



MINAMATA
CONVENTION
ON MERCURY

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**Conference of the Parties to the
Minamata Convention on Mercury
Fourth meeting**

Online, 1–5 November 2021 and Bali, Indonesia,
21–25 March 2022
Agenda item 5

International cooperation and coordination

**Review of Minamata Convention initial assessment reports by
the World Health Organization**

Note by the secretariat

1. In order to raise awareness about the preparedness and outstanding needs of health ministries regarding the implementation of the health-related articles of the Minamata Convention on Mercury, the World Health Organization reviewed all 59 Minamata Convention initial assessment reports that had been submitted to the secretariat of the Convention as at 31 July 2021, as well as two national implementation plans. The World Health Organization has submitted to the secretariat a publication¹ that summarizes the findings of the review and contains a number of recommendations for the attention of the Conference of the Parties.
2. That publication is set out, as received by the secretariat, in the annex to the present note.

¹ World Health Organization, *Review of Minamata Convention Initial Assessment Reports: Key Findings for Health* (Geneva, 2021). Available at www.who.int/publications/i/item/9789240041011.

Annex

Review of Minamata Convention initial assessment reports: key findings for health

REVIEW OF MINAMATA CONVENTION INITIAL ASSESSMENT REPORTS

Key findings for health



Review of Minamata Convention initial assessment reports: key findings for health

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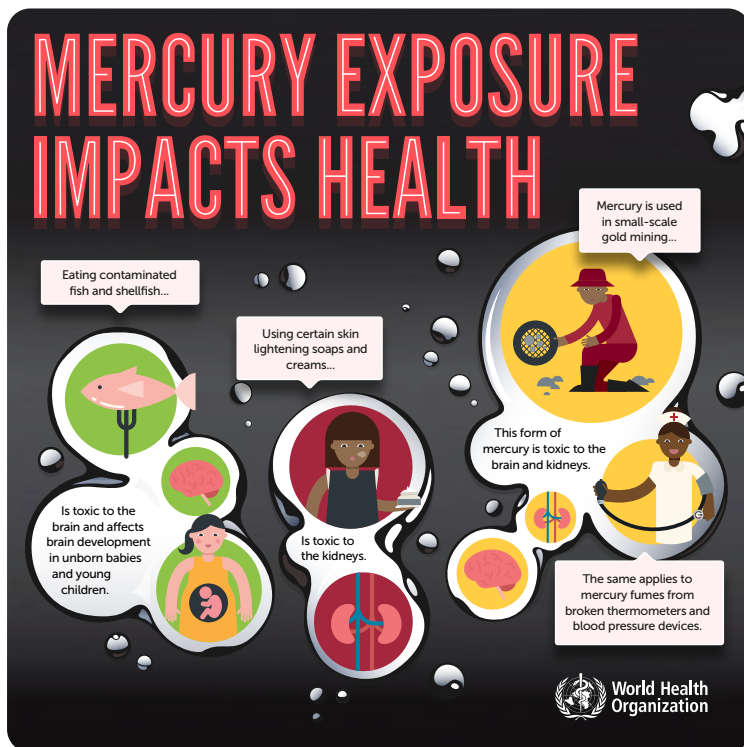
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INTRODUCTION



The Minamata Convention on Mercury is a global, legally binding treaty, which was adopted in 2013 and entered into force on 16 August 2017.

The core of the Convention is protection of human health, as stated in Article 1: “to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds”. Implementation of the Convention requires multisectoral action, including the health sector.

In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.11: “Public health impacts of exposure

to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention”. The resolution acknowledges WHO’s input to the Convention and defines the roles and responsibilities of WHO and ministries of health in its implementation. The resolution encourages Member States to:

- promptly sign, ratify and implement the Convention;
- address health aspects of exposure to mercury;
- recognize the inter-relationship between health and environment and ensure close cooperation between the respective authorities;
- promote appropriate health-care services for prevention, treatment and care of mercury poisoning; and
- facilitate exchange of epidemiological information among Parties to the Convention and with the international community.

A leading role for health ministries is envisaged in the health-related articles, including:

+Hg

Article 4

Mercury- added products, in particular, mercury-added thermometers, sphygmomanometers, dental amalgam, skin lightening creams and antiseptics



Article 16

Health aspects



Article 17

Information exchange



Article 7

Artisanal and small-scale gold mining, in particular the development of public health strategies



Article 18

Public information, awareness and education



Article 11

Mercury waste



Article 19

Research, development and monitoring



Article 12

Contaminated sites

In the past few years, many national governments have prepared Minamata Initial Assessment (MIA) reports to strengthen national decision-making to achieve ratification of the Minamata Convention and to assess and build national capacity for implementation of Parties' obligations.

In order to raise awareness about health ministries' preparedness and outstanding needs to be able to implement the health-related articles of the Convention, WHO reviewed all the 59 MIA reports that had been submitted to the Secretariat of the Convention up to 31 July 2021 and also two national implementation plans, from Japan and Peru. The data for each country reported in this review are derived from those sources and were current on the date on which the report was submitted to the Convention Secretariat.

The guidance of the United Nations Development Programme¹ was used as the framework for the review. Use of those guidelines was not, however, mandatory for the countries, and the structure and content of many of the reports differed from those guidelines.

¹ Minamata initial assessment report. Suggested structure and contents. October 2020. Inter-organization Programme for the Sound Management of Chemicals; 2020 (<https://www.undp.org/publications/undp-minamata-initial-assessment-guidance>).

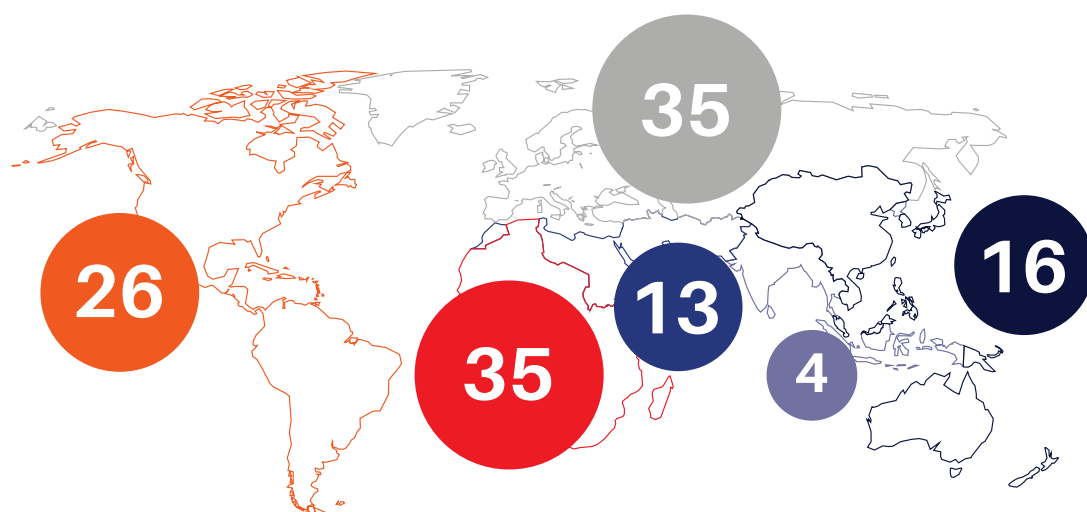
GENERAL INFORMATION



WHO Member States that are Parties to the Convention







As of 31 July 2021, 132² countries were Parties to the Convention, of which 129 are Member States of WHO, comprising two thirds of WHO's Member States.³ The numbers of WHO Member States that are Parties to the Convention in each of the six WHO regions are shown in Fig. 1. In nearly all the WHO regions, about two thirds to three quarters of WHO Member States are Parties to the Convention.

Figure 1. Numbers of WHO Member States per WHO region that are Parties to the Convention (as of 31 July 2021)



Numbers of WHO Member States that are Parties to the Convention as of 31 July 2021 **129**

Representation by WHO region

- | | | |
|--|--|--|
|  Africa Region |  Eastern Mediterranean Region |  European Region |
|  South-East Asia Region |  Region of the Americas |  Western Pacific Region |

This map presents WHO regions; the boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

² Information on countries that have become Parties to the Convention can be found at: <https://www.mercuryconvention.org/en>

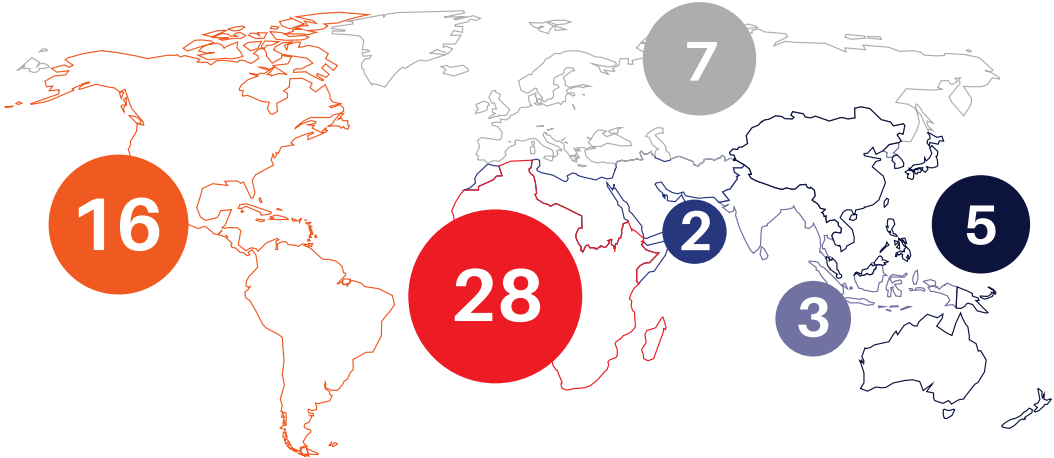
³ The WHO Member States in each region are listed at: <https://www.who.int/countries>

Twenty-three of the 41 WHO Member States and associate members that are small-island developing states are Parties to the Convention.

MIA reports by WHO Member States

Fig. 2 shows the numbers of WHO Member States in each Region that have officially submitted MIA reports to the Convention Secretariat.⁴ The numbers include 11 Member States that are not yet Parties to the Convention.

Figure 2. Numbers of WHO Member States per region that submitted MIAs and national implementation plans (as of 31 July 2021)



Numbers of WHO Member States that submitted MIAs and national implementation plans as of 31 July 2021 61

Representation by WHO region

- Africa Region
- Eastern Mediterranean Region
- European Region
- South-East Asia Region
- Region of the Americas
- Western Pacific Region

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⁴ Includes the national implementation plans of Japan and Peru

FINDINGS OF THE REVIEW



Health ministry participation in preparation of MIA reports

One aim of the review was to determine the participation of health authorities in preparing MIA reports. It was found that, overall, only about one half of the MIA reports indicated that ministries of health had participated in their development. Table 1 gives the numbers of MIA reports with evidence of health ministry involvement, by WHO region. Of the 14 reports submitted by small-island developing states, evidence of ministry of health participation was seen in 10.

Table 1. Characteristics of MIA reports by WHO Member States (as of 31 July 2021)

WHO region	No. of Member States	Member States that are Parties to the Convention		No. of Member States that submitted MIA reports ⁵	No. of reports that indicated health authority involvement in MIA		
		No.	%		Ministry of health	Other	None stated
Africa	47	35	74	28	14	2	12
Americas	35	26	74	16	11	1	4
Eastern Mediterranean	21	13	62	2	1	-	1
European	53	35	66	7	3	1	3
South-East Asia	11	4	36	3	2	-	1
Western Pacific	27	16	59	5	1	-	4
Total	194	129	66	61	32	4	25

Despite the large number of WHO Member States among Parties to the Convention, the review raises concern about the participation of health ministries in the preparation of MIA reports.

- No evidence of health ministry participation in the MIA was seen in about half the reports.
- Reports from 11 countries did not indicate the role of health authorities in implementing *any* of the Convention’s health-related articles.

⁵ Includes some Member States that are not Parties to the Convention

- Nearly two thirds of the reports reviewed did not mention any priorities for action in relation to Article 16: Health aspects.
- One third of the reports did not mention involvement of their health ministry in implementation of Article 16.
- Reports from five countries indicated that Article 16 was the *only* article for which health authorities were assigned responsibility.
- In nearly half the reports, health authorities were not reported to be involved in implementing any aspect of Article 4: Mercury-added products.
- Reports from a few countries indicated that Article 4 was the *only* article for which health authorities were assigned responsibility.
- Reports from only seven countries indicated any responsibility of health authorities for implementing Article 7: Artisanal and small-scale gold mining (ASGM), even though ASGM National Action Plans are required to include a public health strategy.
- Despite concern about the management of health-care waste containing mercury, only nine countries identified health authorities' responsibilities for implementing Article 11: Mercury waste.
- Only eight countries foresaw a role for health authorities in assessing mercury-contaminated sites, despite the explicit call in Article 12 for health risk assessments at such sites.
- Although development and dissemination of health information, especially epidemiological and toxicological information, on mercury and its effects are stressed in Articles 17, 18 and 19, ministries of health were cited as responsible in this regard in less than one fourth of the reports.

These findings are at odds with the recognition by 194 WHO Member States of the role of the health sector, set out in World Health Assembly resolution WHA 67.11 (2014).

Sources of mercury emissions and releases as cited in MIA reports

The sources of mercury most frequently cited in the MIA reports were primary metal production, consumer products containing mercury and waste incineration.

Primary metal production, as defined in the UNEP Toolkit for identification and quantification of mercury releases used for the mercury inventory, includes industrial mining, primary processing of metals and gold extraction with mercury amalgamation. These activities are known to contribute substantially to global mercury emissions, as quantified in the UNEP Global mercury assessment (2018). ASGM and non-ferrous metal production were found to be the most important sources of global releases.⁶

Inventories of mercury-added medical devices

Table 2 summarizes the findings of the review regarding inventories of mercury-added products in which the health sector is expected to play a lead role in inventory preparation. Nearly all Parties that submitted MIA reports had inventories of mercury-added thermometers, five of six had inventories of dental amalgam, and half had inventories of sphygmomanometers. More than half of the MIA reports from the African Region described inventories of skin-lightening products, while such information was reported only rarely from other regions. Almost none of the reports mentioned inventories of mercury-containing antiseptics.

⁶ Source: <https://www.mercuryconvention.org/en/resources/global-mercury-assessment-2018>

Table 2. Numbers of MIAs per region that reported inventories of mercury-added products

WHO region	No. of MIAs reviewed	Mercury-containing thermometers	Mercury-containing sphygmo manometers	Antiseptics containing mercury	Skin-lightening products containing mercury	Dental amalgam
AFR	28	27	15	1	17	25
AMR	16	14	7	-	-	13
EMR	2	2	1	-	-	2
EUR	7	7	3	-	1	3
SEAR	3	3	3	-	1	3
WPR	5	3	1	-	1	2
Total	61	56	30	1	20	48

Health-related articles – capacity for implementation and priorities for action

The health sector priorities identified in some reports differed significantly from those that emerged from regional workshops convened by WHO during the period 2015–2018 in all WHO regions on implementation of the Minamata Convention and resolution WHA67.11 (2014). The participants, who represented ministries of health in 108 Member States, identified issues and challenges and their need for technical assistance (see Box 1). The review of MIA reports and national implementation plans, however, was based on submissions from only 61 Member States, half of which did not indicate involvement of the health ministry. This may explain at least partly why the findings of this review of MIA reports varied from the conclusions of the regional workshops.

Box 1: Conclusions of WHO Regional workshops

Participants representing ministries of health from 108 member states identified issues and challenges confronting the ministries in each WHO region as well as needs for technical assistance including the following:



The health sector's role in implementation of the Convention is often narrowly seen as focused on relatively few issues, such as mercury-containing medical devices, health-care waste containing mercury, and ASGM in some countries. All regions identified the need for capacity building to address those issues.



There is a need to raise awareness among policy-makers and health workers alike on a broader range of mercury issues within health-care settings, as well as to raise awareness on mercury-related health issues outside the health sector. Stronger participation by health authorities in the MIAs could be an effective starting point.



All regional workshops identified a need for awareness-raising and education on mercury and health. Support is needed for development of risk communication strategies and tools.



With regard to the phase-out of manufacture, import and export of mercury-containing medical measuring devices and phase-down of dental amalgam, workshop participants often stressed the need to effectively disseminate information on available alternatives, to address clinicians' concerns on safety and cost-effectiveness of alternatives and to develop and enforce adequate standards for procurement.



The need for infrastructure to safely transport, store and dispose of health-care waste containing mercury was identified by many workshop participants in every region, in addition to the need for relevant training.



Regarding monitoring and surveillance, many countries face challenges in terms of technical capacity and laboratory capacity to establish baseline conditions and subsequently to conduct monitoring. Human biomonitoring was seen as an effective approach to identify and monitor vulnerable populations, but many countries require assistance in biomonitoring.

Several key issues, although not universal, were highlighted by more than one region:



Exposure to mercury among ASGM workers and their families is a concern in all regions but not in all countries. Many participants identified a need for assistance to develop and implement national action plans and public health strategies.



Many participants from small-island developing states expressed concern about mercury in fish. A need was seen for increased research and surveillance on mercury contamination of fish products and for effective consumer risk education programmes.



The use of mercury in traditional medicine, although excluded from the Convention, was highlighted as a concern by many countries, especially in Asia and in the WHO Eastern Mediterranean Region.



Another issue that was seen to be of wide concern, particularly in Asia, Africa and the Caribbean, is the use of mercury in skin-lightening cosmetics.

Mercury-added products

While nearly every country that submitted an MIA report to the Convention Secretariat included an inventory of mercury-added thermometers and half of those provided inventories of mercury-containing sphygmomanometers, very few countries reported control measures to phase out such devices. As shown in Table 3, only eight countries reported one or more measures not to allow the manufacture, import of mercury-added products in general. Among these countries, seven have prohibited the importation and three prohibited the manufacture of such products, while no country disallowed exportation. Twelve countries reported measures specifically to address mercury-containing medical measuring devices. Several of those countries reported policies or guidelines for the replacement of such devices, although it was not clear whether their intent is to replace such devices at the end of their service life or to substitute mercury-free devices for mercury-containing devices already in use. A few countries reported having prohibited the sale or purchase of mercury-containing medical measuring devices, while other countries reported only that unspecified action had been taken to reduce the number of such devices.

Table 3. Numbers of MIA reports that indicated measures were in place to control health-related mercury-added products under Article 4 of the Convention

WHO region	No. of MIAs reviewed	Not allow import, export and/or manufacture of mercury-added products in general	Mercury-containing medical measuring devices	Antiseptics containing mercury	Cosmetics containing mercury	Phase down use of dental amalgam
AFR	28	3	4	1	4	5
AMR	16	1	3	1	3	3
EMR	2	-	1	-	1	-
EUR	7	1	1	-	3	1
SEAR	3	1	1	1	-	1
WPR	5	2	2	1	2	3
Total	61	8	12	4	13	13

Few of the MIA reports included inventories or controls over antiseptics containing mercury. This situation may reflect little use of such antiseptics. Only four countries reported having measures to control them. Colombia regulates the importation and commercialization of mercurochrome (also known as merbromin) and mercury sulfate antiseptics, and Cabo Verde, Malaysia and Sri Lanka exercise regulatory controls over all topical antiseptics containing mercury.

Inventories of skin-lightening products containing mercury were provided in half of the MIA reports from the Africa Region but in only a few reports from other regions. Thirteen countries reported measures to address cosmetics containing mercury. Seven prohibit the presence of mercury in cosmetic products or set standards to limit its concentration. Japan effectively prohibits the presence of mercury in cosmetics by establishing a standard of "mercury-free". Other countries in this group reported regulating aspects such as production, licensing or commercialization of cosmetics containing mercury.

With regard to dental amalgam, although five out of every six countries provided inventories, only one out of every six reported measures to phase down its use. The information in the reports was insufficient to determine how current measures to phase down use of amalgam compare with the requirements of Article 4.

More than half of the reports identified development of regulations, strategies and plans as priorities for phase-out or, in the case of dental amalgam, phase-down. As shown in Table 4, about one third reported that enforcing regulations they had already established or implementing plans they had already developed was a priority. Only a third of the reports indicated that capacity-building in this area was necessary. This was unexpected, as every WHO regional consultation strongly emphasized the importance of capacity-building in relation to Article 4.

Table 4. Numbers of MIA reports that stated priorities for action with respect to health-related articles of the Convention

Article		Priorities for action			
		Develop regulations, strategies and plans	Enforcement or implementation	Capacity-building and awareness-raising	Other
Article 4: Mercury-added products	Annex A, Part I	34	18	20	4
	Annex A, Part II	29	20	23	7
Article 7: ASGM		18	7	11	2
Article 11: Mercury waste		26	15	11	4
Article 12: Contaminated sites		11	13	1	3
Article 16: Health aspects		15	8	12	7
Article 17: Information exchange		9	10	1	2
Article 18: Public information, awareness and education		24	15	23	3
Article 19: Research, development and monitoring		14	6	12	7

In some MIA reports, priorities for action are described in general terms and are not entirely clear. In particular, when a priority for mercury-containing medical measuring devices is described as “to phase out mercury-added products”, it is unclear whether that means developing measures to not allow the import, export or manufacture of these devices or that devices would be substituted before the end of their service life. It is encouraging however that many of the priorities identified in the MIA reports go beyond the minimum measures required by the Convention. For example, several reports mentioned development of guidelines for identifying alternatives to mercury-free medical devices and for procurement of mercury-free medical devices as priorities.

Artisanal and small-scale gold mining

Fifteen national action plans for ASGM were submitted to the Secretariat, 14 of which, as shown in Table 5, included public health strategies. Health ministries were, however, reported to be involved in the development of less than half.

Table 5. National action plans for artisanal and small-scale gold mining

WHO region	No. of plans submitted	With public health strategy		With health authority participation	
		Yes	No	Yes	No
AFR	12	11	1	3	8
AMR	1	1	-	1	-
EMR	-	-	-	-	-
EUR	-	-	-	-	-
SEAR	-	-	-	-	-
WPR	2	2	-	2	-
Totals	15	14	1	6	8

As shown in Table 4, nearly a third of the MIA reports indicated that a priority for action in relation to ASGM was the development of regulations, strategies or plans, and very few identified enforcement of regulations that were already established or implementation of plans that were already developed as priorities. Almost none of the MIA reports from regions other than Africa noted that capacity-building for health workers in public health strategies was a priority, although every WHO regional consultation had identified that need.

An unexpected finding of the review was that, of the 28 countries that have officially notified the Conference Secretariat that ASGM in their territories is “more than insignificant”, only four identified miners as a group at risk of exposure to mercury.

Health-care waste containing mercury

Fewer than one third of the MIA reports indicate that measures were in place to address health-care waste (Table 6). Furthermore, in many reports, it was not clear whether the measures were well enforced or if they extended beyond infectious waste and sharps to include heavy metals such as mercury.

Fewer than half of the reports identified a need to develop regulations on health-care waste containing mercury, only one fourth identified a need to better enforce existing regulations, and only one sixth indicated that the capacity of health workers should be strengthened in this area. These findings contrast with those of the WHO regional consultations, in all of which training and development of waste management infrastructure were stressed.

Table 6. Numbers of MIA reports per region indicating control measures in place for addressing Articles 11, 12 and 16–19

WHO region	No. of MIAs reviewed	Article 11	Article 12	Article 16	Article 17	Article 18	Article 19
AFR	28	7	1	10	6	12	3
AMR	16	4	2	8	1	4	-
EMR	2	1	-	1	1	1	-
EUR	7	3	1	4	2	7	2
SEAR	3	2	1	2	3	2	1
WPR	5	1	3	3	2	2	1
Totals	61	18	8	28	15	28	7

Contaminated sites

Only eight of the MIA reports indicated capacity to assess health risks posed by mercury-contaminated sites; however, only one in five reports mentioned that regulations for health risk assessment of contaminated sites needed to be developed or enforced or relevant strategies and plans needed to be developed or implemented.

Only one report noted that capacity should be built to assess health risks posed by contaminated sites, although only eight countries indicated that measures were in place for that purpose.

Health aspects

Slightly fewer than half of the MIA reports indicated that measures were in place to implement Article 16. As shown in Table 7, most focused on occupational exposures.

Table 7. Numbers of reports of measures to implement Article 16

Measures to implement Article 16	No. of MIA reports
Identify and protect populations at risk	8
Prevent occupation exposure	24
Promote health-care services	4
Build capacity of health-care professionals	3

Few countries reported any measures to identify and protect other groups at risk of exposure to mercury, to promote relevant health-care services or to establish and strengthen relevant institutional and health professional capacity. The lack of information on health measures might be due to the absence of health ministries in preparation of a significant proportion of the MIA reports, as 13 of the reports with no information on measures relevant to Article 16 did not record health ministry participation in the MIA process.

About one fourth of the reports identified a need to develop regulations, strategies and plans in this area, and one fifth identified a need for capacity-building and awareness-raising. Eight reports indicated a need to enforce regulations and to implement existing plans.

Information exchange

Only one fourth of the reports mentioned capacity to facilitate exchange of health information. Development of strategies and plans for information exchange was cited as a priority in only nine MIA reports and implementation of existing strategies or plans in only 10.

Public information, awareness and education

Measures to inform, alert and educate the public or to train and educate specific target groups were mentioned in about half of the reports; however, in many cases, the measures were implemented by environmental authorities as single activities with external funding and in connection with preparation of the country’s MIA report. Fewer than half of the reports identified as priorities the development of regulations, strategies or plans or communication strategies and tools or strengthening institutional capacity for public information, awareness-raising and education.

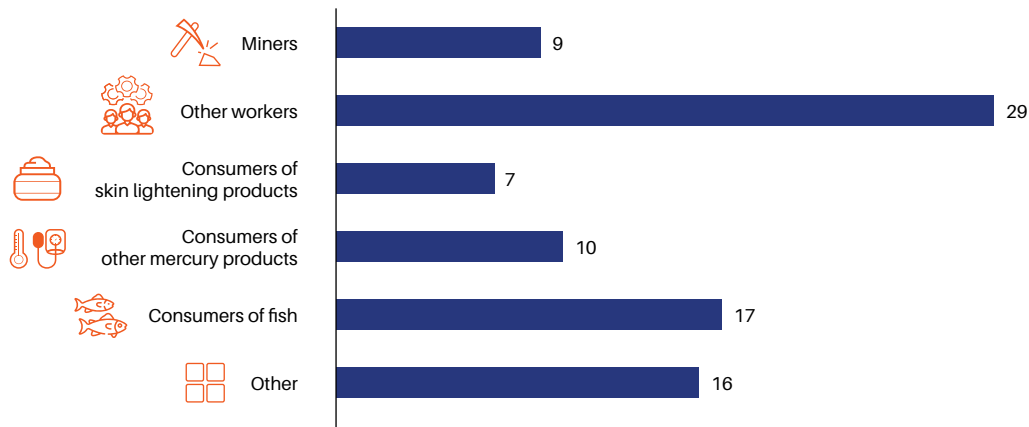
Research, development and monitoring

Although little mention was found in the reports of existing capacity to monitor levels of mercury in vulnerable populations or to assess health impacts, fewer than a quarter of the MIAs mentioned that developing this capacity was necessary. In the WHO regional workshops, however, many participants reported challenges in establishing baselines and conducting monitoring because of insufficient technical and laboratory capacity.

Populations at risk and gender dimensions

About half of the reports identified workers other than miners as a population group at risk due to exposure to mercury. The second most widely mentioned risk group globally, in one in three reports, was consumers of fish. Fig. 3 shows the population groups at risk due to mercury exposure as identified in the reports.

Figure 3. Population groups reported in MIAs as at risk due to exposure to mercury

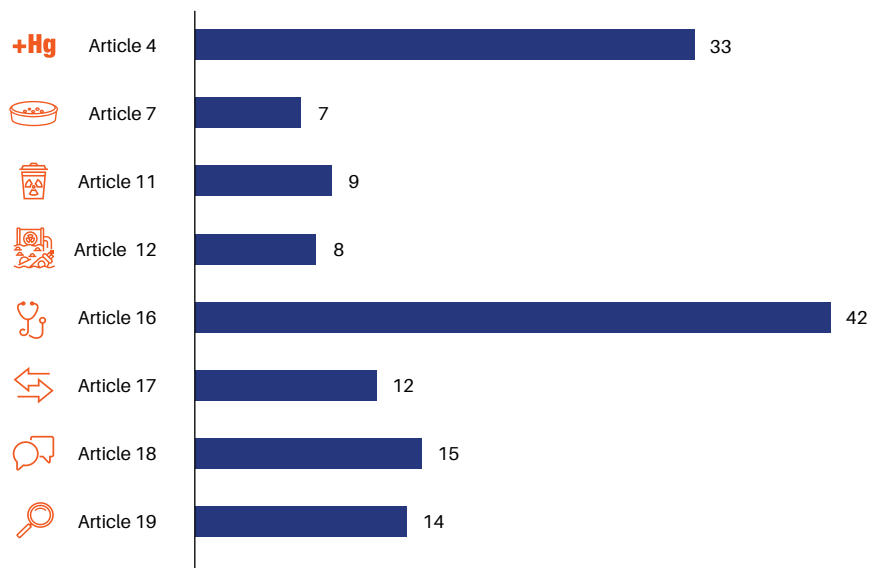


More than half of the MIA reports identified gender-related risks for pregnant women and women of child-bearing age. Gender-dominant occupational exposure was not widely seen as a risk in the reports, except in the African region, from which about one third of the MIA reports identified this risk.

Role of ministries of health in implementation of the health-related articles of the Convention

As seen in Fig. 4, Article 16 (Health aspects) and Article 4 (Mercury-added products) are the two health-related articles of the Convention for which health authorities were most frequently recognized in the reports as responsible for implementation. Ministries of health were identified as responsible for implementation of Article 16 in two thirds of the MIA reports and for Article 4 in slightly more than half. However, few reports mentioned that health authorities were responsible for implementing other health-related articles, especially Articles 7, 11 and 12.

Figure 4. Numbers of MIA reports that indicated articles for which health ministries are responsible





CONCLUSIONS AND RECOMMENDATIONS

Many WHO Member States have heeded the call of World Health Assembly resolution WHA67.11 (2014), which encourages them to “promptly sign, ratify and implement” the Minamata Convention on Mercury. As of 31 July 2021, 132 countries were Parties to the Convention, of which 129 are Member States of WHO. The review found that Member States have put in place many measures to implement the health-related articles of the Convention, although it was also found that more work is necessary. For example, fewer than half of the countries documented measures to implement Article 16, “Health aspects”, and most of those focused on occupational health and neglected other at-risk groups, ensuring appropriate medical treatment or strengthening institutional and professional capacity.

Priorities for action were identified for all of the health-related articles, some of which exceeded the minimum requirements of the Convention. The main priorities, cited in about two thirds of the reports, were phasing out use of mercury-containing medical measuring devices, beyond not allowing their import, export or manufacture, and phasing down the use of dental amalgam. Other priorities for action, identified in more than half the reports, were measures to implement Article 18, “Public information, awareness and education”, and Article 11, “Mercury waste”.

Despite the strong presence of WHO Member States among the Parties to the Minamata Convention and despite progress made in implementing relevant measures, this review of MIA reports raises concern about the extent of engagement of ministries of health in the MIA process and therefore in the implementation of the health-related articles of the Convention. Health ministries did not appear to have been involved in preparing about half the reports, and, in many cases, the role of health ministries in implementing the health-related articles was not yet defined. These findings are at odds with the recognition by 194 WHO Member States of the role of the health sector, set out in World Health Assembly resolution WHA67.11 (2014). The MIA reports in which health ministries were not involved may therefore not fully reflect their achievements, future plans and priorities.

The following recommendations are made.

- ▶ To improve the engagement of health ministries in national implementation of the Minamata Convention on Mercury, it is recommended that all concerned authorities recognize the role of health ministries in implementing the health-related articles and that health authorities strengthen their understanding of the requirements of the Convention.
- ▶ WHO recommends that each Party's national focal point convene all relevant sectors and strengthens intersectoral collaboration, particularly with the health sector, in implementing the Convention and in reporting on progress and challenges.
- ▶ Ministries of health, in collaboration with sectoral partners and with the support of the international community, might focus on the near-term priorities that emerge from this review, including phase-out of mercury-containing medical measuring devices, the phase-down in use of dental amalgam, developing infrastructure and building capacity for safe management of health-care waste containing mercury, and the development of public health strategies for ASGM.
- ▶ Ministries of health might review existing policies, programmes and practices that contribute to implementation of the health-related articles, identify challenges to implementation and identify necessary technical support and assistance.
- ▶ It is recommended that ministries of health consult WHO guidance documents, particularly *Strategic planning for implementation of the health-related articles of the Minamata Convention on Mercury*⁷ (WHO, 2019) and *Minamata Convention on Mercury: Annotated bibliography of WHO information*⁸ (WHO, 2021).
- ▶ The second round of progress reports by Parties to the Minamata Convention, due by the end of 2021, may indicate achievements, strengths and challenges in implementing the health-related articles and national intersectoral collaboration. It is recommended that each Party use its progress report to identify the requirements of the health sector and opportunities for strengthening collaboration.
- ▶ The WHO Secretariat will use the findings of this review and progress reports to identify the necessary country support. Donors are encouraged also to use the findings in making decisions on financial support.
- ▶ All stakeholders are invited to consult the further information contained in the WHO report of an informal global consultation with policy-makers in dental public health, Monitoring country progress in phasing down the use of dental amalgam contained in document UNEP/MC/COP.4/INF/26.⁹
- ▶ The WHO Secretariat will share information collected through a global survey of regulation of skin-lightening cosmetics (under way).
- ▶ The United Nations Development Programme's guidance on the structure and content of Minamata Initial Assessment reports should be updated to include further measures to strengthen intersectoral collaboration, particularly with the health sector.
- ▶ The Seventy-sixth World Health Assembly, in 2023, is scheduled to consider a report on implementation of the WHO Chemicals Road Map, which includes action on the Minamata Convention. This will provide an opportunity for ministries of health to discuss actions taken, priorities and needs for support from the WHO Secretariat.
- ▶ The Secretariat of the Minamata Convention is requested to make the present report available to all Parties and other stakeholders.

⁷ <https://www.who.int/publications/i/item/9789241516846>

⁸ <https://www.who.int/publications/i/item/9789240022638>

⁹ <https://www.mercuryconvention.org/en/documents/dental-amalgam-information-world-health-organization>



Chemical Safety and Health Unit
Department of Environment, Climate Change and Health
World Health Organization
Avenue Appia 20, CH 1211 Geneva 27, Switzerland
<https://www.who.int/health-topics/chemical-safety>
www.who.int/ipcs/en
ipcsmail@who.int

