



EDITORIAL

SETTING THE SCENE FOR SORDSA — THE IMPORTANCE OF OCCUPATIONAL RESPIRATORY DISEASE SURVEILLANCE IN SOUTH AFRICA

The first half of the 20th century has seen large epidemics of occupational lung diseases caused by exposure to mineral dusts. Acknowledgement of these 'silent' epidemics took many years; consequently, especially for asbestos-related lung diseases, many new cases of disability and death will continue to manifest themselves well into the new century both in South Africa and elsewhere.¹ However, with the exception of current mine workers, many of whom are subject to statutory periodic monitoring for lung diseases, we have little systematically collected data on mineral dust-related respiratory diseases in South Africa. A major limitation in the data collected on current mine workers is that occupational lung diseases caused by mineral dust are progressive in nature and in a high proportion of cases these manifest after exposure to dust has ceased.² Since many workers are migrants who return to their sending areas where they do not have follow-up medical examinations, the burden of unrecognised occupational lung diseases in these workers may be high,³ but is mostly unknown.

During the second half of the 20th century, especially after World War II, a large increase in the production and use of synthetic materials took place, with a corresponding introduction into the workplace of many chemical agents that can cause respiratory diseases. More than 200 sensitising and irritant agents are now known to cause work-related asthma⁴ and the application of new and established sensitising agents in industrial processes is being constantly expanded. It was only in the mid 1980s, as a result of population-wide occupational surveillance programmes in several developed countries, that it was recognised that work-related asthma had become the occupational lung disease of the new century.⁵ Exposure to organic material such as grain dust and animal proteins, and exposure to pesticides and insecticides in agriculture, have also been shown to lead to work-related asthma and hypersensitivity pneumonitis.⁶ These diseases are often under-diagnosed and not linked to workplace exposure, and their extent in South Africa is unknown.

A form of occupational lung disease data collection has been in place in South Africa since 1993. Medical practitioners are required under Section 25 of the Occupational Health and Safety Act of 1993 to report cases of occupational disease to the

Chief Inspector, Occupational Health and Safety.⁷ However, this routine reporting has not worked in the past.⁸

Consequently, although the incidence of work-related respiratory disease among South African workers is likely to be high, there are no systematic data on the problem. Arising out of this need for data on occupational respiratory diseases in the non-mining industries and among former mine workers, Surveillance of Work-related and Occupational Respiratory Diseases in South Africa (SORDSA) was established in October 1996.⁸ SORDSA is a collaborative project of the National Centre for Occupational Health, Department of Health; the Department of Labour; the South African Thoracic Society; the South African Society for Occupational Medicine; and the South African Society for Occupational Health Nurses, and is supported by the WHO/SA Technical Co-operation Programme. SORDSA aims to monitor the extent and distribution of work-related respiratory diseases; to identify hazardous industries, occupations and agents; to create awareness of work-related respiratory diseases; to develop a model surveillance system for occupational diseases in South Africa; and to link the information collected with intervention and prevention in the workplace.

During the first 3 years SORDSA has collected important information through voluntary reports by occupational medicine practitioners, pulmonologists and occupational health nurses. This information includes the types and distribution of occupational lung disease in South Africa, and the suspected causal agents and industries. In this issue we present surveillance results from 3 years of reporting. Although there are some limitations to their use, these data have previously not been available in South Africa. Equally important, SORDSA has contributed to the recognition and awareness of occupational respiratory diseases and their causative agents through dissemination of awareness posters, hazard-alert brochures and other information.

Up to now, SORDSA's main priorities have been building the reporting structure to obtain good surveillance data, and increasing awareness of occupational lung diseases. It is envisaged that SORDSA will henceforth concentrate on implementing programmes for prevention of occupational respiratory diseases. The potential of intervention programmes, in collaboration with the Department of Labour, provincial occupational health units and the professional societies where appropriate, is large. SORDSA identifies priority exposures, industries and diseases by province. Sensible targeting of action is therefore possible, and could include a wide range of co-ordinated health-promotion activities.

The scope of these intervention activities can be demonstrated using the example of spray paints containing isocyanates, which have led to cases of occupational asthma being reported to SORDSA. Producers and suppliers of spray paints could be involved in efforts to reduce disease, for



example by improving knowledge about safe use, upgrading warning labels and material safety data sheets to emphasise the danger, and exploring alternative, safer products. Health hazard evaluations of spray painters could be undertaken by provincial agencies to identify affected workers and evaluate hazard control measures. Seminars could be held with employers and spray painters to discuss best practice and to develop practicable solutions to hazard control. Publications with guidelines could follow these seminars and be distributed to users. The compensation authorities could be alerted to the problem so that claims are facilitated. By means of ongoing surveillance through SORDSA, the effects of these interventions in reducing disease incidence can be monitored.

SORDSA's success in its primary objective of prevention of occupational respiratory diseases will be through continued information dissemination, collection of reliable data on occupational lung disease distribution, extent and causes, and the construction of targeted intervention programmes. However, this depends on increased funding and staffing, sustained interest in SORDSA and the realisation of the full potential of this programme.

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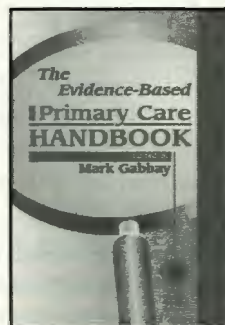
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