MY COMMENTS AND RECOMMENDATIONS ON WHO RELEASE FOR COP3/AFRICAN COUNTRIES.

1.

…….to not allow after 2021 the manufacture, import and export of dental amalgam for use in deciduous teeth, children under 15 years, pregnant women, and breastfeeding women, and after 2024, dental amalgam, except where no mercury-free alternatives are available after 2024 (UNEP/MC/COP.3/21).

2020-2021 –PHASE DOWN

2021-2024 –PHASE OUT

With the inclusion of 'except where no mercury-free alternatives are available after 2024' there should not be any opposition to the African amendment since this takes care of populations that may be at disadvantage.

2.

……The aim of the survey was to better understand the awareness, involvement, and views of this group of policy makers in dental public health about the Minamata Convention on Mercury and the proposed amendment to Annex A. In line with Article 16, subparagraph 2(a) of the Convention, which provides that the COP should consult with WHO in considering health-related issues, the intention of this work was to inform the discussions during COP3.

The WHO used a more scientific approach to the issue under discussion….Amendment at COP 3. This is better approach than that of the FDI which placed an emphasis on the opinion of material experts and a one sided webinar.

3.

77.2% reported that mercury free alternatives were available in their country

37.7% reported that mercury free alternatives were not affordable to the most vulnerable and marginalized population groups… most of these respondents (66.7%) were from low and medium income countries. …… Except statement in 1 above takes care of this population group too

54.5% of the respondents reported that they had NOT being involved in meetings organized either by Min of Environment or Heath to discuss implementation of the convention or the phase down in the use of dental amalgam……

This is an area African delegates have to look into. If Environment people treat this issue as their baby alone without caring other stakeholders along it is a serious error because the convention itself emphasized the importance of involvement of ALL stake holders particularly the Dental community and Dental professional associations. (I can testify that in Nigeria all stakeholders were carried along. However, whether the FMEnv regarded the FMHealth as equal partners in this process can only be

answered by the officers concerened….anybody from the FMHealth at COP3? Any Dentist from Nigeria at COP3 ??).

4.

… The top priority provision mentioned by the respondents was "*Setting national objectives aiming at dental caries prevention and health promotion, thereby minimizing the need for dental restoration".* The least activities reported by the respondents were related to amending insurance policies and promoting research on mercury-free alternatives.

National priorities have being set in Nigeria long time ago. The National policy is at its final stages. …The national Oral health policy is being reviewed presently and will hopefully will reflect this paragraph……integration of the principles of minimum intervention dentistry with its cornerstone principles of risk assessment, prevention, health promotion, and minimally invasive restorative treatment including Basic package of Oral Care (BPOC) and Atruamatic Restorative Treatment (ART).

African representatives at COP3 should note this and try to get this across to dental professional groups and dental officers and public health officers of the ministry of Health.

5.

The least activities reported by the respondents were related to amending insurance policies and promoting research on mercury-free alternatives.

This observation is a serious error on the part of the focal points for the implementation of this convention. Amending insurance policy should be a top priority. Sweden was able to achieve rapid phase down because based on overwhelming scientific evidence the Swedish government stopped payments for mercury dental amalgam…Please see the example from Nordic countries flyer being prepared for our website attached.

Promoting research into mercury free alternatives –particularly the high viscosity and hybrid glass ionomers should also be a priority. Countries in Asia are already making glass ionomers from local raw materials…African countries should take a cue from this/

6.

The Convention does not specify an implementation timeline to phase down the use of dental amalgam. Participants were asked to provide what they considered would be a realistic timeline to implement the phase down for their countries. The dates proposed varied depending on participants' national contexts and the complexity of activities they currently undertake. In broad terms, most participants provided a timeframe between 2020 to 2030 to complete the phase down in use of dental amalgam. Conversely, a few responded that it was difficult to estimate a realistic timeline due to the specific challenges encountered in their countries.

Yes this is strong point. European parliament voted in 2017 for phase down till 2030. FDI statements 1 and 2 did not state any specific time lines ('PHASE DOWN AD INFINITUM'). The WHO has therefore agreed with the European parliament. BUT THE CONVENTION ALLOWS NATIONS TO TAKE MEASURES EVEN OUTSIDE THE 9 PROVISIONS.

7.

About half of the participants (n=40, 51.3%) were aware of the proposed amendment to Annex A of the Convention. 42.3% of the respondents (n=33) agreed with the proposal whereas 57.7% (n=45) partially agreed/disagreed, disagreed or were unsure (respectively 32.1% (n=25) partially agreed/partially disagreed, 20.5% (n=16), disagreed and 5.1% (n=4) were unsure.

This is the survey result that matters most. I guess the respondents cut across different continents with different environmental pollution challenges. The UNEP /WHO publication on health and environment interaction reported that worldwide, environmental pollution was responsible for about 25\5 of human diseases \but in Sub-Saharan Africa the rate was higher at 35% . This is one of the reasons Africa cannot afford a prolonged phase down till 2030. The other reasons are 1. In most African countries there are no organized system for the collection, sorting and safe storage or treatment of mercury wastes generated in the dental clinics 2. Amalgam separators are expensive to procure and maintain 3. The requisite infrastructure and technology for treating wastes generally and mercury wastes in particular are NOT well established and it will take heavy investments and long gestation period to have one in place similar to the Swedish chemical agency (www.chemi.se).

African delegates on their return should brief their governments and concerned stakeholders accordingly. They should convey a meeting of all stakeholders and brief them and get their fee back as well as securing their understanding and support.

8.

Irrespective of agreeing or disagreeing with the proposed amendment, 49 participants reported concerns associated with phasing out dental amalgam which included the following: 26 mentioned issues with their countries' readiness to implement the proposal within the timeframe proposed due to lack of supporting structures or because the proposed phase out date is soon. 21 mentioned delivery of low quality dental restorative treatments and potential therapeutic failures given that dental amalgam has specific clinical indications and a true substitute for dental amalgam was not yet available in the market. 31 participants mentioned it could negatively impact access to dental care due to the higher cost of mercury-free alternatives and lack of appropriate equipment and infrastructure in resource-limited settings which could lead to increased health inequalities.

This is a complex paragraph. I will attempt to break it up to make the import easily understandable

a. 26 mentioned issues with their countries' readiness to implement the proposal within the timeframe proposed due to lack of supporting structures or because the proposed phase out date is soon.

   This can be a very big challenge in African countries where bureaucracy can be unusually slow. However, our recommendations for African countries is germaine in this context:

African governments should commence phase down as soon as possible:

-Drawing up a national action plan if they have not done so already.
-Putting in place the necessary legislations to support phase down in vulnerable groups (pregnant and lactating women, children from 1-15 years).
-Removing or reducing import duties and taxes on glass ionomer restoratives (high viscosity) and bioactive bisphenol free composite restoratives.
-Updating dental schools/training institutions curricula.
-Supporting the training of dental students' simulation laboratory (400level) and clinical dentistry training (500 and 600 levels).
-Updating the training of general dental practitioners in mercury free dentistry (MID) through seminars, conferences and hands on workshops.

b.

21 mentioned delivery of low quality dental restorative treatments and potential therapeutic failures given that dental amalgam has specific clinical indications and a true substitute for dental amalgam was not yet available in the market.

This is of course NOT true

i. Mercury dental amalgam belongs to GV Back's era of 'drill and fill dentistry' of 19th and 20th century. The drill and fill approach to managing tooth decay treated the symptoms of the disease rather than the causes and resulted in destruction of healthy tooth tissues, progressively larger and more complex restorations, increased costs, eventual loss of the tooth and poor oral health outcome (Ismail et al 2013,2015).

ii. The current evidence based 21st century approach to management of tooth decay is minimum intervention dentistry (MID). The cornerstones of MID include early caries diagnosis and risk assessment, oral health promotion, targeted preventive non-surgical treatments, minimally invasive restorative treatments and frequent recall visits to re-evaluate caries risk. (Domejean et al 2017, Ismael et al. 2015).

iii. Adhesive bioactive restorative materials (high viscosity/hybrid glass ionomers, bioactive bisphenol free composites) are the preferred restorative materials for minimum intervention dentistry (Domejean et al. 2009, 2017, Ismael et al. 2013, 2015).

iv. This is a reflection of the poor access to current scientific knowledge in the current evidenced based management of tooth decay (cariology) by the respondents. This why we formed the Dentists Committee for a mercury free Africa with the goal and objectives stated below:
-Goal: To motivate and train African Dentists to practice 21st century dentistry (minimum intervention dentistry) which is mercury free.
Objectives:
-To safeguard human health and the environment from mercury pollution for future generations of Africans.
-To promote mercury free dentistry (minimum intervention dentistry/21st century dentistry) in Africa through seminars, curriculum update and hands on workshops.
-To collaborate with interested governments, parties, agencies and associations/societies locally and globally in advancing our goal and objectives.

Can we get any support from GEF fund and other sources to achieve these objectives. And spread the gospel of mercury free dentistry across Africa- from Lagos to CapeTown, Ivory Coast to Cairo Rabat to Nairobi ?????

vi. Our website is configured to reach dentists with the current scientific knowledge in mercury free dentistry from 2020 to 2024 (aligned with the Ghana resolution).

c.

31 participants mentioned it could negatively impact access to dental care due to the higher cost of mercury-free alternatives and lack of appropriate equipment and infrastructure in resource-limited settings which could lead to increased health inequalities.

African government should remove or reduce import duties and taxes on high viscocity /hybrid glass ionomer restoratives and bioactive bisphenol free composite restoratives. They should also support updates of dental schools' curriculum and retraining of general dental practitioners and research into

local sources of raw materials for the manufacture of these materials. These are the essential components of 'Leapfrogging' phase down strategy.

9.

There were participants who reported that the proposed amendment would cause no significant impact in the delivery of oral health services in their countries, especially for the 2021 phase out date (n=38) in comparison to the 2024 phase out date (n=27). One of the main reasons was reported by 18 participants who explained that their countries had already taken similar policy measures to avoid the use of dental amalgam in deciduous teeth, children, pregnant or breastfeeding women; and a few also mentioned that the material could still be used when it was deemed strictly necessary. 10 out of the 18 participants were from high-income countries. It also was interesting to note that of the 18 participants, 7 agreed with the proposed amendment, 3 partially agreed/disagreed, and 8 disagreed.

2021 is phase down terminal date for vulnerable groups: pregnant and lactating women, children from 1-15 years and in deciduous teeth.

Phase out terminate date as proposed in Ghana meeting is 2024. So we have 4 years to take action in Africa.

Good that some countries and some institutions with some countries have taken similar measures even on their own based on the guidance of the senior dentist.

Potential environmental impact of the mercury free alternatives will continue to be researched like all new materials.

Conclusion and Recommendations

Conclusion and Recommendation no 1.

The results showed that dental amalgam is still used in most of the countries and is viewed as a restorative material that is needed for the equitable delivery of oral health care services. The affordability of dental amalgam has been one of the reasons for its availability. Even though 61 participants reported the availability of mercury-free alternatives, among them, 23 (37.7%) indicated that these were not affordable for the most vulnerable and marginalized population groups. A substantial number of participants reported they were not fully prepared to phase out the dental amalgam within the timeframe proposed in the amendment and anticipated negative consequences due to the lack of a true substitute of dental amalgam in the market and the higher cost of alternatives. Furthermore, the results also drew attention to the weak level of involvement of half of the participants in the phase down of the use of dental amalgam in their countries.

a. true substitute of dental amalgam in the market and the higher cost of alternatives. This has been dealt with in my previous mails and observations as written above. True substitutes are available but more expensive… refer to recommendations for African governments in the preceding sections.
b. Weak level of involvement of the dental sector by the focal points should be addressed by the ministries of environment

Conclusion and Recommendation no 2.

Based on this survey, it appears that a phase out of dental amalgam approach is not a one-size-fits-all solution for all countries but an ultimate goal that should be reached at some point, and certainly an option that should be implemented in some countries based on specific needs and situations. In any case, substantial preliminary work is required at both global and national levels before moving toward the goals suggested by the proposed amendment to Annex A. Phasing out dental amalgam without the required supporting evidence on alternatives, national situation assessments, and the involvement of key stakeholders could compromise the delivery of quality dental treatments and increase health

inequalities in access to essential oral health care and therefore impact the achievement of Universal Health Coverage.[1]

a. Yes phase down and phase out is not a one size fits all. Each country, continent should be allowed to decide on what strategy to adopt. The European parliament decision to phase down till 2030 should NOT be imposed on ALL.
b. Universal health coverage is another sore issue when it comes to provision of oral health care at community level. Frequently in many African countries oral health is often neglected and exclude from universal health coverage. Even oral health is not treated as primary provider in health insurance payment scheme but as secondary providers requiring referral from a primary provider. Basic package of oral care (BPOC) and Atraumatic restorative treatment (ART) should be integrated in the UHC plan of all African countries…..This should be a major take home message and recommendation for African delegates….to take back to their governments and ministries of Health (dental divisions).

Conclusion and Recommendation no 3.

In this regard, the WHO position remains unchanged and efforts should focus on accelerating the phase down in use of dental amalgam through a comprehensive, stepwise, and inclusive process that considers a timescale for implementation according to national contexts. Phasing out dental amalgam in the short-term is seen as premature, particularly for low- and middle-income countries with a high prevalence of untreated dental caries.

a. The WHO has actually agreed with us that phase down should be done according to timescale considered depending on our different nation situations. …..VERY GOOD

b. Phasing out dental amalgam in the short-term is seen as premature, particularly for low- and middle-income countries with a high prevalence of untreated dental caries. Exception rule in the proposed amendment takes care of this….So in essence there is no ground to oppose the African group position.

[1] Universal health coverage is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship.

Conclusion and Recommendation no 4.

In light of the results, reinforcement of the collaboration between Ministries of Health and Environment appears to be a matter of urgency. These ministries' Parties to the Convention should engage the oral health community during the discussions, strategic planning, and delivery of activities to phase down the use of dental amalgam to ensure all views are considered. Setting up a national coordination committee under Ministry of Health and Ministry of Environment leadership could create an environment conducive to consensus building for the health sector. In the meantime, it is important to reiterate the need for further research, both private and public, to make available a quality mercury-free restorative material that is affordable, biocompatible, clinically effective, user-friendly, and environmentally sound.

a. Reinforcement of the Collaboration between Environment and Health Ministries is a vital strategy.
b. However, other ministries are involved if even peripherally at times. These include:

1. Ministries of Education……..mercury free dentistry curriculum update & Strengthening Science of dental material units of Faculties of Dentistry.

2. Ministries of Science and Technology –research into local sources for manufacture of high viscosity/hybrid glass ionomer restoratives

3. Ministries of women affairs –pregnant/lactating women and children

4. Ministries of Agriculture –increasing concentration of mercury in the soil will also be a concern to them

5. Local Chambers of Industries and Commerce- we will need investors in the technology required to make locally mercury free restorative (local manufacture of high viscosity/hybrid glass ionomer restoratives).
   Etc.
6. The ministries parties to the convention…… national coordination committee under Ministry of Health and Ministry of Environment leadership…….The WHO regards BOTH ministries as parties to the convention… even though Environment is the custodian of the articles and Focal point..Any representative from the Ministries of Health at COP 3????

Conclusion and Recommendation no 5 (FINALLY).

Finally, the implementation of the Minamata Convention provides the opportunity to rethink the model of dentistry towards health promotion and integrated disease prevention, along with the wider use of mercury-free alternatives and minimally invasive care. From an environmental perspective, the environmental impact of mercury-free alternatives still needs to be carefully assessed.

a. This is particularly germaine for the dental division and the community health divisions of the ministries of Health as well as the ministries of Education.
b. The principles of minimum intervention dentistry should be integrated into the curriculum of all dental schools and into all community health / oral health policies at all levels-primary. Secondary and tertiary levels. In particular Basic Package of Oral Care (BPOC) and Atraumatic restorative treatment (ART) should be integrated into primary health care services at the community level.
c. A structure to monitor and evaluate regularly the effect of all technologies, chemicals and consumables used in clinical settings is long overdue particularly in African countries. This should be a stand out recommendation for ALL African governments if we are to protect our environment and the health of future generations.

Finally I will repeat my observation in conclusion and recommendation above for effect:

The ministries parties to the convention…… national coordination committee under Ministry of Health and Ministry of Environment leadership…….The WHO regards BOTH ministries as parties to the convention… even though Environment is the custodian of the articles and Focal point..Any representative from the Ministries of Health at COP 3????

Sincerely,

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