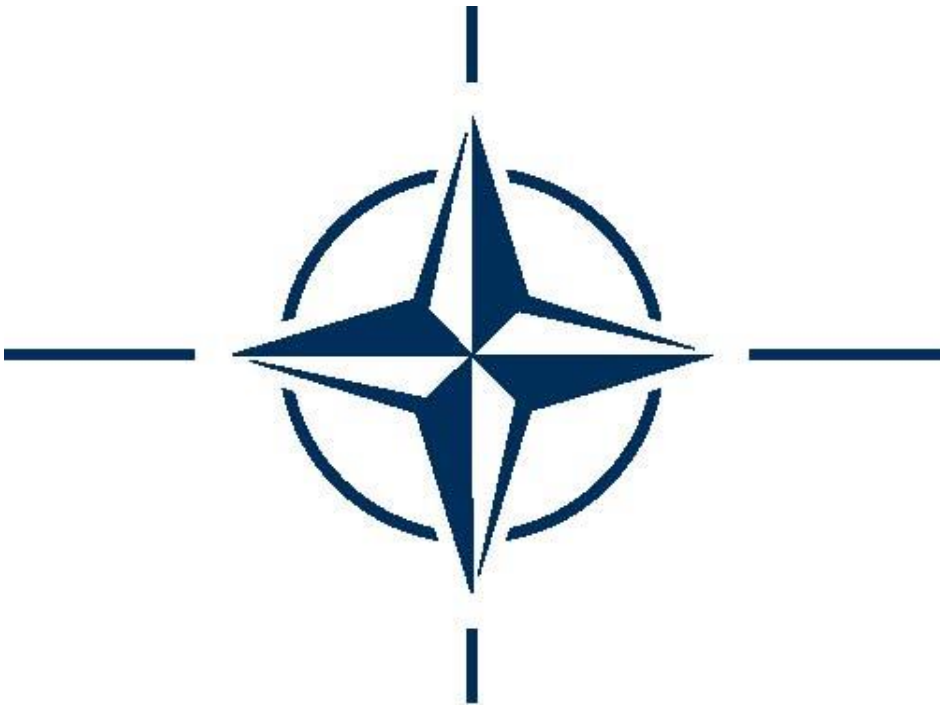
NATO STANDARD

AMedP-6.1

THE CIVIL MILITARY PLANNING PROCESS ON ORAL HEALTH CARE AND DEPLOYMENT OF DENTAL CAPABILITIES IN ALL OPERATIONS WITH A HUMANITARIAN COMPONENT

Edition A Version 3

APRIL 2023



NORTH ATLANTIC TREATY ORGANIZATION

ALLIED Medical PUBLICATION

Published by the
NATO STANDARDIZATION AGENCY (NSA)

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

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NATO LETTER OF PROMULGATION

6 April 2023

1. The enclosed Allied Medical Publication AMedP-6.1, edition A, Version 3, THE CIVIL MILITARY PLANNING PROCESS ON ORAL HEALTH CARE AND DEPLOYMENT OF DENTAL CAPABILITIES IN ALL OPERATIONS WITH A HUMANITARIAN COMPONENT, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2584.

2. AMedP-6.1, Edition A, Version 3 is effective upon receipt and supersedes AMedP-6.1, Edition A, Version 2, which shall be destroyed in accordance with the local procedure for the destruction of documents.

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Database for the complete list of existing reservations.	

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
EST	In case of any deployment, the STANAG is acceptable for the Estonian Defence Forces when the national dental team are deployed as an integral part of Role 2 and Role 3 hospitals only.
GRC	Hellenic Navy: The STANAG applies only in case of participation in humanitarian missions by Role 2 or Role 3 modules with dental care specialists. Hellenic Air Force: GRC cannot participate in humanitarian missions in Role 2 and Role 3 modules.
LVA	STANAG applies only in case if LVA participate in humanitarian missions by ROLE 2 or ROLE 3 modules with dental care specialists.
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Database for the complete list of existing reservations.	

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CHAPTER 1 INTRODUCTION

Dental problems and oral pain are very common in most countries. Oral conditions affect 3.5 billion people worldwide. The burden of oral disease accounted for 28 million DALY's (disability-adjusted life-years) in the Global Burden of Disease Study 2019. Untreated caries in permanent teeth was the most common health condition (2 billion people worldwide) to the GBD 2019 Study[1]. Oral Health is determinant factor for quality of life (and has a proven strong correlation with general health. In most low- and middle-income countries, the prevalence of oral diseases continues to increase with growing urbanization and changes in living conditions. (WHO).[2]

Most dental diseases are chronic diseases. Caries, periodontitis, oral pathology are the most common causes of oral problems. These diseases are mostly preventable diseases.

Based on AJMedP-6 a medical component can be tasked to provide humanitarian care for local people. Due to the morbidity rate of oral health disease in most populations part of the requested care will be in the dental field. This document provides guidelines and considerations for planning and delivering oral health care in missions with a humanitarian character as described in AJMedP-6. (sept 2021 STANAG 2563)

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CHAPTER 2 HUMANITARIAN ORAL HEALTH CARE

2.1. PRINCIPLES

The main principle for humanitarian aid is to provide necessary care for local people or refugees. The provided care should be tailored to meet the needs of local people without undermining local oral health care system availability, the level of local care, and allow oral health care sustainment after Operation withdrawal by local care providers or IO/NGO's.

Chronic diseases require continuing care and prevention. Long term sustainability of care should be considered in the planning process. Prevention of most diseases, general and oral, can be achieved by improving personal hygiene. The WHO developed a program for improving health in a 'fit for school' plan[3]. In this plan, improving oral health habits are combined with hand washing and the distribution of anti-worm tablets in elementary schools.

2.1.1. The three phases in humanitarian oral health care

1. Pain relief
2. Prevention
3. Education and support of patients and local care providers

2.1.2. General Guidelines[4]

1. Adjust deployed dental team activities in accordance with existing local resources and level of care
2. Focus on activities that can be sustained
3. Work together with local care workers
4. Support the improvement of local delivery of care services (infection prevention control)
5. Be aware of creating tension between local care workers and the local population through deployed activities
6. The final goal is to empower local people and not to leave them more dependent

2.2 MILITARY ORAL HEALTH CARE

In most military operations, oral health care capabilities are present. The involved dental personnel can provide humanitarian care using the guidelines described in this document. The skill sets needed are available in every role 2 and 3 scenario. Extra resources, such as supplies and additional equipment, might be required when operating on a larger scale or in an off-base location.

Military care providers will be present for a relatively short period, therefore in all operations with a humanitarian component the continuity of care should be considered. The program should be simple on every level so local care providers or NGO/IO can take over easily after deployment.

2.3 CONSIDERATIONS FOR PLANNING

Decisions on planning are made in consultation with the deployed dental team.
The humanitarian aid should never be provided to the detriment of the military unit's integral oral health care support. Thus, deployment of extra personnel and resources may be required in support of a humanitarian operation.

2.3.1. First consideration

The first consideration is applicable to every mission type.

Is local oral health care available?
If **no**: military care providers could provide care on limited levels as described in the diagram below.
If **yes**: first investigate local oral health care needs through communication with local care providers.

2.3.2. Second consideration

Is Civil-Military Co-operation (CIMIC) or Civil-Military Medical Interface available?
If **no**:
Help to improve local facilities with materials, supplies and/or personnel.
Education of local care providers can be added to the program.
If **yes**:
Good communication with CIMIC, local care providers and authorities is needed.
Patients should be aware of what oral health care is available.
Next focus on improvement through provision of materials, supplies and personnel, starting a prevention program like 'fit for school' when possible.
Education of local care providers can be added to the program.

2.4. POSSIBILITIES FOR ORAL HEALTH CARE ACROSS DIVERSE MISSION TYPES

In NATO (AJMedP-6) five types of missions are described:

a. Article 5 operations

b. Non-article 5 operations crisis response operation (NA5CRO):
1. Peace Support Operations (PSO)
2. Non-Combattant Evacuation Operations (NEO)
3. Humanitarian Assistance Operations (HA)
4. Medical Humanitarian Assistance (MHA)

In the schedule below, the possible levels of oral health care for the diverse mission types are described.

Type of mission	**Article 5**	**PSO**	**NEO**	**HA**	**MHA**
Levels of OH Care	Pain relief	Pain relief Prevention Education and support of patients and local care providers	Pain relief	Pain relief Prevention Education and support of patients and local care providers	Pain relief Prevention Education and support of patients and local care providers

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ANNEX A CODE OF GUIDELINES

A.1. Providers of humanitarian oral health care ensure knowledge of:

1. local health situation
2. existing health programs
3. 'evidence-based' strategies
4. international recommendations for health care

A.2. Pain relief

Pain relief in rural environments is, in most cases, tooth extraction.

A.3. Prevention:

Tooth brushing with fluoride toothpaste is most effective and relatively simple. [5,6]

Important:

1. Daily frequency of brushing
2. Meticulous brushing of all tooth surfaces
3. Not rinsing after brushing
4. Fluoride toothpaste with anti-caries efficacy

Less important:

1. Technique of brushing
2. Condition of the tooth brush

The fluoride toothpaste should be silica-based (SMFP toothpaste is likely to have reduced anti-caries efficacy)
1500 ppm fluoride is most effective

A.4. Education:

Patients (fit for school, Childsmile)[7,8]
(Potential) Local care providers (tell, show, do)

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ANNEX B LITERATURE

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