discussions on the asbestos hazard. Nevertheless, a new law had been drawn up that would come into force in 2009 and list the asbestos industry as hazardous, mandate the reporting of asbestos-related illness and introduce stringent workplace controls in all sectors.

There was a notable lack of asbestos awareness not only among the public and the workforce but also among professionals and government officials. In the past, a former Director of the National Cancer Institute publicly stated that there was no risk of malignancy from the use of chrysotile asbestos. Propaganda spread by asbestos lobbyists firmly lodged this sentiment in the public consciousness. The lack of mortality and disease data on the incidence of asbestos-related diseases was used to support industry’s false assurances. Compounding these factors was widespread medical ignorance on occupational medicine; there had been only one case of occupational mesothelioma reported during the last few years. Although, the ILO’s adoption (2006) of a policy to phase out the use of asbestos had encouraged the authorities in Sri Lanka to take action, there were multiple challenges to be faced before a national ban could be adopted:

- lack of data and national statistics;

- lack of asbestos awareness among legislators, medical professionals, the public, trade unions and workers;
- lack of information on effective and cost-efficient asbestos-free alternatives.

Having heard from an activist and a civil servant, it was highly appropriate that the next speaker was trade unionist Gerard Seno who is the National Vice President of the Associated Labor Unions – Trade Union Congress of the Philippines (ALU-TUCP) [60].

Although the Philippines Constitution guaranteed the rights of workers to just and humane conditions of work, and provisions of the Occupational Safety and Health

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Standards aimed to protect workers against injury, sickness or death through safe working conditions, the daily reality of workers in the asbestos industry, on building sites and at former U.S. bases – Subic Bay, Zambales and Clark, in the northern province of Pampagna – was tainted by high levels of hazardous asbestos exposure. According to a graph shown by the speaker, asbestos consumption in the Philippines peaked in 1970 at 4,500 tons, went down to 2,900 tons in 1975, shot up to 3,400 tons in 1980 and since then had continued to rise. As a result of unsafe working conditions, thousands of workers remained at risk as the import, manufacture, processing and use of chrysotile asbestos and asbestos-containing products were allowed in the Philippines [61].

Within the government there was a conflict of opinion about the asbestos hazard; the majority of departments supported a policy of controlled use. Under this regime, the regulated use of chrysotile in certain high-density products continued but the use of other types of asbestos (amosite, crocidolite, etc.) and the spraying of all forms of asbestos remained banned. There was a dichotomy between departments; the Construction Industry Authority of the Philippines, the Environmental Management Bureau and the Bureau of Working Conditions either felt that controlled use remained the way forward or that the case for change had not been made; either way they did not support an outright ban. “Only the Department of Health (DOH) sees the need to stop the use of asbestos to eliminate asbestos-related diseases,” accepting ILO recommendations.

A trade union coalition made up of the ALU, TUCP and the BWI had developed a two-pronged asbestos campaign which lobbied for the passage of a worker-friendly law based on internationally accepted standards and instruments banning asbestos [62] and the expansion of mandatory measures to minimize hazardous exposures. Initiatives to raise awareness of the asbestos hazards which had been

pursued, in conjunction with other social partners were:

- an asbestos roundtable on International Workers’ Memorial Day, 2006;
- a ban asbestos workshop for local union leaders, 2006;
- seminars to raise grass-roots asbestos awareness, 2006;
- meetings with government agencies, 2006-2008;
- an asbestos forum for grass-roots groups, 2007;
- political lobbying (2008) on Asbestos Senate Bill No. 741 and House Bill No. 2079;
- a 2009 bilateral meeting with key political leaders to pave the way for a third bill, incorporating ALU-TUCP proposals, to ban asbestos.

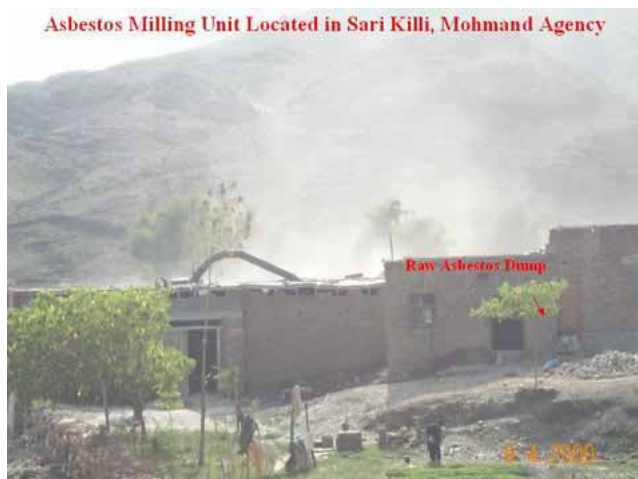
A detailed strategy was discussed for taking the campaign forward in the Philippines which included political lobbying, building relationships with government agencies, an education program and use of new technology to reach a wider audience.

Asbestos Scenario in Pakistan was the title of the presentation by Associate Professor Dr. Noor Jehan from the Department of Environmental Sciences, University of Peshawar, Pakistan. There were no national regulations on the use, import, sale, work with or disposal of asbestos. Asbestos mining operations began in Pakistan in 1958; two years later, asbestos importing began with an initial shipment of 60 tons. Pakistan was currently sourcing 30,000 tons/year of asbestos from abroad and producing more than 30,000 tons/year locally. Seventy percent of mines now producing asbestos in Pakistan became operational between 2000-2007; there were no standards or regulations to protect the miners. Measurements taken by the speaker showed colossal airborne asbestos levels at the mine itself and extensive contamination of miners’ work clothes and groundwater. To meet sustained high levels of demand, raw fiber and asbestos-containing products were imported by multinational and local companies for use in construction materials, furniture [63], insulation products, water pipes, friction materials, etc.

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The ubiquity of asbestos use meant that contaminated products were everywhere: in houses, public places such as ministerial buildings, academic institutes, schools, offices, hospitals, playgrounds, and throughout the construction and industrial sectors. Airborne sampling by polarized light microscopy, X-ray diffraction and scanning electron microscopy had shown that industrial workers, students, patients, children, women and even infants were exposed to high levels of airborne asbestos fibers in different parts of Pakistan. Another particularly worrying issue was the asbestos contamination of talc produced in Pakistan which had been documented by the speaker. As a

Asbestos Milling Unit Located in Sari Killi, Mohmand Agency



result of these widespread exposures, there were high incidences of asbestos-related cancers such as mesothelioma [64] and cancers of the lungs, larynx, gastrointestinal tract and ovaries in Pakistan [65]. It was likely that asbestos mortality would rise dramatically in the coming decades. In July 2005, Pakistan ratified the Rotterdam Convention [66]. Since then the government had set up a National Technical Advisory Committee on Chemicals which had its first meeting in 2008. At a subsequent meeting on April 21, 2009, data which the speaker had accumulated since 1990 on asbestos issues in Pakistan were presented; as a result of this the government decided to include all types of asbestos on a list of hazardous materials. The minutes of that meeting noted:

“1/6 – After detailed deliberations on the use, hazards and risks to human health and environment and its alternatives, the Committee decided that Chrysotile Asbestos may be brought under PIC Procedure within six months [67].

2/6 – Complete phasing out mechanism for Chrysotile Asbestos will be developed in next three years.” [68]

This decision marks a sea change in Pakistan’s policy on asbestos.

Community activist Muthamad Darisman from the Sedane Labour Resource Center (LIPS) described a grass-roots initiative in the Bogor District, West Java for: *Setting up a Ban Asbestos Network in Indonesia – Bridging Union-Community Gap*. There were no laws in Indonesia which regulated the use of asbestos, no data on the incidence of asbestos-related diseases, no official attempts to identify asbestos victims and a low level of asbestos awareness amongst government officials and members of the public. Within this context, the use of asbestos and asbestos-containing products was substantial at 58,060 tons/year; Indonesia was the world’s 8th largest importer, producer, and consumer of asbestos and asbestos-containing material [69]. Data from the Manpower Department estimated that in 2004, 7,233 people worked with asbestos-contain-

ing products such as roofing materials, insulation products, brake systems, etc. In an attempt to assess the impact that asbestos operations had on a local community, staff from LIPS began exploratory discussions with personnel from the Public Health District Office, the Manpower Office and Social Security Department, workers from the PT Jeil Fajar asbestos factory and community members who lived nearby. These discussions followed on from work conducted in Cibinong, Bogor (2008) by a Korean–Indonesian research team which found indications that workers and local people living within a 500 meter radius of the factory were suffering from lung disorders of an unknown origin.

Following consultation with public health bodies, an investigation was made of occupational conditions in the Bogor area, which established that asbestos was being used in the manufacture of toys; although health department staff said they would like to take action on the asbestos hazard, they could not do so due to lack of resources. In March 2009, LIPS held a workshop with stakeholders, including local government officials, asbestos workers, community representatives and occupational health and safety specialists. As a result of the recommendations approved by that meeting, LIPS began a program to identify asbestos victims in the Bogor industrial zone. This work would need to overcome obstacles presented by the lack of transparency of government departments and the entrenched bureaucracy which stymied grass-roots mobilization in Indonesia. Efforts were being made to work with trade unions to identify asbestos-using factories in the Bogor area. Training for the PT Jeil Fajar workforce would be undertaken to raise awareness of the asbestos hazard. Building on the outcome of the asbestos work conducted at this factory, the LIPS outreach project would be extended to include other occupational safety and health hazards in Bogor, Krawang and Tangerang. Links would be forged with other social actors such as medical professionals, environmental activists and groups campaigning for OSH rights. The lessons learned and the network created by this grass-roots-led initiative would constitute the foundation of the Indonesian Ban Asbestos Network.

Another community activist, Trevor Sun, Project Manager of the Hong Kong Workers' Health Centre (HKWHC) [70], shared his experiences with conference delegates in the presentation: *Ban Asbestos Campaign in Hong Kong*. Although the use of amosite and crocidolite asbestos was banned in Hong Kong by the Environmental Protective Department under s. 80 of the Air Pollution Control Ordinance (1996), the use of chrysotile remained legal. Nevertheless, recent import levels of raw fiber and chrysotile-containing products had fallen from 121 and 107 tons respectively in 2003 and 2004 to 47 tons in 2007 [71]. Hong Kong sectors where occupational exposure to chrysotile continued included: vehicle servicing (brake and clutch linings), lift servicing (brake pads), building maintenance, boiler repair work, demolition and

ship-breaking. The number of workers being exposed to asbestos was unknown.

The number of mesothelioma cases documented in Hong Kong rose from a total of 30 by 1995, to 60+ by 2004; average mesothelioma mortality between 2001 and 2004 was 10 deaths/year with a peak of 15 in 2002. Construction workers featured prominently amongst the groups of workers at risk of contracting mesothelioma due to high levels of asbestos used in the 1960s-1970s and the long latency period of asbestos cancer. In 2006, HKWHC staff, working with sufferers, family members and trade unionists, began a campaign to add mesothelioma to the list of compensated illnesses included in the Pneumoconiosis Compensation Ordinance. Success was achieved when the Pneumoconiosis Compensation Fund Board and the Labour Advisory Board agreed to extend government coverage to include mesothelioma under the re-titled **Pneumoconiosis and Mesothelioma (Compensation) Ordinance (2008)**. Despite this success, the HKWHC remained concerned about the hidden hazard posed by asbestos in 15,600 privately-owned buildings, many of which were built during the era of high asbestos consump-



tion [72]. Pictures shown by the speaker revealed the ubiquity of such constructions and the presence of deteriorating asbestos-cement materials.

A sample taken from a commercial center in Kowloon on March 19, 2009 tested positive for the presence of chrysotile. At a press conference (March 27, 2009) to announce the findings, the HKWHC's concerns were expressed, and specific recommendations were made as to how the government might address the myriad of problems arising from asbestos in old buildings. In late 2009, the HK government will start a project along these lines.

The title of the presentation by Matdiah Bin Mohammad [73], ***Banning Asbestos in Malaysia***, underlined the fact that the Malaysian Trades Union Congress (MTUC) advocated the prohibition of asbestos [74]. As well as lobbying for a national ban, the MTUC supported the use of safer substitutes, a just transition for workers, enforcement of occupational safety and health laws and a coordinated effort

to raise asbestos awareness throughout the country. On International Workers Memorial Day 2009, the MTUC launched a workers' petition which called for the implementation of these measures. Despite the existence of legislation to minimize hazardous asbestos exposures [75], there were little available data quantifying the health effects of asbestos use in Malaysia; as a result, Malaysian asbestos victims remained invisible [76]. There was no government surveillance program and the reporting of asbestos-related disease by medical practitioners was rare due to widespread ignorance. As part of its campaign, the MTUC was trying to generate greater asbestos awareness through a variety of means including training, publicity, meetings and the distribution of information to union members, employers, government officials and medical professionals. The speaker concluded with an affirmation of his organization's position: "The MTUC will," he said "continue relentlessly with the campaign until the total ban of asbestos comes into full force in Malaysia."

There were many questions asked and comments made during the final segment of this plenary session which revealed:

- the key role NGOs and victims' groups had to play in mobilizing support for asbestos bans;
- the overwhelming lack of the medical expertise, diagnostic skills and equipment needed to diagnose asbestos-related disease;
- the failure of medical specialists and academic researchers to bridge the divide between higher learning and workers' needs; "there's a huge gap between the state-of-the-art research being done and what workers have on the ground level";
- the urgent need to collect core data on the incidence of disease; in the vacuum created by lack of government action, victims' groups should document the injured;
- the need to help government officials, such as some encountered in Indonesia, who were prevented from taking action on the asbestos hazard by bureaucratic obstacles; trade unions and community organizations could play a useful role in helping them overcome these and other challenges;
- that the struggle to ban asbestos had to be fought collectively on many fronts.

A delegate from the New Trade Union Initiative expressed the feelings of many of those present when she said:

"In India, state hospitals and clinics exist in hollow structures without facilities and basic medicine. Workers have to fight to get these centers to work for them... it's a political fight to get your health care; it's a political battle for the workers and victims to get the correct kind of medical expertise into these areas to identify their disease and get compensation... It's a political battle to change the rules of the game."