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**IMPLEMENTATION OF THE REGIONAL ORAL HEALTH STRATEGY:
UPDATE AND WAY FORWARD**

Report of the Regional Director

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BACKGROUND

1. Oral health (ORH) is an essential component of health in general. Considering their morbidity and their socioeconomic impact, oral diseases are a major public health problem even though they can be avoided. Their consequences, such as pain and functional limitations, have an adverse impact on the health of individuals and communities.

2. In 1998, the WHO Regional Committee for Africa adopted a ten-year (1999–2008) regional strategy for oral health.¹ The strategy underlines the most severe oral health problems that people live with. It sets out five priority thrusts: development and implementation of national strategies, integration of oral health into health programmes, service delivery, a regional education and training approach, and development of an oral health management information system.

3. Dental caries and diseases of the tissues supporting the dentition are predominant oral diseases because of changes in the diets of people and inadequate management of these conditions. In 2003, between 60% and 80% of school-age children² in the African Region, who represent the most vulnerable group, were affected. In adults, noncommunicable diseases are sometimes responsible for gingival diseases, other diseases of the supporting tissues and tooth loss. Diabetes, cardiovascular diseases, cancers and chronic respiratory diseases share common risk factors with oral diseases;³ some of these factors, like excessive intake of sugar and alcohol, use of tobacco and poor oral hygiene, can be avoided.

4. Noma is a major problem in the Region. It has well-known risk factors: poverty, malnutrition, infectious diseases such as measles, malaria and HIV/AIDS. Noma affects especially children aged between 2 and 6 years causing severe orofacial mutilations and a high mortality if left untreated. Based on notifications by 22 countries in 2006, the number of cases of noma in the Region was estimated at 42 800.⁴ Some countries like Lesotho, Zambia and Zimbabwe reported cases of noma among children and adults infected with HIV.⁵

5. Among HIV-infected patients, the prevalence of oral lesions associated with the infection varies between 50% and 60%; the severity of these lesions is recognized as an indicator of HIV infection and a prediction of progression of the infection into AIDS.⁶ Oropharyngeal cancers are also on the increase in many countries generally due to increasing tobacco abuse. In Africa, between 1995 and 1998, the age-standardized incidence of oropharyngeal cancers was 1.9 per 100 000 inhabitants;⁷ in 2005 it rose to 6.9 per 100 000 inhabitants in eastern and southern Africa.⁸

¹ WHO, *Oral health in the African Region: A regional strategy 1999–2008*, Brazzaville, World Health Organization, Regional Office for Africa (AFR/RC48/R5), 1998.

² Petersen PE et al, The global burden of oral diseases and risks to oral health, *Bulletin of the World Health Organization* 83(9): 661–669, 2005.

³ WHO, *The world oral health report 2003*, Geneva, World Health Organization (WHO/NMH/NPH/ORH/03.2), 2003.

⁴ WHO, Noma today: a public health problem? Report of an expert consultation organized by the Oral Health Unit of the World Health Organization using the Delphi method, Geneva, World Health Organization (WHO/MMC/NOM/98.1), 1998.

⁵ Chidzonga MM, HIV/AIDS orofacial lesions in 156 Zimbabwean patients at referral oral and maxillofacial surgical clinics, *Oral Diseases* 9: 317–322, 2003.

⁶ Coogan M, Greenspan J, Challacombe S, Oral lesions in infection with human immunodeficiency virus, *Bulletin of the World Health Organization* 83 (9): 700–706, 2005.

⁷ Parkin DM et al, *Cancer in Africa: Epidemiology and prevention*, Lyon, IARC Scientific Publication No. 153, 2003.

⁸ Petersen PE et al, The global burden of oral diseases and risks to oral health, *Bulletin of the World Health Organization*, 83(9): 661–669, 2005.

6. During the Sixtieth World Health Assembly, Member States adopted Resolution WHA60.17 on oral health.⁹ The resolution emphasizes the need to incorporate oral diseases into noncommunicable disease programmes.

7. The purpose of this document is to report on the progress made during the ten years of implementation of the regional strategy for oral health and propose new actions, taking into account current issues and challenges and in keeping with the recommendations contained in Resolution WHA60.17.

ISSUES AND CHALLENGES

8. Since the adoption of the regional strategy, significant progress has been made by Member States. However, many issues and challenges persist.

9. Twenty-two countries have developed and started implementing national oral health policies, strategies and programmes¹⁰ based on a manual produced by WHO. Nine countries have national noma control programmes. In 1998, 14 countries had an oral health officer in the Ministry of Health; according to a regional survey conducted in 2007, the results of which will soon be published, this number increased to 23, reflecting an effort by governments in favour of oral health. However, oral health officers are rarely involved in decision-making regarding the planning and development of health programmes.

10. Concerning the integration of oral health into health programmes, 25 countries have developed specific oral health interventions in HIV/AIDS control, maternal and child health, and school health. The oral health programme is however implemented piecemeal in national health plans.

11. Oral health care services are located mainly in national or regional hospitals in urban centres. In 2007, geographical coverage was estimated at one dental service for 146 534 inhabitants. However, dental services pay very little attention to preventive and preservative dental care, and are essentially geared towards emergency treatment with the attendant risks of nosocomial infection. Facilities and equipment are grossly inadequate. Moreover, most dental services are dependent on sophisticated technology which poses serious problems of supply and maintenance.

12. The methods and tools of prevention of oral diseases are known but they have not always been integrated into action plans; the interventions proposed in the regional strategy were hardly implemented. In spite of the strategic orientations provided in the strategy, the prevention of oral diseases and promotion of oral health were not given priority, and the health interventions implemented did not place sufficient emphasis on primary prevention. Fluoridation as a public health measure is not widely used. At the same time, defluoridation whenever there is excess fluoride in the water is not widely practised. Community participation in improvement of oral health remains weak.

13. Twenty countries have reported that they have domestic financing and additional funding by partners mainly for implementation of the noma control programme; however, in Member States, resources allocated to oral health are limited and inadequate, coming essentially from the national budget. The resources do not permit the implementation of some activities, such as the use of

⁹ Resolution WHA60.17, Oral health: action plan for promotion and integrated disease prevention, Sixtieth World Health Assembly, Geneva, May 2007.

¹⁰ WHO, Writing oral health policy: A manual for oral health managers in the WHO African Region, Brazzaville, World Health Organization, Regional Office for Africa (AFR/ORH/05.1), 2005.

fluorine, that are inaccessible or costly. The cost of treatment of oral diseases is high,¹¹ and lack of management of these diseases has a significant economic and social impact on people.

14. A regional education and training approach has been developed based on the guidance provided in the regional strategy. The dentist per inhabitants ratio has improved significantly, from 1:150 000 in the late 1990s¹² to 1:31 000 in 2004,¹³ representing a total of 23 735 dentists. Auxiliaries in the dental profession have been trained using the Primary Health Care (PHC) approach. They include 1000 dental nurses in 17 countries and 7717 dental hygienists in 30 countries practising at district level. There are significant disparities between countries; the human resources of the Region fall short of the needs of countries and the WHO standards and recommendations of at least one dentist per 10 000 inhabitants, thus hampering efforts to decentralize the provision of oral health services. The training of dentists is often ill-adapted to needs, and auxiliary dental personnel very often work without a referral system.

15. Fifteen countries have a system for collection of data on oral diseases that is essentially focused on dental caries and periodontal diseases. The overall picture of oral diseases has changed, especially with the emergence of oral manifestations of HIV/AIDS. Existing surveillance systems are no longer in keeping with the epidemiological profile of oral diseases, hence the need for a review of indicators. WHO has compiled a list of 22 essential indicators,¹⁴ giving special attention to vulnerable groups and the negative consequences of risk factors. Though these indicators were selected on the basis of quality criteria, their use will depend on the performance of national health information systems which have been weak, resulting in inadequate availability of reliable data.

16. STEPwise surveys on noncommunicable disease risk factors did not include the oral health module. There are virtually no ORH-specific operational researches, thus limiting relevant information for planning. The involvement of development partners in research and oral health is generally weak.

ACTIONS PROPOSED

17. The ten-year (1999–2008) strategy for oral health in the WHO African Region remains relevant. The progress made in its implementation can be consolidated and the challenges addressed through appropriate actions.

18. **Strengthen the political commitment of governments.** This is crucial to implementing the guidelines contained in the regional strategy. It is also essential to strengthen advocacy, resource mobilization and allocation, collaboration and partnership, capacity building and public education.

19. **Strengthen national coordination of oral health programmes** by appointing an officer in the Ministry of Health to facilitate the development of policy on oral health including noma, concerted actions and effective implementation of programmes. In countries where oral health officers have already been appointed, their duties should be clearly defined and their authority strengthened.

¹¹ WHO, *The world oral health report 2003*, Geneva, World Health Organization (WHO/NMH/NPH/ORH/03.2), 2003.

¹² WHO, *The world oral health report 2003*, Geneva, World Health Organization (WHO/NMH/NPH/ORH/03.2), 2003.

¹³ WHO, *The African regional health report, 2006*, Geneva, World Health Organization, 2006.

¹⁴ WHO, *Standardization of oral health information in the African Region: Report of the regional workshop, May 2005*, Brazzaville, World Health Organization, Regional Office for Africa (AFR/ORH/07.1), 2007.

20. **Adopt an integrated approach** to improving oral health, in keeping with Resolution WHA60.17 and based on the common risk factor approach, by prioritizing actions for sensitization and education of people. Oral health will be integrated into primary schools curricula and in programmes relating to school health, HIV/AIDS, maternal and child health, Integrated Management of Childhood Illness and noncommunicable diseases. The Primary Health Care strategy will continue to be the cornerstone of the acceleration of the implementation of integrated oral health programmes, thus enabling rural communities and vulnerable groups to have access to basic care. WHO will facilitate the development and implementation of the integrated approach for the incorporation of oral health into other programmes by providing appropriate technical guides to Member States.

21. **Develop and implement oral health promotion programmes**, with emphasis on the identification of health determinants in communities and on community participation in health. WHO will promote the development of mechanisms to enhance capacity to design and implement oral health prevention interventions.

22. **Increase national budget allocation** to oral disease prevention and control activities and involve oral health officers in their management. WHO will join forces with Member States in the mobilization of additional resources.

23. **Invest in appropriate infrastructure and equipment**, and develop a management system for their maintenance and for regular supply of consumables. Special attention should be given to the prevention of nosocomial infections. Dental medicines will be made available, and accessibility will be ensured using the PHC-based concept of essential medicines.

24. **Increase the availability of skilled and motivated oral health personnel** to address the needs of people particularly at district level. For this purpose, it will be necessary to develop training programmes, including supervisory training for staff categories matching the existing needs and infrastructure of countries, and also to promote networking and alliance building for the sharing of positive experiences at regional level.

25. **Develop or strengthen surveillance systems** of programmes by integrating essential oral health indicators into the health information system. It will also be necessary to promote the incorporation of noma surveillance into the integrated disease surveillance and response system and to include the oral health module in the WHO STEPwise surveys.

26. **Encourage research to provide evidence** on the cost-effectiveness of oral health interventions. Research is also required on the public health implications of excess fluoride consumption. Facilitate the development of methods and tools for monitoring and evaluation of the implementation of oral disease prevention and oral health promotion interventions.

27. **Strengthen intersectoral and multisectoral partnerships**, including the private sector and nongovernmental organizations. WHO collaborating centres and other partners will be involved in the implementation of national oral health programmes.

28. The Regional Committee is invited to examine and adopt the actions proposed.