

MID-TERM PROGRESS REPORT

on the implementation of the Regional oral
health strategy 2016 –2025: Addressing oral
diseases as part of noncommunicable diseases
in the WHO African Region



World Health
Organization

African Region

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**World Health Organization
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Contents

Acknowledgements	iv
Abbreviations	v
Executive summary	vii
1. Background	1
2. Purpose of the assessment	2
3. Methodology of the assessment	3
4. Results	4
4.1 Status of implementation of the Regional strategy against each objective	4
4.2 Challenges and opportunities	14
5. Discussion	16
6. Strengths and limitations of the assessment of the Regional oral health strategy	20
7. Future priority activities and recommended actions	21
8. Conclusion	23
9. References	24
Annex. The Regional Oral Health Strategy 2016-2025 in the WHO African Region Mid-term Assessment - Online Questionnaire Survey	26

List of figures

Figure 1 Existence of oral health unit, dedicated staff for oral health in MoH in all Member States	4
Figure 2 Sources of funding for oral health activities in all Member States	6
Figure 3 Participation of oral health unit or dedicated officers working in oral health in national programmes to reduce common NCD risk factors in 42 Member States	8
Figure 4 Oral health unit or dedicated officer working in oral health that participated in advocating the regulation and/or banning of the sale and advertisement of unhealthy products in 42 Member States	9
Figure 5 Situation of integration of oral health into school health interventions among all Member States	9
Figure 6 Situation of fluoride toothpaste promotion among all Member States	11
Figure 7 Situation of oral health service payment among selected Member States	11
Figure 8 Proportion of Member States that integrated oral health indicators into the existing integrated surveillance system	13

List of tables

Table 1 Summary of the existence of a policy document related to oral health in all Member States	5
Table 2 List of Member States with the defined competencies for non-oral health professionals for task shifting	12

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Abbreviations

AFRO	WHO Regional Office for Africa
CHW	community health worker
CSO	civil society organization
DHIS2	District Health Information System 2
GSHS	global school-based student health survey
HMIS	Health Management Information System
IDSR	Integrated Disease Surveillance and Response
M&E	monitoring and evaluation
MS	Member State
MoH	Ministry of Health
NCD	noncommunicable disease
PHC	primary health care
RC	Regional Committee
SDGs	Sustainable Development Goals
STEPS	STEPwise approach to NCD risk factor surveillance
TAG	technical advisory group
UHC	universal health coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VAT	value added tax
WASH	water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization
WHO NCD CCS	WHO Noncommunicable Disease Country Capacity Survey



Executive summary

The Regional oral health strategy 2016–2025: addressing oral diseases as part of noncommunicable diseases (NCDs) was endorsed in 2016. The strategy supports Member States in prioritizing oral health through integrating oral diseases into NCD prevention and control programmes in the context of universal health coverage (UHC).

The strategy sets 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, promote oral health, and ensure access to appropriate fluorides; (c) to strengthen health system capacity for integrated prevention and control of oral diseases; and (d) to improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.

This mid-term progress report describes the status of implementation of the strategy using the results of the survey of all 47 Member States, which assessed the status of implementation of the priority interventions under each objective.

National leadership on oral health was assessed using indicators related to oral health governance structures within the ministries of health. Oral health units were reported in 38 Member States, of which 20 were under the NCD unit. In six Member States, the oral health unit was part of the national multisectoral NCD mechanism overseeing NCD engagement beyond the health sector. Seventeen Member States had at least one oral health policy document. Additionally, 17 Member States had incorporated the oral health agenda into general health policy documents including national health and NCD policies. While Member States advocated increased investment in oral health, nine Member States reported no funds for oral health interventions.

To reduce common risk factors for oral diseases and other NCDs, the oral health units and/or dedicated oral health officers contributed to the national tobacco control programme in 20 Member States,

and to promoting healthy diet in 26 Member States. Moreover, 39 Member States improved access to fluoride toothpaste and promoted its utilization by the populations. However, it is difficult to measure how these interventions have contributed to reducing common risk factors, while it is equally difficult to assess the coverage of the population using fluoride toothpaste as there are not enough resources to put appropriate surveillance systems in place.

In terms of health system strengthening, 28 Member States included oral health services into their essential health packages. About half of Member States delivered essential oral health services without any financial protection mechanism for patients. Despite low numbers of skilled oral health workforce (the regional average of 3.3 dentists per 100 000 population between 2014 and 2019), representing about one-tenth of the global average ratio; only 11 Member States had a plan for task shifting oral health services to non-oral health professionals.

Regarding surveillance and monitoring systems, 31 Member States integrated oral health indicators into existing integrated surveillance systems such as the District Health Information System 2 (DHIS2) and the WHO STEPwise approach to NCD risk factor surveillance. Only nine of the 17 Member States that reported having an oral health policy document established a monitoring system to track progress.

While some positive aspects were observed in the implementation of the Regional strategy, it was difficult to measure progress due to the lack of baseline data and of a monitoring framework. Moreover, the lack of political commitment, policies, resources, and data, delayed the acceleration of the oral health agenda. The COVID-19 pandemic also disrupted oral health services.

Despite these challenges, several opportunities exist to build the momentum around the oral health agenda, including the WHO resolution on oral health adopted at the Seventy-fourth session of the World Health Assembly in 2021, which requested the WHO

Secretariat to develop a global strategy on oral health in consultation with Member States by 2022 and its action plan with a monitoring framework to be developed by 2023. Such global initiatives can be leveraged to increase political commitment and strengthen the implementation of the Regional strategy.

The following actions are proposed to accelerate the implementation of the Regional strategy:

Member States to:

- (a) Strengthen political commitment to address oral health as part of NCDs and UHC by leveraging regional and global strategies;
- (b) Allocate adequate resources to implement national oral health policies focusing on key priority areas defined on the basis of the lessons learnt from this mid-term assessment;

- (c) Foster integrated, cost-effective oral health services and surveillance, relying on efficient workforce models as part of health system strengthening.

WHO to:

- (a) Develop an integrated monitoring framework for the Regional strategy that is aligned with the forthcoming global monitoring framework for the global oral health action plan towards 2030;
- (b) Consider the extension of the Regional strategy to align it with the duration of the global strategy;
- (c) Provide guidance and tools to Member States to build capacity and mobilize resources to support the development and implementation of national oral health strategies and plans.

1. Background

The World Health Organization (WHO) defines oral health as the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential [1].

Oral diseases are among the most common noncommunicable diseases (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 WHO African Region mainly include dental caries, periodontal disease, oral cancer, orofacial trauma, oral manifestations of HIV infection, birth defects, and noma [2].

Around 45% of the population in the WHO African Region was estimated to suffer from oral diseases in 2016 without notable improvements in the previous 25 years [3]. The burden of oral diseases reflects significant inequalities, with marginalized populations disproportionately impacted. For example, noma is a disease that destroys the mouth and face of mostly young children. If left untreated, it is fatal in 90% of cases. A marker of extreme poverty, it is primarily found in Sub-Saharan Africa [4]. Despite efforts to improve the oral health situation in countries, siloed and vertical approaches, rather than integrated, cost-effective strategies remained the standard over recent decades.

Oral diseases share common risk factors with NCDs, as recognized in the Political Declaration of the United Nations General Assembly High-level Meeting on the Prevention and Control of NCDs in 2011 [5]. This provides a unique opportunity to integrate oral diseases into NCD prevention and control programmes and prioritize oral health in the context of NCDs.

To this end, the *Regional oral health strategy 2016–2025: addressing oral diseases as part of NCDs* was endorsed by Member States during the Sixty-sixth session of the Regional Committee (RC) for Africa in 2016. This strategy has provided Member States with a basis for developing coherent national plans on oral health and aligning them with the implementation of the Global Action Plan for the Prevention and Control of NCDs 2013–2030 in the Region moving toward universal health coverage (UHC) [2].

The overall aim of the 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 UHC.

The strategy proposes five targets:

- (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 care facilities are able to provide safe basic oral health care by 2025.

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, promote oral health, and ensure 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.

Under each objective, the strategy provides a set of priority interventions.

2. Purpose of the assessment

Member States agreed to submit a mid-term progress report on the strategy at RC70 (2020) as part of the monitoring and evaluation (M&E) of the strategy's implementation. As the Secretariat of the Member States, the WHO Regional Office for Africa (AFRO) has the responsibility of assessing

and reporting on the progress of the oral health situation and implementation of the strategy in a timely manner, identifying gaps and challenges; and prioritizing activities and recommendations in relation to the end of the strategy in 2025.

3. Methodology of the assessment

In line with the AFRO's evaluation guidance [6], the assessment followed a participatory approach by engaging with stakeholders at all stages of the assessment process (design, data collection, analysis and interpretation of the findings). Moreover, as the implementation of the strategy relies on Member States, WHO and partners, their respective perspectives were considered in this assessment.

The key assessment questions were:

- What progress has been made in implementing the strategy, especially in terms of its objectives and priority interventions?
- What are the gaps and challenges in the implementation of the strategy?
- What are the future priority activities, monitoring indicators, and recommended actions towards the end of the strategy in 2025?

Since the Regional strategy did not have an M&E framework nor any baseline information, a questionnaire was developed based on the priority interventions under each objective, aiming to assess the implementation status of the strategy in the 47 Member States of the WHO African Region (Annex). An informal technical advisory group (TAG)¹ supported the process that included a pilot test with selected Member State representatives prior to the main data collection exercise.

In addition to quantitative questions, the questionnaire included open-ended questions to understand (1) the opportunities and challenges in the implementation of the strategy at the country level, and (2) countries' requests to WHO to accelerate the implementation of the strategy at the country level.

Data Collection

- Data were collected using an online questionnaire administered through a web-based platform (RedCap) between 24 August and 23 October 2021. Respondents were oral health focal points, mainly chief dental officers,

relevant staff members from the ministry of health (MoH) or NCD focal points or relevant staff members from the WHO country offices in the 47 Member States. Most Member States had more than one respondent to complete the survey as some sections were specialized and required the expertise of different officials.

Data quality and validation

- The RedCap software is the data collection tool used and it has built-in internal validation processes during data entry. Some Member States completed the survey offline due to several reasons (notably internet connectivity), using a Microsoft Word version of the questionnaire. The offline versions of the questionnaire were manually checked for completion and validity.
- The questionnaire was then scanned for errors and inconsistencies.
- Each respondent was requested to provide supporting documents (such as policy documents) to allow for verification and validation of their responses. When discrepancies occurred between entries the country response and the documents provided, the respondent was contacted directly for clarification, and the responses were updated accordingly.

Data analysis

- The data were downloaded from the web-based platform to an Excel-readable file. Data cleaning was performed by AFRO to ensure the consistency of responses within a question and its sub-questions. All statistical analyses were carried out using IBM SPSS Statistics.²
- For all analyses, the denominator used was the total number of responses received for that particular question. Therefore, although the total sample is 47, some responses had a smaller denominator due to incomplete responses. In addition, some questions were analysed within a subgroup, thus also leading to a smaller denominator.

¹ The TAG comprises a number of experts who have provided advice on the assessment methodology, indicators, data collection tools, results and recommendations. The work with the TAG was virtual, conducted through the Zoom platform and emails. The TAG met online once during the assessment and focused on the methodology and data collection tools.

² IBM Corp. Released 2020. IBM Statistical Package of Social Sciences (SPSS) Statistics for Windows, Version 27.0. Armonk, NY: IBM Corp

4. Results

4.1 Status of implementation of the Regional strategy against each objective

The response rate for the questionnaire was 100%. All 47 Member States responded to the questionnaire. Below is a summary of the status of implementation against pre-defined priority interventions under each objective.

Objective 1: 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 MoH, and functional multisectoral coordination with other government sectors and ministries.*

More than 80% of the Member States reported having an oral health unit, division, department, or directorate. Out of the remaining nine Member States without the oral health structure in the MoH, Algeria, Comoros, Liberia, and Malawi reported having a dedicated officer for oral health, and Burundi, Eswatini, Gambia, Rwanda, and South Sudan did not have a dedicated officer (see Figure 1).

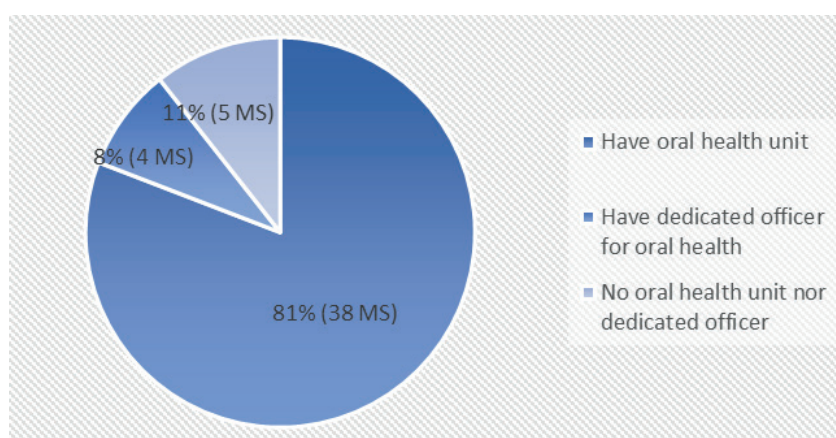
In the twenty Member States³ that reported having an oral health unit, this was under the NCD division, department or directorate within the MoH organizational structure. Furthermore, out of these 20 Member States, 10 Member States⁴ had a national NCD multisectoral commission, agency or mechanism that oversees NCD engagement, policy coherence and accountability of sectors beyond health. For six of them⁵, the oral health unit was part of the national NCD multisectoral commission, agency or mechanism.

Of the remaining 18 Member States whose oral health unit was not under the NCD unit, 10 Member States⁶ worked closely with the NCD unit.

Of the four Member States including Algeria, Comoros, Liberia, and Malawi with no oral health unit but a dedicated officer for oral health, Comoros and Liberia had officers who were members of the national NCD multisectoral commission, agency or mechanism.

(b) *Integrating oral health into all relevant policies and public health programmes, including policies related to NCDs.*

Figure 1 : Existence of oral health unit, dedicated staff for oral health in MoH in all Member States



3 Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Guinea, Guinea-Bissau, Madagascar, Mali, Niger, Sao Tome and Principe, Sierra Leone, Togo, and United Republic of Tanzania.

4 Benin, Cameroon, Chad, Congo, Equatorial Guinea, Eritrea, Guinea, Sierra Leone, Togo, and United Republic of Tanzania.

5 Benin, Equatorial Guinea, Eritrea, Guinea, Sierra Leone, and Togo.

6 Cabo Verde, Lesotho, Mauritania, Mauritius, Nigeria, Seychelles, South Africa, Uganda, Zambia, and Zimbabwe.

Seventeen⁷ out of the 47 Member States reported having at least one oral health-focused policy document. Expired policy documents were included in this analysis because expired documents were still in use to guide implementation in some Member States. The document could either be an oral health policy, oral health strategy or oral health action plan. Due to the fluidity in the definitions of policy, strategy, and plan, we have considered the existence of any of these as evidence of an official government guidance document.

In the near future, these numbers are expected to increase as 15 Member States⁸ reported having draft oral health-focused policy documents (policy, strategy or action plan). It is important to note that Equatorial Guinea, Mali, South Africa, and Zambia

among these 15 Member States had operational and/or expired oral health policy documents as described above, in addition to their engagement in drafting new documents.

Seventeen Member States⁹ incorporated oral health issues into other general health-related government policy documents including national health development plans or NCD policies.

In summary, more than 50% of Member States¹⁰ had either an oral health-focused document or had incorporated oral health into other general health documents including national health or NCD policies.¹¹ (see Table 1)

Table 1: Summary of the existence of a policy document related to oral health in all Member States

Existence of a policy document related to oral health	No. of Member States (%)	List of Member States
At least one operational or expired oral health-focused policy document	17 (36.2%)	Cameroon, Chad, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Guinea, Madagascar, Mali, Mauritius, Namibia, Niger, Rwanda, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.
Draft oral health-focused policy document	15 (31.9%)	Algeria, Botswana, Cabo Verde, Côte d'Ivoire, Equatorial Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Senegal, South Africa, Zambia, and Zimbabwe.
Oral health issues in-corporated into other general health-related government policy documents including national health development plans or NCD policies.	17 (36.2%)	Benin, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, Madagascar, Mauritius, Niger, Nigeria, South Africa, South Sudan, Togo, and Zambia.

7 Cameroon, Chad, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Guinea, Madagascar, Mali, Mauritius, Namibia, Niger, Rwanda, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.

8 Algeria, Botswana, Cabo Verde, Côte d'Ivoire, Equatorial Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Senegal, South Africa, Zambia, and Zimbabwe.

9 Benin, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, Madagascar, Mauritius, Niger, Nigeria, South Africa, South Sudan, Togo, and Zambia.

10 Benin, Burkina Faso, Cabo Verde, Cameroon, Chad, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, and Zambia

11 This does not include draft documents.

Regarding integration of oral health into public health programmes, 23 Member States¹² reported that oral health interventions were integrated into existing public health programmes such as school health, maternal and child health, healthy ageing, nutrition, NCDs, and integrated health service delivery programmes.

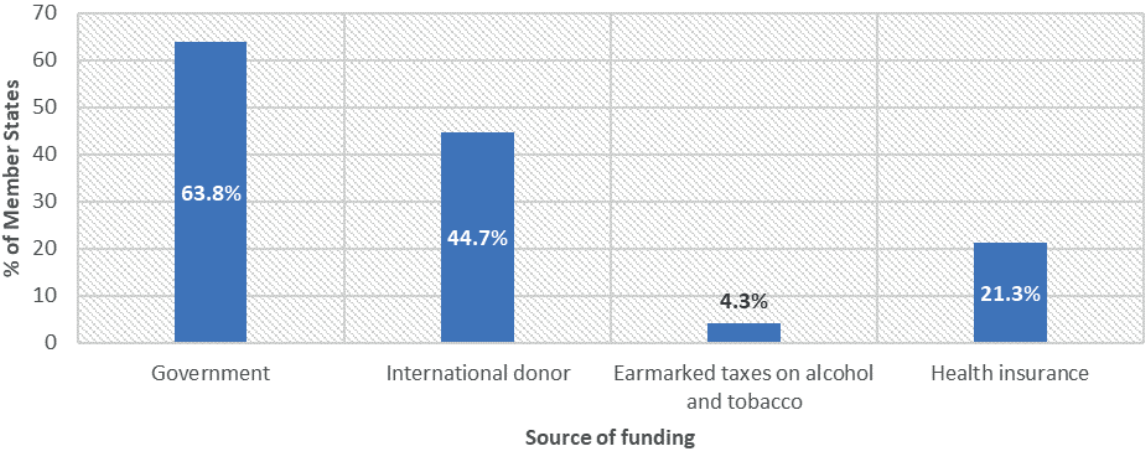
(c) Advocating increased social, political and resource commitment to oral health in the context of NCDs through raising awareness and targeted communication with decision-makers, the media and the public, including the involvement of opinion leaders as champions and ambassadors to the cause.

More than half of the Member States reported advocating increased commitment to oral health in the context of NCDs (28 MS¹³/47 MS).

Since the endorsement of the Regional oral health strategy in 2016, Eritrea, Guinea, Nigeria, and Togo reported having passed or ratified a law related to oral health. Eleven Member States¹⁴ increased the financial resources allocated to oral health since the strategy's endorsement.

Out of the 47 Member States, 30 Member States¹⁵ reported receiving funds to conduct oral health activities from government sources, 21 Member States¹⁶ from international donors, South Africa and Zimbabwe from earmarked taxes on alcohol and tobacco and 10 Member States¹⁷ from health insurance (see Figure 2). Nine Member States¹⁸ reported receiving no funds for oral health activities.

Figure 2: Sources of funding for oral health activities in all Member States



(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.

12 Cabo Verde, Chad, Comoros, Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Guinea, Kenya, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.
 13 Angola, Burkina Faso, Cabo Verde, Central African Republic, Chad, Equatorial Guinea, Eritrea, Ethiopia, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Togo, United Republic of Tanzania, Zambia, and Zimbabwe.
 14 Cabo Verde, Eritrea, Gambia, Guinea, Lesotho, Mauritius, Rwanda, Seychelles, South Africa, Zambia, and Zimbabwe.
 15 Algeria, Botswana, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Eritrea, Eswatini, Gambia, Guinea, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.
 16 Angola, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Guinea, Guinea-Bissau, Kenya, Liberia, Mauritania, Mauritius, Niger, Sao Tome and Principe, Senegal, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.
 17 Algeria, Democratic Republic of the Congo, Gabon, Guinea, Liberia, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.
 18 Angola, Burundi, Cameroon, Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana and South Sudan.

Member States established collaboration with donor agencies and developmental partners, including WHO, and United Nations Children's Fund (UNICEF) (20 MS¹⁹/47 MS), civil society organizations (CSOs) such as national dental associations (22 MS²⁰/47 MS), and the private sector (10 MS²¹/47 MS).

(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 diseases and provision of oral health care.

Some Member States have a mechanism in place to ensure the participation and/or empowerment of the community and/or civil society in the promotion of oral health, prevention of oral diseases or provision of oral health care (14 MS²²/47 MS). Member States reported using the following types of mechanisms: empowerment of village and community health workers (CHW), for example, by including an oral health module in the CHW training manual; community awareness and outreach campaigns; school oral health services; empowerment of teachers and students on school campuses; development of school oral health clubs; and media engagement.

Out of the 14 Member States with a mechanism in place to ensure the participation of the community and/or civil society, engagement with partners occurred most at the implementation stage (10 MS²³), followed by the planning stage (seven MS²⁴).

The least engagement occurred at the monitoring stage (five MS²⁵).

Objective 2: Reduce common risk factors, promote oral health, and ensure 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.

The findings for (a) and (b) above are as follows.

Oral health units or dedicated officers working in oral health participated in several national programmes to reduce common NCD risk factors.

Among the 42 Member States²⁶ with an oral health unit or a dedicated officer working in oral health, the participation was as follows: national tobacco control programmes (20 MS²⁷), reduce harmful alcohol consumption (15 MS²⁸), and promote healthy diets (26 MS²⁹) (see Figure 3). In terms of a healthy diet, some focused on reducing the consumption of

19 Algeria, Burkina Faso, Cabo Verde, Central African Republic, Chad, Eritrea, Gabon, Guinea, Guinea-Bissau, Kenya, Lesotho, Mauritius, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, United Republic of Tanzania, and Zimbabwe.

20 Algeria, Benin, Burkina Faso, Cabo Verde, Central African Republic, Chad, Democratic Republic of the Congo, Eswatini, Guinea-Bissau, Lesotho, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Africa, Togo, United Republic of Tanzania, Zambia, and Zimbabwe.

21 Algeria, Burkina Faso, Central African Republic, Malawi, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.

22 Cabo Verde, Chad, Côte d'Ivoire, Eritrea, Lesotho, Malawi, Namibia, Niger, Rwanda, Seychelles, South Africa, Togo, Uganda, and Zambia.

23 Côte d'Ivoire, Eritrea, Lesotho, Niger, Rwanda, Seychelles, South Africa, Togo, Uganda, and Zambia

24 Cabo Verde, Namibia, Niger, Rwanda, South Africa, Togo, and Zambia.

25 Niger, Rwanda, Seychelles, Togo, and Zambia.

26 All Member States except Burundi, Eswatini, Gambia, Rwanda, and South Sudan.

27 Algeria, Benin, Burkina Faso, Cabo Verde, Central African Republic, Congo, Equatorial Guinea, Guinea, Kenya, Lesotho, Liberia, Mauritania, Mauritius, Namibia, Niger, South Africa, Togo, Uganda, Zambia, and Zimbabwe.

28 Algeria, Botswana, Burkina Faso, Guinea, Kenya, Lesotho, Liberia, Mauritius, Niger, Sao Tome and Principe, Sierra Leone, South Africa, Togo, Zambia, and Zimbabwe.

29 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Eritrea, Gabon, Ghana, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Togo, United Republic of Tanzania, and Zambia.

sugars (25 MS³⁰/26 MS), salt (11 MS³¹/26 MS) and saturated fats (eight MS³²/26 MS), while others focused on increasing the consumption of fruits, raw vegetables and dietary fibre (22 MS³³/26 MS).

(c) *Promoting healthy living and working environments conducive to healthy lifestyles, for example, access to safe water and improved sanitation for proper oral hygiene in schools, workplaces, cities, health care settings and community-based establishments.*

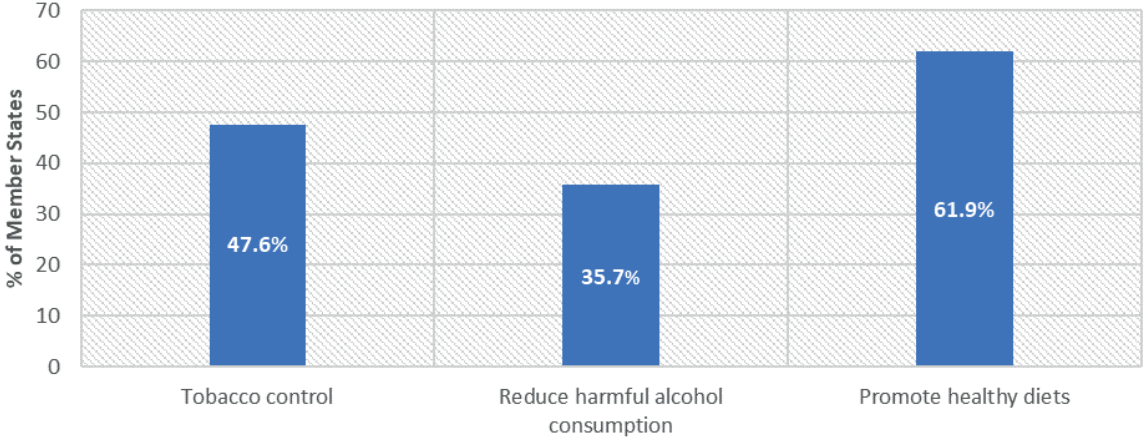
Among the 42 Member States that have an oral health unit or a dedicated officer working in oral health, 13 Member States³⁴ worked on promoting healthy living and working environments conducive to healthy lifestyles, by, for example, collaborating

with the water sanitation and hygiene (WASH) team to improve access to safe water for proper oral hygiene in schools.

(d) *Advocating banning of 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.*

Among the 42 Member States that have an oral health unit or a dedicated officer working in oral health, some participated in advocating the regulation and/or banning of **the sale** and **the advertisement** of unhealthy products such as alcohol, tobacco, and products high in sugars, salt or fat (see Figure 4).

Figure 3: Participation of oral health unit or dedicated officers working in oral health in national programmes to reduce common NCD risk factors in 42 Member States



30 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Democratic Republic of the Congo, Gabon, Ghana, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Togo, United Republic of Tanzania, and Zambia.

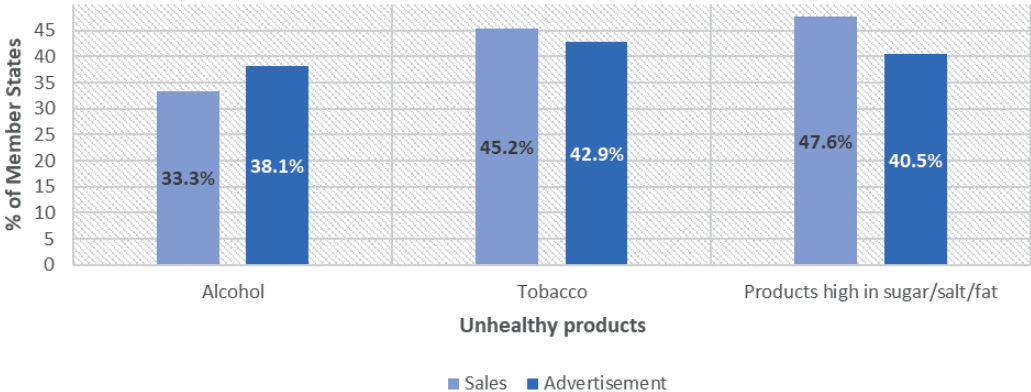
31 Algeria, Burkina Faso, Ghana, Guinea, Liberia, Madagascar, Mali, Niger, South Africa, Togo, and Zambia.

32 Algeria, Gabon, Ghana, Liberia, Mali, Niger, Sao Tome and Principe, and Togo.

33 Algeria, Benin, Botswana, Burkina Faso, Democratic Republic of the Congo, Gabon, Ghana, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Sao Tome and Principe, Seychelles, South Africa, Togo, and Zambia.

34 Algeria, Botswana, Cabo Verde, Eritrea, Ethiopia, Guinea, Liberia, Mauritius, Niger, Sierra Leone, South Africa, Togo, and Zambia.

Figure 4 : Oral health unit or dedicated officer working in oral health that participated in advocating the regulation and/or banning of the sale and advertisement of unhealthy products in 42 Member States

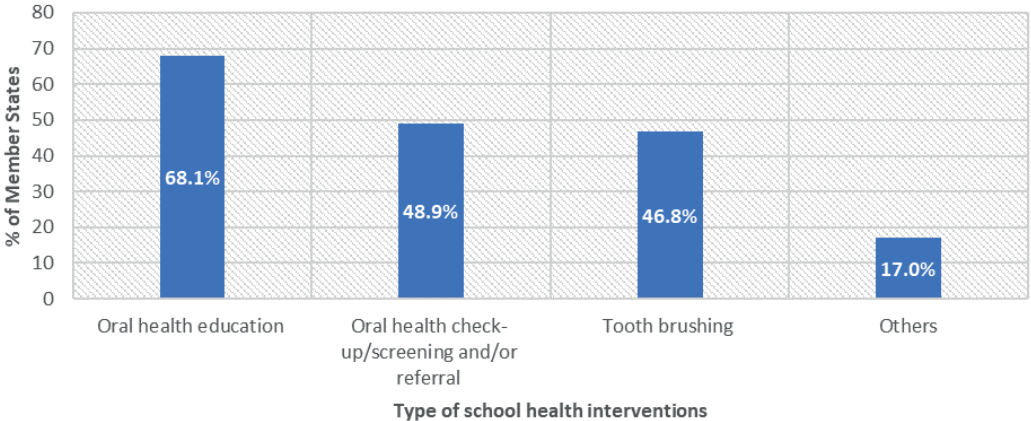


For all unhealthy products, school settings were the most common settings for regulating and/or banning the advertisement or sale of unhealthy products.

(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.

Besides 14 Member States³⁵, all Member States integrated oral health into general school health interventions. These interventions included oral health education (32 MS³⁶), oral health check-up/screening and/or referral (23 MS³⁷), tooth brushing (22 MS³⁸) and others (eight MS³⁹). Other interventions included oral disease prevention and control (atraumatic restorative treatment, simple restoration, fissure sealant application and fluoride varnish) and integration of oral health issues into teacher training (see Figure 5).

Figure 5: Situation of integration of oral health into school health interventions among all Member States



35 Benin, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea Bissau, Sao Tome and Principe, South Sudan, and Zimbabwe.
 36 Algeria, Angola, Botswana, Burkina Faso, Cabo Verde, Equatorial Guinea, Eritrea, Eswatini, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.
 37 Algeria, Botswana, Côte d'Ivoire, Eritrea, Eswatini, Gabon, Ghana, Guinea, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa, Togo, Uganda, and Zambia.
 38 Algeria, Botswana, Burkina Faso, Eritrea, Eswatini, Gabon, Ghana, Guinea, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa, Togo, and Zambia.
 39 Algeria, Lesotho, Liberia, Mauritius, Niger, South Africa, Uganda, and Zambia.

(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.*

The findings for (f) and (g) above are as follows. All Member States except Burundi, Cabo Verde, Chad, Comoros, Equatorial Guinea, Guinea-Bissau, Mauritania, and Sao Tome and Principe implemented the promotion of fluoride toothpaste as an appropriate fluoridation method. (see Figure 6)

Among the 39 Member States that responded to the question regarding the promotion of fluoride toothpaste as an appropriate fluoridation method, only Malawi reported having removed the value added tax (VAT) from fluoride toothpaste.

Democratic Republic of the Congo, Guinea and Rwanda added fluoride toothpaste to their essential medicines list, and 14 Member States⁴⁰ promoted fluoride toothpaste in specific settings such as schools. Ethiopia, Eswatini, Gambia and Madagascar reported promoting salt fluoridation.

In terms of legislation for quality fluoride toothpaste, Zambia and Zimbabwe reported enacting legislation related to the promotion of quality fluoride toothpaste and Algeria and Eritrea reported enacting legislation related to other oral health products.

Objective 3: 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.*

Most Member States reported having defined essential health packages (37 MS⁴¹/47 MS), and 28 Member States⁴² of 37 Member States included oral health services in these packages. Screening for oral conditions (24 MS⁴³/28 MS), urgent dental treatment (25 MS⁴⁴/28 MS), and basic restorative treatment (24 MS⁴⁵/28 MS) were reported to be part of the defined oral health services.

(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.*

This section asked about the financial systems used to cover the essential/basic oral health services via multiple-choice questions. The financial systems were divided into the following three categories: (1) full financial protection, completely free of charge through a national public health insurance scheme **and/or** a third-party payment scheme in health insurance; (2) co-payment where individuals pay part of the service cost through a national public health insurance scheme **and/or** a third-party payment scheme in health insurance; and (3) no financial protection, with individuals paying the full cost of service. These categories were completed for each of the three oral health service groups: screening (24 MS), urgent dental treatment (25 MS) and basic restorative services (24 MS) (see Figure 7).

40 Algeria, Democratic Republic of the Congo, Gabon, Guinea, Lesotho, Liberia, Malawi, Mauritius, Namibia, Nigeria, Rwanda, South Africa, Uganda, and United Republic of Tanzania.

41 All Member States except Botswana, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Equatorial Guinea, Gambia, Guinea-Bissau, and Mauritania.

42 Algeria, Angola, Cabo Verde, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania and Zambia

43 Algeria, Angola, Cabo Verde, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Gabon, Guinea, Kenya, Lesotho, Malawi, Mali, Mauritius, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.

44 Algeria, Angola, Cabo Verde, Democratic Republic of the Congo, Eritrea, Eswatini, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.

45 Algeria, Angola, Cabo Verde, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Rwanda, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, and Zambia.

Figure 6: Situation of fluoride toothpaste promotion among all Member States

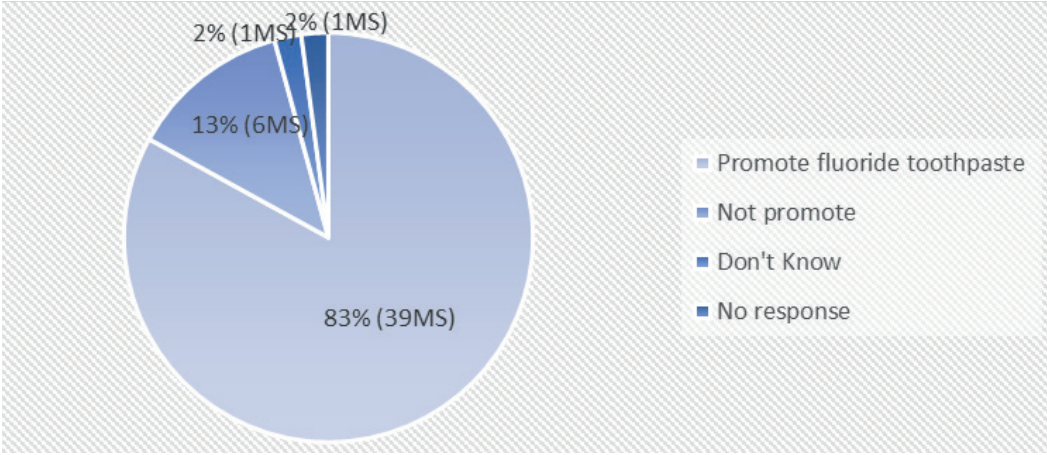
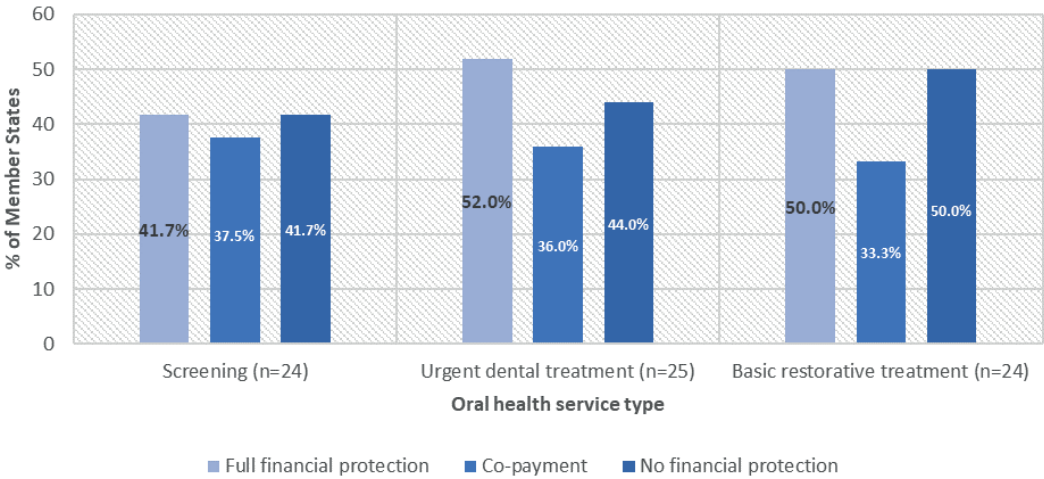


Figure 7: Situation of oral health service payment among selected Member States



Since the payment scheme was different according to population groups (such as age groups) in some Member States, some of them reported multiple payment schemes. However, in summary, oral health services in approximately half of the Member States in each category were not fully or partially covered by financial protection.

(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.

Twenty-four Member States⁴⁶ developed a list of oral health essential consumables including drugs or other supplies for the management of oral diseases, and 15 Member States⁴⁷ among them integrated their list of oral health essential consumables into their essential medicines list. Regardless of integration of oral health essential consumables into the essential medicines list, 15 Member States⁴⁸ reported distributing oral health essential consumables for the management of oral diseases at the primary care level. Among these 15 Member States, Algeria, Cabo Verde, Eswatini, Niger, Rwanda, Seychelles, South Africa, and Togo reported that the oral health

46 Algeria, Burkina Faso, Cabo Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Guinea, Kenya, Madagascar, Malawi, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, and United Republic of Tanzania.
 47 Algeria, Burkina Faso, Cabo Verde, Chad, Democratic Republic of the Congo, Eswatini, Guinea, Kenya, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Togo, Uganda, and United Republic of Tanzania.
 48 Algeria, Cabo Verde, Eswatini, Guinea, Kenya, Malawi, Mauritius, Niger, Rwanda, Senegal, Seychelles, South Africa, Togo, Uganda, and United Republic of Tanzania.

essential consumables were distributed to more than 50% of primary care facilities, while Guinea, Malawi, Mauritius, Senegal, Uganda, and United Republic of Tanzania covered less than 50% of primary care facilities. Kenya responded “Don’t Know”.

Concerning oral health consumables, 16 Member States⁴⁹ were taking active measures to phase down the use of dental amalgam. Measures taken by Member States to do so included forming a national committee to develop a plan to phase down the use of amalgam in all oral health facilities, developing a national policy, strategy and plan to phase down the use of dental amalgam, advising oral health professionals against amalgam use, issuing an order banning the use of products containing mercury (including amalgam), withdrawing amalgam dental materials from the supply chain, encouraging the use of alternative dental materials, increasing the availability of alternative dental materials and prohibiting the import and procurement of products containing mercury.

(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.

Among all Member States, 18 Member States⁵⁰ had maintenance plans for dental equipment to ensure their operational functions, and 11 Member States⁵¹ among them reported that the maintenance plans were operational.

(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.

Seventeen Member States⁵² in all were providing training to oral health professionals alongside other health and community workers 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.

Out of all Member States, 11 Member States⁵³ had a plan for task shifting oral health care to non-oral health professionals. This group of Member States defined the required competencies for oral health care for each of the following health-care provider categories (see Table 2).

Table 2: List of Member States with the defined competencies for non-oral health professionals for task shifting

Health-care provider categories	List of Member States
Doctors	Benin, Guinea, Malawi, Niger, Sierra Leone, Togo, and United Republic of Tanzania.
Nurses	Benin, Guinea, Malawi, Niger, Sierra Leone, South Africa, Togo, and United Republic of Tanzania.
Midwives	Guinea, Niger, Sierra Leone, and Togo.
Community Health Workers	Guinea, Malawi, Niger, Nigeria, Sierra Leone, South Africa, Togo, and Zambia.

49 Angola, Botswana, Eswatini, Guinea, Kenya, Madagascar, Mauritius, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Zambia, and Zimbabwe

50 Angola, Botswana, Burkina Faso, Cabo Verde, Eswatini, Gambia, Ghana, Guinea, Malawi, Mauritania, Mauritius, Namibia, Niger, Rwanda, Seychelles, Sierra Leone, South Africa, and United Republic of Tanzania.

51 Botswana, Eswatini, Gambia, Guinea, Malawi, Mauritius, Niger, Rwanda, Seychelles, South Africa, and United Republic of Tanzania.

52 Angola, Benin, Burkina Faso, Cabo Verde, Congo, Ethiopia, Guinea, Lesotho, Liberia, Mauritius, Niger, Rwanda, South Africa, South Sudan, Togo, United Republic of Tanzania, and Zambia

53 Benin, Burkina Faso, Guinea, Malawi, Niger, Nigeria, Sierra Leone, South Africa, Togo, United Republic of Tanzania, and Zambia

Objective 4: Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research

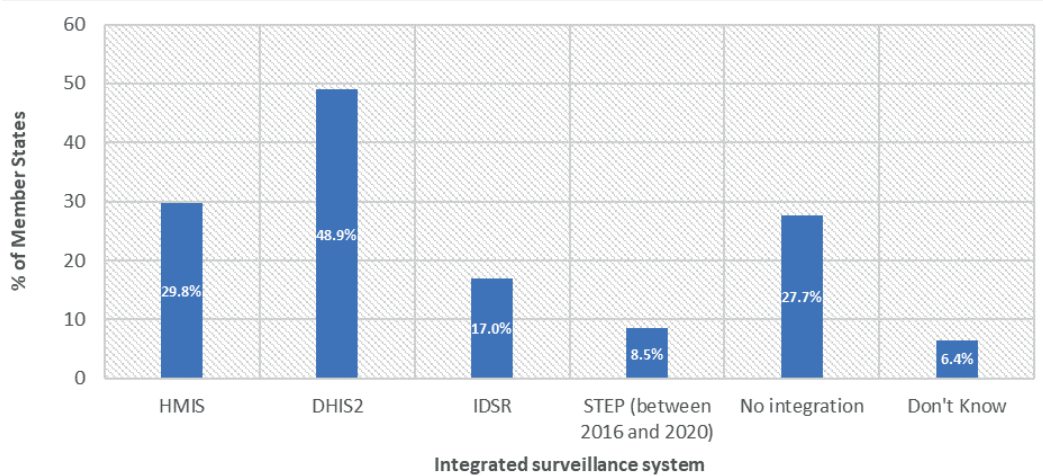
(b) *Generating quality data on oral health conditions and related risk factors through sentinel and population-based studies to support advocacy, planning and monitoring.*

(a) *Integrating systematic collection of oral health data into existing health management information systems (HMIS) and into ongoing NCD survey tools (STEPS, NCD CCS, GSHS, etc.).*

Member States integrated oral health indicators into their national HMIS (14 MS⁵⁴/47 MS), District Health Information System 2 (DHIS2) (23 MS⁵⁵/47 MS) and Integrated Disease Surveillance and Response (IDSR) (eight MS⁵⁶/47 MS). Moreover, after the adoption of the Regional strategy in 2016, Algeria, Cabo Verde, Sao Tome and Principe, and Zambia conducted oral health module of STEPs surveys until 2020⁵⁷. Thirteen Member States⁵⁸ out of all Member States did not integrate any oral health data or survey tools into the existing system (see Figure 8).

The following oral health conditions are being monitored under Member States’ national sentinel surveillance systems among all Member States: oral cancer (14 MS⁵⁹), noma (12 MS⁶⁰), infant oral mutilation in Comoros, Guinea, Rwanda, and Uganda, and dental caries and periodontal diseases in Benin, Burkina Faso, Gabon, and Uganda. Twenty-three Member States⁶¹ out of 47 were not monitoring any oral health conditions under sentinel surveillance systems.

Figure 8 Proportion of Member States that integrated oral health indicators into the existing integrated surveillance system



54 Benin, Burkina Faso, Eritrea, Gabon, Guinea, Mauritius, Mozambique, Namibia, Niger, Rwanda, Togo, Uganda, United Republic of Tanzania, and Zambia.
 55 Benin, Botswana, Burkina Faso, Côte d’Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Lesotho, Madagascar, Malawi, Mali, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, and Zambia.
 56 Burkina Faso, Guinea, Mali, Niger, Nigeria, Rwanda, Senegal, and Togo.
 57 WHO. STEPwise Approach to NCD Risk Factor Surveillance (STEPS). <https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps>.
 58 Angola, Central African Republic, Chad, Comoros, Congo, Equatorial Guinea, Eswatini, Gambia, Guinea-Bissau, Kenya, Liberia, Sierra Leone, and Zimbabwe.
 59 Algeria, Burkina Faso, Comoros, Guinea, Malawi, Niger, Rwanda, Sao Tome and Principe, Seychelles, South Africa, Togo, Uganda, Zambia, and Zimbabwe.
 60 Benin, Burkina Faso, Central African Republic, Comoros, Guinea, Malawi, Niger, Nigeria, Rwanda, Senegal, Togo, and Zimbabwe.
 61 Angola, Botswana, Burundi, Cameroon, Chad, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Sierra Leone, South Sudan, and United Republic of Tanzania.

Among 18 Member States⁶² that conducted population-based surveys, 15 Member States⁶³ used their data for various purposes, as follows: advocacy (11 MS⁶⁴), planning (13 MS⁶⁵), monitoring (11 MS⁶⁶), and reviewing policies and guidelines only in Uganda.

(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.

Only nine⁶⁷ of the 17 Member States that reported having an operational or expired oral health-focused governance document (refer to the section under Objective 1) established an M&E system to track the progress of the implementation of these plans.

Guinea, Niger and Togo reported employing innovative data collection techniques for M&E using digital technology, such as mobile phones and tablets.

(d) Building partnerships with research institutes, universities and other relevant institutions to develop and implement operational research⁶⁸ for improving the generation of evidence-based decision-making, policies and advocacy on oral health.

Eleven Member States⁶⁹ had established partnerships to develop and implement operational research to strengthen evidence-based decision-making policies and advocacy concerning oral health. These partners were international organizations such as WHO and UNICEF, governments (bilateral cooperation), academic institutions and CSOs.

(e) Supporting the development of tools, and best buys (cost-effective interventions) for the integrated prevention and management of oral diseases within NCD programmes.

Benin, Burkina Faso, Guinea, Rwanda, Togo and Zambia responded to this question, having supported the development of tools and best buys for integrated prevention and management of oral diseases within NCD programmes.

4.2 Challenges and opportunities

In addition to describing the situation against the priority interventions defined under each objective, Member States provided details of the challenges and opportunities they faced in the implementation of the Regional strategy. Respondents also shared needs for technical assistance and support from WHO to enable them to accelerate the implementation of the strategy at country level.

4.2.1 Challenges to the advancement of the oral health agenda

- **Lack of strategies**, such as policy, strategy and legislation that hinder the advancement of the oral health agenda for all four objectives.
- **Lack of resources**, including financial, human resources, dental equipment and technical capacity, which impede the implementation of the policies/strategies.
- **Lack of political will and prioritization**, especially for Objective 1 relating to national advocacy, leadership, and partnerships.
- **Missed integration opportunities** in other areas, such as WASH and workforce training, including in training programmes, general health service, and primary health care (PHC).
- **Absence of oral health representation in MoH**, which hindered the strengthening of governance and leadership of oral health at the country level.
- **Poor engagement and coordination with stakeholders and other programmes**, which impeded a multisectoral approach, resulting in the weak integration of oral health into other areas.

62 Algeria, Burkina Faso, Central African Republic, Chad, Gabon, Guinea, Kenya, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania, and Zambia.

63 Algeria, Burkina Faso, Chad, Gabon, Guinea, Kenya, Malawi, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania, and Zambia.

64 Algeria, Gabon, Guinea, Kenya, Malawi, Namibia, Rwanda, Senegal, Uganda, United Republic of Tanzania, and Zambia.

65 Algeria, Burkina Faso, Chad, Guinea, Kenya, Malawi, Namibia, Rwanda, Senegal, South Africa, Uganda, United Republic of Tanzania, and Zambia.

66 Algeria, Guinea, Malawi, Namibia, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania, and Zambia.

67 Eritrea, Guinea, Mali, Namibia, Niger, Rwanda, Togo, United Republic of Tanzania and Zambia.

68 WHO. Operational research provides decision-makers with information to enable them to improve the performance of their programmes.

69 Algeria, Guinea, Malawi, Mauritius, Mozambique, Niger, Nigeria, Rwanda, South Africa, Uganda and Zimbabwe.

- **Lack of evidence, research, and an M&E system** to support decision-making and track progress in oral health activities.
- **Focus on curative care, with little attention** paid to promotion and prevention.
- **Lack of enabling environment** (including lack of access to water, work overload for CHWs) to support the implementation of oral health projects.
- **The COVID-19 pandemic**, which negatively impacted oral health prevention and promotion programmes.

4.2.2 Opportunities for the advancement of the oral health agenda

- **Integration of oral health into other health programmes/policies**, such as national health strategic plans, NCD and UHC strategies, the UNICEF programme, NCD programmes (such as the WHO package of essential noncommunicable [PEN] disease interventions for primary health care [7]), CHW training, integrating oral health indicators into existing surveillance systems for all four objectives.
- **The World Health Assembly (WHA) resolution on oral health (WHA74.5) [8] and the global strategy on oral health [1]** will afford the opportunity to prioritize the oral health agenda.
- **Partners and donors' technical and financial support** for oral health activities.
- **Roll-out of new strategies in MoH**, such as the introduction of national health insurance to improve funding for health, which is crucial for oral health as part of a UHC benefit package.
- **Strengthening human resources for oral health**, such as increasing the number of dental, medical, nursing, and dental therapy schools as well as the presence of CHWs (for example, to support task shifting and improve the skills mix).
- **Strengthening existing measures related to common risk factors**, such as strict tobacco legislation and taxation as well as taxation of sugar-sweetened beverages, which are already

in place and can contribute to preventing oral diseases.

4.2.3 Recommendations/requests for support made by Member States to WHO

Advocacy

- Work towards prioritizing the oral health agenda among high-level policy-makers, including ministers of finance.

Capacity building

- Train and share information with chief dental officers to familiarize them with existing strategy/guidance documents and identify areas of opportunity to strengthen collaboration between Member State and United Nations (UN) agencies.

Technical and financial support

- Assess the oral health situation and develop and implement the oral health policy.
- Assess fluoride concentration in food and water as well as the oral health situation.
- Develop a model to decentralize oral health services to the subdistrict levels.

Surveillance

- Select important oral health indicators that must be tracked and reported in HMIS in the Region. Data reports for oral health need to be generated, analysed and disseminated; and ultimately used in political decision-making.

Research

- Encourage and promote operational research.

5. Discussion

The assessment demonstrates that most Member States are committed to implementing aspects of the priority interventions under each objective of the Regional oral health strategy, although it is difficult to measure the overall progress achieved compared to 2016 when the Regional strategy was adopted since there is no baseline information derived from a formal monitoring framework.

The following is a discussion under each objective.

Under **Objective 1**, which aims to strengthen national advocacy, leadership and partnerships to address oral diseases as part of NCDs through a multisectoral approach, implementation was reported in most Member States. This was demonstrated particularly through the establishment of units to promote oral health and prevent and control oral diseases. While this is a commendable achievement, there is a need to encourage and support some Member States that are lagging behind in establishing their independent oral health unit to lead the work on oral health issues and promote integration with NCDs. The unit should be supported by human and financial resources and tools for advocacy that would be instrumental in establishing strong infrastructure to advance oral health. This unit will also provide reliable, trustworthy channels for collaboration with other departments, institutions, as well as national and global partners.

At the governance level, there is a demonstrated effort to strategically plan for the management of oral health issues, but there is a large gap, with almost half of the Member States missing governance documents. This gap needs to be addressed urgently. At the same time, it is promising that 15 Member States reported drafting oral health-focused governance documents. The existence of a policy document could be an indicator of Member States' seriousness about planning for oral health. However, the quality of the document as well as the implementation of the plan largely determine the outcomes, and both features were beyond the scope of this assessment.

We found measurable awareness about the importance of integrating oral health into general health policies such as national health and NCD

policy documents. However, this awareness was only present in less than 40% of Member States. Therefore, many Member States may need support with establishing mechanisms and finding opportunities to harness the benefits of integrating with NCDs and other general health policies.

Advocacy for increasing social, political, and resource commitment to oral health can be measured in various ways. Since there is no baseline against which a comparison can be made before and after the endorsement of this strategy, advocacy for oral health based on this assessment could be considered inadequate, as demonstrated by the low commitment of Member State governments to fund oral health activities and the rare presence of laws or rules to regulate the field in the Region.

Moreover, as some Member States mentioned as challenges, the lack of political will and prioritization is linked to this lack of advocacy. At the same time, during WHA74 in 2021, in addition to the existence of the Regional oral health strategy, the WHO resolution on oral health (WHA74.5) was adopted globally – 14 years after the last consideration of oral health by the WHO decision-making body. This resolution, as well as the global strategy on oral health which was adopted during WHA75 in 2022, should be useful advocacy documents for communicating the value of oral health to all policy-makers, partners, CSOs and the private sector to increase political and resource commitment to oral health [1, 8, 9].

Some Member States established collaborations and developed mechanisms to engage the community and civil society. However, these endeavours were minimal. To achieve PHC, namely, “[a] whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities” towards UHC in the context of the Sustainable Development Goals (SDGs), it is critical to ensure the political engagement of communities and other stakeholders from all sectors to define the problems and solutions and prioritize actions through policy dialogue, which should include issues related to oral health [10].

Objective 2 aims to reduce common risk factors, promote oral health and ensure access to appropriate fluorides. Several Member States' oral health units have participated in national programmes to reduce NCD risk factors. It was more common for Member States to report contributing to promoting a healthy diet, such as reducing the consumption of sugar, than to tobacco control and reducing alcohol consumption. This may be considered as a proxy indicator of integrating work with NCD departments. It is also a good sign of collaboration. However, among the Member States that responded, there is room for improvement by covering all identified areas in the strategy. Moreover, it is difficult to measure how these interventions contributed to reducing common risk factors due to the lack of comparative population-based data.

In this assessment, Member States were slightly more inclined to engage in banning the advertising of unhealthy products than in regulating or banning sales. Schools were the most common setting for advocating banning the sale and advertisement of unhealthy products. There is an opportunity for Member States to better utilize other settings, such as the workplace and community, to increase the impact of their work. A limitation of this survey is that we only measured these two control strategies because they were mentioned in the strategy. However, it is understood that oral health units can also use different measures, such as a sugar tax, as more than 40% of Member States in the Region had taxation on sugar-sweetened beverages in 2019 [11].

Thirty three out of 47 Member States integrated oral health into general school interventions, including oral health education, oral health check-up/screening and/or referral and tooth brushing. Indeed, WHO and United Nations Educational, Scientific and Cultural Organization (UNESCO) recently launched a new initiative, "Making Every School a Health Promoting School" through the development and promotion of the Global Standards for Health Promoting Schools. Some Member States in the Region have been selected as early adopter countries. Moving forward, it is important to integrate oral health into a holistic health-promoting school approach rather than an independent oral health project in the school setting [12].

The adequate intake of fluoride has a beneficial effect on oral health in both children and adults. Fluoride prevents caries by several different actions

[13]. Our findings have shown that many Member States were able to promote the use of fluoride toothpaste, although very few were able to enact legislation related to the promotion of quality fluoride toothpaste. Programmes for salt and water fluoridation were rarely reported. One Member State highlighted the challenge of imposing taxation on fluoride toothpaste as fluoride toothpaste is considered a cosmetic hygiene product, and is therefore, subject to taxation. The latest WHO essential medicines list includes fluoride toothpaste [14], which may support the acceleration of appropriate regulation and legislation in countries (such as removing VAT) to promote the production, importation, distribution, packaging, labelling, affordability and accessibility of quality fluoride toothpaste.

Objective 3 aims to strengthen health system capacity for integrated prevention and control of oral diseases. The Regional oral health strategy outlines the need to achieve UHC through the inclusion of oral health services within the essential health package with financial protection. Half of the Member States have already included oral health services in the essential health package, and most reported that their packages covered screening services, urgent care and basic restorative treatment for all age groups. However, for approximately half of the Member States that included oral health services in their essential health care packages, the services were provided without financial protection.

Indeed, according to the latest UHC service coverage index, UHC coverage in the Region was behind the global situation in 2017. Countries with low service coverage and high financial hardship need to strengthen both their service delivery and health financing arrangements, giving priority to addressing inequities [15]. Moreover, without the inclusion of oral health in UHC, systemic health outcomes will worsen and ultimately contribute to growing health disparities [16]. Indeed, the UN high-level meeting on UHC recognized the importance of integrating oral health into UHC to achieve the UHC goals [17]. As part of the UHC initiative, it is critical to increase access to oral health services, promotion and care without imposing a financial burden on individuals.

As an essential oral health service and in relation to essential medicines and consumables, it is vital to phase down the use of dental amalgam as part of the Minamata Convention on Mercury with the aim

of protecting human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds. As of November 2021, 36 Member States⁷⁰ in the Region were party to this Convention [18]. Based on our assessment, around one third of Member States reported taking some measures to phase down the use of dental amalgam. All the reported interventions seem to be in the early planning stages of phasing down. According to the informal WHO global consultation on the progress of phasing down the use of dental amalgam in 2021 [19], despite some progress, one third of the Member States in the Region that participated in the consultation reported no plan to phase down the use of dental amalgam. They also reported relatively high usages of dental amalgam as a restorative material and rarely reported on the existence of insurance policies and programmes that cover the costs of using dental amalgam-free or mercury-free alternatives. Very few reported having regulations for the disposal of dental amalgam waste and indicated a lack of dental facilities with installed dental amalgam separators compared to the other five WHO regions [19]. By integrating oral health into UHC through strengthening the health system, the holistic approach should be accelerated from oral health promotion to oral disease control through a multisectoral approach to phase down the use of dental amalgam, including establishing concrete timelines for each country's phase down.

Another important aspect of strengthening health systems to enable integrated oral health promotion, prevention and control of oral diseases is the health workforce. In the Region, only a limited number of trained oral health professionals are available. For example, the Region had 3.3 dentists for 100 000 people between 2014 and 2019, which was around one tenth of the global ratio of 32.8 per 100 000 population, according to the WHO National Health Workforce Account Data Platform [20]. Moreover, almost two thirds of all dental assistants and therapists⁷¹ work in the WHO European and Americas Regions, while only about 4% work in the African Region. In this context, it is very important to strengthen the health workforce based on the population's needs. This could be done by strengthening mid-level providers' capacity and task shifting from oral health professionals to other

health professionals, such as primary care workers, as well as from dentists to mid-level providers, such as dental assistants and therapists. According to our assessment, capacity building and planning for task shifting to non-oral health professionals was limited. There may be a need to showcase successful models in similar countries to support Member States. To assist Member States, AFRO has been working to develop oral health training for primary care workers, including CHWs, to meet the demand for oral care services [21].

Objective 4 aims to improve integrated surveillance of oral diseases, M&E of programmes and research. Strengthening the integrated surveillance of oral diseases and conditions, analysis of the oral health system and policy data, evaluation of oral health programmes and operational research are essential to enabling evidence-informed decision-making and advocacy [1]. However, 13 out of 47 Member States had not integrated any oral health indicators into their existing integrated surveillance systems at the time of the assessment. Even if Member States integrate oral health indicators into the surveillance system, some Member States might not collect data due to lack of resources. Furthermore, some Member States collect data through the integrated surveillance system or the national oral health survey; however, the data would not be used to develop evidence-based policies, strategies or track the progress of implementation of the strategies/policies.

Indeed, the Regional strategy set the five targets to be achieved by 2025. However, due to lack of comparative population-based data as well as baseline data, it would be difficult to measure these targets so that this assessment focuses on reviewing the status of implementation of the priority interventions under each objective based on the survey conducted with Member States.

Based on Member States' requests, WHO is developing a global action plan for public oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030. In line with this global action plan and its monitoring framework as requested by some Member States in the Region, there is an urgent need to establish a relevant, feasible and realistic

70 The 11 Member States not party to the Convention are: Algeria, Angola, Cabo Verde, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Liberia, Mozambique, Malawi and South Sudan.

71 "Dental assistants and therapists" comprise dental therapists, dental hygienists, dental nurses and dental assistants.

monitoring framework for the Regional oral health strategy and select important oral health indicators that must be tracked and reported in HMIS in the Region.

In relation to research, enhanced partnerships and innovative approaches, such as the use of digital technologies (for example, the mOralHealth Programme [22]), are necessary to improve the implementation, dissemination and utilization of research.

6. Strengths and limitations of the assessment of the Regional oral health strategy

This assessment has several strengths. First, all 47 Member States participated in the survey (100% response rate). The methodology and data collection tools were reviewed by members of the informal TAG for their validity, relevance, and precision. The questionnaire was also pilot tested with selected Member States prior to the main data collection exercise, and all recommendations were taken into account to improve the survey format. Thorough validation processes were followed to improve the quality of the responses. Secondly, respondents were able to use the questionnaire as an internal checklist guiding the implementation of the strategy in each Member State, so that

the assessment as such may have provided an additional motivation to accelerate implementation measures.

Regarding limitations, as with all surveys, there is a risk of bias related to incorrect responses, either due to respondent's expectations or from knowledge gaps, misconceptions, or simply wrong answers. Despite the 100% response rate, some questions remained unanswered. Moreover, due to the concept of the assessment, the collected information primarily covered the public sector, so information on the sector of private providers is limited.

7. Future priority activities and recommended actions

Based on the findings of the assessment, the ambitious set out in the WHO resolution on oral health (WHA74.5) and the global strategy on oral health are all relevant to the regional context considering the high burden of oral diseases in the Region, weak oral health care systems, and competing health priorities. The following recommended actions are re-emphasized.

Member States are urged to:

- Reflect on their respective oral health situation in the context of this mid-term assessment. The survey results should be used to identify priority areas for focused interventions and accelerated action for each Member State.
 - Strengthen political commitment at the highest levels to address oral health as a priority area as part of NCDs, PHC and UHC, using global and regional political documents, such as the WHO resolution on oral health (WHA74.5), and the regional and global oral health strategies.
 - Establish and strengthen oral health units with dedicated staff within MoH, and develop and implement multisectoral and cross-cutting oral health policies, strategies and plans as part of NCDs, PHC, UHC and emergency responses (such as for COVID-19) across the life course.
 - Allocate adequate resources to implement national oral health policies focusing on key priority areas based on the lessons learnt from this assessment.
 - Integrate oral health into all policies as a particularly important action, especially in low-resource settings to multiply outcomes by maximizing efforts.
 - Mobilize, involve, and empower communities to enable people to increase control over and improve their oral and general health as well as to develop oral health-care systems based on community needs.
 - Foster integrated, people-centred health services by enabling inter professional education, task shifting and a more extensive team approach that involves mid-level and community health providers.
- Reinforce oral health surveillance by integrating oral health into existing integrated disease surveillance systems.
 - Leverage digital technologies (such as mOralHealth) to improve oral health literacy among populations and policy-makers, build the capacity of health professionals and enhance early detection and surveillance of oral diseases.
 - Conduct operational research and document lessons learnt on the various aspects of the priority interventions.
 - Explore opportunities for collaborations and partnerships across sectors, thereby strengthening domestic funding and resource allocation for oral health. Collaborations may include, but are not limited to public, private, academic, and community-based entities.

WHO and partners should:

- Advocate for increased political commitment at the highest levels to address oral health as part of NCDs, PHC and UHC.
- Provide holistic guidance, tools, and standards to Member States in their efforts to develop and implement national oral health action plans for the prevention and control of oral diseases as part of NCDs, PHC and UHC.
- Support the inclusion of basic oral health services in essential health packages as part of the UHC benefit package and include oral health medicines/consumables in the essential medicines list.
- Mobilize resources to support countries in developing and implementing national oral health action plans.
- Contribute and work towards the development, production and distribution of quality oral hygiene products and oral health materials as part of the WHO Model List of Essential Medicines, such as fluoride toothpaste, glass ionomer cement and silver diamine fluoride, that are affordable, safe and environmentally friendly.

- Develop a priority oral health research agenda in the Region and support operational research to generate evidence for cost-effectiveness and feasibility of population-wide measures and their public health impact.
- Support the development of an efficient workforce model in the Region.
- Build the capacity of the oral health focal points and other professionals to accelerate the oral health agenda at the country level.
- Identify success stories in the Region and disseminate them as examples to serve as models to other Member States. Success stories could involve the engagement of the community and result in successful partnerships and innovative funding schemes.
- Establish an integrated monitoring framework for the Regional oral health strategy and select important oral health indicators that must be tracked and reported in HMIS in the Region, and which align with the global action plan and its monitoring framework.
- Consider the extension of the Regional strategy to align it with the duration of the global strategy on oral health.

8. Conclusion

Given the available evidence, we conclude that despite commitment of Member States to implement some priority oral health interventions, many challenges persist that require collective, focused, and accelerated actions.

The assessment served as a sensitization tool to Member States to recall and re-invigorate the commitments made when adopting the Regional oral health strategy. In concert with the global

strategy on oral health and the accompanying global action plan and global monitoring framework, more concrete progress is expected from all WHO Member States. The existing policy documents at national, regional, and global levels provide ample guidance for reforming and strengthening national oral health care systems, so that progress can be accelerated and populations in the African Region can enjoy better oral health.

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Annex: The Regional Oral Health Strategy 2016-2025 in the WHO African Region Mid-term Assessment - Online Questionnaire Survey

The Regional Oral Health Strategy 2016-2025 in the WHO African Region Mid-term Assessment - Online Questionnaire Survey

A: Background and Purpose

The Regional Oral Health Strategy 2016-2025: Addressing Oral Diseases as Part of Noncommunicable Disease (NCD) was endorsed by Member States during the Sixty-sixth session of the Regional Committee for Africa (RC66) in 2016. This Strategy guides Member States to take a more integrated approach to promoting oral health and preventing and controlling oral diseases, with the aim of universal health coverage.

Member States requested that the WHO Regional Office for Africa assess and report on the progress made in the implementation of the Strategy, to identify gaps and challenges and prioritize the activities to be scaled up by the end of the Strategy in 2025.

The purpose of this survey is to assess the progress of implementation of the Strategy. The elements of this survey will also serve as an internal checklist for the implementation of the Strategy in your country.

The information collected through this survey will be presented as part of the mid-term progress report of the Strategy which will be submitted at RC72 in 2022 along with related materials. The results of this survey will be used to develop monitoring and evaluation indicators for the Strategy.

We have divided this survey into four areas related to pre-defined specific objectives of the Strategy:

- Area 1: Strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach
- Area 2: Reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides

- Area 3: Strengthen health system capacity for integrated prevention and control of oral diseases
- Area 4: Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research

B: Process

A chief dental officer, relevant staff members from the Ministry of Health or NCDs focal point or relevant staff members from the WHO Country Office will coordinate and ensure survey completion. However, in order to provide a complete response, a group of respondents will be needed with expertise in the topics covered in the areas. Please indicate the names and titles of all of those who have completed the survey and which sections they have completed. Please also add any additional information on other sources you consulted in developing your response.

Please note that while there is space to indicate 'Don't Know' for most questions, there should be very few of these responses. If someone indicates 'Don't Know' often, someone more familiar with this information should complete this section. The responses are automatically saved, and you can return to the responses before submitting them. There is a glossary of technical terms at the end of the document.

As far as possible, in order to validate responses, documentation will be requested for affirmative responses throughout the questionnaire. Please make every effort to provide URLs or electronic copies of the requested documentation by email.

If you are unable to provide electronic copies by email, please contact XXX for an alternative means to submit documentation.

C: Data Protection and Privacy

All information you provide will be confidential, and the responses will be de-identified in the final report to ensure anonymity. Responses will be exported to password-protected files for data analysis.

Please complete the survey below the survey below. Thank you.

I agree that my responses will be included in a mid-term progress report of the Regional Oral Health Strategy 2016-2025 and related materials on the condition that neither my name nor any other identifying information is used.

- Yes
 No (This will take you to the end of the survey.)

Please insert the date your consent was given:

You and your country

Please type your country name:

Area 1: Strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.

Please insert the name of the 'Responsible officer' who will complete Area 1 of the survey:
Their institution and position within the institution:
Their e-mail address:

Area 2: Reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.

Please insert the name of the 'Responsible officer' who will complete Area 2 of the survey:
Their institution and position within the institution:
Their e-mail address:

Area 3: Strengthen health system capacity for integrated prevention and control of oral diseases.

Please insert the name of the 'Responsible officer' who will complete Area 3 of the survey:
Their institution and position within the institution:
Their e-mail address:

Area 4: Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.

Please insert the name of the 'Responsible officer' who will complete Area 4 of the survey:
Their institution and position within the institution:
Their e-mail address:

General question

(a) Have you read the WHO African Regional Oral Health Strategy 2016-2025?
(Please select only one option)

- Yes
 No

Skip logic: If the answer is yes, go to question (b). If the answer is no, go to question in area 1.

(b) Have you utilized this strategy to guide you in the promotion of the oral health agenda? (Please select only one option)

- Yes
 No

(c) The WHO African Regional Oral Health Strategy was useful to my country's work in promoting the oral health agenda.' Do you agree with this statement? (Please select only one option)
Strongly agree

- Agree
 Neither agree nor disagree
 Disagree
 Strongly disagree

Area 1: Strengthen national advocacy, leadership and partnerships for addressing oral diseases as part of NCDs through a multisectoral approach.

1.1 Within the organizational structure of the Ministry of Health, does your country have
(Please select only one option):

- (a) an Oral Health Unit
(b) an Oral Health Department
(c) an Oral Health Directorate
(d) Other
(e) Country does not have a Unit, Department or Directorate of Oral Health.

You chose 'other'. Please specify:

Please indicate in which year it was established of your selected structure:

Skip logic: If the answer is (e), go to question 1.2 and then 1.5. If the answer is (a), (b), (c) or (d), go to 1.3.

1.2 Does your country have a dedicated officer working in oral health at the Ministry of Health? (Please select only one option)

- (a) Yes
(b) No

1.3 Is the Oral Health Unit/Department/Directorate under the NCD Unit/Department/Directorate in the Ministry of Health? (Please select only one option)

- (a) Yes
(b) No

Skip logic: If the answer is (b), go to question 1.4. If the answer is (a), go to 1.5.

1.4 Is this Oral Health Unit/Department/Directorate working in close collaboration with the NCD Unit/Department/Directorate department in the Ministry of Health? (Please select only one option)

- (a) Yes
(b) No

Skip logic: If the answer is (a), go to question 1.5. If the answer is (b), go to 1.7.

1.5 Is there a national multisectoral commission, agency or mechanism that oversees NCD engagement, policy coherence and accountability of sectors beyond health? (Please select only one option)

- (a) Yes
(b) No

Skip logic: If the answer is (a), go to question 1.6. If the answer is (b), go to 1.7.

1.6 Is the Oral Health Unit/Department/Directorate or a dedicated officer working in oral health part of the national multisectoral commission, agency or mechanism? (Please select only one option)

- (a) Yes
(b) No

1.7.1 Does your country have the following policy documents? National Oral Health Policy
Does your country have a National Oral Health Policy? (Please select only one option)

(Definition of Policy: A specific official decision or set of decisions designed to carry out a course of action endorsed by a political body, including a set of goals, priorities and main directions for attaining these goals.)

- (a) Yes
(b) Document is currently in the drafting stage.
(c) No
(d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.7.2.

- Please provide a URL of the document if available.
- Please upload an electronic copy of the document to support your answer.
- Please state the policy title and include the duration of the policy. For example: 'Oral Health Policy2016-2025'.

Is this policy operational? (Please select only one option)

(Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it.)

- (a) Yes, it is operational
(b) No, it is not yet operational
(c) No, it has expired
(d) Don't Know

Please indicate whether the National Oral Health Policy includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
(b) No
(c) Don't Know

1.7.2 Does your country have the following policy documents? National Oral Health Strategy
Does your country have a National Oral Health Strategy? (Please select only one option)
(Definition of Strategy: A long-term plan designed to achieve a particular goal)

- (a) Yes
(b) Document is currently in the drafting stage.
(c) No
(d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.7.3.

- Please provide a URL of the document if available.
- Please upload an electronic copy of the document to support your answer.
- Please state the strategy title and include the duration of the strategy. For example: 'Oral Health Strategy 2016-2025'.

Is this strategy operational?

(Please select only one option)

(Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it.)

- (a) Yes, it is operational
- (b) No, it is not yet operational
- (c) No, it has expired
- (d) Don't Know

Please indicate whether the National Oral Health Strategy includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

1.7.3 Does your country have the following policy documents? National Oral Action Plan

Does your country have a National Oral Health Policy? (Please select only one option)
(Definition of Action plan: A scheme of course of action, which may correspond to a policy or strategy, with defined activities indicating who does what (type of activities and people responsible for implementation), when (time frame), how and with what resources to accomplish an objective)

- (a) Yes
- (b) Document is currently in the drafting stage.
- (c) No
- (d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.7.4.

- Please provide a URL of the document if available.

- Please upload an electronic copy of the document to support your answer.
- Please state the plan title and include the duration of the policy. For example: 'Oral Health Plan 2016-2025'.

Is this plan operational? (Please select only one option) (Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it.)

- (a) Yes, it is operational
- (b) No, it is not yet operational
- (c) No, it has expired
- (d) Don't Know

Please indicate whether the National Oral Health Plan includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

1.7.4 Does your country have the following policy documents? Oral Health module as part of the National Health Policy/Strategy/Action Plan

Does your country have an Oral Health module/section as part of the National Health Policy/Strategy/Action Plan?

(Please select only one option)

- (a) Yes
- (b) Document is currently in the drafting stage.
- (c) No
- (d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.7.5.

- Please provide a URL of the document if available.
- Please upload an electronic copy of the document to support your answer.
- Please state the document title and include the duration of the policy. For example: 'National Health Policy 2016-2025'.

Is this Policy/Strategy/Action Plan operational? (Please select only one option) (Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it.)

- (a) Yes, it is operational
- (b) No, it is not yet operational
- (c) No, it has expired
- (d) Don't Know

Please indicate whether the document includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

1.7.5 Does your country have the following policy documents? Oral Health module as part of the NCD Policy/Strategy/Action Plan

Does your country have an Oral Health module as part of the NCD Policy/Strategy/Action Plan? (Please select only one option)

- (a) Yes
- (b) Document is currently in the drafting stage.
- (c) No
- (d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.7.6.

- Please provide a URL of the document if available.
- Please upload an electronic copy of the document to support your answer.
- Please state the document title and include the duration of the document. For example: 'National NCD Plan 2016-2025'

Is this Policy/Strategy/Action Plan operational? (Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it.) (Please select only one option)

- (a) Yes, it is operational
- (b) No, it is not yet operational
- (c) No, it has expired
- (d) Don't Know

Please indicate whether the document includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

1.7.6 Does your country have the following policy documents? Other

Does your country have any other relevant Policy/Strategy/Action plan which is integrated oral health agenda? (Please select only one option)

- (a) Yes
- (b) Document is currently in the drafting stage.
- (c) No
- (d) Don't Know

Skip logic: If the answer is (a), answer following questions. If the answer is (b), (c), (d), go to 1.8.

- Please provide a URL of the document if available.
- Please upload an electronic copy of the document to support your answer.
- Please state the document title and include the duration of the policy. For example: 'Oral Health Plan 2016-2025'.

Is this Policy/Strategy/Action Plan operational? (Operational means that a policy, strategy or plan of action is being used and implemented in the country, and has resources and funding available to implement it. (Please select only one option)

- (a) Yes, it is operational
- (b) No, it is not yet operational
- (c) No, it has expired
- (d) Don't Know

Please indicate whether includes a component on 'multisectoral coordination with other government sectors and ministries'. (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

1.8 Are oral health agendas integrated into other relevant public health programmes? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If yes, please list names of all the programmes which include oral health agendas.

If yes, please upload an electronic copy of the listed documents, where possible, to support your answer.

- 1.9 Has your country implemented any one-time or periodic national public education and awareness campaign on oral health - for example, by addressing common risk factors such as tobacco, alcohol or sugars?
(Please select only one option)

Examples of national public education and awareness campaigns include large-scale campaigns targeted at large segments of the population or the whole population using mass media and lasting for a longer period of time or repeated throughout the year.

- (a) Yes
(b) No
(c) Don't Know

- 1.10 Is your government advocating for increased commitment to oral health in the context of NCDs? (Please select only one option)

- (a) Yes
(b) No
(c) Don't Know

- 1.11 Has an oral health policy been passed or a law ratified since the endorsement of the Regional Oral Health Strategy in 2016?
(Please select only one option)

- (a) Yes
(b) No
(c) Don't Know

- 1.12 Has your government been able to increase the financial resources allocated to oral health since the endorsement of the Regional Oral Health Strategy in 2016?
(Please select only one option)

- (a) Yes
(b) No
(c) Don't Know

- 1.13 What are the sources of funding for your country's oral health activities?
(Please select all that apply.)

- (a) General government revenues
(The money received from taxation, and other sources, such as privatization of government assets, to help finance expenditures)
- (b) International donors
(Organizations which extend across national boundaries and which give funds for projects of a development nature)

- (c) Earmarked taxes on alcohol, tobacco etc.
(Taxes which are collected and used for a specific purpose)
- (d) Health insurance
- (e) Other
- (f) No funding for oral health activities

You chose 'other'. Please specify the other source of funding you selected:

- 1.14 Please indicate in the section below whether your country has established sustainable collaborations to serve the oral health agenda with the mentioned partners.

- 1.14.1 Donor agency or Development partner (Please select only one option)

(Development partners: Bilateral donors and multilateral agencies, including United Nations agencies and multilateral financial institutions - engage in social protection in different ways, applying different emphases that reflect their individual mandate)

- (a) Yes
(b) No
(c) Don't Know

If the answer is yes, please list the development partners with whom your country has established sustainable collaborations.

- 1.14.2 Civil society organization (Please select only one option)
(A civil society organization (CSO) or non-governmental organization (NGO) is any non-profit, voluntary citizens' group which is organized on a local, national or international level)

- (a) Yes
(b) No
(c) Don't Know

If the answer is yes, please list the civil society organization partners with whom your country has established sustainable collaborations.

- 1.14.3 Private sector (Please select only one option)

- (a) Yes
(b) No
(c) Don't Know

If the answer is yes, please list the private sector partners with whom your country has established sustainable collaborations.

1.15 Do you have a mechanism to ensure participation and/or empowerment of community and/or civil society in the promotion of oral health, prevention of oral health diseases or provision of oral health care? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If the answer is yes, please describe the mechanism. Please provide a URL of all supporting documents. Please upload relevant documents here.

Skip logic: If the answer is (a), go to question 1.16. If the answer is (b) or (c), go to 1.17.

1.16 At what stage is your country involving the community and/or civil society as a partner? (Please select all that apply.)

(A community is a specific group of people, often living in a defined geographical area, who share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. Civil society refers to a wide array of organizations: community groups, non-governmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations)

- (a) Planning
- (b) Implementation
- (c) Monitoring
- (d) Other
- (e) Don't Know

If you select 'other', please specify the other stages at which your country is involving the community and/or civil society as a partner.

1.17 What are the gaps, challenges and opportunities facing your country as you work on achieving *Area 1: Strengthening national advocacy, leadership and partnerships for*

addressing oral diseases as part of NCDs through a multisectoral approach? Please also describe any success stories in this area.

Area 2: Reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides.

2.1 Please indicate whether the Oral Health Unit/Directorate/Department or a dedicated officer working in oral health has participated in the following national programmes (you may select more than one option):

- (a) Tobacco control, including e-cigarettes programme
- (b) Reduce harmful alcohol consumption programme
- (c) Don't Know

2.2 Does the Oral Health Unit/Directorate/Department or a dedicated officer working in oral health participate in activities promoting a healthy diet? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Skip logic: If the answer is (a), go to question 2.3. If the answer is (b) or (c), go to 2.4.

2.3 What are the topics covered in the activity or activities identified in 2.2? (Please select all that apply.)

- (a) Reduce consumption of sugar
- (b) Reduce consumption of salt
- (c) Reduce consumption of saturated fat
- (d) Increase consumption of fruits, raw vegetables and dietary fibre
- (e) Other
- (f) Don't Know

If you select 'other'. What are the other topics covered in the activity or activities identified in 2.2?

2.4 Does the Oral Health Unit/Directorate/Department or a dedicated officer working in oral health promote healthy living and working environments conducive to healthy lifestyles - for example, by collaborating with the water sanitation and hygiene (WASH) team to improve access to safe water for proper oral hygiene in schools? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

2.5.1 Please indicate whether the Oral Health Unit/Directorate/Department or a dedicated officer working in oral health is advocating for regulating and/or banning **“the sale”** of the following unhealthy products.

Alcohol (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Tobacco (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Products high in sugar/fat/salt (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Please indicate the key settings in which the regulating and/or banning of **“the sale”** of each of these products is active:

Alcohol (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

Tobacco (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

Products high in sugar/fat/salt (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

2.5.2 Please indicate whether the Oral Health Unit/Directorate/Department or a dedicated

officer working in oral health is advocating for regulating and/or banning **“the advertisement”** of the following unhealthy products.

Alcohol (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Tobacco (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Products high in sugar/fat/salt (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Please indicate the key settings in which the regulating or banning of **“the advertisement”** of each of these products is active:

Alcohol (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

Tobacco (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

Products high in sugar/fat/salt (Please select all that apply.)

- (a) School
- (b) Workplace
- (c) Community
- (d) Other
- (e) Don't Know

2.6 Has your country integrated oral health into general school health interventions? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If the answer is yes, please select the type of oral health interventions (Please select all that apply).

- (a) Oral health education
- (b) Oral health check-up/screening and/or referral
- (c) Toothbrushing
- (d) Other

If you select 'other', please specify the other oral health interventions that your country integrated into general school health interventions.

2.7 Please select the fluoridation methods implemented in your country.

Fluoride toothpaste (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Salt fluoridation (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Water fluoridation (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Other (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If you select 'other', please specify the other fluoridation methods implemented in your country.

2.7.1 Please indicate if your country is using any of the following methods to promote the implementation of fluoride toothpaste use? Removed the value-added tax (VAT) from fluoride toothpaste. (Please select only one option)

(VAT: Value-added tax' (VAT) is a 'multi-stage' tax on all consumer goods and services applied proportionally to the price the consumer pays for a product. Although manufacturers and wholesalers also participate in the administration and payment of the tax all along the manufacturing/distribution chain, they are all reimbursed through a tax credit system, so that the only entity who pays in the end is the final consumer. Most countries that

impose a VAT do so on a base that includes any excise tax and customs duty. Example: VAT representing 10% of the retail price. Some countries, however, impose sales taxes instead. Unlike VAT, sales taxes are levied at the point of retail on the total value of goods and services purchased.)

- (a) Yes. Please state the year in which your country removed the value-added tax (VAT) from fluoride toothpaste.
- (b) No
- (c) Don't Know

Added to the essential medicine list (Please select only one option)

- (a) Yes. Please state the year in which your country added fluoridated toothpaste to the essential medicine list.
- (b) No
- (c) Don't Know

Promoted the use of fluoride toothpaste in specific settings. (Please select only one option)

- (a) Yes. Please state the year in which your country promoted the use of fluoridated toothpaste in specific settings.
- (b) No
- (c) Don't Know

2.7.2 Please indicate if your country is using any of the following methods to promote the implementation of salt fluoridation use?

Removed the value-added tax (VAT) from salt with fluoride. (Please select only one option)

(VAT: Value-added tax' (VAT) is a 'multi-stage' tax on all consumer goods and services applied proportionally to the price the consumer pays for a product. Although manufacturers and wholesalers also participate in the administration and payment of the tax all along the manufacturing/distribution chain, they are all reimbursed through a tax credit system, so that the only entity who pays in the end is the final consumer. Most countries that impose a VAT do so on a base that includes any excise tax and customs duty. Example: VAT representing 10% of the retail price. Some countries, however, impose sales taxes instead. Unlike VAT, sales taxes are levied at the point of retail on the total value of goods and services purchased.)

- (a) Yes. Please state the year in which the VAT was removed from salt with fluoride.
- (b) No
- (c) Don't Know

Added to the essential medicine list (Please select only one option)

- (a) Yes. Please state the year in which your country added salt with fluoride into the essential medicine list.
- (b) No
- (c) Don't Know

Promoted the salt fluoridation in specific settings. (Please select only one option)

- (a) Yes. Please state the year in which your country promoted salt fluoridation in specific settings.
- (b) No
- (c) Don't Know

2.7.3 Please indicate whether your country has participated in lobbying to promote water fluoridation? (Please select only one option)

- a) Yes. Please state in which year your country has initiated the lobbying.
- b) No
- c) Don't Know

2.8 Has your country enacted legislation related to the promotion of quality fluoride toothpaste? (Please select only one option)

- (a) Yes.
- (b) No
- (c) Don't Know

If yes, please list the name(s) of the legislation(s) related to the promotion of quality fluoride toothpaste and the date it was passed. _

If yes, please provide URL for all fluoride toothpaste supporting documents.

2.9 Has your country enacted legislation related to the promotion of other oral health products? (Please select only one option)

- (a) Yes.
- (b) No
- (c) Don't Know

If yes, please list the name(s) of the legislation(s) of other oral health products and the date it was passed.

If yes, please provide electronic copy of all supporting documents for other legislation.

2.10 What are the gaps, challenges and opportunities facing your country as you work on achieving *Area Reduce common risk factors, promoting oral health and ensuring access to appropriate fluorides*? Please also describe any success stories in this area.

Area 3: Strengthen health system capacity for integrated prevention and control of oral diseases.

3.1 Does your country have a defined Essential Health Package? (Please select only one option)
(In the WHO African Region, many countries have been defining the essential services as an essential health/basic package that is affordable. The essential health package often consists of a limited list of public health and clinical interventions to be provided at primary and/or secondary level care.)

- (a) Yes
- (b) No
- (c) Don't Know

Skip logic: If the answer is (a), go to question 3.2. If the answer is (b), go to 3.4.

3.2 Does the Essential Health Package include oral health services? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If yes, please state in which year oral health has been included.

If yes, please provide a URL of all supporting documents.

If yes, please provide electronic copy of all supporting documents.

3.3.1 Please select the services that are included in the essential (oral) health package.

Screening for oral conditions
(Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Urgent treatment for providing emergency oral care and oral pain relief (Please select only one option) (Urgent or emergency oral health care may include interventions that address acute oral infections; swelling; systemic infection; significant or prolonged bleeding; severe pain not controllable with analgesia; oral health care interventions that are medically required as a pre-intervention to other urgent procedures; and dental/orofacial trauma)

- (a) Yes
- (b) No
- (c) Don't Know

Basic restorative dental procedures to treat existing dental caries (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Other (Please select only one option)

- (a) Yes. If yes, please specify what other services are being provided.
- (b) No
- (c) Don't Know

3.3.2 Please provide the target population covered by the included oral health service.

Screening for oral conditions
(Please select all that apply).

- (a) All ages
- (b) Children and/or Adolescents and/or youth
- (c) Elderly
- (d) Other

Urgent treatment for providing emergency oral care and oral pain relief (Please select all that apply).

- (a) All ages
- (b) Children and/or Adolescents and/or youth
- (c) Elderly
- (d) Other

Basic restorative dental procedures to treat existing dental caries (Please select all that apply).

- (a) All ages
- (b) Children and/or Adolescents and/or youth
- (c) Elderly
- (d) Other

Other (Please select all that apply).

- (a) All ages
- (b) Children and/or Adolescents and/or youth
- (c) Elderly
- (d) Other

3.3.3 Please provide the situation of the treatment's payment. (Please select all that apply).

Screening for oral conditions (Please select all that apply)

- (a) Completely free of charge through a National Public Health Insurance Scheme
- (b) Completely free of charge through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (c) Individual pays part of the service cost through a National Public Health Insurance Scheme
- (d) Individual pays part of the service cost through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (e) Individual pays the full cost of service
- (f) Other
- (g) Don't Know

Urgent treatment for providing emergency oral care and oral pain relief (Please select all that apply).

- (a) Completely free of charge through a National Public Health Insurance Scheme
- (b) Completely free of charge through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (c) Individual pays part of the service cost through a National Public Health Insurance Scheme
- (d) Individual pays part of the service cost through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (e) Individual pays the full cost of service
- (f) Other
- (g) Don't Know

Basic restorative dental procedures to treat existing dental caries (Please select all that apply).

- (a) Completely free of charge through a National Public Health Insurance Scheme
- (b) Completely free of charge through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (c) Individual pays part of the service cost through a National Public Health Insurance Scheme
- (d) Individual pays part of the service cost through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (e) Individual pays the full cost of service
- (f) Other
- (g) Don't Know

Other (Please select all that apply).

- (a) Completely free of charge through a National Public Health Insurance Scheme
- (b) Completely free of charge through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (c) Individual pays part of the service cost through a National Public Health Insurance Scheme
- (d) Individual pays part of the service cost through a third-party payment schemes in health insurance (e.g., voluntary insurance)
- (e) Individual pays the full cost of service
- (f) Other
- (g) Don't Know

3.4 Has your country developed a list of dental essential consumables, drugs or other supplies for the management of oral diseases? (Please select only one option)

- (a) Yes.
- (b) No
- (c) Don't Know

Skip logic: If the answer is (a), go to question 3.5. If the answer is (b) or (c), go to 3.7.

3.5 Has your country integrated this list of oral health essential consumables, drugs or other supplies into the essential medicine list? (Please select only one option)

- (a) Yes.
- (b) No
- (c) Don't Know

If yes, please provide a URL of all supporting documents.

If yes, please provide electronic copy of all supporting documents.

3.6 Has your country distributed the oral health essential consumables, drugs or other supplies for the management of oral diseases at the primary care level? (Please select only one option)

- (a) Yes.
- (b) No
- (c) Don't Know

If yes, please indicate the percentage coverage of distribution at primary care level (Please select only one option)

- (a) More than 50% of primary care facilities are covered in my country
- (b) Less than 50% of primary care facilities are covered in my country
- (c) Don't Know

3.7 Is your country taking active measures to phase down the use of dental amalgams? (Please select only one option)

- (a) Yes. Please describe what measures your country is taking to phase down the use of dental amalgams.
- (b) No
- (c) Don't Know

3.8 Does your country have maintenance plans of dental equipment to ensure their operational functions? (Please select only one option)
Maintenance of dental equipment is the process of keeping the dental equipment in proper working order to avoid them breaking down, and restoring to working order when needed.

- (a) Yes.
- (b) No
- (c) Don't Know

Skip logic: If the answer is (a), go to question 3.9. If the answer is (b) or (c), go to 3.10.

3.9 Are the maintenance plans operational?
(Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

3.10 Are oral health professionals being trained alongside other health and community workers as part of training in NCD interventions? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

3.11 Does your country have a plan for task shifting oral health care to non-oral health professionals? (Please select only one option)
(Task shifting involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.)

- (a) Yes
- (b) No
- (c) Don't Know

If yes, please provide a URL of all supporting documents.

If yes, please provide an electronic copy of all supporting documents.

Skip logic: If the answer is (a), go to question 3.12. If the answer is (b) or (c), go to 3.13.

3.12 Please indicate whether your country has defined the required competencies for oral health care for each of the following health care provider categories
(A competency is the observable ability of a person, integrating knowledge, skills, and attitudes when performing tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable.)

Doctor (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Nurse (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Midwife (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Community Health Worker
(Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Other (Please select only one option)

- (a) Yes. Please specify who the other health care providers are.
- (b) No
- (c) Don't Know

3.13 What are the gaps, challenges and opportunities facing your country as you work on achieving *Area 3: Strengthen health system capacity for integrate prevention and control of oral diseases*? Please also describe any success stories in this area.

Area 4: Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research.

4.1 Please select the systems or survey tools that have integrated oral health data.
(Please select all that apply.)

- (a) National Health Management Information System.
- (b) District Health Information System 2 (DHIS2).
- (c) Integrated Disease Survey Response (IDSR).
- (d) Other.

(e) No integration of oral health data or survey tools into the existing system.

(f) Don't Know

- Please state the year of integration into the National Health Management Information System.
- Please state the year of integration into the District Health Information System.
- Please state the year of integration into the Integrated Disease Survey Response.
- Please list other systems or survey tools being used.
- Please provide a URL describing data being collected for surveillance.
- Please provide an electronic copy of documents describing data being collected for surveillance.

4.2 Sentinel surveillance involves a limited number of recruited participants, such as health care providers or hospitals, who report specified health events that may be generalizable to the whole population. Please select the oral health conditions that are being monitored under the sentinel surveillance system. (Please select all that apply.)

(a) Oral Cancer

(b) Noma

(c) Infant Oral Mutilation (It involves the extraction of unerupted deciduous canine teeth in young infants owing to the corresponding swellings being mistaken as the cause of diarrhoea and fever. The rudimentary practice, undertaken by local healers, can sometimes be fatal. (V. Wordley & R. Bedi, 2019))

(d) Other.

(e) No oral health condition is being monitored under the sentinel surveillance system.

(f) Don't Know

If you select 'other', please specify the other oral health conditions that are being monitored under the sentinel surveillance system.

4.3 Has your country conducted population-based oral health studies? (Please select only one option)

(a) Yes

(b) No

(c) Don't Know

Skip logic: If the answer is (a), go to question 4.4. If the answer is (b) or (c), go to 4.5.

4.4 Have you used the data from the population-based study?

(a) Yes

(b) No

(c) Don't Know

If you select yes, please select the purpose of the usage of the data. (Please select all that apply)

(a) Advocacy

(b) Planning

(c) Monitoring

(d) Other

You selected 'other'. Please specify the other purposes of usage of data.

4.5 If your country has an existing oral health policy/plan/programme, do you have an established monitoring and evaluation system to track progress in the implementation of these plans? (Please select only one option)

(a) Yes

(b) No

(c) Don't Know

(d) Not Applicable (no oral health policy/plan programme)

Skip logic: If the answer is (a), go to question 4.6. If the answer is (b), (c) or (d), go to 4.7.

4.6 Do you use innovative data collection technologies in the process? (Please select only one option)

(a) Yes

(b) No

(c) Don't Know

If yes, please describe the innovative data collection technologies being used in the process. (e.g. leverage mobile technology)

4.7 Has your country established partnerships to develop and implement operational research for strengthening evidence-based decision-making, policies and advocacy concerning oral health? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

If yes, please list the names of your country partners made to develop and implement operational research for strengthening evidence-based decision-making, policies and advocacy concerning oral health.

4.8 Has your country supported the development of tools and best buys (cost-effective interventions) for the integrated prevention and management of oral diseases within NCD programmes? (Please select only one option)

- (a) Yes
- (b) No
- (c) Don't Know

Skip logic: If the answer is (a), go to question 4.9. If the answer is (b) or (c), go to 4.10.

4.9 Describe the type of support provided for the development of best buy interventions (e.g., financial support).

4.10 What are the gaps, challenges and opportunities facing your country as you work on achieving *Area 4: Improve integrated surveillance of oral diseases, monitoring and evaluation of programmes and research?* Please also describe any success stories in this area.

FINAL question

Please add your comments on the barriers and challenges facing implementation and the opportunities to accelerate the oral health agenda in your country as well as any suggestions or requests for WHO.

This checklist is to help you revise whether the requested documents have been shared.

Document	Please check if you shared the document.	Please check if you were unable to share the document.
1.7 Oral Health Policy, Strategy, Plan		
1.8 Relevant public health programmes which include oral health agendas		
1.15 Documentation demonstrating a mechanism to ensure participation and empowerment of community		
2.8 Documentation related to fluoride toothpaste legislation		
2.9 Documentation related to oral health products apart from fluoride toothpaste		
3.2 Description of oral health care services in essential health package		
3.11 Plan for task shifting		
4.1 Data being collected for surveillance		
Any other document you think could be useful to the assessment (Please name it)		



**World Health
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African Region