Capacity Building Workshop to Develop the National Roadmap for Implementation of the Regional Oral Health Strategy in the African Region: Meeting Report

World Health Organization

REGIONAL OFFICE FOR Africa

Capacity Building Workshop to Develop the National Roadmap for Implementation of the Regional Oral Health Strategy in the African Region: Meeting Report

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Abbreviations

AFRO	WHO Regional Office for Africa
AOI	Aide Odontologique Internationale
ART	Atraumatic Restorative Treatment
CPITN	Community Periodontal Index of Treatment Needs
DALYs	Disability-Adjusted Life Years
DMFT	Number of decayed, missing or filled teeth
DPM	Director Programme Management
DHIS2	District Health Information System 2
FDI	World Dental Federation
GBD	Global Burden of Disease
GPW13	WHO's Thirteenth General Programme of Work
GSHS	Global school-based student health survey
HQ	Headquarters
IADR	International Association for Dental Research
ISDR	Integrated Disease Surveillance and Response
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NCD	Noncommunicable Diseases
PHC	Primary Health Care
PNLMBD	Programme National de Lutte contre les maladies Bucco-dentaire et le Noma (National Programme for the Control of Oral Diseases and Noma)
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
SSBs	Sugar- Sweetened Beverages
STEPS	STEPwise approach to noncommunicable disease risk factor surveillance
UHC	Universal Health Coverage
UN	United Nations
UNHLM	UN High-Level Meeting

YLD	Years Lost due to Disability
WASH	Water and Sanitation and Hygiene
WHO	World Health Organization
WHO CC	World Health Organization Collaborating Centre
WHO CC NYU	WHO Collaborating Centre on Evidence-based Dentistry & Quality Improvement, New York University College of Dentistry
WHO PEN	WHO Package of Essential Noncommunicable Disease Interventions

Executive Summary

The Capacity Building Workshop to Develop the National Roadmap for Implementation of the Regional Oral Health Strategy in the African Region was held in Brazzaville, Republic of Congo, from 27 February to 1 March 2019. More than 40 participants attended the meeting, including chief dental officers from Ministries of Health (MoH), focal points of Noncommunicable Diseases (NCDs) from World Health Organization (WHO) country offices in 20 Member States, experts from the WHO Collaborating Centre at the New York University College of Dentistry and other partners.

The main objective of the meeting was to agree on top priority actions for integrated prevention and control of oral diseases as part of NCDs and Universal Health Coverage (UHC), mindful of progress made by countries in the Region and guided by the Regional Oral Health Strategy 2016-2025: addressing oral diseases as part of NCDs (AFR/RC66/5). The workshop programme included sharing of country achievements, expert input and partner contributions covering a broad range of policy aspects, implementation challenges and opportunities, as well as global developments relevant to country implementation and monitoring, such as the Minamata Convention on Mercury.

Over the course of the deliberations, participants and invited experts acknowledged the overall progress made in the oral health agenda. They expressed concern over existing gaps in policy intentions and implementation, notably progress towards achieving UHC, including essential oral health care, which remains slow. Furthermore, the continuing public health challenge of noma in several countries of the Region was highlighted. Improved multisectoral collaboration, political leadership and commitment, community involvement and ownership, and appropriate budget allocations for sustainability were identified as crucial elements necessary for accelerated action.

The workshop explored and identified cost-effective mechanisms for delivery of essential oral health care, including the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN) and other fiscal and policy recommendations in the WHO “best buys”. National roadmaps corresponding to the respective national contexts were developed to accelerate implementation of the Regional Oral Health Strategy. In addition, specific actions, including strengthening collaboration between participants to promote oral health and oral diseases prevention and control in the Region, set out in an outcome document signed by all participants were recommended to strengthen oral health care systems, guided by the four priority action areas of the Regional Oral Health Strategy.

1. Background

Oral diseases such as dental caries, periodontal diseases, oral cancers and noma were recognized as part of noncommunicable diseases (NCDs) at the first UN High-Level Meeting on the Prevention and Control of NCDs (UNHLM) and are increasingly being recognized as a major public health problem in the WHO African Region (the Region) in light of the rising NCD burden.

In the Region, caries prevalence is high, with an estimated 60%–90% of children and adults affected. 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%. Oral diseases share risk factors with the leading NCDs, including tobacco use, harmful alcohol consumption and unhealthy diets high in sugars, all of which are increasing in the Region. (1)

Due to unequal distribution of oral health professionals and lack of appropriate facilities, most oral diseases remain untreated. Additionally, many countries have no national oral health policy. As of 2011, only 27 countries had a national policy on oral health, while only 14 of those countries had a dedicated oral health budget. (2) One of the major barriers to the improvement of oral health in the Region is the absence of a clear statement of oral health policy to guide countries' oral health activities. 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.

To this end, the Regional Oral Health Strategy 2016-2025: addressing oral diseases as part of NCDs (AFR/RC66/5) was endorsed in 2016. (3) The strategy has provided countries with a basis for developing coherent national plans for areas of oral health to align their contribution to the implementation of the Global Action Plan for the Prevention and Control of NCDs, 2013-2020 (4) in the Region.

Since the endorsement of the regional strategy in 2016, only 30% of countries have an operational oral health policy/action plan in the Region, according to the WHO NCD Country Capacity Survey 2017 (5). That is why the WHO Regional Office for Africa (AFRO) is convening regional workshops with key stakeholders, including focal points of oral health and NCDs from Member States, to provide updated guidance on prevention and control of oral diseases and find concrete ways to improve and accelerate actions for oral health as part of NCD initiatives based on the regional strategy. Implementation of comprehensive oral health policies will contribute significantly towards achieving both UHC and the Sustainable Development Goals (SDGs) within the context of the WHO's Thirteenth General Programme of Work (GPW13)[1]. (6)

[1] GPW13 sets out WHO's strategic direction, outlines how the Organization will proceed with its implementation and provides a framework to measure progress in this effort.

1.1. Objectives

The workshop general objectives were:

(a) To contribute to reducing the burden of NCDs in the Region.

(b) To contribute to accelerating achievement of UHC and SDGs.

The specific objectives were:

(a) To understand the current situation of oral health in the Region.

(b) To discuss the Regional Oral Health Strategy 2016-2025: addressing oral diseases as part of NCDs (AFR/RC66/5).

(c) To enhance knowledge on how to develop the action plan for prevention and control of oral diseases as part of a national multisectoral action plan for prevention and control of NCDs based on the draft national roadmap for oral disease prevention and control.

(d) To develop a draft national roadmap for oral disease prevention and control at country level based on countries' priorities.

1.2. Expected outcomes

(a) Participants provide an update on the oral health situation and the implementation of oral disease prevention and control, and identify the priority agenda in each country.

(b) Participants increase understanding of the regional strategy and identify priority actions from the regional strategy based on their country context.

(c) Participants strengthen their capacity to develop an action plan for prevention and control of oral diseases as part of a national multisectoral action plan for prevention and control of NCDs.

(d) Participants draft a national roadmap for oral disease prevention and control based on countries' specific priority actions.

2. Summary of Proceedings

The workshop was officially opened by Dr Waogodo Joseph Cabore, Director Programme Management (DPM), WHO Regional Office for Africa. He acknowledged the huge burden of oral diseases in the Region and emphasized the importance of implementing the Regional Oral Health Strategy to tackle the problems in realistic, contextualized ways through integration of oral health into existing programmes such as NCDs, Child Health, Primary Health Care (PHC) and UHC in the context of GPW13 towards SDGs. On behalf of WHO, he also expressed appreciation to Hilfsaktion Noma e.V. for providing support for the implementation of the regional noma control programme since 2013.

After DPM's address, Mr Mathis Winkler, Head of Projects, Hilfsaktion Noma e.V., spoke about the institution's past collaboration with WHO and expressed its willingness to continue collaborating with WHO and its Member States not only for noma prevention but also for the improvement of oral health in general, as a prerequisite for preventing noma.

After the introduction of participants, the overview and objectives of the workshop were presented. The morning was utilized to familiarize participants with the Regional Oral Health Strategy. Participants read the entire strategy document, including its objectives, targets, and priority interventions based on each objective. (ANNEX 1)

The method of work during the workshop included plenary presentations, discussions and group work. This method facilitated the sharing of experiences, exchange of ideas, identification of priorities and strengthening of capacity for developing the multisectoral action plan and the national roadmap.

The workshop was organized into the following sessions:

(i) Country presentations in line with the priority areas of the Regional Oral Health Strategy.

(ii) Presentations by partners, including the International Association for Dental Research (IADR), World Dental Federation (FDI), Hilfsaktion Noma e.V., WHO Collaborating Center on Evidence-based Dentistry & Quality Improvement of New York University College of Dentistry (WHO CC NYU) and Aide Odontologique Internationale (AOI), on their activities.

(iii) Identification of barriers and facilitators to the development and implementation of each country's oral health strategy.

(iv) Other key areas for accelerating implementation of the Regional Oral Health Strategy presented by WHO colleagues from the NCDs, Health System and Resource Mobilization clusters.

(v) Overview of the WHO Oral Health Programme and innovative ways to accelerate oral health promotion.

(vi) Development and presentation of the roadmap for oral health promotion in each country.

(vii) Signature of the outcome document by all participants.

(viii) Closing remarks by DPM.

2.1. Country presentations – six case studies based on priority areas of the Regional Oral Health Strategy and noma control

During this session, six countries made presentations on the topics below related to the priority areas of the Regional Oral Health Strategy in order to share the lessons they learned with other Member States:

(a) Strengthening national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.
(b) Reducing common risk factors, promoting oral health and ensuring access to appropriate fluorides.
(c) Strengthening health system capacity for integrated prevention and control of oral diseases.
(d) Improving integrated surveillance of oral diseases, monitoring and evaluation (M&E) of programmes and research.
(e) Noma prevention and control.

All country presentations were structured in the same way:

- A summary of the oral health situation (disease burden, priority areas, policy and organogram of oral health division).
- Implementation of each priority area, including challenges and facilitators.
- Next steps.
- Suggestions for other countries on how to implement each priority area.

Priority Area 1: Strengthen oral health as part of NCDs through a multisectoral approach by Tanzania

Tanzania is one of the countries that are well advanced in strengthening oral health as part of NCDs. For example, it has fully integrated oral health into an NCD strategic plan and the organogram of its Ministry of Health (MoH) combines oral health and NCDs into one section.

The adoption by the country of three national oral health plans and one policy guideline has contributed to strengthening oral health as part of NCDs. The first plan focused on a more conventional model such as restorative dentistry and then moved to the preventive and promotive model. The current plan is more integrated into the health system at all levels. To enhance the multisectoral approach, the country's training institution for oral health professionals has tried to promote inter-professional collaboration.

However, Tanzania has faced difficulties in strengthening political commitment at the highest levels to address oral health as one of the priority areas of the NCDs agenda. This is because of its low priority and inadequate resources and investment for enhancing multisectoral collaboration and partnerships to support implementation of cost-effective interventions for oral health as part of NCDs. Moreover, it is difficult to integrate oral disease prevention into NCD prevention by

addressing common risk factors as well as include essential oral health care services as part of UHC initiatives.

Tanzania's experience gave rise to the following suggestions for strengthening oral health as part of NCDs: (i) strengthen national leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach; (ii) establish/strengthen an oral health unit under the umbrella of or in close collaboration with the NCD department in MoH; (iii) integrate oral health into all relevant policies and public health programmes; (iv) advocate for increased social, political and resource commitment to oral health in the context of NCDs; and (v) encourage sustainable collaboration inside and outside the health sector.

Priority Area 2: Implement a common risk factors approach, including better access to fluorides: fluoride legislation by Madagascar

Madagascar selected salt fluoridation and fluoridated toothpaste as population-based fluoridation measures. To promote better access to fluoride, legislation on salt fluoridation (2014) and fluoridated toothpaste regulations/standards (updated 2018) was endorsed.

The facilitators for the promotion of fluoridation are (i) technical and financial multisectoral collaboration within central and external government services, including the private sector and NGOs, through close communication; (ii) encouraging/accompanying measures such as implementation of a fiscal policy reducing taxes on fluoride products and technical support for producers of salt fluoridation and fluoridated toothpaste; and (iii) well prepared communication plan for stakeholders including suppliers and consumers to promote fluoridation safety. Barriers to implementation of the approach include difficulty in (i) obtaining stakeholders' commitment as well as consensus amongst the population for salt fluoridation and fluoridated toothpaste and (ii) determining/setting an affordable price for fluoridated toothpastes.

In fact, the decision to implement public health interventions depends on context (population needs/preference), intervention (evidence, cost-effectiveness), availability of resources, networking and stakeholders' commitment. It would therefore be better to identify appropriate measures based on the above points. Moreover, to ensure the sustainability of the oral health programme, it is critical to carry out M&E.

Priority Area 2: NCDs common risk factors approach, including sugars tax by South Africa

In South Africa, oral health has been integrated into various initiatives such as national school health policies, clinical booklet, and the primary health service.

For the NCDs common risk factors approach, the taxation of sugars is a good example of multi-stakeholder collaboration. In the health sector, the introduction of a tax on sugar-sweetened beverages (SSBs) was facilitated by the Health Promotion, Nutrition and Oral Health clusters. When advocating for the importance of the SSB tax, dental caries was included as part of disease burdens due to sugars. Dentists were involved in advocating for the adoption of the SSB tax during cabinet public hearings on the tax. In addition, a fraction of the sugars tax, now called the Health Promotion

Levy, is given back to the Health Department for the prevention of NCDs including oral health conditions.

In promoting oral health, South Africa still faces difficulties such as an unregulated food environment, marketing of unhealthy foods and beliefs that oral diseases are not fatal diseases, which leads to oral health having lower priority. Political leadership and support from the senior management beyond the oral health field (their understanding that oral health is an important part of general health), collaboration with other health programmes, dental school leadership and the involvement of all oral health stakeholders are required for the successful implementation of the NCDs common risk factors approach in South Africa.

Priority Area 3: Strengthen health system capacity towards achieving universal health coverage by Mauritius

Mauritius is one of the advanced countries in sub-Saharan Africa that have a strong health system that is moving towards achieving UHC. According to UHC service coverage indicators, Mauritius (64%) is significantly advanced compared with the average in the Region (42%). (7) In the public sector, under the Director of the dental service in Ministry of Health and Quality of Life, a comprehensive oral health package including oral health promotion, basic oral health service (diagnosis, extraction, temporary and permanent fillings, fluoride application, pit and fissure sealant) and specialized dental services (oral surgery, orthodontics and endodontics) are provided free of charge.

However, the limited availability of public funds and escalating costs of treatment present a challenge to the sustainability and improvement of the provision of free, high-quality oral health services in the public sector. In addition, high out-of-pocket spending in the private sector is caused by high user charges and unregulated price-setting. Moreover, the formulation and implementation of a national oral health action plan and a robust surveillance system for oral diseases would contribute to achieving full universal oral health coverage. Additionally, service delivery is focused more on treatment rather than on promotion.

Therefore, to strengthen the oral health system towards UHC, the government should invest more in oral health promotion; sustain the provision of free health services in the public sector; further strengthen and enhance the quality of care with emphasis on patient-centred services; consider introducing user fees for expensive specialized health services paid through private health insurance and increasing the percentage of GDP spent on health so as to reach the target of 5% by 2030 set by the WHO.

Priority Area 4: Integrate surveillance of oral diseases (DHIS2, STEPS) by Senegal

Senegal has integrated oral health components into its existing health surveillance system. These include the District Health Information System (DHIS2) and WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS).

In oral health surveillance, the difficulty in obtaining the consensus and participation of dentists in collecting and reporting information regularly hinders the collection of high-quality routine information and leads to a lack of data for evidence-informed decision-making.

The integration of oral health components into STEPS (step 2) first happened in 2015 through the collaboration and coordination of the steering committee, which included staff from MoH, universities and other stakeholders at all stages (planning, training, data collection, interpretation, and reporting).

Moreover, analysis of the existing oral health information system identified non-compliance, lack of harmonized tools and non-exhaustive entry forms as causes of difficulty in the integration of oral health into existing surveillance tools.

To overcome those challenges, a participatory approach was utilized to develop and validate a data carrier, and then the oral health components were integrated into the DHIS2 platform. The training of a dental officer to use the DHIS2 platform was facilitated in 2018.

For noma surveillance, Senegal included noma in the list of diseases to be monitored for elimination by integrating noma into the framework of Integrated Disease Surveillance and Response (IDSR) through the Epidemiological Surveillance Division in MoH.

Considering the integration of oral health into existing surveillance tools, it was recommended to (i) involve all stakeholders by working with other health sectors; (ii) collaborate with health information system actors; (iii) sensitize stakeholders and actors; and (iv) advocate with decision-makers and partners.

Priority Area 5: Noma prevention and control by Niger

There is a division of the National Programme for the Control of Oral Diseases and Noma (PNLMBD) in the country's Ministry of Public Health. The PNLMBD has five sections, namely programme coordination, clinical service, resource management, social mobilization and epidemiology. The noma and oral disease control strategy consists of four pillars namely (i) training of trainers (health workers, teachers, students, community leaders, etc.); (ii) social mobilization (awareness campaigns); (iii) curative management; and (iv) disease control, including disease surveillance.

Niger has faced challenges such as insufficient numbers of staff at PNLMBD, including no epidemiologist, lack of health care staff at peripheral health facilities, and lack of recent data on oral health. However, the existence of an updated national health policy and strong collaboration with NGOs, Ministry of Public Health and other public health institutions facilitate the control of oral diseases and noma.

The Niger experience shows that, despite the encouraging results and considerable resources provided in an integrated and harmonious way at different levels to control certain NCDs, it is important to integrate noma into an existing surveillance platform such as DHIS2 to develop an integrated strategy for the prevention and management of oral diseases. Moreover, due to its

characteristics, noma control depends on the sensitization of the population and the capacity building of all actors involved in the fight against oral diseases. A noma programme should thus be integrated into the continuous development of actions and activities with communities through empowerment and social mobilization, led and coordinated by the regional coordinators and focal points of the Regional Noma Control Programme.

Below are the salient points of this session based on the six country presentations.

Integration of oral health into NCD initiatives

- Integration of oral health into NCD programmes may result to better resource mobilization.
- Most countries have an NCD strategy/policy, which is an entry point for integrating oral health components into NCD strategy/policy.

Policies vs implementation

- Plans and policies are in place; however, this does not always translate into budgetary allocation and implementation at country level. Commitments are made at a high political level.

Oral health surveillance

- Most countries seem not to have baseline data on oral health. Hence, the integration of oral health components into existing surveillance tools (STEPS, DHIS2, Multiple Indicator Cluster Survey (MICS), and Global school-based student health survey (GSHS)) is an entry point for gathering oral health information.

Fortification of salt with fluoride vs policies to reduce salt intake

- Where salt is used as a vehicle for fluoride, salt intake at a country level should be monitored so that adjustments can be made if required to the levels of fluoride in the salt to ensure that the population is receiving optimum levels of exposure to fluoride.
- Some countries report having excess fluoride and expressed concern over population-based fluoridation. Those responsible for public oral health should be aware of the total fluoride exposure/intake of the population before programme implementation, and an adequate surveillance system is required to avoid excess exposure to fluoride.

2.2. Presentations by partners

During this session, partners made presentations to share their experiences, and build/strengthen collaboration between them, Member States and WHO. A summary of the presentations is provided below.

International Association for Dental Research (IADR)

The IADR's mission is to advance research and increase knowledge for the improvement of oral health worldwide; to represent the oral health research community; and to facilitate the communication and application of research findings. Moreover, IADR is one of two oral health NGOs in official relations with WHO and supports the WHO Oral Health Programme by providing updated high-quality evidence.

IADR is supporting the Member States in the Region by promoting epidemiological research and providing evidence-based intervention options, especially for disease prevention. The IADR Regional Development Program contributes to building the capacity of researchers in the Region.

World Dental Federation (FDI)

FDI serves as the principal representative body for over one million dentists worldwide. It is one of two oral health NGOs in official relations with WHO and supports the WHO Oral Health Programme by advocating for oral health prioritization and disseminating WHO guidance materials to the oral health community.

In the Region, the FDI strategy is to (i) establish and reinforce the credibility of national dental associations; (ii) acquire and develop leadership and management skills; and (iii) facilitate effective peer-to-peer exchange of information. In addition, FDI contributes to advocacy through the World Oral Health Day, surveillance of oral diseases, acceleration of integration of oral health into NCDs as a member of the NCDs Alliance, and enhancement of inter-professional collaboration.

WHO Collaborating Centre on Evidence-based Dentistry and Quality Improvement, New York University College of Dentistry (WHO CC NYU)

WHO CC NYU supports the WHO Oral Health Programme by designing innovative and effective oral health surveillance methods; developing innovative protocols for prevention and control of oral diseases across the lifespan; and providing training and technical assistance. Its strategic priority area is UHC. It supports WHO by providing evidence which contributes to developing "Best Buys for Oral Health" and an Investment Case for Oral Health.

In the Region, WHO CC NYU supports WHO and its Member States through evidence generation and translation; provision of technical support to Member States for surveys, epidemiology and surveillance; capacity development-training courses. It also serves as a Global Think Tank through facilitating discussion and dialogue to push current public dental health boundaries towards oral health integration and UHC.

Hilfsaktion Noma e.V.

Hilfsaktion Noma e.V. is a German charitable NGO. It provides financial support to the countries of the Region that have an especially high noma burden to help them to eradicate noma through a holistic approach including prevention, sensitization, treatment and research in collaboration with WHO.

Lessons learned from its previous experiences in implementing successful oral health programmes in the Region include (i) the importance of ownership by local partners without strong local supporters who stand behind a project, failure is all but guaranteed; (ii) need for smooth communication between partners, with both donor and recipient being aware of their obligations and willing to fulfil them; (iii) capacity to implement and execute projects is much more important than availability of funds; and (iv) need for a "global" perspective with the involvement of all stakeholders at all levels of the health sector to ensure the successful implementation of projects.

Good oral health is a prerequisite for the prevention of noma. Therefore, Hilfsaktion Noma e.V. can also assist in any way possible in promoting oral health in the Region.

Aide Odontologique Internationale (AOI)

AOI is a French international NGO supporting the development, implementation and evaluation of innovative oral health strategies. As a facilitator, AOI assists partners in implementing their own projects. The lessons learned from the implementation of country programmes, such as a salt fluoridation and iodation programme in Madagascar, helped to identify key factors to enhance success and prevent failures, namely motivation of stakeholders from decision-makers to project implementers; a supportive legislative framework; a framework for quality assurance; and appropriate communication and monitoring.

In line with the Regional Oral Health Strategy, AOI facilitates training, implementation and research based on lessons learned from country experiences, the capacity building of MoH staff in collaboration with partners experts, institutions, universities, NGOs, and the private sector.

2.3. Sharing of experiences: Accelerating action aligned with the Regional Oral Health Strategy

The purpose of this session was to enable countries with a national oral health policy/action plan to share experiences with countries that do not yet have them using the world café methodology, which created an interactive question-answer dynamic. The participants were divided into six groups made up of countries both with and without a national oral health policy/action plan.

The discussion question was:

- What are the difficulties/opportunities and suggestions for developing and implementing an oral health action plan/ oral health components of a NCDs action plan?

At the end of the group work, the difficulties identified included: (i) lack of oral health data; (ii) lack of resources; (iii) lack of awareness among decision-makers; (iv) health workers' lack of expertise; (v) low political commitment; (vi) lack of visibility for oral health; (vii) segmentation of the departments involved in oral health; (viii) inappropriate coordination; and (ix) unequal ability to develop plans.

The opportunities were: (i) pay due attention to NCDs; (ii) advocacy and sensitization of political actors; (iii) UHC; (iv) integrated programmes in different settings such as schools; (v) sugars taxes; (vi) primary health services; and (vii) involvement of different experts.

The suggestions to accelerate implementation of the oral health action plan were: (i) call on expertise when needed; (ii) develop partnerships for implementation; (iii) involve partners; (iv) invest in training and monitoring; and (v) increase the recognition of oral health by WHO.

2.4. Updates on developments in global health: Noncommunicable diseases, universal health coverage, and resource mobilization

The purpose of this session was to learn from colleagues from AFRO about developments in important global health areas relevant to oral health integration: NCDs, UHC, and general resource mobilization. Each presenter spoke about current initiatives in their area of work, including challenges, opportunities, and suggestions on how to strengthen or integrate oral health into the areas of work.

Noncommunicable diseases (NCDs)

The burden of NCDs has increased in the Region, and NCDs will become a major contributor to mortality if the current trend were unchanged by 2025. Oral diseases share common risk factors with major NCDs, including tobacco use, unhealthy diet and alcohol consumption. This presents an opportunity for integration and synergy of oral health with major NCDs.

The Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the African Region (2011) recommended the prioritization of NCDs in the Region, including oral health. The Global Action Plan for the Prevention and Control of NCDs 2013 recognized the primary role and responsibility of governments in responding to the challenge of NCDs and the important role of international cooperation in the support of national efforts. The SDGs also offer an opportunity to further strengthen commitments to reverse the rising burden of NCDs, and six NCD-related targets are included under Goal 3 Good health and well-being.

Under the umbrella of the NCDs cluster, AFRO has supported its Member States through normative, technical assistance, advocacy, networking to strengthen governance, risk factor control, strengthening health systems and providing surveillance in line with the Regional Oral Health Strategy.

To accelerate the oral health agenda at the country level, oral health should be better integrated into existing platforms such as STEPS or the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN) for primary care in low-resource settings. WHO PEN has provided an innovative and action-oriented set of cost-effective interventions that can be delivered with an acceptable quality of care, even in resource-poor settings, from early detection to management of four major NCDs and their risk factors. "Promoting Oral Health in Africa: Prevention and control of oral diseases and noma as part of essential noncommunicable disease interventions" (2016) (8) has provided cost-effective basic interventions to integrate oral health components into WHO PEN.

Universal health coverage (UHC) and health systems

UHC is defined as "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship". The dimensions to be considered by UHC are: Who is covered? What services are offered? What proportion of cost is covered?

In the Region, during the Millennium Development Goals (MDGs) era, certain health outcomes were improved. For example, the reduction in the maternal and child mortality rate was partially achieved due to improved availability and use of health services, in line with an increase in health expenditure. However, according to the UHC dimensions index, service availability and financial risk protection did not perform well in the Region. Africa is still a continent with a large impoverished population and low health coverage.

From MDGs, SDGs represent an overarching aspiration for health development in countries. Social, commercial, environmental and political targets across other SDGs act as determinants of SDG3. As part of SDG3, UHC is an overarching health services target.

What is WHO doing to achieve UHC and SDGs? WHO develops tools such the WHO Framework for Action for Universal Access to Health, which provides a single interlinked logical framework to integrate systems and services for the attainment of SDG3.(9) (Figure 1)

The health system is the engine for achieving universal coverage. To strengthen the health system, it is important to have clear processes for monitoring health sector performance; plan investments based on their impact on health system performance; integrate work going on in programmes; strengthen health systems and rethink service delivery (people-centred, investment across all public health functions from promotion to palliative, shift from basic (affordable) to essential (needed) health service packages, targeted at all life cohorts).

To integrate oral health into UHC, it is important to (i) integrate planning and budgeting of national and subnational development plans or health plans; (ii) design essential oral health services packages, including development and integration of the essential medicines list, and consider health financing (general tax and health insurance); (iii) integrate oral health components into existing health information systems such as Service Availability and Readiness Assessment (SARA) surveys and STEPS; and (iv) shift service delivery mechanisms from disease-oriented to integrate a people-centred health service.

To improve M&E, there is need to consider how we can better work together to harness existing resources around information and knowledge management, accelerate capacity building in new areas of work, and build a common platform for engagement and joint work.

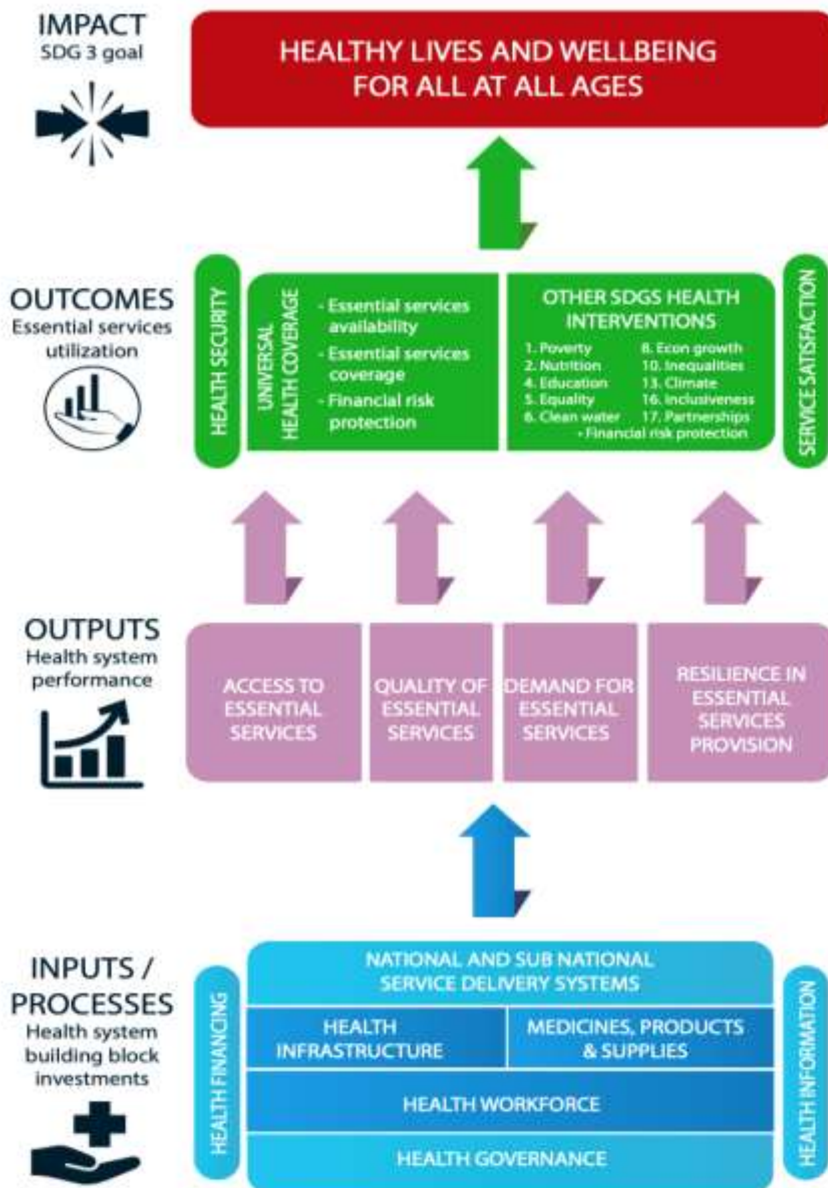

Fig. 1: Framework for Health System Strengthening towards UHC and the SDGs

Resource mobilization

The global environment is characterized by GPW13. The gap observed in the implementation budget of GPW13 needs to be filled, and there is a decrease in flexible funds, hence the need for resource mobilization at all three levels of the Organization (Headquarters, Regional Office and country office). This implies forging new partnerships and increasing the annual contributions of countries. Possible solutions include (i) professionalizing the resource mobilization function; (ii) building staff capacity in resource mobilization; and (iii) developing a roadmap in accordance with the general plan of work. It is important to link any action to GPW13 and the roadmap.

To identify potential donors, it would be better to conduct donor mapping. There are some useful tools available for mapping, for example, Donor Tracker[2]. Moreover, there is greater need to engage existing donors in order to maintain donor relations for future funding opportunities.

For engagement with non-state actors including donors (NGO, private sector, etc.) for projects implemented in collaboration with WHO and Member States, a collaborative framework called the WHO Framework of Engagement with Non-State Actors (FENSA)[3] exists for strengthening WHO engagement with non-state actors and protecting its work from potential risks such as conflicts of interest, reputational risks, and undue influence. Any engagement project with a non-state actor must be sent to AFRO which will forward it to WHO/HQ for verification and compatibility with the rules of the Organization.

2.5. Current oral health initiatives; Disruptive innovation

This session provided updates on global oral health initiatives as well as creative and stimulating ideas for breaking with the current traditional mindset for the future of oral health.

The WHO Oral Health Programme: a Three-Year Roadmap (2018-20). Opportunities and Priorities in the current global health context

Despite its high burden, oral health is still a neglected and under-resourced area of work, even within WHO. In the current global health context, the opportunities for moving oral health forward within the global health agenda lie with NCDs, SDGs, UHC and the Minamata Convention. Building on these global health opportunities, the WHO Oral Health Programme has developed a three-year work plan in the context of GPW13 towards SDGs.

The work plan 2018-2020 comprises five main pillars:

(i) Development of a Global Oral Health Report: Develop and disseminate a new Global Oral Health Report, including cost-effective interventions to strengthen political commitment at the highest levels to address oral health as one of the priority areas of NCDs.

[2] https://donortracker.org/

[3] https://www.who.int/about/collaborations-and-partnerships/who-s-engagement-with-non-state-actors

(ii) Phase-down of the use of dental amalgam according to the Minamata Convention on Mercury: Support countries to phase down the use of dental amalgam in the framework of the Minamata Convention on Mercury.
(iii) Support population-based strategies for oral disease prevention: Build the capacity of countries to implement a mix of population-based strategies and people-centred care approaches related to sugar consumption, tobacco control and fluoride exposure.
(iv) Use of digital technology to improve oral health: Develop a mOralHealth programme to contribute to better prevention and control of oral diseases such as oral cancer and noma.
(v) Strengthening global information systems for oral health monitoring: Update oral health indicators and support national oral health surveys and the use of existing NCD survey tools.

To achieve the five pillars, collaboration between staff from the WHO Oral Health Programme, all three levels of WHO, WHO CCs and chief dental officers at MoHs in each country, as well as other stakeholders such as IADR, and FDI is crucial.

Accelerating progress in oral health coverage through innovation, disruption and new thinking

To revitalize the international political commitment to oral health and intensify implementation of cost-effective interventions for the prevention and control of oral diseases at country level, creative and stimulating ideas for breaking with the current traditional mindset are required. A shift away from a technology-heavy and dentist-centred approach is needed so that prevention and long-term management are prioritized.

Four key areas of innovation should be considered:
(a) To rethink current oral health metrics and data sources
(b) To develop stepwise and modular models of care suitable for UHC
(c) To define oral health best buys
(d) To know the cost and scale of investment in order to plan and act more effectively

To rethink our metrics and data sources

Current metrics such as number of Decayed, Missing or Filled Teeth (DMFT)/Community Periodontal Index of Treatment Needs (CPITN) are complex and require special knowledge to understand them. Moreover, the current metrics are not comparable to any other mainstream health indicators.
While there is a need for up-to-date information and baselines, traditional oral health surveys are costly and complex and their policy relevance is uncertain. Alternatively, the Global Burden of Disease (GBD) (Incidence, Prevalence, Disability-Adjusted Life Years (DALY)/Years Lost due to Disability (YLD)) has solid estimations of the oral disease burden for all countries. There is room for improvement, but oral disease baseline data is better than it ever has been in history.

To develop stepwise and modular models of care suitable for UHC

Currently, the majority of the four billion of people who are at the base of the pyramid (income of less than US$ 3-5/day) have limited access to essential oral health care service. The basic package of oral care including oral urgent treatment, affordable fluoride toothpaste, and atraumatic restorative treatment (ART), was developed in the 1990s and published in 2002. While the package

has been implemented in communities where it is accepted by populations, and non-dental providers feel comfortable about the tasks after training, there are challenges to maintain and scale up access due to common problems with supplies and financing, the complexity of ART procedures and the policies of many dental associations, which present major bottlenecks for delegation to non-dentist providers. Additionally, the lack of comprehensive package evaluations, costing models for integration into PHC and implementation pathway including supportive framework has hindered the scale-up of the package globally.

However, in order to achieve universal oral health coverage, the expansion of reach and coverage, including task shifting (dentists to non-dentists), improved scope and quality of care (high cost efficiency/return on investment/evidence-base), financial protection, and an enabling policy framework, will be required.

To define oral health "Best Buys"

To integrate oral health into UHC, "Best Buy Interventions on Oral Health" are crucial. "Best Buys" will be developed based on the best available evidence, by scoping and setting priorities excluding non-essential interventions, implementing a public health mindset that addresses multiple levels (population, healthcare, community and self-care) and considering realistic health system capacities.

To know the cost and scale of investment in order to plan and act more effectively

An investment case is a description of the changes that a country wants to see regarding a specific health issue and a prioritized set of investments required to achieve these results. It is not a comprehensive description of all the activities underway to address the issue in the country.

Based on inputs, investment case tool (Figure2) provides outcomes which can be helpful for

- Policy: Prioritization and resource allocation costing
- Service: Planning workforce, infrastructure
- Public health: Modelling intervention effects
- Monitoring

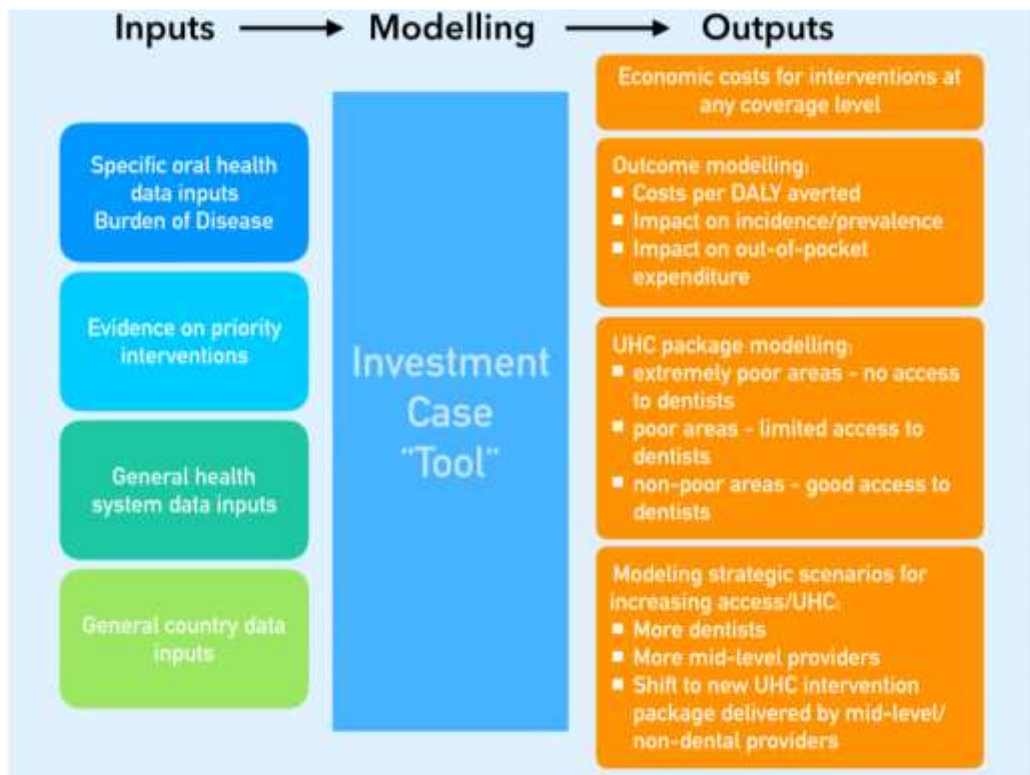

Fig.2: Concept of the Investment case model from inputs, modelling, output

In conclusion, five recommendations were made to accelerate progress in oral health coverage:

(a) Achieving UHC for essential oral health care should be a top political priority.
(b) Data for planning is available, but there is a need to find and use it.
(c) The right intervention priorities need to be defined - less is more.
(d) Coverage needs to be increased -universal is universal, and an essential package should be accessible for everyone.
(e) Start simple - make the best use of existing resources and then initiate stepwise/modular improvement.

3. Roadmap

Based on the framework for the Regional Oral Health Strategy, discussion of successful case models, barriers and opportunities to the implementation of oral health programmes, updates to the global health agenda and disruptive thinking, each country in collaboration with staff from MoH and the WHO country office was to develop a national roadmap using the worksheet (ANNEX 2), considering the points below:

(a) Identify the form/scope of a supportive policy framework and the documents required
(b) Identify needs for the oral health plan/policy- prioritize the problems of oral diseases/health system in the country.
(c) Define the objectives of the plan/policy based on the prioritized problems and objectives of the Regional Oral Health Strategy.
(d) Define the targets of the plan/policy based on the problems, objectives and targets of the Regional Oral Health Strategy.
(e) Identify and list the key entry points for integrated action for oral disease prevention and control considering stage of life cycle, health topic/programme and delivery platform.
(f) Identify priority interventions based on objectives, key entry points and priority intervention listed in the Regional Oral Health Strategy.
(g) Identify and list key performance indicators for priority interventions.
(h) Plan how to strengthen the link between MoH and WHO country office to leverage required technical support.

All 20 countries made presentations on the roadmap. Below are the salient points of the session.

How to strengthen the link between MoH and WHO country office to leverage the required technical support

- The key is to have regular contacts between counterparts at MoH and WHO country office, ensure collaborative planning and implementation of planned activities, and assess progress. The wider scope of the WHO country officer allows for maximal outputs across various health departments and the strengthening of social relationships.

Oral health in all relevant policies

- Countries that gave presentations on policy and strategy on oral health must find out if oral health is reasonably included in policies and strategies.

Review of priority list of problems (oral cancer)

- Countries should consider oral cancer as well as dental caries, periodontal diseases, as this would serve as the best entry strategy to an NCD programme, and countries are encouraged to conduct research on cancer as the magnitude and extent of the problem might be underestimated.
- Chewable forms of tobacco cause oral cancers. Hence, there is a need to have strong country regulations on tobacco control.

Discussion on promoting access to healthcare by non-dental professionals, who are more accessible to the larger population in deprived and rural areas

- Health care services and specialists are deployed at urban health facilities and the majority of those living in rural areas have limited access to health care services. Under this situation, task shifting has benefited the majority of the population, hence the need to ensure that most people access basic health care through UHC.
- There is a need for an effective M&E framework to ensure that the scope of practice of trained cadres is within the agreed scope for public safety and ethics. Technology can be used to provide monitoring remotely through video conferencing and best practices have to be identified and scaled up.
- Professionals must have trust in the trained cadres and provide support as and when necessary.

Regional networking

- A subgroup of close countries (geographically, language) should be established to provide a network and support for one another (regional and subregional networking and collaboration).

4. Outcome Document, Closing Remarks and Next Steps

At the end of the workshop, participants agreed on an outcome document (ANNEX 3) which highlights the need for accelerated action in oral health and recommends specific actions to strengthen oral health care systems in countries, guided by the four priority action areas of the Regional Oral Health Strategy outlined below.

(a) To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach:

- Strengthen and formalize collaboration with key stakeholders from different sectors and disciplines.
- Foster political leadership for UHC with essential interventions for oral diseases and NCDs as key components.
- Increase budget allocations based on intervention costing and investment cases to enable improved population coverage.
- Actively support advocacy events in the context of global health events, for example, during the Seventy-second World Health Assembly (20–28 May 2019) or around the high-level meeting of the United Nations General Assembly on UHC (23 September 2019).

(b) To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides:

- Use fiscal measures through taxation of products with high content of sugars, alcohol and tobacco.
- Reduce or eliminate taxes and levies on oral health-promoting products such as fluoride toothpaste to increase access and affordability.

(c) To strengthen health system capacity for integrated prevention and control of oral diseases:

- Accelerate the development of essential oral care packages with evidence-based and cost-effective interventions ("Best Buys"), addressing the most common population needs.
- Ensure that essential oral care is universally accessible through delivery at primary care level.
- Align oral health workforce planning with NCD and other national health workforce planning frameworks, including developing skills and competencies, scopes of practice and professional regulations to enable effective delivery of quality services.
- Invest in health facility maintenance, Water and Sanitation and Hygiene (WASH) in health care settings and ensure availability and affordability of essential medicines and supplies including safe alternatives for dental amalgam.

(d) To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research:

- Encourage and promote the inclusion of the optional oral health module in ongoing and future national STEPS.
- Use all existing information sources (e.g., GBD, DHIS2, SARA, GSHS and MICS) to monitor and evaluate service coverage quality, outcomes and costs.
- Encourage application of oral health indicators comparable with other disease indicators, in addition to traditional oral disease-specific indicators.
- Support the definition of appropriate tracer indicators to monitor oral health care in UHC.

The workshop was officially closed by Dr Waogodo Joseph Cabore, DPM, who placed emphasis on the following points:

(i) The way forward is important, so the participants have to immediately clear, finalize and adopt the roadmap. The quality of work done should be ensured through peer review by sharing the roadmap with colleagues in other countries for inputs and comments.

(ii) Should there be financial challenges in implementing the roadmap, participants should be proactive and select quick wins entry points such as child and adolescent health.

(iii) Mid-term review report of the Regional Oral Health Strategy is expected to be submitted to the WHO Regional Committee next year, so participants should be active and hold regular meetings with WHO officers for implementation of the roadmap.

(iv) A teleconference/close follow-up should be organized in three months to report on progress and challenges encountered at country levels.

Annex 1: Regional Oral Health Strategy 2016-2025: Addressing oral diseases as part of NCDs (AFR/RC66/5)

Aim
• 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.
Objectives
• To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach. • To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides. • To strengthen health system capacity for integrated prevention and control of oral diseases. • To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.
Targets
• Halt the increase of dental caries in children and adolescents by 2025. • A 25% reductionofprematuremortalityfromoralcancerby2025. • At least 25% increase in population using fluoridated toothpaste for the prevention of tooth decay on a daily basis by 2025. • At least 50% of the population with expressed needs have access to oral health-care services by 2025. • At least 10% of primary health care facilities are able to provide safe basic oral health care by 2025.

Under each objective, there were listed priority interventions.

Objectives of the Regional Oral Health Strategy	**Priority interventions listed in the Regional Oral Health Strategy**
To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.	• 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. • Integrating oral health into all relevant policies and public health programmes, including policies related to NCDs. • 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. • 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. • 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.
To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.	• Participating in tobacco control, including e-cigarettes, and in actions against harmful alcohol consumption to prevent oral diseases, cancers and other health consequences. • 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. • 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. • 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. • 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. • Identifying, promoting and implementing appropriate fluoridation methods to ensure population-wide access to adequate levels of fluorides. • Encouraging legislation conducive to the production, importation, distribution, packaging, labeling, affordability and accessibility of quality fluoride toothpaste, including reduction or elimination of taxes on fluoridated toothpaste and other oral health products.
To strengthen health system capacity for integrated prevention and control of oral diseases.	• 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. • 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. • 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. • 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. • 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. • 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.

To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.	• Integrating systematic collection of oral health data into existing health information systems (HMIS) and into ongoing survey tools (STEPS, DHS, NCD Country Capacity Surveys, GSHS, etc.). • Generating quality data on oral health conditions and related risk factors through sentinel and population-based studies to support advocacy, planning and monitoring. • 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. • 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. • Supporting the development of tools, and best buys (cost-effective interventions) for the integrated prevention and management of oral diseases within NCD programmes.

Annex 2: National Roadmap for Implementation of the Regional Oral Health Strategy in the African Region 2016-2025

Q1: Identify form/scope of supportive policy framework and documents required

Please list existing oral health policy framework and document and its timeline *ex. Oral Health Policy (2017 to 2025), Oral Health Action Plan, Oral Health Components of the NCD action plan*
What kinds of form/scope of supportive policy framework and documents do you want to develop/update?

Q2: Identify needs for the oral health plan/policy

Please identify and prioritize the problems of oral diseases in your country.

Rank of prioritization (1-most problems to 6 or 7- least problems)	***Oral diseases***
	Dental caries

	Chronic periodontal disease
	Oral cancer
	Congenital abnormalities
	Noma
	Oral manifestation of HIV
	Oro-facial trauma
	Others: Please describe in detail *( )*

Please identify and prioritize the problems of health system in your country.

Rank of prioritization (1-most problems).	***Health system***
	Inadequate leadership for addressing oral diseases as part of NCDs
	Inadequate oral health information system
	Inadequate number/competency of oral health personnel
	Inadequate integration of oral health essential services into the primary care service

	Inadequate oral health financing mechanism
	Inadequate access to the essential oral health medicines and products
	Others: Please describe in detail *( )*

If you have any other important problems which should be prioritized in your country (ex. inadequate common risk factor control), please list below.

Q3: Define the objectives of your plan/policy

Please define the objectives of your plan/policy based on the problems (Refer Q2) and objectives of the Regional Oral Health Strategy.

The four objectives of the Regional Oral Health Strategy are;
(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.

List the objectives of your plan/policy

Q4: Define the targets of your plan/policy

Please define the targets of your plan/policy based on the problems (Refer Q2) and objectives (Refer Q3) and targets of the Regional Oral Health Strategy.

The five targets of the Regional Oral Health Strategy are;
(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.
(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.

List the targets of your plan/policy

Q5: Define key entry points for interventions/actions

Please identify and list the key entry points for integrated action for oral disease prevention and control considering Stage of life cycle, Health topic/programme, Delivery platform.

Stage of life cycle

ex. Newborn health, Child health, Adolescent health, Pregnant and child birth, Adults, Older people, Total population

Health topic/programme

ex. NCDs, Nutrition, HIV/AIDS, Adolescent health, Child health, Environmental health including water, sanitation and hygiene, Immunization, Neglected tropical diseases, Occupational health

Delivery platform

ex. Policy intervention at national and subnational levels, Community-based delivery platform, Healthy setting (ex. schools, cities), Periodic outreach programme/mobile programme, Out patients – primary care settings (health centre)

Please list the key entry points for integrated action for oral disease prevention and control.

Key entry points no.	*Stage of life cycle*	*Health topic/programme*	*Delivery platform*
1			
2			
3			
…			
…			
…			
…			

Q6: Identify prioritized interventions based on your objectives and key entry points

Please identify priority interventions based on your objectives (Refer Q3), key entry points (Refer Q5) and priority interventions listed in the Regional Oral Health Strategy (see below table).

Objectives of the Regional Oral Health Strategy	**Priority interventions listed in the Regional Oral Health Strategy**
(a) To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.	1.1 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. 1.2 Integrating oral health into all relevant policies and public health programmes, including policies related to NCDs. 1.3 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. 1.4 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.

	1.5 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.
(b) To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.	2. 1 Participating in tobacco control, including e-cigarettes, and in actions against harmful alcohol consumption to prevent oral diseases, cancers and other health consequences. 2.2 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. 2.3 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. 2.4 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. 2.5 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. 2.6 Identifying, promoting and implementing appropriate fluoridation methods to ensure population-wide access to adequate levels of fluorides.

	2.7 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.
(c) To strengthen health system capacity for integrated prevention and control of oral diseases.	3.1 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. 3.2 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. 3.3 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. 3.4 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. 3.5 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.

	3.6 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.
(d) To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.	4.1 Integrating systematic collection of oral health data into existing health information systems (HMIS) and into ongoing survey tools (STEPS, DHS, NCD Country Capacity Surveys, GSHS, etc.). 4.2 Generating quality data on oral health conditions and related risk factors through sentinel and population-based studies to support advocacy, planning and monitoring. 4.3 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. 4.4 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. 4.5 Supporting the development of tools, and best buys (cost-effective interventions) for the integrated prevention and management of oral diseases within NCD programmes.

Please list priority interventions.

Your objectives (Refer Q3)	Priority interventions

Q7: Indicators and targets to monitor implementation progress

Please identify and list key performance indicators for priority interventions (Refer Q6)

Your objectives (Refer Q3)	Identified priority interventions (Refer Q6)	Key performance indicator (KPI) for the interventions	Resource of KPI
Ex	Integrating systematic collection of oral health data into existing health information systems (HMIS) and into ongoing survey tools	At least one oral health indicator is integrated into the District Health Information System	DHIS 2

Q8: How to strengthen the link between MoH and WHO country office (WCO) to leverage required technical support

Please discuss and plan how to strengthen the link between MoH and WCO to leverage required technical support.

Next 3 months plan	**Next 6 months plan**	**Next 1 year plan**

Q9: Only for Benin, Burkina Faso, Niger, Nigeria and Senegal

How to improve noma action planning based on the noma evaluation recommendation

Based on the noma evaluation recommendations, please prioritize the recommendations and discuss and list how to improve those points.

Priority (which recommendations your country to prioritize)	**How to improve those points?**

Annex3: Outcome Document

Capacity Building Workshop to Accelerate Implementation of the Regional Oral Health Strategy 2016-2025: Addressing oral diseases as part of NCDs
Brazzaville, Congo, 27 February – 1 March 2019

Achieving Oral Health for All through Universal Health Coverage in the African Region – A Call for Action

In August 2016, the Sixty-sixth WHO Regional Committee for Africa[1] endorsed a resolution (AFR/RC66/R1) and a strategy entitled *Regional oral health strategy 2016–2025: addressing oral diseases as part of noncommunicable diseases*[2] (AFR/RC66/5). This high-level commitment calls for better prioritization of oral health as part of *the Global Action Plan for the Prevention and Control of NCDs 2013-2020*.

Chief dental officers from ministries of health, NCD focal points from WHO country offices in 20 Member States,[3] experts from the WHO Collaborating Centre at NYU College of Dentistry, AOI,[4] Hilfsaktion Noma e.V. and non-State actors in official relations with WHO; IADR[5] and FDI,[6] from 27 February to 1 March 2019 attended the capacity building workshop to accelerate implementation of the Regional oral health strategy, convened by the WHO Regional Office for Africa (AFRO) in Brazzaville, Congo. The main objective of the meeting was to agree on top priority actions for integrated prevention and control of oral diseases as part of NCDs and UHC,[7] mindful of progress made by countries in the Region and guided by the Regional Oral Health Strategy.

The workshop programme included sharing of country achievements, expert input and partner contributions covering a broad range of policy aspects, implementation challenges and opportunities, as well as global developments relevant to country implementation and monitoring, such as the Minamata Convention on Mercury.[a] Over the course of the deliberations, participants and invited experts acknowledged the overall progress made in the oral health agenda. They expressed concern over existing gaps in policy intentions and implementation. Notably, progress towards achieving UHC, including essential oral health care, remains slow. Furthermore, the continuing public health challenge of noma in several countries of the Region was highlighted. Improved multisectoral collaboration, political leadership and commitment, community involvement and ownership, and appropriate budget allocations for sustainability were identified as crucial elements necessary for accelerated action.

The workshop explored and identified cost-effective mechanisms for delivery of essential oral health care, including the WHO PEN[8] and other fiscal and policy recommendations in the WHO "best buys".[9] National road maps corresponding to the respective national contexts were developed to accelerate implementation of the Regional Oral Health Strategy. In addition, specific actions were recommended to strengthen oral health care systems in countries, guided by the four priority action areas of the Regional Oral Health Strategy, which are:

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[a] The Minamata Convention on Mercury. Text and annexes http://www.mercuryconvention.org/Convention/Text/tabid/3426/language/en-US/Default.aspx

(a) To strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach:

- Strengthen and formalize collaboration with key stakeholders from different sectors and disciplines.
- Foster political leadership for UHC with essential interventions for oral diseases and NCDs as key components.
- Increase budget allocations based on intervention costing and investment cases to enable improved population coverage.
- Actively support advocacy events in the context of global health events, for example, during the Seventy-second World Health Assembly (20–28 May 2019) or around the high-level meeting of the United Nations General Assembly on universal health coverage (23 September 2019).

(b) To reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides:

- Use fiscal measures through taxation of products with high content of sugars, alcohol and tobacco.
- Reduce or eliminate taxes and levies on oral health-promoting products such as fluoride toothpaste to increase access and affordability.

(c) To strengthen health system capacity for integrated prevention and control of oral diseases:

- Accelerate the development of essential oral care packages with evidence-based and cost-effective interventions ("best buys"), addressing the most common population needs.
- Ensure that essential oral care is universally accessible through delivery at primary care level.
- Align oral health workforce planning with NCD and other national health workforce planning frameworks, including developing skills and competencies, scopes of practice and professional regulations to enable effective delivery of quality services.
- Invest in health facility maintenance, WASH[10] in health care settings and ensure availability and affordability of essential medicines and supplies including safe alternatives for dental amalgam.

(d) To improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research:

- Encourage and promote the inclusion of the optional Oral Health module in ongoing and future national STEPS.[11]
- Use all existing information sources (e.g., GBD,[12] DHIS2,[13] SARA,[14] GSHS,[15] MICS)[16] to monitor and evaluate service coverage quality, outcomes and costs.
- Encourage application of oral health indicators comparable with other disease indicators in addition to traditional oral disease-specific indicators.
- Support the definition of appropriate tracer indicators to monitor oral health care in UHC.

Country participants welcomed WHO's leadership and the guidance provided through the Regional Oral Health Strategy 2016 – 2025. They requested all three levels of WHO to:

- Advocate for increased political commitment at the highest level to address oral health as part of NCDs and related risk factors as well as integrate oral health within UHC in line with WHO's Thirteenth General Programme of Work.
- Provide guidance and resources to assist Member States to fully meet the recommendations of the Regional Oral Health Strategy.
- Support and facilitate regional networks for information sharing among stakeholders to foster integration of oral health within NCDs.
- Develop a mid-term progress report of the Regional Oral Health Strategy by 2020.

Partner organizations and WHO Collaborating Centres were requested to:

- Support country adaptation of the Regional Oral Health Strategy, including action against noma in affected countries.
- Support the development of "best buys" for oral health and related aspects required for full integration of essential oral care in UHC, including improved costing and investment case models.
- Disseminate WHO guidance and resources to civil society organizations including professional associations.

Signed by the participants in Brazzaville, Congo, on 1 March 2019

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1. Sixty-sixth WHO Regional Committee for Africa, Addis Ababa, 19-23 August 2016
2. NCDs: noncommunicable diseases
3. Algeria, Benin, Botswana, Burkina Faso, Eswatini, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Niger, Senegal, South Africa, United Republic of Tanzania, Uganda
4. AOI: Aide Odontologique Internationale
5. IADR: International Association for Dental Research
6. FDI: World Dental Federation
7. UHC: universal health coverage
8. WHO PEN: WHO Package of Essential Noncommunicable Disease Interventions
9. "Best buys" and other recommended interventions for the prevention and control of noncommunicable diseases based on an update of Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs 2013–2020
10. WASH: Water, Sanitation and Hygiene
11. STEPS: STEPwise approach to surveillance
12. GBD: Global Burden of Disease
13. DHIS2: District Health Information System version 2
14. SARA: Service Availability and Readiness Assessment
15. GSHS: Global school-based student health survey
16. MICS: Multiple Indicator Cluster Survey

Annex4: List of Participants

No.	Name	Organization	Country
1	Dr Farida Saibi	MoH	Algeria
2	Dr Jean Guy Adjalla	MoH	Benin
3	Dr Raoul Saisonou	WHO Benin	
4	Ms Mildred Masiga	MoH	Botswana
5	Dr Moagi Gaborone	WHO Botswana	
6	Dr Rose Drabo	MoH	Burkina Faso
7	Mr Zougrana Tiga Pascal		
8	Dr Makhosazana Mabuza	MoH	eSwatini
9	Ms Bawinile Mdziniso	WHO eSwatini	
10	Dr Asmamaw Workeneh	WHO Ethiopia	Ethiopia
11	Dr Maxewell Adjei	MoH	Ghana
12	Mrs Akosua Kwakye	WHO Ghana	
13	Dr Miriam Wamotho Muriiti	MoH	Kenya
14	Dr Joyce Nato	WHO Kenya	
15	Dr Eva Barijaona	MoH	Madagascar
16	Dr Martha Chipanda		Malawi
17	Dr Mohameden Abdallahi		Mauritania
18	Dr Saidou Niang	WHO Mauritania	
19	Dr Basti Risi Kinnoo	MoH	Mauritius
20	Mrs Vinoda Pitchamootoo Vythelingam	WHO Maurituis	
21	Dr Amalia Issufo Mepatia	MoH	Mozambique
22	Dr Celeste Moreira Amado		
23	Mr Chriiatian Tjingovera John	MoH	Namibia
24	Dr Celia Kaunatjike	WHO Namibia	
25	Dr Bola Alonge	MoH	Nigeria
26	Dr Mary Dewan	WHO Nigeria	
27	Dr Assoumane Baye	MoH	Niger
28	Dr Codou Badiane Mane	MoH	Senegal
29	Dr Mady Ba	WHO Senegal	
30	Dr Mcuba Mzimkhuludr	MoH	South Africa

31	Mr Eugene Mahlehla	WHO South Africa	
32	Dr Semeni Shaban Mohamed	MoH	Tanzania
33	Dr Ray Masumo		
34	Dr Alphoncina Nanai	WHO Tanzania	
35	Dr Juliet Nabbanja Katumba	MoH	Uganda
36	Dr Benoit Varenne	WHO HQ	Switzerland
37	Mrs Gahore Live Vanina	WHO AFRO	Republic of Congo
38	Dr Prebo Brango	WHO AFRO	Republic of Congo
39	Dr Grace Kabaniha	WHO AFRO	Republic of Congo
40	Mrs Bikounda Yvonne Nadia	WHO AFRO	Republic of Congo
41	Dr Yuka Makino	WHO HQ/AFRO	Switzerland/Republic of Congo
42	Dr Habib Benzian	WHO CC New York University	USA
43	Mr Mathis Winkler	Hilfsaktion Noma e.V.	Germany
44	Dr Margaret Wandera	International Association for Dental Research	Uganda
45	Dr Olabode Ijarogbe	World Dental Federation	Nigeria

ANNEX 5: AGENDA

DAY 1: Wednesday, 27 February 2019 Chair: Kenya (Ministry of Health (MoH), WHO Country Office (WCO)) Rapporteur: Namibia (MoH, WCO)		
Time	**Agenda**	**Responsible**
08:00 - 09:00	Reception and registration of participants	**WHO Secretariat**
Session 1. 09:00 - 09:30	**Official opening of the workshop**	**WHO Secretariat**
'	• Welcome remarks by Dr Waogodo Joseph Cabore, Director Programme Management, WHO AFRO • Speech by Mr Mathis Winkler, Head of Projects, Hilfsaktion Noma e.V. • Group photo	
09:30 - 10:00	**Healthy break**	
Session 2. 10:00 - 11:00	**Objectives and working methodology**	**WHO Secretariat**
	• Introduction of participants, reminder, objectives, expected results and schedule • Administrative information and safety briefing (10:30 to 10:45) • Each participant to write 3 points which should be achieved during the workshop	Dr Yuka Makino (WHO HQ/AFRO) WHO security team (WHO AFRO)
Session 3. 11:00-12:00	**The Regional Oral Health Strategy – introduction and overview**	**WHO Secretariat**

	Presentation and Q & A	Dr Benoit Varenne (WHO HQ)
12:00 - 13:30	**Lunch break**	
Session 4. **13:30 - 15:30**	**Country presentation – 6 case studies based on priority areas of the Regional Oral Health Strategy and Noma control**	**Member States**
	• Strengthen oral health as part of NCDs through a multisectoral approach: Tanzania • Implement common risk factors approach including better access to fluoride (Madagascar: Fluoride legislation) (South Africa: NCDs common risk factors approach including sugars tax) • Strengthen health system capacity towards Universal Coverage: Mauritius • Integrate surveillance of oral diseases (DHIS2, STEPS): Senegal • Noma prevention & control: Niger (Each country, maximum 15 mins presentation and 5 mins Q & A)	
15:30 - 15:40	**Healthy break**	
Session 5. **15:40 - 16:40**	**Presentations by partners**	**Experts and Partners**

	Each donor, partner can address how to support countries: • IADR • FDI • WHO Collaborating Centre New York University • Hilfsaktion Noma e.V. • AOI (Each organization, maximum 8 mins presentation and 2 mins Q & A)	Dr Margaret Wandera (IADR) Dr Olabode Ijarogbe (FDI) Prof Habib Benzian (WHO CC New York University) Mr Mathis Winkler (Hilfsaktion Noma e.V.)
16:40 - 16:50	**Wrap-up of day 1 - programme day 2**	**WHO Secretariat**
Dinner in Town		

DAY 2: Thursday, 28 February, 2019 Chair: Burkina Faso (MoH, WCO) Rapporteur: Benin (MoH, WCO)		
Time	**Agenda**	**Responsible**
Session 6. 08:30 - 11:00	**Sharing of experiences: Accelerating action aligned with the Regional Oral Health Strategy**	**WHO Secretariat, Member States, Experts**
08:30 - 09:50	• Knowledge sharing among Member States – countries with a national oral health policy/action plan share experiences with countries that do not yet have a policy/action plan (six tables/groups) • Table host (facilitator and rapporteur): Mauritania, Benin, Senegal, Botswana, Ethiopia, Ghana	Facilitators: WHO Secretariat and Experts 6 groups, World Café Style
09:50 – 10:10	**Healthy break**	
10:10 – 11:00	• Plenary discussion and sharing of World Café results (Each group, maximum 6 mins presentation and 2 mins Q and A)	6 groups
Session 7. 11:00 - 12:00	**Updates on developments in global health: UHC, NCDs, Resource mobilization**	**WHO Secretariat, Experts**

	Each speaker present: • Current initiatives in their area of work • Opportunity how to integrate oral health (Each presentation, maximum 15 mins presentation and 5 mins Q & A)	Dr Prebo Barango (WHO AFRO NCDs) Dr Grace Kabaniha (WHO AFRO Health System) Ms. Live Vanina Gahore (WHO AFRO Resource Mobilization)
12:00 – 13:00	**Lunch break**	
Session 8. 13:00 - 14:30	**Current Oral Health Initiatives, Disruptive innovation**	**WHO Secretariat, Experts**
	• Presentation of ongoing projects/global oral health initiatives by the WHO Oral Health Programme (mOral Health, Minamata Convention) (15 mins presentation and 5 mins Q &A) • Preliminary presentation and discussion about "disruptive innovation"- technology, health, Silver Diamine Fluoride, Sugars legislation, Best Buys - anything that breaks with the current traditional planning and intervention mindset.	Dr Benoit Varenne (WHO HQ) Dr Habib Benzian (WHO CC NYU)

Session 9. 14:30 – 17:30	Development of the National Roadmap for Implementation of the Regional Oral Health Strategy	WHO Secretariat, Member States, Experts
14:30 - 15:00	• A national roadmap to accelerate action aligned with the Regional Oral Health Strategy including; – Using existing policy frameworks or creating additional ones? – Potential entry points to accelerate national action aligned with the regional strategy (WASH, School Health?)	Dr Yuka Makino (WHO HQ/AFRO)
15:00 – 15:30	**Healthy break**	

15:30-17:30	Group work - each country group to identify: • Form/scope of supportive policy framework and documents required • Key entry points for integrated action • Prioritized interventions aligned with the four priority areas of the Regional Oral Health Strategy • Indicators and targets to monitor implementation progress • How to strengthen the link between MoH and WCO and leverage required technical support	Noma priority countries (Benin, Burkina Faso, Niger, Nigeria and Senegal) 15:30-16:00: Provide key recommendations from the noma evaluation 16:00-17:30: Group work - each country group to identify: • Form/scope of supportive policy framework and documents required • Key entry points for integrated action • Prioritized interventions aligned with the four priority areas of the Regional Oral Health Strategy • Indicators and targets to monitor implementation progress • How to strengthen the link between MoH and WCO and leverage required technical support • How to integrate noma in oral health/NCD action planning?	Facilitators: WHO Secretariat and Experts 20 groups by each country
17:30-17:45	**Wrap-up of day 2 - programme day 3**		**WHO Secretariat**

DAY 3: Friday, 1 March 2019 Chair: Nigeria (MoH, WCO) Rapporteur: eSwatini (MoH, WCO)		
Time	**Agenda**	**Responsible**
Session 10. 08:30 - 09:30	**Development of the National Roadmap for Implementation of the Regional Oral Health Strategy**	**WHO Secretariat, Member States, Experts**
	Group work - each country group to identify: • Form/scope of supportive policy framework and documents required • Key entry points for integrated action • Prioritized interventions aligned with the four priority areas of the Regional Oral Health Strategy • Indicators and targets to monitor implementation progress • How to strengthen the link between MoH and WCO and leverage required technical support • For noma priority countries: how to integrate noma in oral health/NCD action planning?	Facilitators: WHO Secretariat and Experts 20 groups by each country
Session 11. 09:30 - 10:30	**Outcome document of the meeting**	**WHO Secretariat, Member States, Experts**
	Discussion of a consensus document and possible recommendations from the meeting	

10:30 - 10:40	**Healthy break**	
Session 12. **10:40 - 12:30**	**Presentation on the draft national roadmap 1**	**Member States**
	8 countries present their draft national roadmap: Algeria, Benin, Burkina Faso, Madagascar, Mauritania, Mozambique, Niger, Senegal, (each country, maximum 10 mins presentation including Q & A)	
12:30 - 13:30	**Lunch break**	
Session 12. **13:30 - 16:00**	**Presentation on the draft national roadmap 2**	**Member States**
	12 countries present their draft national roadmap: Botswana, eSwatini, Ethiopia, Ghana, Kenya, Malawi, Mauritius, Namibia, Nigeria, South Africa, Tanzania, Uganda (each country, maximum 10 mins presentation including Q & A)	
Session 13. **16:00 - 16:30**	**Closing session**	**WHO Secretariat**
	• Plenary approval of the outcome document • Next steps and timelines • Closing remarks by Acting Director of NCDs cluster, WHO AFRO	

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