

## Abstracts

Although it is well recognised that silicosis is one of the most common occupational lung diseases worldwide, exposure to silica dust in the workplace plays an even larger role in global health as it contributes to the Tuberculosis (TB) epidemic. TB is now the most prevalent and most deadly infectious disease worldwide accounting for 1.3 million deaths per year. Silica dust exposure, even without clinically evident silicosis, has been demonstrated to increase the life-long risk of TB. Furthermore, occupational silica dust exposure among workers who are HIV positive in high-burden TB countries is a deadly combination increasing the risk of active TB by 15-fold. Global TB efforts are almost exclusively focused on case identification and treatment with few resources going to prevention. Silica dust controls in the workplace can be an effective TB prevention strategy that has yet to be fully understood and embraced by global health funders. Low cost silica dust controls have been demonstrated even in resource constrained informal sector enterprises. Investments in dust controls in the workplace to prevent disease are more cost effective than programs to identify and treat cases of TB. Countries with a high burden of TB and HIV with large mining and construction sectors should be prioritised. There is increased recognition that the global response to the TB epidemic is falling short and that drug-resistant TB is a growing threat. Occupational health professionals can play an instrumental role in making the case that silica dust controls should be incorporated into global health strategies to help meet the UN Sustainable Development Goals to end TB by 2030.

#### 1741b PROTECTING HEALTH CARE WORKERS FROM OCCUPATIONAL TUBERCULOSIS AND ITS EFFECTS: LONG ON GUIDELINES, SHORT ON IMPLEMENTATION?

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Guidelines for prevention of occupationally-acquired tuberculosis developed by the CDC in the 1990s onwards established the primary prevention triad of administrative, environmental and personal protective practices, augmented by secondary prevention measures such as screening for and treatment of latent tuberculosis infection and active disease in health care workers. More recently, a refocusing on the administrative level as 'Find (patient) cases Actively, Separate temporarily and Treat effectively' (FAST) has been advocated. The difficulty of applying all of these measures in low resource high tuberculosis burden settings, where most cases of occupational tuberculosis occur, was recognised by the WHO in the late 1990s. WHO modified its guidelines to apply to settings characterised by undiagnosed tuberculosis in all parts of the health system, HIV-TB co-occurrence, limitations on staff and other resources for triage, isolation, environmental controls and respirators, delays in diagnosis and in treatment of patients and shortage of drug sensitivity testing. Secondary prevention is similarly limited by shortage of skills, particularly in occupational health, and constrained by staff fears regarding lack of confidentiality and job security. Competition for management attention and resources, with attendant fragmentation of effort, add to the problem. Health care workers activists have recently called for advocacy pressure on governments and health authorities to take seriously the need to prevent

transmission of tuberculosis in health care facilities, particularly in the face of rising drug resistant tuberculosis and co-occurrent HIV. This includes an occupational health approach capable of encompassing the whole spectrum of prevention. It would give weight to primary prevention appropriate to low resource settings, but also include surveillance of occupational tuberculosis, co-management of HIV and TB, protection of students, provision of effective treatment, strengthening of worker rights in the form of income, leave and job protection, stigma reduction while promoting self-disclosure, and compensation for those permanently affected.

#### 1722 POLICIES FOR ELIMINATION OF ASBESTOS RELATED DISEASES (ARDS): A GLOBAL PICTURE

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**Aim of special session** Due to their high incidence and high rates of mortality ARDs are the occupational diseases with the greatest impact. In spite of intensive preventive actions in many countries, the incidence of ARDs are often still growing as the latency periods of malignancies are expiring. Even more disturbingly asbestos is still used in many parts of the world.

There are several ongoing national and global initiatives and programmes for elimination of ARDs, including primary prevention through a ban, protection of demolition workers and better identification, notification, registration, reporting and compensation of disease cases. Policies in countries and continents have several common features, but also important differences in practical implementation and results.

To achieve a decline of ARDs globally, global actions for elimination of use of asbestos are required together with a careful protection of workers in the works for demolition and handling of existing asbestos and asbestos contaminated waste.

The session aims to compile a global overview of the present situation in the ARD elimination policies in different parts of the world by drawing from national and regional experiences and will discuss the proposals for global action for elimination of asbestos-related diseases.

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#### 1722a OPENING POLICIES FOR ELIMINATION OF ASBESTOS RELATED DISEASES (ARDS): A GLOBAL PICTURE

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