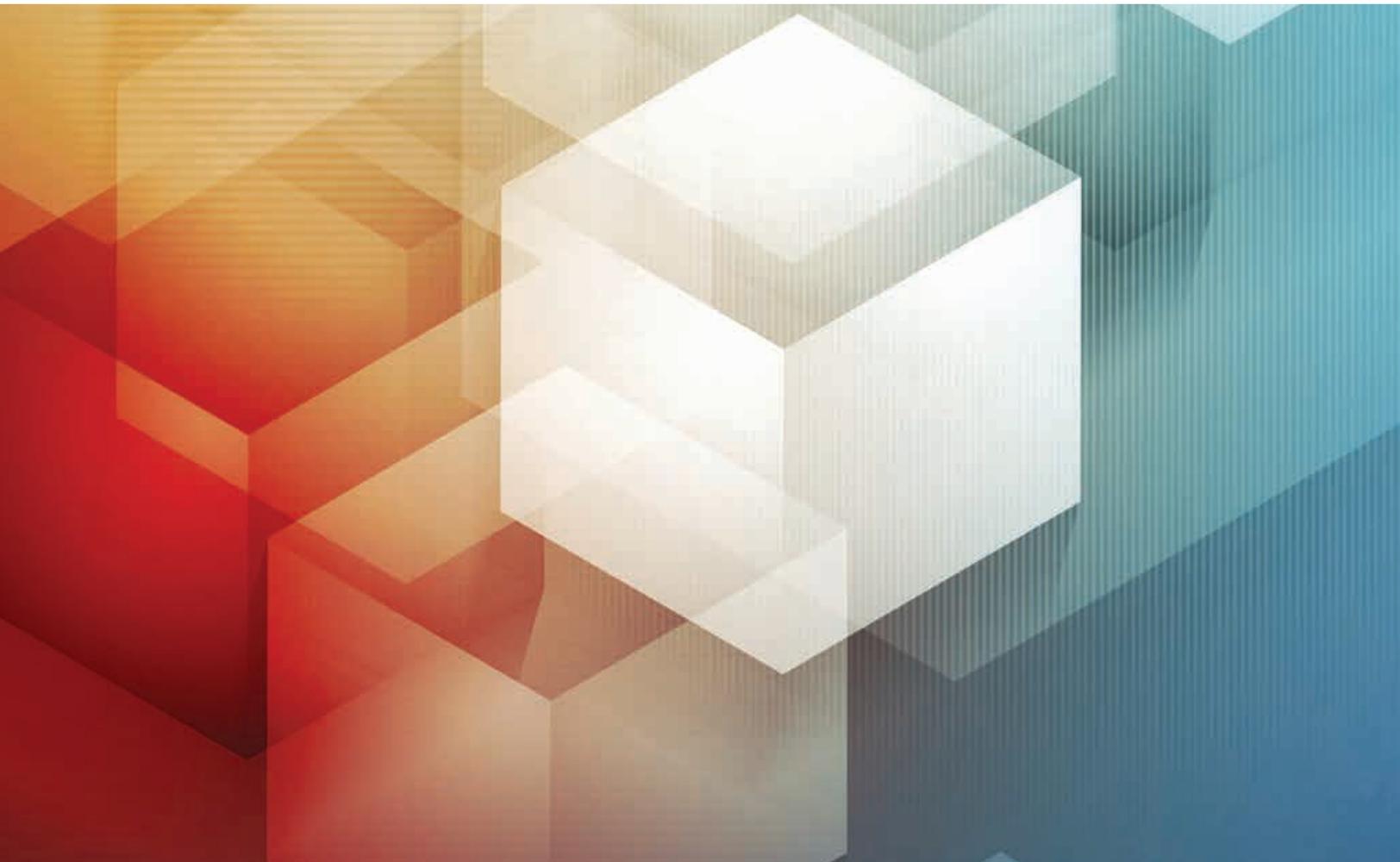




For environmental
occupational health
safe and responsible use

Rotterdam Convention

COP7 MEETING – 2015



Rotterdam Convention

COP7 MEETING – 2015

For environmental
occupational health
safe and responsible use





For environmental, occupational health, safe and responsible use

BY POST AND EMAIL

October 28, 2014

Mr Jim Willis
Executive Secretary of the Basel, Rotterdam and Stockholm Conventions
UNEP
International Environment House
11-13 Chemin des Anémones
CH-1219 Châtelaine – Geneva
Switzerland
jim.willis@unep.org

NO ANSWER

Subject: Report of the COP6 of the Rotterdam Convention (chrysotile asbestos)

Dear Mr Willis:

I am writing you in my capacity of registered observer in the ordinary meeting of the COP6 of the Rotterdam Convention held in Geneva in April-May 2013 and Chairman of the International Chrysotile Association (ICA).

ICA defends and promotes the responsible use of the chrysotile fibre through the adoption and application of appropriate prevention and control measures regulations, standards, work practices and techniques for its safe use.

I have noticed that the report of the meeting of the COP6 released in the official website of the Rotterdam Convention, states in point 79: *“The Conference of the Parties decided, given the lack of consensus, to include further consideration of the listing of chrysotile asbestos in Annex III of the Convention on the Agenda of its Seventh ordinary meeting”*¹.

First of all, and assuming that my understanding is correct; I do not remember that COP6 had actually taken such a decision. This is all the more striking, since no consensus was reached on this particular issue; on the contrary, some participants, such as the representative of the Russian Federation, wondered whether it would be advisable to temporarily suspend further discussions about a chemical when there is a continuous lack of consensus, meeting after meeting.

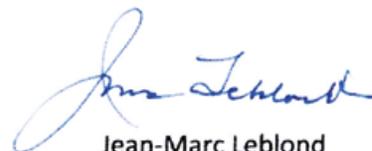
Secondly, I do not understand such a precipitation since Chapter IV of the Rules of procedure of the COPs gives to the President and the Secretariat a comfortable delay of six weeks, before the opening of each COP (next meeting is scheduled in May, 2015), to submit the provisional agenda to the Parties.

I would kindly appreciate any informative element from your Secretariat that could clarify this from a legal point of view or to enlighten me in case I would be misinterpreting this important procedural issue.

Awaiting your comments.

NO ANSWER

Sincerely yours,



Jean-Marc Leblond
Chairman

¹ UNEP/FAO/RC/COP.6/20 Report of the Conference of the Parties to the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade on the work of its sixth meeting.



International Chrysotile Association

For environmental, occupational health, safe and responsible use

October 29, 2014

BY POST AND EMAIL

Mr. Rolph Payet
Executive Secretary of the Basel, Rotterdam and Stockholm Conventions
Secretariat for the Rotterdam Convention
United Nations Environment Programme (UNEP)
11-13 Chemin des Anémones
CH-1219 Châtelaine GE
SWITZERLAND
(rolph.payet@brmeas.org)

Subject: Report of the COP6 of the Rotterdam Convention (chrysotile asbestos)

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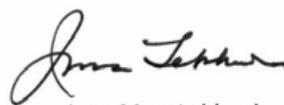
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Awaiting your comments.

Sincerely yours,



Jean-Marc Leblond
Chairman

c.c. :

Mr Clayton Campanhola
Executive Secretary for the FAO part of the Rotterdam Convention
Secretariat for the Rotterdam Convention
Food and Agriculture Organization of the United Nations (FAO)
Viale delle Terme di Caracalla
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Food and Agriculture
Organization of the
United Nations



ROTTERDAM CONVENTION

ROTTERDAM CONVENTION

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00153 Rome, Italy
Tel: +39 06 5705 2061
Fax: +39 06 5705 3224
E-mail: pic@fao.org

Date: 17 March 2015

Subject: Report of the COP6 of the Rotterdam Convention (chrysotile asbestos)

Dear Mr. Leblond,

I write further to your letter regarding the report of the sixth meeting of the Conference of the Parties to the Rotterdam Convention and thank you for this query. Please accept our apologies for the delayed response to your letter.

As you noted, the issue of the agenda for meetings of the Conference of the Parties is governed by Part IV of the Rules of Procedure. You may further note that Rule 10 states:

"The provisional agenda for each ordinary meeting shall include, as appropriate,

- (a) Items arising from the articles of the Convention, including those specified in its article 18;*
- (b) Items the inclusion of which has been decided at a previous meeting;*
- (c) Items referred to in rule 16;*
- (d) The proposed budget as well as questions pertaining to the accounts and financial arrangements;*
- (e) Any item proposed by a Party and received by the Secretariat before the provisional agenda is circulated."*

In the present instance, point (b) is pertinent to the issue in question since, as reflected in paragraph 79 of the report of the sixth meeting of the Conference of the Parties, "The Conference of the Parties decided, given the lack of consensus, to include further consideration of the listing of chrysotile asbestos in Annex III of the Convention on the agenda of its seventh ordinary meeting". You also referred to this conclusion within your letter.

.../...

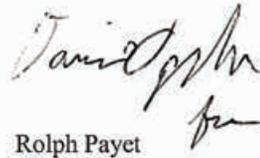
May I also take this opportunity to bring your kind attention to point (c) of rule 10 and rule 16 that provides:

“Any item of the agenda of an ordinary meeting, consideration of which has not been completed at the meeting shall be automatically included in the provisional agenda of the next ordinary meeting, unless otherwise decided by the Conference of the Parties.”

In accordance with Rule 11, for each ordinary meeting, the provisional agenda, together with supporting documents, are distributed in the official languages by the Secretariat to the Parties at least six weeks before the opening of the meeting.

We trust this responds to your question and remain available should you have further questions or need further information.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Rolph Payet', with a small flourish below it.

Rolph Payet

Copy to: Mr. Clayton Campanhola, Executive Secretary for the FAO part of the Rotterdam Convention



International Chrysotile Association
For environmental, occupational health, safe and responsible use

March 23rd, 2015

BY POST AND EMAIL

Mr. Rolph Payet
Secretariat of the Rotterdam Convention
United Nations Environment Programme
International Environment House 1
11-13, Chemin des Anémones
CH1219 Châtelaîne
Geneva, SWITZERLAND

RE : *Report of the COP6 of the Rotterdam Convention (chrysotile asbestos)*

Dear Mr Payet:

I thank you for your reply dated March 17th regarding the report of the sixth meeting of the Conference of the Parties to the Rotterdam Convention.

Unfortunately, you do not address my point which, I still consider very important ahead of the upcoming seventh meeting in May.

First, you raise Rule 10 point (b) of the Rules of Procedure: "*The provisional agenda for each ordinary meeting shall include, as appropriate: (...) b) Items the inclusion of which has been decided at a previous meeting;*"

Since no decision has been taken by the COP6, Rule 10 point (b) is not pertinent. You cannot refer to paragraph 79 of the report of the sixth meeting since it does not reflect what actually happened: no decision was taken by the Parties contrary to what happened, for example, in the third and fourth meetings where Decisions RC-3/3 and RC-4/4 attest to this. Otherwise, could you send us a copy of a similar Decision taken in the sixth meeting of the Conference of the Parties?

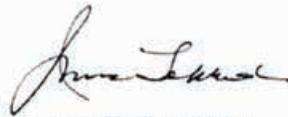
Secondly, you mention point (c) Rule 10 and Rule 16, that states: "*Any item of the agenda of an ordinary meeting, consideration of which has not been completed at the meeting, shall be included automatically in the provisional agenda of the next ordinary meeting, unless otherwise decided by the Conference of the Parties*"

Unless, in this particular case, you made the unnatural assimilation of the wording "*consideration of which*" to the actual inclusion of a substance in Annex III, you will certainly share my opinion that having "*considered*" the inclusion of chrysotile during four conferences of the Parties: the third conference of the parties (2006), the fourth (2008), the fifth (2011) and the sixth (2013), should be enough to have been gone around the issue and thus « completed » it.

My comprehension is that your Secretariat must always reflect the actual discussions among the Parties and be respectful, from the outset, of the rules governing the functioning of the Rotterdam Convention.

I let you know that, at this respect, my procedural issue remains then unsolved.

With my best regards.

A handwritten signature in black ink, appearing to read 'Jean-Marc Leblond', written in a cursive style.

Jean-Marc Leblond
Chairman

c.c.: Mr. Clayton Campanhola, Executive Secretary for the FAO part of the Rotterdam Convention

Alonso Asociados

ASESORES COMUNITARIOS S.L.

Mr Rolph Payet
Executive Secretary
Secretariat of the Rotterdam Convention
United Nations Environment Programme
11-13 Chemin des Anémones
CH 1219 Geneva – Switzerland

Brussels, 23 February 2015

BY EMAIL AND REGISTERED LETTER WITH ACKNOWLEDGEMENT OF RECEIPT

Subject: Technical Chrysotile Asbestos Workshop, Geneva 30-31 March 2015. Role of the Secretariat of the Rotterdam Convention

Dear Mr Payet,

I am writing you in my capacity of counsel of the International Chrysotile Association (ICA).

Although not having been convened, ICA has noticed that you have invited a number of persons to a Technical Chrysotile Asbestos Workshop to be held in Geneva on 30-31 March.

Being a qualified association having a « *particular interest in this chemical* » -as you properly consider those having received your invitation- you will easily understand that ICA has come ahead of time asking to be also invited to such event.

Your procedure is inappropriate and must be denounced.

For years, the Secretariat of the Rotterdam Convention has tried to bypass the consensus rule, has produced dubious minutes of the Conferences of the Parties, has released draft decisions by means of clumsy manoeuvres...with the only aim of getting asbestos chrysotile listed in Annex III of the Rotterdam Convention.

Alonso Asociados

ASESORES COMUNITARIOS S.L.

In a letter dated Octubre 2014, the Chairman of the ICA has adressed a new concern and has asked you for a procedural clarification ahead of COP7 to be held next May. No answer.

Last but not least, you are now blatantly ignoring the International Chrysotile Association by excluding its experts from your list of invitees to an important technical workshop.

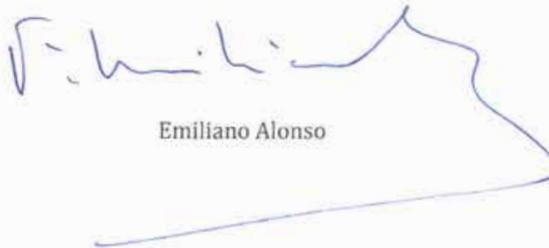
Mr Payet, we need some explanations about this position towards the representatives of the civil society that are particularly qualified in their field of expertise, that is, the chrysotile issue.

Moreover, in the absence of a clear mandate from the Conference of the Parties, the Secretariat must keep its neutral role, gathering information from the relevant actors, respecting the rule of consensus and refraining from any attempt to promote, influence or otherwise, facilitate the listing of a substance in Annex III. This kind of decision belongs to the Conference of the Parties under the rules laid down by the Convention.

In case you find it appropriate, I remain available to discuss the issue with your legal team at any time.

In the meanwhile, I remain.

Sincerely yours



Emiliano Alonso

INCLUSION OF CHRYSOTILE ON THE PIC LIST

As lobbied by the Anti-Asbestos Crusade

IN 2006
THE ROTTERDAM CONVENTION'S
CONCLUSION **WAS**

NO
consensus

IN 2008
THE ROTTERDAM CONVENTION'S
CONCLUSION **WAS AGAIN**

NO
consensus

IN 2011
THE ROTTERDAM CONVENTION'S
CONCLUSION **WAS STILL**

NO
consensus

IN 2013
THE ROTTERDAM CONVENTION'S
CONCLUSION **WAS YET AGAIN**

NO
consensus

**IN 2015, THE ANTI-ASBESTOS LOBBY IS STILL AT IT...
WHY THIS INTERMINABLE CRUSADE ?**

**There is NO consensus on the inclusion of chrysotile
HOW MANY COP MEETINGS ARE NEEDED TO MAKE
THESE ACTIVISTS TO UNDERSTAND**



After four frustrated attempts from the anti-asbestos lobbies and well recognized supporters of the litigation business, again in 2015, all of those great cheerleaders will be present and in full action for the inclusion of chrysotile asbestos fibre type on the Prior Informed Consent (PIC) list of the International Rotterdam Convention.

Anti-asbestos activists working for WHO-ILO and Rotterdam Convention will, as usual, push hard and will not hesitate to take all possible steps nor spare any effort to get the inclusion of chrysotile.

WHY THIS INTERMINABLE CRUSADE?

Because the inclusion of chrysotile on the PIC list is nothing else than a waiting room for a worldwide ban. The official text of the Rotterdam Convention makes no secret about it.

**CRITERIA FOR
LISTING BANNED
OR SEVERELY
RESTRICTED
CHEMICALS
IN ANNEX III**

“CRITERIA FOR LISTING BANNED OR SEVERELY RESTRICTED CHEMICALS IN ANNEX III”

All activists having more vested interests somewhere else than in the field of safe use control have clearly understood that, and since the beginning of the Rotterdam Convention, they are attacking vigorously on all fronts. The silence of the competent authorities of the Rotterdam Convention on this matter must be a great concern for all.

An attentive reading of the Rotterdam Convention reveals that it was created to manage an anarchic trade of severely hazardous pesticides and chemicals that have an unquestionable and severe impact on the environment. The Convention sets out to either ban or strictly regulate such substances for general health reasons or to protect the environment. In other words, the Convention is not there to cover occupational health protection. It has to be emphasized that chrysotile does not pose a threat to the environment and, as ILO International Convention 162 states, the hazards associated with its use are restricted to the workplace.

Unlike the pesticides and chemicals covered by the Convention, its use is strictly regulated; the responsible use policy means that the situation pertaining to chrysotile is simply not comparable to that of the other substances, which are unregulated. The chrysotile trade and

the use of chrysotile are well supervised, and certainly not anarchic. Both are conducted safely and responsibly, with the express aim of protecting the health and physical integrity of persons. This is an occupational health issue, which is more than adequately managed by the implementation of the responsible use policy. The application of the PIC procedure to chrysotile is a patent attempt to discriminate chrysotile in favour of substitute fibres and alternative products in a market where chrysotile is their cumbersome competitor.

Chrysotile fibre has been present in the atmosphere since the creation of the universe: it is found in the soil of every continent. Levels of inhalable dust are so low that they pose no measurable danger for humans, or the environment. Dust levels in the workplace over the years have been reduced so dramatically that the risk is now no higher, and is usually lower, than that, in particular, of the chemicals industry. In fact, in many cases, the risk is so low that it becomes almost technically non measurable.

Let us take the example of silica, which is found everywhere in the environment, and in the workplace. Exposure to excessively high levels of silica has been, and continues to be a real risk for workers health. Stringent workplace controls have had to be introduced over the years.

Silicosis causes pulmonary disorders and ultimately many deaths. Yet, this substance is not proposed for inclusion on the PIC list because, rightly so, the problem is being addressed through intervention in the workplace. Just as with chrysotile fibre, the use of appropriate control methods are the obvious response, as this is an occupational health issue.

Vested interests are spearheading an aggressive international campaign against chrysotile, to ensure the lion's share of a lucrative market and one understands this is a trade war. A trade war which, unfortunately, is not based only on concern for health and safety whatever they may say. Solidarity, even on a health issue, soon wears thin when commercial interests are at stake.

The world urgently needs to place the chrysotile debate in a more rational perspective and set the record straight. In any event, to bring matters to their logical conclusion, and if protecting health and the environment are really paramount, why not include on the PIC list, the 884 products that the International Agency for Research on Cancer (IARC) classifies as known, probable or possible carcinogens, as well as the substitute fibres and alternative products to chrysotile that are recognized as hazardous. Of course, such an approach would be extremely disruptive to

international trade and could even verge on the ridiculous. So, based on the same rhetoric, countries must apply discernment, prudence and far-sightedness before proposing inclusion of certain products on the PIC list of the Rotterdam Convention.

The proposal to include chrysotile on the PIC list, curiously enough, excludes all other industrial fibres on the market. Thus, someone wanted to protect those replacement fibres and products from the restrictions imposed by the PIC procedure, isolating chrysotile to better force it out of the market. The reason why chrysotile is proposed to be added to the PIC list seems to make trading in it extremely difficult. And guess what? The countries backing this proposal also happen to be major exporters of these replacement products.



Of course the other Fibres, which would be excluded from the PIC procedure, would be protected from the avalanche of commercial complications imposed on chrysotile. This is blatantly discriminatory and suspect, because nothing justifies this twisting of generally accepted market rules. Above all the most recent published science does not invite for this action.

This position is clearly more political than scientific, and is sure to increase the anti-chrysotile feelings favouring substitute fibres, even though it is well known that they have to often not been proven to be harmless. The fact that the chrysotile industry and its workers did their homework, recognized the hazards, minimized the risks and implemented improved health and safety measures in the workplace is altogether a remarkable achievement, and should not through discrimination have all these efforts nullified in one shot.

One realizes that this is another diversionary tactic designed to make people forget that. The chrysotile industry has been implementing the responsible use policy for more than 20 years. Furthermore, this natural fibre has unique properties and substitute fibres cannot really fulfill the same role. Moreover, it is an inexpensive, natural product, readily available and very durable, and energy friendly, which makes it a lot more affordable for the poorest countries. Competing interests have concluded that chrysotile must be destroyed because alternative materials cannot compete.

The inclusion has to be seen as an approach that is arbitrarily and unfairly detrimental to the marketing of chrysotile and is also harmful to the poorest populations, in urgent need of infrastructures to improve their quality of life.

In the chrysotile debate, the agenda has too often been tainted with half-truths and bad faith. It is high time for competent authorities to react and denounce this shame. The simple truth is this: today, chrysotile is used in high-density products in which the fibre is encapsulated in a matrix. Chrysotile is no longer flocked or used in friable products. And, there are extremely stringent laws and strict regulations in place, which ensure that this is the case.

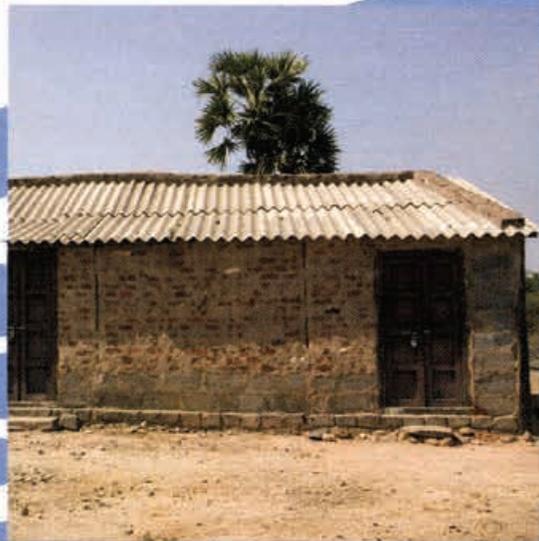
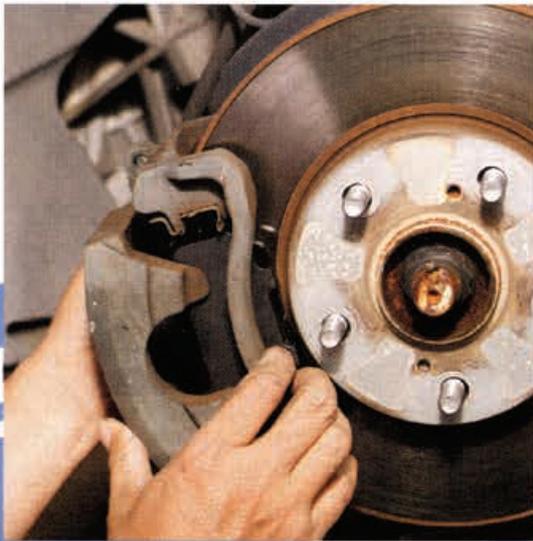
No one must longer be deceived by strident, inflammatory statements or sensationalist headlines. It is important to set the record straight and make sure that good common sense is allowed to rule. There must be an end to the confusion and fear-mongering. The world now has relevant studies showing that it is a fact today the safe use of chrysotile is really there in place.

RESPONSIBLE USE OF CHRYSOTILE IS NOT A MYTH, IT'S A FACT!

In this regard, Europe itself has accepted to extend this principle to its diaphragm manufacturing for many years.

This is a living proof of the concept of the Safe and Responsible approach to the use of chrysotile.

For responsible use of chrysotile



For responsible use of chrysotile

1 There are a number of recognized and published scientific studies supporting the assertion that exposure to chrysotile that respects the current occupational standard of 1 fibre/cc is safe; the risk to health at this level of exposure is so low as to not be measurable.



2 It is irresponsible of anti-chrysotile militants to refuse to read and have an honest discussion about scientific studies that support the possibility of safely using chrysotile.



3 Mining or industrial facilities that use chrysotile respect the industrial exposure standard of 1 fibre/cc. As for the construction industry, the precautions to be taken when removing sprayed asbestos (a practice from the past that has long since been banned) are well known. Modern, high-density materials containing chrysotile are easily handled and do not present a health risk, provided that the necessary precautions are taken.

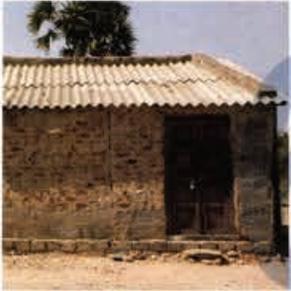


4 Both the World Health Organization (WHO) and the International Labour Organization (ILO), in their official positions approved by Member States, call for responsible and controlled use of chrysotile, and not a ban.





5
It is irrational to treat chrysotile differently from other products, fibres or substances that also carry some risk to health.



6
Emerging and developing countries have full knowledge of the facts, and they continue to import chrysotile because it meets their populations' essential needs.



7
The health impacts of most of the products used as alternatives to chrysotile are much less well documented in terms of scientific research than those of chrysotile (and their potential risk is often unknown). And yet, their use is far less controlled than that of chrysotile.



8
Closing all chrysotile mines and manufacturing plants using chrysotile fibres won't help anyone, anywhere in the world. On the other hand, exporting expertise in controlled use of chrysotile, along with the fiber itself, can contribute significantly to improving conditions for the use of products containing chrysotile throughout the world.



9
What should be considered is the potential for development of the chrysotile industry.

WHAT IS THE LOGIC BEING APPLIED WHEN REQUESTING THE INCLUSION OF THE CHRYSOTILE ASBESTOS FIBRE TYPES ON THE PIC LIST OF THE ROTTERDAM CONVENTION

The unwarranted inclusion of chrysotile on the RC PIC list is just what some are waiting for to speed us the “total ban” crusade, and at the same time will give a strong boost to the marketing of substitute fibres and alternative products which are too often unregulated and rarely scientifically proven safer and less harmful than chrysotile. This underhanded scheme must be denounced.

Numerous and recent scientific studies show that when chrysotile is mined and handled according to appropriate work practices as nowadays, it does not present an unacceptable level of risk for the health of either workers or the general public.

The proposed inclusion of chrysotile on the PIC list of the Rotterdam Convention must raise international concerns and would go beyond the principles of the international Rotterdam Convention, as adopted by its member states.

As with any product or substance presenting a potential health risk, the logical and most appropriate response is to put in place and enforce regulations to ensure the safe and responsible use of those materials.

An increasing number of scientists and governmental authorities have voiced concerns about the potential harmful health effects of some industrial substitute fibres and products proposed to replace chrysotile.

Furthermore, in many instances these substitutes are less durable, are more expensive and very often of lower quality. Any approach related to the use of products or fibres presenting a potential health risk must be based on the most recent and pertinent studies and literature. It is evident that the burden of such proof now rests with the substitute fibres and alternative products offered and found on the market.

Before going toward a total ban of a product, updated scientific evidence must guide responsible people to demand in-depth studies and seriously examine, with qualified scientists, the result and make a decision in light of those results, not on public misperceptions fostered by propaganda or smear campaign. The Rotterdam Convention should no be misused to harm or to eliminate from the international commercial market any product or substance.

Notwithstanding that there will be an economic impact to the listing of chrysotile on the PIC list, the chrysotile industry has generally not argued its position as being based on economic considerations. Rather, it registered its position based on the weight of scientific empirically based analysis. Consequently, ICA supports that a chemical should only be banned if it poses an unreasonable and unmanageable risk. (Acceptable Risk is NOT Zero Risk.)

The fundamental question is whether scientific integrity should outweigh competing or political interests. Moreover, to support listing could undo much of the good work done in promoting the safe and responsible use of chrysotile. As well, it could undermine the support that many customers have provided in their efforts to stem the banning of chrysotile.

For serious consideration is the fact that listing of chrysotile is inconsistent with many domestic legislations and policies as chrysotile is neither banned nor severely restricted in many large countries of the world.

Policies should be based on the best available information and science. The importance of science to proper risk assessment is also acknowledged.

Many countries have made clear their position on the listing of chrysotile under the Rotterdam Convention at the four last Conference of the Parties held in recent years. The Conference of the Parties is the decision making body of the Rotterdam Convention.

In the Conference of the Parties (COP 7) meeting (2015), there is nothing new added to the scientific chrysotile file which would justify the Assembly to change the position taken on four separate occasions. Everything points to the contrary. Again, a proposal for inclusion of chrysotile must be refused and strongly rejected by the participants from different countries.

The preoccupations and hopes expressed, against the inclusion of chrysotile on the PIC list, by the competent authorities from many governments during the deliberations of precedent COP meetings must be heard again. There is no new scientific evidence justifying a change in the position taken before, so in 2015, for the same reasons, a proposal for inclusion of chrysotile fibres on the PIC list should be refused again and, no one should allow themselves to be influenced by the anti propaganda. Science should talk louder than perceptions and false accusations.

The fundamental issue regarding chrysotile that was discussed over the years at the Rotterdam Convention Conferences of Parties (COP) was the following: Should chrysotile be designated as a dangerous substance and be subjected to the Prior Informed Consent (PIC) procedure when it is traded internationally? Ultimately, in four occasions, the COP could not reach consensus.



Countries that represent some 70% of the world's population still use chrysotile and strongly believe this can be done safely. They are reluctant, and for cause, to submit international trade of chrysotile to a procedure they clearly deem redundant with other international agreements, such as Convention 162 of the International Labour Organization, and which thus becomes an unjustified impediment. There are underlying economic issues here, since products competing with chrysotile are produced in the countries that are most strongly opposed to chrysotile.

At the heart of the matter lie scientific issues: countries producing and using chrysotile believe that it has been scientifically demonstrated that safe use is possible, some countries going even further and claiming an absence of adverse health impacts on their population, despite a near-century of utilization. They also point to the absence of information on substitute products that have been much less studied than chrysotile as to their impact on human health.

As long as the scientific issues at the core of the chrysotile issue will not have been resolved, the stalemate will continue at the Rotterdam Convention.

Comments on WHO ICD-10 database and the article 'Global mesothelioma deaths reported to the World Health Organization between 1994 and 2008' (Delgermaa et al. 2011)

David M. Bernstein, Ph.D. Consultant in Toxicology 40 chemin de la Petite-Boissière 1208 Geneva,
Switzerland Tel: +41 22 7350043 Fax: +41 22 7351463 e-mail: davidb@itox.ch

1 SUMMARY:

Examination and analysis of the ICD-10 WHO database clearly contradict the conclusions reported by the WHO authors that "Our analysis shows that the disease burden is still predominantly borne by the developed world. However, since asbestos use has recently increased in developing countries, a corresponding shift in disease occurrence is anticipated."

The database shows that in the developed world the incidence is no longer increasing but decreasing. In addition, the results presented by income group show no statistically significant relationships for Middle and low income workers who would be largely working with chrysotile in developing countries.

The WHO ICD-10 database which has data through 2012 shows that for men, the number of total mesothelioma cases from all mesothelioma classifications worldwide has never exceeded in men 12,758 cases per year (maximum in 2009).

For women, the number of cases has never exceeded from all mesothelioma classifications worldwide 3,327 cases per year (maximum in 2008).

The ICD-10 database shows that when only pleural and peritoneal mesothelioma are considered, that the number of pleural and peritoneal mesothelioma cases worldwide has never exceeded in men 6,543 cases per year (maximum in 2009).

2 INTRODCUTION

The article by Delgermaa et al. 2011, that appeared in the Bulletin of the World Health Organization provides a superficial presentation of the data in the WHO database.

The database that the WHO used for analysis has since been updated by the WHO on their web site and is referred to as Mortality, ICD-10 and is available at:

http://www.who.int/healthinfo/statistics/mortality_rawdata/en/

The database has 4342 entries for mesothelioma for 103 country over 19 years from 1994-2012. The disease codes used in the database were specified in the International Statistical Classification of Diseases and Related Health Problems 10th Revision, which is available at:

<http://apps.who.int/classifications/icd10/browse/2010/en>

3 MESOTHELIOMA CLASSIFICATIONS IN THE WHO DATABASE

For mesothelioma, there are 6 subdivisions of the disease code as follows:

C45 Mesothelioma (Site not reported)

C45.0 is a specific ICD-10-CM diagnosis code C45.0 Mesothelioma of pleura

C45.1 is a specific ICD-10-CM diagnosis code C45.1 Mesothelioma of peritoneum

C45.2 is a specific ICD-10-CM diagnosis code C45.2 Mesothelioma of pericardium

C45.7 is a specific ICD-10-CM diagnosis code C45.7 Mesothelioma of other sites

C45.9 is a specific ICD-10-CM diagnosis code C45.9 Mesothelioma, unspecified

4 TOTAL NUMBER OF DEATHS BY MESOTHELIOMA IN THE WHO DATABASE

In the WHO report the authors present in Table 1 of the report (not shown here) at total of 92,253 mesothelioma deaths in the mortality database of the World Health Organization, worldwide, 1994-2008 (14 years).

In the updated ICD-10 database, over the 19 years of the database, the total number of cases of mesothelioma (from all the above classifications) was 169,537. This amounts to an average of 8,923 cases of mesothelioma (from all the above mesothelioma classifications) per year for all 103 counties in the database.

As shown in Table 1 below, most cases of mesothelioma appear to be classified as C45.9 Mesothelioma, unspecified.

Table 1: Summary statistics of the total number of deaths reported in the ICD-10 WHO database for each classifications of mesothelioma for 19 years over all 103 counties worldwide.

Breakdown Table of Descriptive Statistics (Mortcid10_C45_by Country Code.sta) N=4342 (No missing data in dep. var. list)						
mesothelioma classification	Total deaths Means	Total deaths N	Total deaths Sum	Total deaths Std.Dev.	Total deaths Minimum	Total deaths Maximum
C45 - Site not reported	17.15	290	4,973	32.87	1	180
C450 - Pleura	61.80	1071	66,183	146.63	1	1047
C451 - Peritoneum	8.73	824	7,192	13.26	1	75
C452 - Pericardium	1.73	237	410	1.23	1	6
C457 - Other sites	13.82	731	10,104	37.89	1	365
C459 - Unspecified	67.85	1189	80,675	213.54	1	1694
All Grps	39.05	4342	169,537	137.37	1	1694

Table 2 shows from the database the number of total cases of mesothelioma reported over the 19 years by country for those countries with more than 100 total cases (over the 19 years).

The most cases were reported for the United States with a total of 29,665 cases over 19 years or an average of 1,561 cases per year.

Table 2: Summary statistics of the TOTAL NUMBER OF CASES OF MESOTHELIOMA FOR ALL CLASSIFICATIONS IN THE ICD-10 DATABASE reported over the 19 years by country for those countries with more than 100 total cases

Breakdown Table of Descriptive Statistics (Mortcid10_C45_by Country Code.sta) N=4342 (No missing data in dep. var. list)						
Name	Total Deaths Means	Total Deaths N	Total Deaths Sum	Total Deaths Std.Dev.	Total Deaths Minimum	Total Deaths Maximum
All Grps	39.0	4342	169537	137.4	1	1694
United States of America	262.5	113	29665	454.8	1	1694
United Kingdom, England and Wales	203.2	99	20116	328.8	1	1324
United Kingdom	219.5	91	19977	339.2	1	1361
Germany	133.8	131	17523	259.8	1	1047
Japan	87.8	169	14835	154.0	1	795
France	99.6	95	9459	126.7	1	435
Italy	155.5	50	7775	240.3	1	800
Australia	63.1	107	6752	103.2	1	427
Netherlands	52.7	125	6593	94.7	1	372
Spain	33.7	117	3943	40.0	1	149
Canada	43.3	83	3597	67.7	1	278

South Africa	92.9	29	2693	55.1	1	180
Mexico	20.1	108	2172	22.5	1	105
Belgium	28.6	67	1917	39.0	1	126
United Kingdom, Scotland	19.1	95	1817	27.3	1	102
Sweden	15.6	109	1705	19.4	1	74
Poland	15.6	97	1511	24.1	1	111
Argentina	13.0	115	1497	16.5	1	63
Denmark	10.6	129	1361	13.6	1	66
Brazil	6.6	205	1354	5.9	1	26
Finland	11.4	106	1210	17.7	1	68
Norway	10.7	91	978	14.9	1	52
Peru	12.1	72	872	52.0	1	365
Austria	12.6	68	854	15.3	1	62
Croatia	8.4	96	808	13.5	1	54
Czech Republic	5.6	141	789	5.0	1	24
New Zealand	12.6	62	780	19.1	1	69
Romania	8.1	94	763	7.6	1	30
Republic of Korea	17.5	39	683	14.9	1	63
Hungary	5.0	118	589	3.9	1	16
Chile	5.9	88	516	5.2	1	26
Colombia	6.5	77	497	5.9	1	25
United Kingdom, Northern Ireland	6.6	64	423	7.9	1	28
Israel	5.7	70	399	6.7	1	25
Serbia	13.3	30	399	5.6	4	27
Slovenia	11.4	28	320	6.6	3	25
Portugal	5.0	45	224	4.3	1	19
Slovakia	5.5	38	209	2.7	1	12
Venezuela	2.2	73	160	1.3	1	6
Hong Kong SAR	3.4	45	153	3.8	1	15
Lithuania	2.4	64	151	2.0	1	9
Serbia and Montenegro, Former	4.3	33	142	4.1	1	17
Latvia	3.4	42	141	2.4	1	9
Ireland	6.0	21	125	7.7	1	29

5 CASES OF 'PLEURAL' AND 'PERITONEAL' MESOTHELIOMA IN THE WHO ICD-10 DATABASE

In their report, the authors present numerous figures purporting to show the relationship between of the evolution of the number of deaths from mesothelioma over time as illustrated in Figures 1 and 2 (Figures 6 and 7 from the WHO report) shown below. In these figures, it should be noted that the authors do not present the number of actual

deaths but rather an “Age adjusted mortality rate (per millions of population)”. They state that the diameter of the circles are proportional to the size of the population at risk. There is no mention of what are the actual sizes of these populations. However, more important there is no presentation of the standard deviations of the means and whether the data show enough statistical power to make these associations.

In addition, the authors state that these are the results for ‘pleural’ and ‘peritoneal’ mesothelioma. When only these two mesothelioma codes were selected in the database, even fewer cases are reported.

The actual data on which these figures were based are summarized in Table 3 below. For ‘pleural’ and ‘peritoneal’ mesothelioma, there were a total of 73,375 deaths over 19 years for all countries or an average of 3,862 deaths per year worldwide. The largest number of deaths from ‘pleural’ and ‘peritoneal’ mesothelioma was reported for Germany as 16,044 over 19 years or an average of 844 deaths per year. Thus, the presentation of the figures in the WHO report is very misleading as there is no presentation of the actual number of cases on which these presentations were based.

However, even more important as shown in Figure 1 below (reproduced from Fig. 6 of the WHO report) are the findings that All Mesothelioma deaths; Male deaths and Female deaths are steadily decreasing in rate and number (size of circles) for the last 3 time points presented.

The WHO ICD-10 database which has data through 2012 shows that for men, the number of total mesothelioma cases from all mesothelioma classifications worldwide has never exceeded in men 12,758 cases per year (maximum in 2009).

For women, the number of cases has never exceeded from all mesothelioma classifications worldwide 3,327 cases per year (maximum in 2008).

The ICD-10 database shows that when only pleural and peritoneal mesothelioma are considered, that the number of pleural and peritoneal mesothelioma cases worldwide has never exceeded in men 6,543 cases per year (maximum in 2009).

Figure 1: Copy of Figure 6 from the WHO report

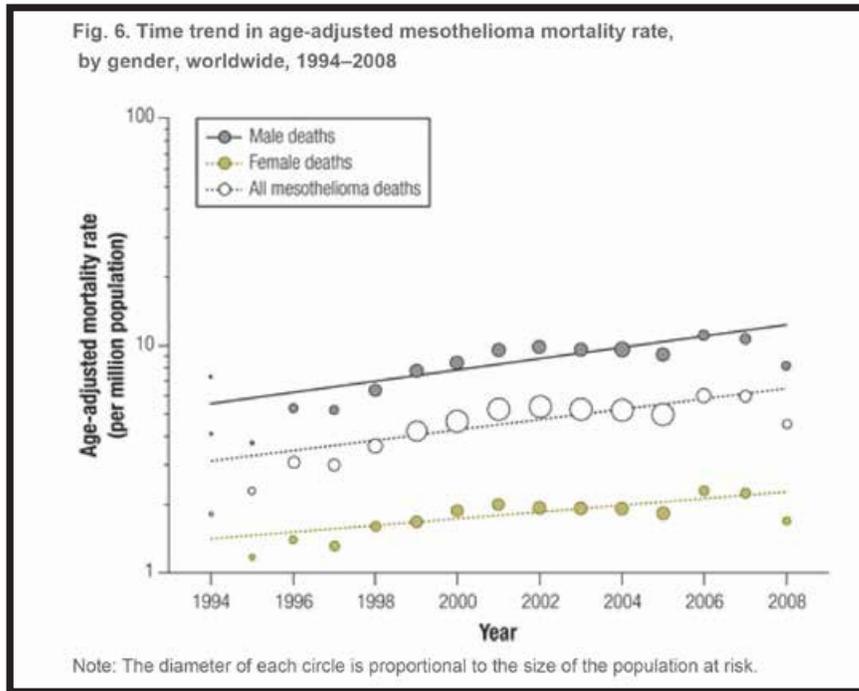


Figure 2: Copy of Figure 7 from the WHO report

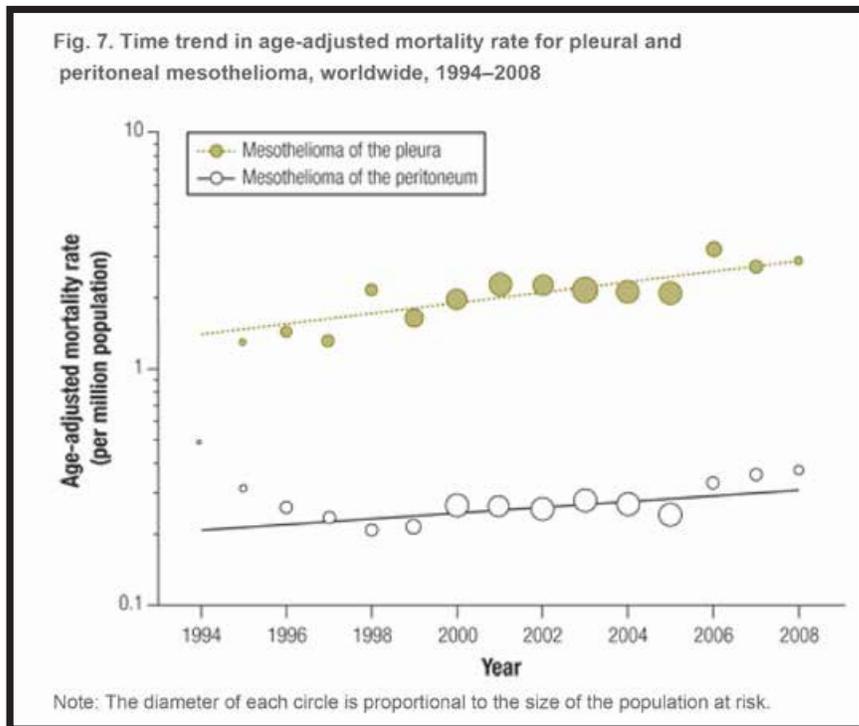


Table 3: Summary statistics of the number of cases of 'PLEURAL' AND 'PERITONEAL' MESOTHELIOMA reported over the 19 years by country for those countries with more than 100 cases

Breakdown Table of Descriptive Statistics (Mortcid10_C45_by Country Code.sta) N=1895 (No missing data in dep. var. list) Include condition: v7="C450" or v7="C451"

Name	Deaths Means	Deaths N	Deaths Sum	Deaths Std.Dev.	Deaths Minimum	Deaths Maximum
All Grps	38.7	1895	73375	113.6	1	1047
Germany	267.4	60	16044	338.5	6	1047
Japan	169.2	68	11506	212.3	16	795
Italy	278.5	24	6685	301.3	18	800
United Kingdom	159.8	40	6392	198.1	9	547
France	138.9	44	6112	156.2	6	435
United Kingdom, England and Wales	127.2	44	5596	154.4	7	430
United States of America	67.8	48	3254	50.1	20	194
Spain	45.7	52	2376	48.4	4	149
Poland	25.6	52	1333	29.3	1	111
United Kingdom, Scotland	28.1	45	1265	36.0	1	102
Netherlands	20.1	62	1246	26.4	1	113
Australia	22.6	51	1155	34.6	1	194
Finland	18.3	63	1151	20.3	1	68
Denmark	13.7	68	933	16.9	1	66
Croatia	12.2	60	731	15.9	1	54
Austria	17.3	40	690	18.2	1	62
Brazil	6.6	101	667	5.3	1	23
New Zealand	19.6	34	666	23.5	1	69
Romania	12.5	52	649	7.6	1	30
Sweden	11.2	52	580	13.0	1	41
Czech Republic	7.7	75	578	5.6	1	24
Norway	9.9	50	496	13.9	1	49
Mexico	10.1	44	443	9.4	1	40
Canada	11.0	40	439	10.6	1	35
Belgium	11.9	31	369	13.7	1	50
Argentina	8.2	45	367	7.1	1	29
Hungary	5.2	63	327	3.9	1	16
Chile	5.2	38	197	4.1	1	14
United Kingdom, Northern Ireland	6.4	30	191	7.1	1	23
Portugal	4.9	27	132	4.5	1	19
Serbia and Montenegro, Former	5.4	22	118	4.6	1	17
Colombia	3.5	33	117	2.8	1	11

6 WHO REPORT: REGRESSION ANALYSIS CARRIED OUT USING THESE DATA TO CHARACTERIZE THE TIME TREND IN THE AGE-ADJUSTED MORTALITY RATE

In the WHO report the authors present as shown in Table 4 (Table 2 from the WHO report) a summary of the findings of the regression analysis carried out using the data, from 46 countries which reported deaths due to mesothelioma for more than 5 years, to characterize the time trend in the age-adjusted mortality rate.

The authors stated that:

“For all mesothelioma deaths, the age-adjusted mortality rate increased significantly at an annual rate of 5.37%. The annual increase in men, at 5.85%, was more than 60% greater than in women, at 3.48% (Fig. 6). When data were analysed by the anatomical site of the mesothelioma, the increasing trend was most apparent for the category of unspecified sites, for which the annual increase was 7.80%. The second most rapid increase was for pleural mesothelioma, at 5.20%, followed by peritoneal mesothelioma, at 2.78% (Fig. 7). Analysis of the trend in different continents showed a significant annual increase of 3.67% in Asia and of 3.44% in Europe (Fig. 8; available at: <http://www.who.int/bulletin/volumes/89/10/11-086678>). **In addition, there was a significant annual increase of 5.54% in high-income countries, but no significant increase in middle and low-income countries (Fig. 9). Finally, analysis of data from selected countries identified a significant annual increase of 3.46% in Japan and a significant annual decrease of 0.84% in the United States (Fig. 10).**”

However, as shown in yellow in Table 4 (annotated Table 2 WHO report), many of the reported relationships were not statistically significant.

- By Continent: the America and Oceania showed no statistically significant relationships.
- By Country income group: Middle and low showed no statistically significant relationships.
- By Selected Countries: United Kingdom of Great Britain and Northern Ireland and South Africa showed no statistically significant relationships.

As mentioned in the WHO text, the relationship for the United States of America significant annual decrease of 0.84%

The authors also did not mention as shown in Figure 3 below (Fig. 8 from the WHO report) that for Europe in 2008 (dark grey circles) that there was a significant decrease in incidence.

These findings are contradictory to the conclusions presented by the authors that “Our analysis shows that the disease burden is still predominantly borne by the developed world.” The results presented by WHO show that in the developed world the incidence is no longer increasing but decreasing.

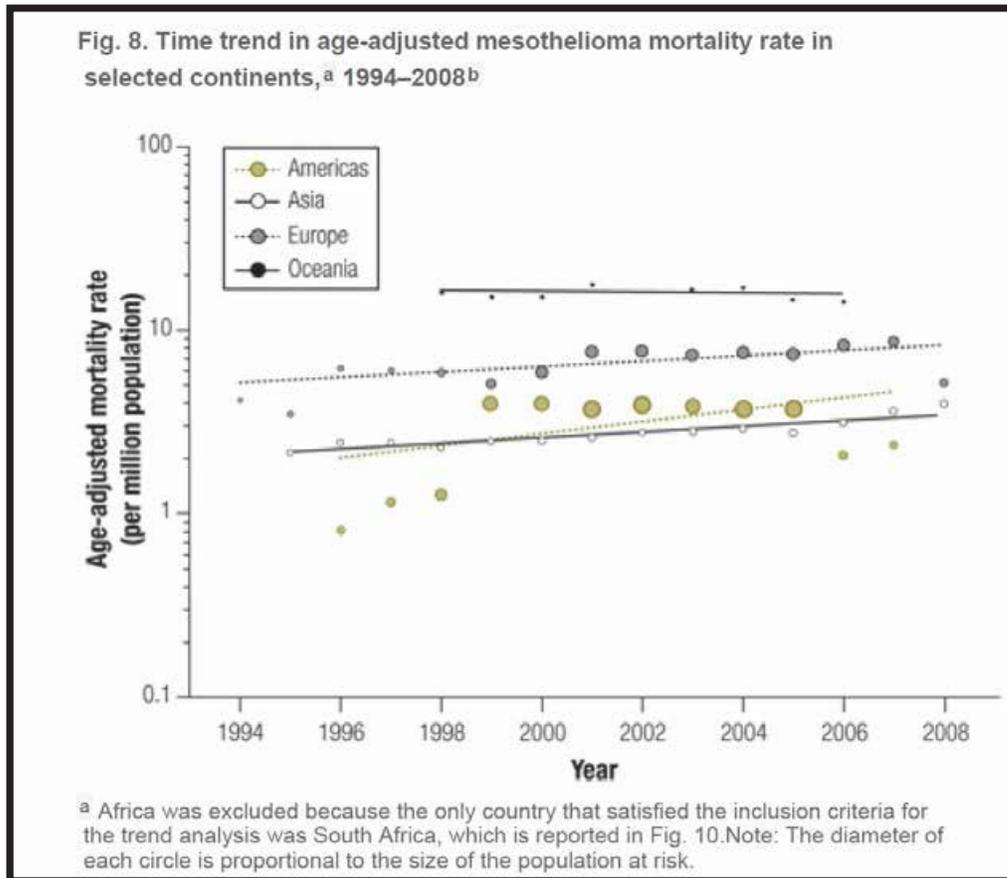
In addition, the authors state that “However, since asbestos use has recently increased in developing countries, a corresponding shift in disease occurrence is anticipated.” However, the

results presented by income group show no statistically significant relationships for Middle and low income workers who would be largely working with chrysotile in developing countries.

Table 4 (Reproduced from Table 2 of the WHO report)

Table 2. Regression analysis of time trend in age-adjusted ^a mesothelioma mortality rate, worldwide, 1994–2008					
Category	Regression parameter ^b			Annual change	
	b or slope	95% CI	P	%	95% CI
Gender					
Male	0.02	0.01 to 0.04	0.0003	5.85	3.25 to 8.51
Female	0.01	0.01 to 0.02	0.0008	3.48	1.74 to 5.26
All	0.02	0.01 to 0.03	0.0002	5.37	3.06 to 7.74
Anatomical disease site					
Pleura	0.02	0.01 to 0.03	0.0006	5.20	2.67 to 7.78
Peritoneum	0.01	0.003 to 0.02	0.0166	2.78	0.59 to 5.03
Unspecified	0.03	0.01 to 0.05	0.0040	7.80	2.90 to 12.93
Continent^c					
Americas	0.03	-0.01 to 0.08	0.1148	7.89	-2.18 to 18.99
Asia	0.02	0.01 to 0.02	< 0.0001	3.67	2.64 to 4.71
Europe	0.01	0.003 to 0.03	0.0149	3.44	0.78 to 6.17
Oceania	-0.002	-0.01 to 0.01	0.6295	-0.51	-2.90 to 1.92
Country income group					
High	0.02	0.01 to 0.04	0.0010	5.54	2.66 to 8.50
Middle and low ^d	0.01	-0.001 to 0.02	0.0621	2.16	-0.12 to 4.51
Selected countries					
United States of America	-0.004	-0.01 to -0.001	0.0076	-0.84	-1.34 to -0.34
United Kingdom of Great Britain and Northern Ireland	0.003	-0.004 to 0.01	0.3403	0.68	-0.88 to 2.27
Japan	0.01	0.01 to 0.02	< 0.0001	3.46	2.86 to 4.07
South Africa	-0.01	-0.01 to 0.001	0.0959	-1.47	-3.22 to 0.31

Figure 3 (Fig. 8 from the WHO report)



CONCLUSION

At this Conference of the Parties (COP 7) of the Rotterdam Convention on the Prior Informed Consent (PIC) Procedure, participants from numerous countries around the world representing their respective competent authorities will have to make decision and, for any inclusion on the PIC list, it can be achieved only by consensus, as required by the official text of the Convention.

The formal objective of the Rotterdam Convention is to promote shared responsibility and cooperative efforts among Parties in the international trade of certain hazardous chemicals in order to protect human health and the environment from potential harm and to contribute to their environmentally sound use by facilitating information exchange.

Over the years, the Rotterdam Convention has turned into a kind of anti-asbestos forum in which anti-asbestos lobbies are pushing as far as possible their crusade against chrysotile. They obviously use the COP meetings as springboard for their cause and the authorities of the Rotterdam Convention surprisingly are keeping a questionable silence when some people working for the Convention are active and in support of all this.

Unfortunately, for the COP 7 Conference in 2015, one can expect the same unhealthy approaches and the same scenario be repeated when serious discussions over the real new science will be put aside again.

The Secretariat of the Rotterdam Convention has never hesitated nor spared any effort to get chrysotile fibres on the PIC list of the Convention. One shall always recall that once a product or a substance is included on that list, it should be removed from the market (**severely restricted to the market**) or be banned. It is exactly what Annex III of the Rotterdam Convention is calling for.

At each Conference of the Parties (COP meetings) the Secretariat of the Rotterdam Convention has approached the assembly of delegates with some kind of initiative or document, unfortunately, clearly « guided » towards the inclusion of the chrysotile fibres on the PIC list.

DO NOT FORGET

ROTTERDAM CONVENTION – OPERATION OF THE PRIOR INFORMED CONSENT PROCEDURE FOR BANNED OR SEVERELY RESTRICTED CHEMICALS. It is exactly where anti-asbestos activists want to put chrysotile.

COP 7 meeting is called for 2015 and will not be different.

This time, once again, the report of COP 6 meeting – written by the Secretariat — is not factual and is twisted. Furthermore, more recently, there has been a biased Note by the Secretariat supporting the inclusion of chrysotile on the PIC list.

It is more than reasonable for member states to insist and to disagree by requiring immediate correction of this « trap » DRAFT DECISIONS brought up in the report of COP 6 and in the Note by the Secretariat. This includes to vote against and to denounce this unhealthy strategy. All the kind of stratagems used many time for the inclusion of chrysotile on the PIC list must stop.

That is worth something to recall again that the unwarranted inclusion of chrysotile on the PIC list is exactly what some are waiting for to speed up the total ban crusade and at the same time will give a strong boost to the marketing of substitute fibres and alternative products which are too often unregulated and rarely scientifically proven safer and less harmful than chrysotile. This underhanded scheme must not be acceptable ...

Why?

Because numerous and recent published scientific studies are teaching us that when chrysotile is used in high density products with appropriate work practices as nowadays it does not present an unacceptable level of risk for the

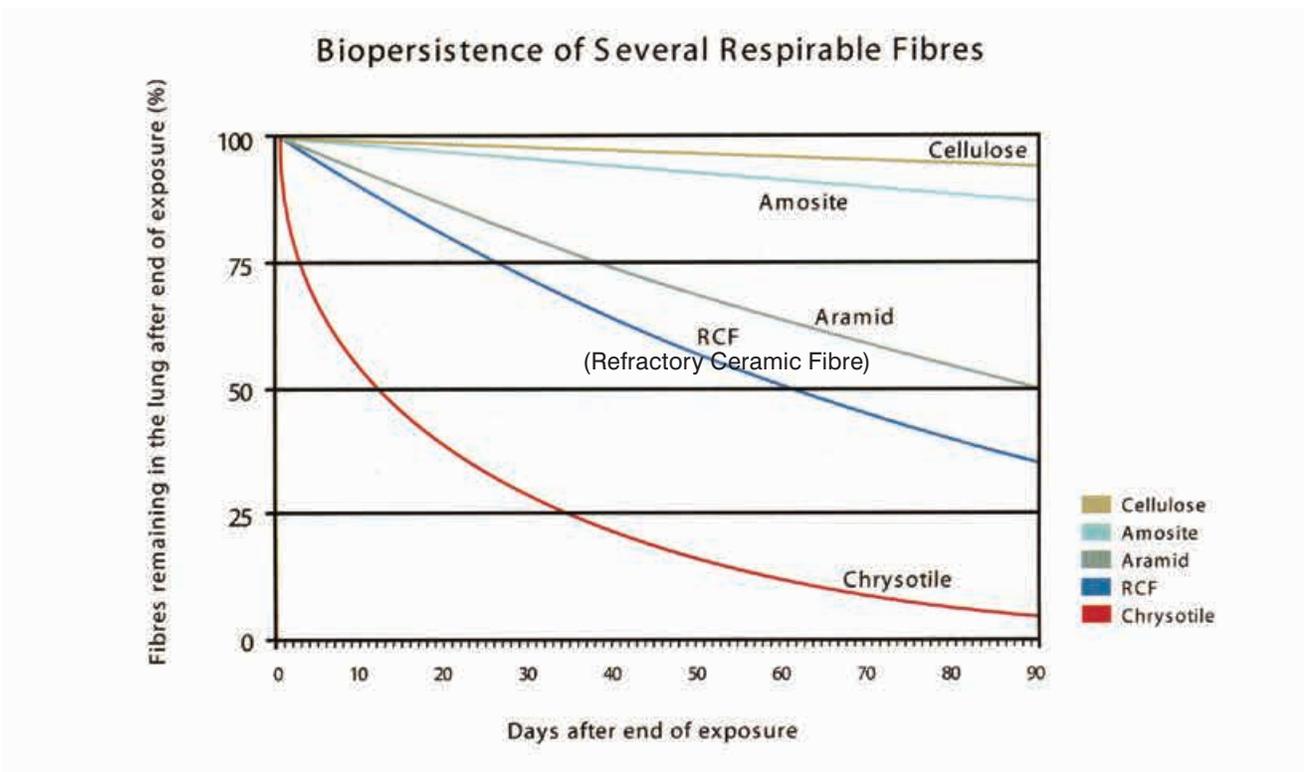
health of either workers or the general public. It is fair and desirable that chrysotile be not included on the PIC list. Recent studies and research are certainly not requesting nor inviting the Parties to change the traditional position on the inclusion. Chrysotile is too important for people in need for such natural mineral and they have the right to improve their living conditions as they see fit. Poor countries represent two third of the humanity and they should never be the subject of harassment anymore.

It is crystal clear that the Rotterdam Convention Secretariat does not have in hands nor is in position to present to member states the necessary scientific data that invite the COP 7 meeting to include chrysotile on the PIC list of the (chemicals) that are banned or severely restricted for the market.

In 2015, there is definitively no scientific reason nor new science that invite or indicate to the participants of the COP 7 conference that they should change their position which has been to refuse to include chrysotile fibre on the PIC list of the Rotterdam Convention for four times.

CHRYSTOLE AND AMPHIBOLES: DO NOT MIX UP

Of all the fibres analyzed, chrysotile is the fibre which is most quickly eliminated from the body.



Biopersistence: It is the length of time for inhaled particles to persist in the lungs and adversely affect surrounding tissues before they are eventually cleared.



Biopersistence studies have been carried out on a number of different respirable particles. It has now become clear that there are vast differences among various respirable particles presently used by industry.

There seems to be a continuum of values for biopersistence of mineral particles, from very short persistence (low durability) to practically indefinite persistence (very high durability).

Chrysotile has not to be included and for just cause. It is not scientifically demonstrated.





For environmental
occupational health
safe and responsible use