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**REGIONAL ORAL HEALTH STRATEGY 2016–2025:  
ADDRESSING ORAL DISEASES AS PART OF NONCOMMUNICABLE DISEASES**

**Report of the Secretariat**

**EXECUTIVE SUMMARY**

1. In the African Region, oral diseases are among the most common noncommunicable diseases (NCDs) and may affect people throughout their lifetime, causing pain, disfigurement, social isolation, distress and even death. They share risk factors with the leading NCDs, including tobacco use, harmful alcohol consumption and unhealthy diets high in sugar, all of which are increasing in the Region.
2. Oral diseases have a negative social impact and adverse consequences on the quality of life of affected people, while their treatment places a considerable economic burden on individuals, communities and countries. Due to unequal distribution of oral health professionals and lack of appropriate facilities, most of the oral diseases remain untreated in the Region. Many countries have no national oral health policy and are facing a shortage of oral health-care workers.
3. Despite efforts and commitments made at country level to implement effective interventions during the past decade, progress in addressing the burden of oral diseases in an equitable and integrated manner remains slower than expected. The global and regional momentum on NCDs provides a unique opportunity for countries to prioritize oral health so as to directly contribute to the reduction of NCDs and their shared risk factors.
4. The proposed strategy focuses on four objectives and aims to achieve five oral health targets in realizing effective prevention and control of oral diseases in the WHO African Region. The document contains a set of priority actions that include enhancing advocacy, leadership and multisectoral action, reducing common risk factors, strengthening health systems, improving integrated oral health surveillance and measurement of progress, as well as conducting research related to oral diseases.
5. The Regional Committee reviewed and adopted this strategy and the proposed actions.

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## INTRODUCTION

1. Oral health is integral to the general health and well-being of all people.<sup>1</sup> It is fundamental for the ability to breathe, eat, swallow, speak or even smile. Impairment of functions related to oral health can seriously interfere with the ability to interact with others, attend school and work. In the African Region, poor oral health causes millions of people to suffer from severe pain, increases out-of-pocket expenses for households and affects people's quality of life and well-being.
2. In 1998, the Regional Committee adopted a ten-year oral health strategy.<sup>2</sup> It set out five priority thrusts, namely: development and implementation of national strategies; integration of oral health into health programmes; service delivery; a regional education and training approach; and development of an oral health management information system. The review of the status of implementation of this Strategy indicated achievements in oral health interventions within HIV/AIDS, maternal and child health, school health as well as in the education and training programmes of oral health professionals. The review also highlighted the need for integrated oral health promotion to overcome the remaining challenges.<sup>3</sup>
3. In 2007, the World Health Assembly adopted a resolution on oral health.<sup>4</sup> The document listed priority actions for tackling the social determinants of oral health and reducing exposure to common risk factors of noncommunicable diseases (NCDs). The resolution further emphasized the need to build capacity in oral health systems at primary health care level as a means of prevention and control of oral diseases.
4. During the 7th Global Conference on Health Promotion in 2009, WHO organized a special session on social determinants of oral health. The outcomes of the meeting re-emphasized that the promotion of oral health and prevention of oral diseases must be provided through primary health care and that integrated approaches are the most cost-effective and realistic ways of reducing the gap between the poor and the rich.<sup>1</sup>
5. The Brazzaville Declaration on NCDs in the WHO African Region was a milestone political commitment prior to the UN High-Level Meeting on the Prevention and Control of NCDs held in 2011 in New York.<sup>5</sup> Oral health is increasingly being recognized as a major public health problem in Africa in light of the rising NCD burden.
6. The Sustainable Development Goals (SDGs) set out a holistic agenda to guide global development until 2030, with Goal 3 focusing on good health and well-being. The SDG agenda which includes social determinants, NCDs and universal health coverage, is providing an anchor and entry point for better prioritization of oral health in the Region.
7. This is the first oral health strategy that is aligned and interlinked with the global NCD agenda. It is intended to provide guidance to Member States for catalysing action for prevention and control of oral diseases.

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<sup>1</sup> Petersen PE, Kwan S. The 7th WHO Global Conference on Health Promotion - towards integration of oral health (Nairobi, Kenya 2009). *Community Dent Health*. 2010;27:129-135.

<sup>2</sup> WHO, Oral Health in the African Region: A Regional Strategy 1999 – 2008, Document AFR/RC48/9, 1998.

<sup>3</sup> WHO, Implementation of the Regional Oral Health Strategy: update and way forward. Document AFR/RC58/9, 2009.

<sup>4</sup> WHO, Oral health: action plan for promotion and integrated disease prevention. Document WHA60.17, 2007.

<sup>5</sup> WHO, The Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the WHO African Region, Brazzaville, 2011.

## SITUATION ANALYSIS AND JUSTIFICATION

### Situation analysis

8. Oral diseases are among the most common NCDs with high social, economic and health-system impacts. They affect people throughout the life course, causing pain, disfigurement, social isolation, distress and even death. Oral diseases in the Region mainly include dental caries, periodontal disease, oral cancer, oro-facial trauma, oral manifestations of HIV infection, birth defects and noma.

9. In the African Region, caries prevalence is high with 60%–90% of children and adults affected, though severity is still low for most countries.<sup>6</sup> From 1990 to 2010, the regional average increase in disability-adjusted life years (DALYs) from the burden of dental caries was between 42% and 78%. Over the same period, the burden of periodontal disease increased between 68% and 75%.<sup>7</sup> Severe periodontal diseases, together with dental caries, are leading causes of tooth loss.

10. Oral cancer is largely preventable, yet the prevalence of oro-pharyngeal cancer is high, particularly among middle-aged men, and is increasing mainly in eastern and southern Africa.<sup>0</sup> This is mainly due to increasing tobacco use and harmful consumption of alcohol as well as traditional practices such as the chewing of khat and tobacco, which have high carcinogenic potential.

11. Oral manifestations of HIV infection are common, with 40%-50% of infected and up to 84% of patients with AIDS showing oral lesions like candidiasis.<sup>8</sup> Oro-facial trauma accounts for 5% of all injuries globally and for about half of all deaths due to injuries. It is increasing as a result of interpersonal violence, road traffic injuries and civil conflict.<sup>9</sup>

12. Noma is a devastating oro-facial gangrene affecting mainly children under six years of age in a context of extreme poverty and malnutrition. It is also often associated with other infectious diseases. Estimates range from 30 000 to 140 000 new cases of noma per annum, and 70% to 90% of children affected die without having received any care.<sup>10</sup> Congenital malformations such as cleft lip and palate are also significant public health problems with an estimated prevalence of 1:500–700 births.<sup>11</sup>

13. Due to unequal distribution of oral health professionals and lack of appropriate facilities, 90% of oral diseases remain untreated and oral health-care coverage for adults with expressed need ranges from 21% to 64% in the Region.<sup>12</sup> As a result, nearly all countries of the Region are facing a constantly high patient demand for essential oral health care, exerting an additional burden on the health-care system.<sup>13</sup>

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<sup>6</sup> Petersen PE, et al, The global burden of oral diseases and risks to oral health, *Bulletin of the World Health Organization*, 83(9): 661–669, 2005.

<sup>7</sup> Marcenes W, et al, Global Burden of Oral Conditions in 1990-2010: A Systematic Analysis. *J Dent Res*. 2013;92(7):592-597.

<sup>8</sup> Awirea IF, Chappinand GN. 2012. Oral manifestations of HIV/AIDS in sub-Saharan Africa: a systematic review. *J Med Applied Biosci*. 4:87 - 102.

<sup>9</sup> Andersson L. Epidemiology of traumatic dental injuries. *J Endod*. 2013; 39:S2-S5.

<sup>10</sup> Marck KW. Noma: a neglected enigma. *The Lancet Global Health*. 2013; 1:e58-e59.

<sup>11</sup> Butali A, Mossey PA. Epidemiology of oro-facial clefts in Africa: Methodological challenges in ascertainment. *Pan Afr Med J*. 2009;2:5.

<sup>12</sup> Hosseinpoor AR, Itani L, Petersen PE. Socioeconomic Inequality in Oral Healthcare Coverage: Results from the World Health Survey. *J Dent Res*. 2010.

<sup>13</sup> Kassebaum NJ, et al, Global Burden of Untreated Caries: A Systematic Review and Metaregression. *J Dent Res*. 2015.

14. The relationship between oral diseases and other NCDs goes beyond common risk factors. Diabetes mellitus is linked with the development and progression of periodontitis. There is a causal link between high sugar consumption and diabetes, obesity and dental caries.<sup>14</sup> Moreover, a high prevalence of untreated tooth decay is a co-factor of low body mass index and stunting.<sup>15</sup>

### **Justification**

15. As of 2011, only 27 countries in the Region had a national policy on oral health, while only 14 of those countries had a dedicated oral health budget. Most of the countries had a shortage of oral health-care workers and lacked data about the proportion of the population covered by preventive measures or by oral health-care services.<sup>16</sup> Over the past decades, vertical programming characterized by isolated disease approaches rather than integrated strategies has remained the standard.

16. The emerging international momentum on NCDs provides a unique opportunity for the Region for better recognition of oral health. Using the solid NCD policy foundations and building on the evidence for reciprocal links between NCDs and oral diseases, this strategy proposes a regional consensus on priority actions based on effective population-wide prevention interventions and comprehensive patient-centred care strategies.

## **THE REGIONAL STRATEGY**

### **Aim, objectives and targets**

17. The aim of this strategy is to contribute to the reduction of the NCD burden and related risk factors by providing effective prevention and control of oral diseases for all people in the African Region within the context of universal health coverage.

18. This strategy focuses on four objectives:

- (a) To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.
- (b) To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.
- (c) To strengthen health system capacity for integrated prevention and control of oral diseases.
- (d) To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.

19. The strategy proposes five targets for measuring mortality and morbidity, risk factors and prevention and national health system response, namely:

- (a) Halt the increase of dental caries in children and adolescents by 2025.
- (b) A 25% reduction of premature mortality from oral cancer by 2025.
- (c) At least 25% increase in population using fluoridated toothpaste for the prevention of tooth decay on a daily basis by 2025.

<sup>14</sup> Guideline: Sugars intake for adults and children. Geneva: World Health Organization; 2015.

<sup>15</sup> Lempert SM, et al, Association between body mass index and caries among children and adolescents. *Community Dent Oral Epidemiol.* 2013 doi: 10.1111/cdoe.12055.

<sup>16</sup> WHO, Regional consultative meeting on integrating oral diseases into the NCD policy framework. Final report. Harare, 2013.

- (d) At least 50% of the population with expressed needs have access to oral health-care services by 2025.
- (e) At least 10% of primary health care facilities are able to provide safe basic oral health care by 2025.

### Guiding principles

20. The following six principles will guide the implementation of this strategy:

- (a) **Public health and community-based approach:** cost-effective interventions that combine population-wide prevention interventions as well as patient-centred care strategies with a focus on primary health care, school health and empowerment for effective self-care, ensuring optimal community involvement.
- (b) **Country ownership and leadership:** the ministry of health leads initiatives for sustained advocacy on oral health as part of the NCD prevention and control programme.
- (c) **Multisectoral collaboration:** effective oral diseases prevention and control require action beyond the health sector involving a range of actors from, for instance, agriculture, communication, education, finance, sports, trade and industry.
- (d) **Universal health coverage:** provide equitable oral health-care services that are appropriate, accessible and affordable for all people, particularly poor and disadvantaged communities.
- (e) **Life-course approach:** tailor oral health interventions to respond to all stages through the course of life, including the changing needs of different age groups, while maintaining a clear focus on prevention of diseases in the early stages of life.
- (f) **Evidence-based approaches and cost-effective interventions:** make evidence, including best practices, the basis for policy development and decision-making, in order to maximize the quality and impact of interventions, as well as best use of scarce resources.

### Priority interventions

21. Strengthen national advocacy, leadership, and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.

- (a) Establishing/strengthening an oral health unit under the umbrella of or in close collaboration with the NCD department in the ministry of health, and functional multisectoral coordination with other government sectors and ministries.
- (b) Integrating oral health into all relevant policies and public health programmes, including policies related to NCDs.
- (c) Advocating for increased social, political and resource commitment to oral health in the context of NCDs through raising awareness and targeted communication with decision-makers, the media and the public, including the involvement of opinion leaders as champions and ambassadors to the cause.
- (d) Encouraging sustainable collaboration inside and outside the health sector, with relevant stakeholders, donor agencies and development partners as well as through regional cooperation and public-private partnerships to forge multisectoral alliances and mobilize resources for the prevention and control of NCDs and oral diseases.
- (e) Ensuring participation and empowerment of the community and civil society in planning, implementation and monitoring of appropriate programmes related to the promotion of oral health, prevention of oral health diseases and provision of oral health care.

22. Reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.

- (a) Participating in tobacco control, including e-cigarettes, and in actions against harmful alcohol consumption to prevent oral diseases, cancers and other health consequences.
- (b) Promoting a healthy diet throughout the life-course, including a decrease in the consumption of foods and drinks containing high amounts of free sugars based on the WHO Sugars Guideline, salt, saturated and trans fats, along with an increase in consumption of fruits, raw vegetables and dietary fibre, such as whole grains.
- (c) Promoting healthy living and working environments conducive to healthy lifestyles, e.g. access to safe water and improved sanitation for proper oral hygiene in schools, workplaces, cities, health care settings and community-based establishments.
- (d) Advocating for banning the sale and advertisement of unhealthy products such as alcohol, tobacco and food high in sugar, fat and salt from key settings such as school premises, workplaces and the community.
- (e) Developing and implementing integrated school health interventions that combine simple daily interventions such as group hand washing and group tooth brushing, building on available models and experiences.
- (f) Identifying, promoting and implementing appropriate fluoridation methods to ensure population-wide access to adequate levels of fluorides.
- (g) Encouraging legislation conducive to the production, importation, distribution, packaging, labelling, affordability and accessibility of quality fluoride toothpaste, including reduction or elimination of taxes on fluoridated toothpaste and other oral health products.

23. Strengthen health system capacity for integrated prevention and control of oral diseases.

- (a) Including basic oral health-care services in the basic package of services provided by the health system, especially for vulnerable and high-risk population groups including early detection, diagnosis and quality care of oral diseases, especially oral cancer and noma.
- (b) Supporting the inclusion of basic oral health-care interventions in third-party payment schemes in health insurance and other financing systems as a means of achieving Universal Coverage.
- (c) Ensuring availability and distribution of affordable essential medical consumables, generic drugs and other adequate supplies for the management of oral diseases with standardized infection control procedures at primary health care level.
- (d) Developing maintenance plans of dental equipment at district and referral levels to ensure their operational functions, including functioning disinfection and sterilization procedures, use of disposable needles and other required measures.
- (e) Promoting capacity building in oral health promotion and integrated disease prevention and management for oral health professionals and other health and community workers matching the oral health needs of the population as part of training for NCD interventions.
- (f) Developing workforce models for integration of basic oral health care within primary health care, based on clear definitions of competencies and skills, including a system of follow-up, re-training and continuing education for PHC workers involved in NCDs and basic oral health care.

24. Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.

- (a) Integrating systematic collection of oral health data into existing health information systems (HMIS) and into ongoing NCD survey tools (STEPS, DHS, NCD Country Capacity Surveys, GSHS, etc.).
- (b) Generating quality data on oral health conditions and related risk factors through sentinel and population-based studies to support advocacy, planning and monitoring.
- (c) Establishing monitoring and evaluation systems to track progress in implementation and impact of existing policies and programmes using innovative data collection and technologies, including mHealth tools.
- (d) Building partnerships with research institutes, universities and other relevant institutions to develop and implement operational research for improving the generation of evidence-based decision-making, policies and advocacy on oral health.
- (e) Supporting the development of tools, and best buys (cost-effective interventions) for the integrated prevention and management of oral diseases within NCD programmes.

### **Roles and responsibilities**

25. The responsibilities of Member States include:

- (a) Strengthening political commitment at the highest levels to address oral health as one of priority area as part of NCDs
- (b) Developing and implementing a multisectoral national oral health action plan including a monitoring and evaluation framework for prevention and control of oral diseases as part of NCDs.
- (c) Mobilizing resources and promoting investment, as well as reinforcing public-private partnerships to support integrated national oral health action plans as part of NCD programmes.
- (d) Developing sustainable mechanisms to enhance multisectoral collaboration and partnerships in the implementation of the priority interventions.
- (e) Coordinating the efforts and agenda of several stakeholders in line with country NCD priorities.
- (f) Promoting training, recruitment and retention of required oral health workers.
- (g) Mobilizing, involving and empowering communities to enable people to increase control over and improve their oral and general health.
- (h) Conduct research and document lessons on the various aspects of the priority interventions.

26. The responsibilities of WHO and partners include:

- (a) Advocating for increased political commitment at the highest levels to address oral health as part of NCDs and related risk factors.
- (b) Providing guidance, tools and standards to Member States in their efforts to develop and implement national oral health action plans for prevention and control of oral diseases as part of NCDs.
- (c) Supporting the inclusion of basic oral health-care services into the basic package of services provided by the health and education systems.
- (d) Mobilizing resources and promoting investment, as well as reinforcing public/private partnerships to support integrated national oral health action plans as part of NCDs programmes.



- (e) Contributing to the development, production, and distribution of affordable quality oral hygiene products as well as of a quality dental filling material that is affordable, safe, and environmentally-friendly.
- (f) Supporting operational research to generate evidence for corrective action and continued learning on the relationship between oral diseases and other NCDs and to demonstrate the public health impact, cost-effectiveness and feasibility of interventions (“Best Buys”).
- (g) Increasing emphasis on integrated prevention and treatment of oral diseases with NCDs and in the context of health professional training curricula at all levels.

## **RESOURCE IMPLICATIONS**

27. The implementation of the strategy will require high levels of national and international commitment. The level of funding needed by WHO to support the implementation of this strategy was estimated assuming that at least half of the countries will request technical support. The total funding requirements over the ten-year period for technical and financial support are projected to be US\$ 13.5 million.

28. Member States should cost, mobilize and allocate financial resources to implement their plans. They should create sustainable mechanisms for coordination of partners in order to pool resources from partners and make optimal use of the opportunities created by the private sector, civil society organizations, faith-based organizations, development partners and other sectors.

## **MONITORING AND EVALUATION**

29. Five oral health targets have been defined. They should be adapted to the national contexts and used to monitor the implementation of this strategy annually. A mid-term progress report of the strategy including a set of progress monitoring indicators will be proposed and presented in 2020. A final evaluation report will be submitted in 2026 to the Regional Committee and will be used to realign and refine a new period of implementation of the strategy.

30. Surveillance of oral diseases and monitoring of national action plans should be part of epidemiological surveillance and monitoring systems of NCD programmes. Existing NCD surveillance tools and modules, such as the WHO STEPS survey, the Demographic and Health Survey (DHS) or the Global School-based Student Health Survey (GSHS) can be adapted for use to capture and analyse data related to oral health.

## **CONCLUSION**

31. The Regional Oral Health Strategy and its proposed priority interventions place high emphasis on addressing common risk factors of NCDs and social determinants of oral health through essential evidence-based, cost-effective and sustainable interventions in the context of universal health coverage. It represents a paradigm shift from vertical programming towards the integration of oral diseases within the NCD agenda.

32. The strategy will contribute to reducing the burden of oral diseases and NCDs at large, and to improving the health of populations. Its implementation will require country ownership supported by a committed global and regional partnership in order to ensure the availability and efficient use of resources.

33. The Regional Committee reviewed and adopted the strategy.