

**From:** Oral health Algérie  
**Sent:** Fri, 17 Sep 2021 11:26:42 +0200  
**To:** VARENNE, Benoit;Fatima BOUSMAHA;ytarfani@yahoo.fr  
**Subject:** [EXT] consultation en ligne

Bonjour Dr Benoit,  
en espérant que vous allez bien ,  
concernant le:

"PROJET DE STRATÉGIE MONDIALE POUR LA SANTÉ BUCCO-DENTAIRE " et de la consultation en ligne: le document répond parfaitement à nos attentes, il est en corrélation avec la "Stratégie Régionale de la Santé bucco-dentaire 2016-2025"

Nous ne pouvons que saluer et encourager les efforts en espérant vivement que le projet soit retenu par le Conseil Exécutif ce qui permettra d'asseoir une véritable politique de santé orale .

cordialement

Dr F.SAIBI/chargée du Programme national de SBD-Ministere de la santé /Algérie

**To:**

VARENNE, Benoit

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## AUSTRALIA

### ***Consultation for Member States on a draft global strategy on oral health***

**September 2021**

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Australia thanks the WHO and academic group for their work on developing the *Draft Strategy on Oral Health* as outlined in the WHO Discussion Paper, in line with resolution WHA 74.5 *Oral health*. For WHO's consideration, Australia has provided general comments on the overall strategy, as well as comments on Strategic Objectives 3, 4 and 5 in the proposed *Draft Strategy on Oral Health*.

#### **General comments on the *Draft Global Strategy on Oral Health***

The *Draft Global Strategy on Oral Health* strongly advocates for universal oral health coverage by 2030. This is supported by Australia and there is alignment between the *WHO Draft Global Strategy* and [Australia's National Oral Health Plan 2015-2024](#). The WHO may wish to consider the approach of 'proportionate universalism' within the *Draft Global Strategy on Oral Health*. This is in recognition that some populations may require additional support or targeted interventions. Using an example from one of the guiding principles in [Australia's National Oral Health Plan 2015-2024](#), the use of 'proportionate universalism' means there is a combination of universal and targeted activities so that vulnerable populations receive additional interventions and support.

Within the *Draft Global Strategy on Oral Health*, the WHO could further consider the roles and structures of national or sub-national management of oral health. For example, there is a shared role between Australian State and Territory Governments in the delivery of oral health care. The *Draft Global Strategy on Oral Health* could consider including both national and sub-national approaches for the management and service delivery associated with oral health.

#### **Strategic Objective 3: Primary Oral Health Care - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care**

For Australia to engage with objective as it relates to health workforce, Australia would refer to recommendations with [Australia's National Oral Health Plan 2015-2024](#). These are aligned with principles in the *Draft Global Strategy on Oral Health*. Relevant recommendations include developing the oral health workforce to meet demand, integrating oral health information management systems with other health information management systems, and tailoring oral health programs across the life course.

**Strategic Objective 4: Oral Health Information Systems - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making**

At present, Australia would have difficulty engaging with this strategic objective and other Member States may face similar challenges. Data on dental services provided in Australia is limited, especially in relation to services provided in the private sector. Furthermore, there are no comprehensive national data sources available. Whilst national public dental service data is collected routinely, it is not nationally comparable, and the available data only focuses on waiting times for some eligible adult patients. Nevertheless, Australia is committed to presenting the most up-to-date data available on the oral health status of Australians and their use of dental care services for use by decision-makers for evidence-based policy making. Australia plans to redevelop this dataset in the future with the aim of producing a nationally comparable, comprehensive dataset.

**Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health**

Where appropriate Australia evaluates the evidence generated by new public health programs or interventions. Australia will look for opportunities for these evaluations to update the research agenda on oral health.

**World Health Organization (WHO) Draft Global Strategy on Oral Health  
Government of Canada's Response for the Web-based Consultation**

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- The Global Strategy on Oral Health is an opportunity to draw attention, at a global level, to the burden of oral diseases.
- Overall, the Strategy seems to be fully in keeping with the technical elements of the Resolution on oral health and the associated Director-General report.
- We would like to note that various diseases, hygienic practices and lifestyle habits may lead to oral health issues that are generally addressed from a curative perspective. It would be helpful to elaborate on the links between nutrition and oral health (e.g. prevention of cleft lip with folic acid supplementation), as well as health issues that could be prevented through appropriate oral health care (e.g. endocarditis and potential pregnancy issues).
- From a technical perspective, the Government of Canada also has the following minor suggestions to propose:
  - In paragraph 4, we would suggest adding the following as a final sentence: “Oral diseases contribute to a number of additional oral diseases and conditions, and vice versa.”
  - We would propose further emphasizing community water fluoridation in paragraph 12 by adding “(e.g. community water fluoridation)” after “community-based methods.”
  - The list of providers in paragraph 14 could be more comprehensive by adding “denturists” among the others already listed (dental assistants, dental nurses, dental therapists and dental hygienists).
  - We would suggest referencing “evidence-based” oral health strategies in paragraph 23.
- Canada thanks WHO for the opportunity to provide feedback.

**From:** BERJAoui, Roxane (DGS/MAEI)  
**Sent:** Thu, 16 Sep 2021 10:38:26 +0000  
**To:** VARENNE, Benoit  
**Cc:** MIKKELSEN, Bente  
**Subject:** [EXT] Draft global strategy on oral health for global web-consultation

Dear colleagues,

France has no specific comments and is looking forward to the action plan for oral public health by 2023 as part of the global oral health strategy.

We are maybe going to prepare specific national recommandations/strategy for oral health as preventive measures and recommandations for oral health are for the moment part of the new Public Health National Strategy , settled a few years ago.

We noted with interest that the action plan states to establish a framework for monitoring progress with clear measurable targets to be achieved by 2030, including tobacco control, alcohol use and so on, as well as community dentistry, health promotion and health education, plus prevention and essential curative care as basic tools for a healthy mouth for all.

This action plan should also include the use of modern digital technology in the area of telemedicine.

Thanks to you.

Best regards,

Dr Roxane BERJAoui / Public Health Doctor MD  
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de la santé**

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Les ministères sociaux agissent pour un développement durable.

Préservons l'environnement : n'imprimons que si nécessaire !

**To:**

VARENNE, Benoit

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Athens 17.9.2021

Consultation on the *WHO Draft Global Strategy on Oral Health* – Official Proposals of the Hellenic Republic (Approved by the Ministry of Health).

Dear Dr Varenne,

Responding to the Consultation on the *WHO Draft Global Strategy on Oral Health* we submit you the official proposals of the Hellenic Republic, approved by the Ministry of Health. The proposals are marked with blue bold letters and characters.

A. We consider very important the existence of sustainable financing of the universal coverage of oral health. Therefore, we propose that the strategy plan be completed as follows:

In the point 30 of the draft, between the second and the third sentence, we suggest to include the following:

*“Oral health providers should be members of the primary health care team and work side-by-side with other health workers in tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups. Financial protection through expanded health insurance coverage - including coverage of oral health services - is one of the cornerstones of universal health coverage. **A guaranteed minimum share of public health expenditure directed exclusively to oral health and dental care is crucial for the above.** Ensuring the reliable availability and distribution of essential medical consumables, generic medicines and other dental supplies is also important for the management of oral diseases and conditions in primary health care and referral services.”*

B. In the point 39 of the draft, we suggest to include the following at the end of the paragraph:

Member States have the primary role in responding to the challenge of oral diseases and conditions. Governments have the responsibility to engage all sectors of society to generate effective responses for the prevention and control of oral diseases and conditions, the promotion of oral health and reduction in oral health inequalities. They should secure appropriate oral health budgets based on intervention costing and investment cases to achieve universal oral health coverage. ***The guaranteed minimum share of public health expenditure directed exclusively to oral health and dental care, mentioned in point 30, is advised to be adopted by the member states.***

C. Also, for the effective monitoring of the oral health of the population and the informed decision making, it is proposed in the point 43 of the draft, to include the following:

Member States should improve oral health surveillance, data collection and monitoring to inform decision-making and advocacy, ***through creating National Monitoring Centres for Oral Health***. This includes strengthening integrated surveillance of oral diseases and conditions, as well as analysis of oral health system and policy data, evaluation of oral health programmes and operational research.

Please accept our warm congratulations for your important contribution on the promotion of oral health policies.

Sincerely yours,

Dr. Aristomenis Syngelakis, Chief Dental Officer, Hellenic Republic

Mrs. Maria Lemonia Tsantidou, Deputy Chief Dental Officer, Hellenic Republic

## WHO National Strategy Oral Health (Draft)

**For 17<sup>th</sup> September 2021**

### **1. Introduction**

At the meeting of August 31<sup>st</sup> Ireland presented its views on the WHO National Oral Health Strategy (Draft). Ireland agrees with the Vision and Goals, the Strategic Objectives, and the roles of EU members states, international partners, and WHO secretariat. We are totally committed to advancing the WHO strategy. As a follow up, Ireland is submitting in writing its comments. The following format has been used:

- An overview of the WHO draft strategy (Section 2).
- An overview of the National Irish Oral Health Policy – Smile agus Sláinte (Section3).
- **Comparison of WHO draft strategy and Smile agus Sláinte (Section 4)** specifically re
  - Vision & Goals,
  - Specific Objectives
- The views of Ireland on the role responsibilities of all entities (**Section 5**).
- **Key comments and clarifications from Ireland re the WHO Draft Strategy (Section 6)**.

The Sections 2 and 3 provide background for the reader. However, **Section 4** identifies the challenges Ireland will face as a member state to implement the WHO strategy and seeks some clarifications. **Section 6 highlights the keys points for Ireland some of which were already presented on August 31<sup>st</sup> at the Geneva meeting for Permanent Missions re Non-Communicable Diseases.** Key issues are highlighted in **bold text** to help the reader.

### **2. Overview of WHO Draft Strategy**

#### **2.1 Background and Context**

- The WHO Draft strategy, to tackle oral diseases, was published on foot of the **World Health Assembly (WHA 74th)**, May 31<sup>st</sup>.
- **The WHO strategy estimates that almost half of the global population are affected by key oral diseases;** dental decay (caries), gum (periodontal) disease, oral cancer.
- **The prevention and care of other rarer conditions, cleft lip and palate and Noma, remains of concern.** Noma, a necrotising, disfiguring facial condition, is a marker of severe poverty and must be addressed.
- **Oral health is defined in terms of its impact on quality of life**, where good oral health enables a person's full participation into society and to achieve their full potential.
- **The links between poor oral health and other non-communicable diseases** are emphasised: cardiovascular disease, diabetes, respiratory conditions, cancer, obesity.
- **Non-Communicable Diseases (NCDs) and poor oral health, share common risk factors** such as tobacco, alcohol, diet, and HPV. Tackling these factors conjointly will enable both better general and oral health.
- **The fiscal impact of poor oral health** is due to the both the impact on participation in society and the cost of care for the private individual.
- Poor oral health is associated with socio-economic deprivation. Resultant **inequalities** are reflected in the amount and severity of dental disease for poor and vulnerable groups.
- Oral health promotion, especially **sugar policies**, are rarely employed **at a national level**.
- Enabling the population **to access fluoride remains challenging** and expensive for people.
- **Oral Healthcare systems are isolated** from the rest of primary care and NCD services.

- **Workforce planning for oral healthcare**, if undertaken, focuses on highly specialised training for dentists. It should include **expansion of other oral healthcare professionals**.
- The **Covid-19 pandemic has impacted detrimentally** on oral healthcare services worsening inequalities. An opportunity to strengthen and integrate with general health services should be seized.

## 2.2 WHO Vision

**Universal Oral Health Care** ensuring access to **ESSENTIAL** oral healthcare, without hardship, by 2030.

## 2.3 WHO Goal

For **WHO to guide member states to produce national plans** that 1) promote good oral health, 2) reduce oral health inequalities, 3) progress towards UHC 4) can evaluate the success of initiatives.

**2.4 WHO 5 strategic guiding principles:** 1) public health approach, 2) integrating oral and general health care, 3) workforce planning and skill mix, 4) people-centred services, 5) appropriate healthcare across the life course, 5) use of digital technology.

## 2.5 WHO Strategic Objectives

- 1) **Governance** - Resources and a national leadership unit to support planning of services
- 2) **Oral health promotion**- Both at policy level and personal prevention. Common risk factor approach – tackle tobacco, alcohol, diet at State and at patient/ one-to-one level.
- 3) **Primary Oral Health Care** – To increase access **to basic** oral health care and align with general healthcare. To ensure financial support for individuals for services and preventive products and medicines.
- 4) **Surveillance**- Ensure adequate systems are in place to plan oral health care and evaluate policies.
- 5) **Research** – Refocus research from identifying problems to solving problems. A focus on assessing interventions e.g., minimal restorations and cost analyses.

## 2.6 Role of WHO

- Set the direction of global oral health advocacy, articulate evidence-based policy principles and provide member states with technical and strategic support.
- WHO will work with global public health partners specially to facilitate implementation in low- and middle-income countries.
- By 2023 will translate strategy into an action plan. By 2024 will recommend cost effective interventions.
- WHO will continue to provide technical guidance including sustainability and consider classifying Noma as a neglected tropical disease.
- WHO will create an oral health data repository and develop indicators for surveys.

## 2.7 Role of Member States

- To generate effective responses for the **prevention and control of oral disease**/conditions and reduction of oral health inequalities.
- **Secure oral health budgets** to enable universal oral health coverage
- **Strong leadership**, coordination, and accountability in oral health.

- Integrate **primary oral health care as part of universal oral health care**, ensure affordability of care, prevention, and personal oral health products e.g., toothpaste
- **Assess workforce** with a focus on mid-level and lay providers.
- **National policies** on risk factors and unhealthy products **e.g., sugar**
- **Oral health surveillance**, monitoring and data collection to inform planning.
- **Refocus training and education of professionals** (dentists and oral health care professionals) to refocus on public health, prevention, problem solving and leadership skills for future professionals.

## 2.8 Role of International Partners

- Role in advocacy, mobilizing resources, source of information, capacity building and research.
- **Partners should work as an international coalition on oral health to be effective.**

# 3. Overview of the National Oral Health Policy: Smile agus Sláinte

## 3.1 Background to current position and future direction: Smile agus Sláinte

The [National Oral Health Policy](#), a whole government policy for Ireland, was published April 2019.

The need for a new Oral Health Policy was driven by three key considerations: changes in oral health; changes in demographics; and changes in technology. The development of the National Oral Health Policy, Smile agus Sláinte (Smile and Health translated from Irish Gaelic) commenced in 2014. The policies contained in it have been informed by the deliberations of oral health professionals through a series of working groups and by detailed research and surveys which were commissioned over the last couple of years. The Economic Services Research Institute of Ireland (ESRI) has had a pivotal role in evaluating proposed service delivery models and in costing proposed future delivery mechanisms.

The policy is aligned with other Government policies, including [Sláintecare](#), [Healthy Ireland](#) and the [First Five Years whole of government strategy for babies, young children, and families](#), as well as the national strategies on disability and mental health. It conforms to international policies, when written, of the World Health Organisation (WHO) and the European Union (EU). The policy embraces the “**no child is left behind**” principle which is aligned with Ireland’s First Five Years and education policies.

Current Irish oral healthcare service provision is based on the Dental Health Action Plan (1994) which was informed by data from the 1980’s. Currently, child, adult and vulnerable groups all have separate oral service structures, in different locations, with varying State schemes as described above and varying approval mechanisms. This system, apart from being out of date with the current healthcare landscape, has left gaps in essential care for the very young and for vulnerable people, including persons with disabilities and older people.

All adults are eligible for emergency oral health care or care provided in a hospital setting. In contrast, eligibility for oral health care in a primary care/community setting is limited to low income assessed households, people over 70 years of age, and those with special needs. These eligible persons are medical card holders comprising circa 39% of the population. The remaining population, if employed or self-employed, can access care under the Department of Social Protection. It is estimated that under both schemes at least 90% of the Irish population can access basic oral health care available under both schemes. **Universal Health Care** provision aligned with **WHO vision** can be progressed under this policy. Ultimately it results in the expansion of oral health care for all children and eligible adults.

**Smile agus Sláinte reorients how care is provided**, in line with Sláintecare, so **that most dental care is provided** in people’s own communities, **as close as possible to where they live**. This is beneficial for service users and allows

acute services to focus on more complex care. What is described in *Smile agus Sláinte* is not a demand led service but instead enables the Irish public to access services and to forge a relationship with their chosen dental practice - **their dental home**. **To support this universal primary care approach**, a safety net system will identify those who do not or cannot attend their local dentist. **This safety net is part of a surveillance system** for vulnerable children and adults, ensuring the most vulnerable, including those on lower incomes, will be supported and that they receive the same quality of service as the rest of the population.

### **3.2 Goals and framework (guiding principles) of the Irish policy**

**The primary goal of the policy** is to enable the whole population to achieve **their personal best oral health**, and to **reduce inequalities** in oral healthcare. The new policy will be delivered through a **primary (oral health) care approach**, where most oral healthcare is provided by a local dental team of a person's choice. This approach emphasises prevention; convenient local access; a person and family-centred approach and enabling choice for the public. The other philosophies that informed the new National Oral Health Policy included the **life course approach**, which supports prevention and oral healthcare from birth into old age. In addition, **the common risk factor approach**, which recognises that risk factors for poor oral health are like those for poor general health, e.g., smoking, alcohol, and diet, was integrated into the new policy. **Mainstreaming**, which supports people with disabilities and vulnerable people to have similar access to health services as all others in the population, was also considered.

### **3.3 Strategic Objectives – Smile agus Sláinte**

#### **3.3.1 Key Policy Strategies/Proposals**

The policy has three strategic pillars/objectives:

- Health and Oral Health Promotion and Protection Programmes.
- Services Provision, and.
- an Evaluation and surveillance Programme

**3.3.2 The first strand** - (oral) health promotion and protection, will reflect the **Healthy Ireland framework** and the water fluoridation policy. It focused on regulation, public policy, and community programmes across the life course.

**3.3.3 The second strand** - the delivery of services, is divided into three components: -

1. **Primary oral healthcare service** providers (local dental practices) will be responsible for the delivery of 'packages of care', including prevention and primary care from birth to old age, tailored across the life course.
2. **The HSE Public Dental Service (PDS), the government salaried service, will be reorientated to** provide oral healthcare services to vulnerable people referred from their local dentist, if necessary. (*The Public Dental Service will also provide more long-term oral healthcare for some people in residential care settings. They will also lead on the oral health promotion programmes as well as the clinical surveillance/evaluation programmes.*)
3. **Advanced Centres of Care** in Dental Hospitals, other hospitals and designated centres will provide care that cannot be provided in a primary care setting

**3.3.4 The third strand - the evaluation (clinical surveillance) programme**, will target key age cohorts across the life course to monitor their oral health status and assess the success of policy initiatives.

Supporting **research programmes**, especially primary care research networks, as well as developing the workforce, such as expanding the role of dental auxiliary staff. The need for **leadership development is also outlined, especially in the areas of public health, primary care, special care services, and leading on advanced (hospital) care.**

The proposed Policy fundamentally alters the current system of oral health care in the country. Implementation of the Policy will therefore require considerable buy-in from the dental service delivery sector and other partners such as Dental Schools.

### 3.4 Strategic Priorities into action

There are 41 actions outlined. The **principal new elements of Ireland's policy are:** -

- **Water fluoridation** remains a cornerstone of oral health policy.
- **Health promotion programmes** to support the whole population will be developed, in parallel with programmes targeted to the most vulnerable. Integrated care will include support of general health initiatives such as HPV vaccine for adolescents.
- Aligning **the basic elements** of the two State services providing care **to over 90% of the population**
- Most care for children and adults will be in **local dental practices, so easily accessible.**
- **Packages of care for children from birth to 16**, delivered in local dental practices, will over time replace the existing episodic school programme,
- The inclusion of preventive and primary care service for children under 6 years of age and teenagers. For the first time, under 6s, teenagers and adults will have **lifetime access to multiple prevention interventions**, such as fissure sealants and fluoride varnishes, from their local dentist, in line with best international practice. Expansion of primary care is also proposed across the whole life course.
- **A focus** on those with higher oral healthcare needs, including **more socio-economically disadvantaged communities**. Improving access for vulnerable groups, including low income, rural dwellers, and people with disabilities, to local dental practices is key. **An additional safety net service**, identifying needs and care that is not available to locally, will ensure that they receive comprehensive care and **will address inequalities.**
- **A reorientation** of the provision of most of the care currently provided by the Public Dental Service (PDS) to a primary care setting to be delivered by local dentists, **in line with general medical services.**
- The PDS, **the safety net service**, will provide care, when required, for vulnerable people including people living in residential care homes. It will also lead on health promotion and surveillance programmes
- **Advanced Centres of Care** (in hospitals) to be designated according to facilities and skills. Advanced care centres will provide specialist services, including dental general anaesthesia.
- Monitoring systems will identify people not taking up services, overall dental needs, and the policy's impact - the **surveillance programme** in the policy.
- There will be a **full review of undergraduate dental education**, including career-long professional mentoring
- **Skill matching programmes** for existing staff, to assess the gaps in training.
- **Research programmes** emphasising **primary care networks** and evaluating practice interventions.
- **A review of workforce needs**, with a particular focus on auxiliary professional and an expansion of their roles where feasible
- **Apprenticeship and training schemes** are to be developed for mid-level oral health care professionals to improve access to the profession and reflect the profile of communities.
- The **appointment of leadership posts nationally** to lead the implementation and evaluation of policy in the areas of public health, primary care, special care and advanced care.
- There will be a phased implementation of the policy until 2030. The Economic Services Research Institute (Ireland) estimate that the proposed services, surveillance and supporting structures could cost in the region of €70-80 million over the next 8 years with an annual phasing in cost of approximately €10 million.

#### 4. Comparison of WHO strategy and National Oral Health Policy (Smile agus Sláinte):

**Table 1: Vision and Goals of WHO. Comparison to Smile agus Sláinte, Comments and Clarifications**

WHO Vision and Goals	Smile agus Sláinte (Irish National Oral Health Policy)	Context and challenges for Ireland to achieve WHO goals	Additional comments on WHO
<b>Essential UHC</b>	Partly. UHC for legislatively eligible population: 40% adults, all children can be put in place	Can combine with Social Insurance system and 90% of population would be covered, which is the intention for all preventive packages.	Need clarification if <b>Basic</b> or <b>Essential</b> care is in question for the whole population: Basic is achievable for the whole population, essential is more challenging for <b>all</b> and requires change in legislation and will be more challenging
<b>Produce a national plan integrated with NCDs and other national health plans</b>	Yes. Smile agus Sláinte was 4 years in development supported by commissioned research, publication, national surveys, and expert working groups.	Smile agus Sláinte Oral health policy aligns with other national policies; chiefly Healthy Ireland, Slaintecare – our national health plans. Common risk factor, Primary Care, Life course & Mainstreaming approaches are core to policy.	The development of a whole government integrative national plan, Smile agus Sláinte without external WHO direction, was lengthy and challenging. <b>WHO incl. EURO leadership and guidance for other countries will be of great benefit for countries developing national policy.</b> Information sharing from countries who have developed policies should be supported to help colleagues.
<b>Oral Health promotion</b>	Yes. Across the life course and as part of national policy and individualised preventive packages for State care.  Alcohol, tobacco, and sugar policy in place, Sugar policy being evaluated for impact on oral health	Water fluoridation is in situ for 70% of population. Fluoride toothpastes (less than 1,500ppm) are classified as cosmetics in Ireland and EU. Many fluoride modes over 1,500ppm are not licensed for use and prescribed off-label. This is a key obstacle to address for fluoride community programmes in small-medium EU countries. Only a restricted child programme for sealants is in place so need expansion across life course, preventive packages will require dentists to reorient and may need upskilling. Sugar tax policy is being evaluated in relation to oral health.	<b>Water fluoridation, or other systemic fluoride community programmes require regular review of dental and general health impacts.</b> Clarification of <b>which fluoride toothpaste and other topical modes</b> should be classed as <b>essential medicines</b> and assessment of the impact of this policy in the EU. <b>Evaluation</b> of policies and programmes must be established from the outset. Integration with national evaluation focussing on <b>quality-of-life measures, access, and public perceptions</b> (see <b>Healthy Ireland Surveys</b> for Ireland's success using such dental measures). Need to clarify if the <b>role of oral healthcare professionals</b> should include NCD general advice and undertaking a broader health protection remit e.g., administering vaccinations <b>Digital technology</b> will facilitate mid-level professionals and lay people to play a key role in enabling access to oral health promotion and prevention.
<b>Inequalities</b>	Yes. This is a key goal for Ireland; ethnic groups (incl. Irish Travellers), refugees, and socially deprived groups. People with disabilities and medically compromised also included.	Inequalities may have been exacerbated in Covid-19 heightening the differences in access.  Mainstreaming approach for vulnerable people upheld but also extra packages of care for the most vulnerable	WHO may need to reassess the desired progress timeline due to the unequal <b>Covid-19 impact</b> on individual countries. We need a factual evaluation of the post-Covid-19 <b>oral health baseline</b> . We may need, along with UHC, specific/targeted inputs into vulnerable groups e.g., <b>safety net services</b> .

**Table 1 (cont.): Vision and Goals of WHO.**  
**Comparison to Smile agus Sláinte, Comments and Clarifications**

WHO Vision and Goals	Does Smile agus Sláinte (Irish National Oral Health Policy) include	Context and challenges for Ireland to achieve WHO goals	Additional comments for WHO
<b>Workforce planning</b>	<p>Yes, a key part of policy. Ireland benefits from the migration of EU members' oral health care professionals to work in Ireland. 40% of new registrants are from EU (not Ireland).</p> <p>Expansion of auxiliary professional groups and provision of clinical care is a key issue.</p>	<p>Independent practice of more auxiliaries to be progressed.</p> <p>Access to mid- level dental professions via apprenticeship/ training rather than University only training In Ireland.</p> <p>Professionals in dentistry mainly come from middle to high socioeconomic groups.</p>	<p><b>WHO direction will support all EU countries to have a similar ethos, standards, and approach to providing oral healthcare</b> enabling easier movement of professionals and people across members states.</p> <p>Need to emphasise the need for greater diversity in the profession and the need for <b>alternative ways to become a dental professional outside of orthodox university access</b>. This is important for disadvantaged people especially from lower socio-economic groups. <b>Different mechanisms to train as a dental professional will enable local communities to 'grow' their own oral healthcare providers</b> especially in vulnerable communities.</p>
<b>People centred</b>	Policy was influenced by public consultation, surveys of the public's needs and their perception of oral health issues.	<p>The Dental Regulator remains the only professional regulator in Ireland with limited lay membership.</p> <p>Inclusion of the public voice in strategic planning is inadequate.</p>	<p>WHO can influence EURO area countries' policies to include public consultation and lay involvement on dental regulation.</p> <p><b>Self-assessment of oral health and oral health quality of life measures</b> are more people centred than normative assessment of oral health.</p>
<b>Life course approach</b>	Irish policy requires reorientation from targeted episodic child health and episodic adult care to a continuous life course approach aligned with general health models across the life course. Choice of dentist for the people is core to Irish policy.	The dental profession has worked in silos of care, across different locations and different rules for different age groups since 1970 (50 years). Both Irish policy, which reflects WHO policy, is a fundamental change in ethos and buy in from the dental profession is challenging	The profession having a <b>more generalist approach with less specialist focus</b> , with a concomitant increase in the status of primary care, is crucial. The excessive focus on specialisation, especially in small-medium populations, in a small profession, makes oral health care less accessible to the most vulnerable; dentistry will continue to be broken into silos of care. <b>Emphasizing generalist primary care and elevating its status</b> is critical for most of the population to access good oral health care easily.
<b>Digital Technology</b>	<p>This does not have a high profile in Irish oral health policy.</p> <p>There is a separate Government digital strategy.</p>	Dental professionals are currently the least likely to use digital technology for communication compared to other professional groups in Ireland. Post Covid-19 this may have altered.	Lay community workers providing <b>oral health promotion</b> may be especially successful using <b>digital technology to reach the public</b> . Professionals may be less accepting of digital technology, for self-care, diagnosis, and treatment, than the population themselves.

**Table 2: Five (5) Strategic Objectives of WHO. Comparison to Smile agus Sláinte, Comments and Clarifications**

WHO Strategic Objectives	Smile agus Sláinte (Irish National Oral Health Policy)	Context and challenges for Ireland to achieve WHO goals	Additional comments for WHO
<b>Governance: resources &amp; national oral health unit (leadership)</b>	Resources are accessed for oral health in competition with all other health services which is challenging.  Strategic leadership posts in public health, primary care, special care (vulnerable populations), advanced (hospital) care. A national operational unit is in place for government salaried services unit in HSE. However, there is difficulty getting the profession to integrate with NCDs and general health.	Move from traditional operational reactive management to a forward thinking, strategic public health approach will be difficult to achieve.  Focus to date has been on treatment provision and specialist training in clinical areas. Expertise, qualifications and leadership in public health, primary care, and special care for the most vulnerable are underdeveloped.	<b>Public health emphasis is welcomed.</b> Recognition of leadership in other key areas needs to be addressed. <b>Primary care leadership is important to raise the status of generalists</b> compared to clinical <b>specialists</b> within the profession.  <b>The WHO EURO regional post is not in place to lead the WHO action plan.</b> Ireland further desires that an identified role or an appointed entity <b>to interact with the EU commission</b> will be put in place. Both roles either separately or as a merged entity will be crucial for policy progress across both EU and WHO EURO members states.
<b>Oral Health promotion: Policy and patient level</b>	National policy in tobacco, alcohol, obesity, and sugar (include sugar tax) and evaluation is in situ. Water fluoridation is mandatory but kept under regular review for safety and effectiveness. Preventive packages for all to be developed over ten years in Ireland to reorientate system to prevention.	Reduction in sugar helped by national tax but dental profession support fluoride uses more than diet/ sugar change.  Water fluoridation core to oral health policy.  Dental profession very focussed on treatment intervention- requires a fundamental change in approach led from within	<b>Need buy-in</b> from dental associations and international partners to reorientate approaches, and a <b>greater focus on sugar and diet</b> . <b>Water fluoridation</b> where it is a viable option, and/or in situ, supports ease of access to fluoride, across the life course, for all social groups, with minimal effort and low per capita cost. However, there is a strong reference to the need for surveillance within the WHO resolution. <b>All systemic programmes</b> , including water fluoridation, <b>require regular review</b>
<b>Primary Oral health care approach; access &amp; financial support for preventive products</b>	Smile agus Slainte aligns oral healthcare with general medical approach, so both types of care to be accessed in the community with a similar approach. Majority of oral health care to be provided in a primary care setting close to the persons home with choice of dentist/ oral healthcare worker across the life course.	Reorientation will be challenging. Skill reassessment of the current workforce since profession from working in silos and doing limited work in State systems are deskilled. Fluoride products at prescription level are all unlicensed in Ireland, need buy-in from companies re licensing of products.	<b>Confusion in Ireland, if WHO calls for basic care for all (or if it is essential care);</b> this needs clarification by WHO. Need a clear definition of essential care <sup>1</sup> .  Primary oral health care needs <b>primary care leadership</b> and academic centres to develop in parallel with <b>much needed dental public health leadership</b> and supporting dental public health academic and community infrastructure.

<sup>1</sup> There are 5 categories of oral health care commonly described: emergency, basic, essential, routine, and advanced. Other definitions can also be explored.

**Table 2 (cont.): Five (5) Strategic Objectives of WHO.  
Comparison to Smile agus Sláinte, Comments and Clarifications**

WHO Strategic Objectives	Does Smile agus Sláinte (Irish National Oral Health Policy) include	Context and challenges for Ireland to achieve WHO goals	Additional comments for WHO
Surveillance and Evaluation	<p>Surveillance and evaluation are a key part of Irish Oral Health Policy (Smile agus Sláinte). Oral health is already measured in National Healthy Ireland surveys with a focus on access, advice re tobacco, sugar tax, oral health promotion, oral health quality of life.</p> <p>The Irish Study of Longitudinal Ageing (TILDA) contains an oral health section.</p> <p>Fluoride surveys and research on oral/ general health is required by law due to mandatory water fluoridation. These reviews are repeated every 5 years. Establishing a nationwide surveillance programme at key ages, 5,16, 45, 70 are part of policy</p>	<p>Healthy Ireland questions could be used as a basis for other countries – we would welcome comparison with other EURO states on these quality-of-life oral health measures.</p> <p>Surveillance can be built into primary care provision but pathfinder studies for hard to access groups are still necessary</p> <p>Digital technology would support more self-evaluation and the issue.</p>	<p>Evaluation measures that do not require a professional dentist or oral health care professional to measure oral health must be included as part of WHO surveillance e.g., <b>quality of life, access measures, self-assessment of oral conditions and disease, other public perceptions, and inputs.</b></p> <p><b>Vulnerable groups may require additional and/or different surveillance approaches, focussed on their challenges.</b></p> <p><b>Possible general health issues related to oral health</b>, as diverse as periodontal disease and respiratory illness, possible impact of systemic fluoride on some health aspects, chemicals in dental materials, just some issues that <b>must be kept under regular review to reassure the public of safety.</b></p>
Research; refocus to problem solving	<p>Commissioned national research on preventive agents and alternative materials. A key issue highlighted is the overall non-success of oral health research to access national funds; the focus has been on surveys to date rather than interventions.</p>	<p>A reorientation of research in Ireland is required. The Department has commissioned research on alternative dental materials, preventive agents for use in practice, oral health promotion programmes and workforce evaluation. Primary Care Research Networks to build research capacity is key.</p>	<p><b>Building capacity in research, especially in Primary Care</b> to reorientate the research.</p> <p>Considering the development of <b>national and EURO wide Primary Care Research Networks</b> is a key part of building capacity and getting reorientation of research.</p>

## 5. The views of Ireland on the roles of WHO, Member States and International Partners

### 5.1 WHO roles

The WHO roles are well articulated and welcome. **A key issue however for Ireland as a EURO member state is the lack of a definitive EURO Regional Oral Health leadership post as in other areas globally.**

There are considerable interdependencies across European states, especially within the EU. We all benefit from the unusual amount of migration of the oral health workforce across Europe. It is essential that we ensure that we have the same ethos and approaches across European states. We must move forward as one to gain best benefit from the strategy. Our populations also move across states. Ensuring equivalence of access to basic or essential care in different

member states will hopefully be key outcome of this Strategy. **Without a singular, focussed leadership there is a real risk that the strategy will be embraced by only some countries.** Shared learning and diversity of ideas is essential. Ireland, having completed a national policy without the benefit of overt WHO direction, can attest that sharing of information, knowledge and expertise will speed up the process.

## 5.2 Member States Roles'

Ireland is fortunate in that a National Oral Health Policy, Smile agus Sláinte, has been developed recently and is approved by Government to be implemented. **This Irish policy, as seen in section 4, embraces the ethos of the WHO strategy.** WHO strategies were a key influence on Irish policy as was up to date research and public consultation. Therefore, our role in putting such a plan in place is completed. However, **the challenge for us will be implementing this policy**, as it represents a fundamental change in direction for the profession and for the training of dentists. Support from other member states taking the same route will be very helpful and guidance from WHO will enable us to push forward and make progress more easily.

It should not be estimated the considerable undertaking developing a joined up integrated policy is for any member state. The dedication and focus required to see it to completion and get support from their government is a major challenge. **It behoves member states like Ireland** who have led such a process to **support their colleagues in the EURO area to progress their policies.**

## 5.3 International Partners

**Dental Schools** across the EURO region will have to **embrace a primary care and a less 'siloed' teaching approach.** In addition, prevention, surveillance, and self-monitoring results as well as research for dentists are all key skills. Arguably public health, including sociology, and improving integration of the profession with other health care workers, will be key to progress the profession. Openness to new educational access routes, such as training schemes, apprenticeships and life-long professional mentoring must be considered. This will support greater diversity within the profession especially for mid-level professionals.

The **national dental associations** have a key role to play in **reorientating their members** away from a treatment orientated system, supporting most of the care in a primary care setting and embracing the public's views and wishes. Clinical care guidelines are crucial to facilitate this reorientation so that core diseases such as dental decay can be managed using alternatives to fillings.

As a small profession this is an enormous opportunity for us across Europe to speak as one voice, regardless of our roles and positions, for the betterment of the public's oral health. It's incumbent upon us all to work together. **The WHO strategy and action plans will be an anchor for us all.**

## 6. Key points from Ireland

### 6.1 General Issues

- Ireland unconditionally **welcomes and supports** the WHO draft Oral Health Strategy. The broad definition of oral health and the **increased emphasis on oral health** rather than a focus on oral disease is valued.
- We have a strong desire to have the **EURO Regional post** filled so that the EURO region, like other WHO regions, can fulfil its mandate and advance the strategy. This will enable **information** sharing amongst countries.

- The EU commission has a particular role within the EURO region also and the EURO role may need to ensure a communication channel with the EU commission.
- Meaningful lay involvement in the regulation of the dental profession is important to ensure that the profession can respond to public concerns.
- Ireland has mandatory water fluoridation policy, which is kept under review for effectiveness and safety. We appreciate the value placed on fluorides as a key preventive agent for dental caries.
- We have concerns regarding the feasibility of toothpastes less than 1,500ppm topical fluorides being classified as essential medicines since they are categorised as cosmetics. We would like it clarified if it is only topical fluorides above this concentration. Licensing of topical fluorides for community programmes is challenging for countries if these products are not licensed.
- We welcome the emphasis on tackling common risk factors at a national level and the particular emphasis on the need for **sugar policies**. Ireland already has [Sugar](#), [Drug and Alcohol Use](#), and [Tobacco](#) policies and taxes in place. A key issue for us is the evaluation of the impact of the Irish sugar tax on dental caries.

## 6.2 Workforce

- Ireland benefits from migration of oral health care workers from the EURO region, particularly the EU area. The WHO strategy will support **standardisation of workforce competencies** across the EURO region which will benefit the whole EURO population and the quality of oral health care received by them.
- We welcome support for the development of the workforce across all levels but emphasise the need to develop more access routes to professional training and would welcome support of apprenticeship and training schemes for technicians, nurses, and other mid-level oral healthcare professionals. **This will improve the diversity of the profession and more closely reflect the population which it will serve.**

## 6.3 Definitions of Oral Healthcare

- Both **essential** and **basic oral healthcare** are referred to within the document. Ireland welcomes clarification of which type of care is in question. **Universal basic care is more achievable by 2030 in Ireland (90%). Essential oral healthcare could be progressed for susceptible groups.**

## 6.4 Evaluation, Surveillance and Research

- We wish for **evaluation measures** that measure the impact of poor oral health on **people's quality of life**, their **access** to oral healthcare services and **self-assessed** oral health. We prefer this approach for its feasibility and sustainability rather than relying only on measures of disease.
- Ireland is committed to **integrating evaluation of oral health as part of general oral health**. Evaluation of oral health in our country is linked with [Healthy Ireland surveys](#), which assess access, functional oral health quality of life indicators and quality of life directly from the public. The [Healthy Ireland Survey Wave 2](#) (2016) found that dentists were the third among health professionals mentioned by the public who provide tobacco advice. Oral health status, oral health quality of life, perceptions of oral health, problems with teeth or dentures and visits to dentists are among the issues covered in the [Healthy Ireland Survey Wave 4 \(2018\)](#) which includes a chapter on oral health
- We ask if WHO could encourage the development of EURO wide and national **primary care research networks** to support research in primary care settings. Such networks will provide collegiate support to develop applied research skills as well as ensuring access to adequate numbers of research participants.

*Dympna A Kavanagh Chief Dental Officer, Ireland, August 31<sup>st</sup>, and September 14<sup>th</sup>, 2021*

**[END]**

## Feedback from Thailand on the draft global oral health strategy

Would MSs agree with the proposed vision and goal of the draft global oral health strategy?

Yes, we agree.

Would MSs agree with the recommended five strategic objectives of the draft global oral health strategy?

Yes, we agree. However, we have some comments as followed.

1. There is no detail about Principle 3 (paragraph 21), the oral health workforce, in the SO. It would be better if you could add in SO3 or the new SO. The added details including the oral health workforce model, training, capacity, and distribution.
2. Principle 6 (paragraph 24), digital technologies, should also add in SO1, SO2, and SO3.
3. In SO4 (paragraph 31), should add "At the national level, strengthening oral health information systems should include systematic collection of oral health status, **social and commercial determinant**, risk factors, **budgeting**, **workforce** and resource spending data using existing health management information systems and promising digital technologies."

Would MSs agree with the roles and responsibilities of MSs, partners and the WHO Secretariat?

Yes, we agree. However, we have some comments as followed.

1. In paragraph 42, the sentence "within the national list of essential medicines" might not be suitable for every country. In our country, the national list of essential medicines includes only drugs. As a result, we propose using another word such as "consumer product" instead of "essential medicines"

## **United Kingdom response to the World Health Organisation consultation**

### **Draft global strategy on oral health (Discussion Paper version dated 9 August 2021)**

**16<sup>th</sup> September 2021**

1. Firstly, we appreciate having the opportunity to comment on the draft global strategy on oral health discussion paper.
2. The United Kingdom (UK) warmly welcomes the development of an oral health strategy and are pleased to see the emphasis on both universal healthcare and integration of oral health into wider strategic priorities. The following comments are suggested to strengthen both the strategic plan and influence the action plan which will follow.
3. Our comments on specific elements of the discussion paper are as follows:

#### ***The vision of the strategy (sections 16-17)***

4. We are pleased with the focus on universal health coverage (UHC). We would suggest the World Health Organisation (WHO) vision for the oral health strategy should also include improving oral health and reducing oral health inequalities. UHC is an important and significant part of the vision however it is recognised that good healthcare is only one factor which influences good health (including oral health). To improve oral health there is a need to reduce the amount and frequency of sugar consumed as well as increase availability of fluorides (both topical and systemic).
5. A wider vision would lead to a broader set of **Guiding Principles (sections 19-24)**. The draft principles largely concentrate on equitable access to oral health care. Whilst we would support this it is unlikely to lead to the improvements in oral health which are required. We welcome the principle of *a public health approach to oral health* but this could be further expanded upon. We support the principle *tailored oral health across the life course*. These principles could include evidence based strategies addressing healthier eating, tobacco cessation, alcohol reduction, supporting self-care (e.g. tooth brushing) across the life course and intervening early for example using '[Best Start in Life](#)' approaches .
6. We recommend that the strategy also includes a section on workforce development. This should not be limited to the development of capacity and capabilities of an oral health workforce but broader strategic intent to improve awareness of oral health and the implications for general health into all health and social care training.

#### ***The Goal of the Strategy (section 18)***

7. Across the UK we already have in place a range of preventive programmes , universal service provision and existing data collection and monitoring and therefore we would welcome the flexibility to allow member states to consider developing targets and indicators in response to individual national situations.

### **Strategic Objective (sections 25-31)**

8. We endorse these comprehensive objectives and think that they provide a good template for future action. We strongly agree that integration into wider strategic priorities and financing action on non-communicable diseases and universal health coverage by Member States is essential.

### **The role of WHO (paragraph 35)**

9. We welcome the action that the WHO will recommend cost-effective oral health interventions as part of the updated Appendix 3 of the WHO Global action plan on the prevention and control of NCD and the WHO universal health coverage intervention compendium.
10. The UK has compiled a large volume of evidence of cost-effective policies and interventions which have been well received and some adopted by other countries. Further information is available here for [England](#), [Northern Ireland](#), [Scotland](#) and [Wales](#)
11. As set out above, we would welcome flexibility to set targets and monitoring based on individual national situations.

### **The role of Member States (paragraph 42)**

12. We support and advocate health taxes and have shared learning on UK sugar levy. Countries may also wish to consider working with commercial companies to encourage them to reformulate products to reduce sugar levels, reducing portion size or shifting consumer purchasing towards lower sugar products. In 2016, the food and hospitality industry were challenged by UK government to reduce sugar by 20% in foods that contribute most to children's sugar consumption, as part of efforts to tackle obesity. Further information can be found [here](#). Scotland has also introduced minimum pricing for alcohol, with further information [here](#).
13. Although 'fluorides' is mentioned elsewhere in the document, there is only mention of toothpastes in this section without any further information regarding the various evidence-based interventions that could be considered at individual, community and population level, to increase fluorides.
14. Fluoride is widely accepted as an agreed clinical intervention to improve oral health. Whether it is applied via daily toothbrushing, via fluoride application by dental teams or through systemic fluoride programmes, as appropriate, such as milk, salt and water fluoridation schemes.

15. There is strong research evidence that daily tooth brushing with fluoride toothpaste reduces the incidence and severity of tooth decay. A greater effect is reported ([Cochrane systematic review 2010](#)): in those who have higher baseline levels of tooth decay, with increased fluoride concentration in the toothpaste, increased frequency of use, and with supervised brushing. [NICE guidance \(PH55\)](#) and PHE ([Commissioning Better Oral Health for children and young people](#)) recommends supervised tooth brushing programmes in nurseries and primary schools.
16. Strong [research evidence](#) on the benefits and impact on inequalities of a national scheme is from the Scottish Childsmile nursery tooth brushing programme which provides daily supervised tooth brushing for all 3-4 and 4-5-year olds attending nursery in Scotland. This initiative has been independently evaluated, showing that it was effective in reducing tooth decay and levelling up oral health inequalities, with the **reduction in tooth decay for those from the most deprived communities almost 4 times the reduction for the least deprived.**
17. Systemic fluoridation programmes such as water fluoridation and salt fluoridation may help reduce oral health inequalities and can be successfully introduced alongside optimal strength fluoride toothpaste. Water fluoridation is supported by the World Health Organisation, the World Health Assembly, the Federation Dentaire Internationale, the International Association for Dental Research and health bodies in many countries around the world, including the US Centers for Disease Control and Prevention (which named water fluoridation as one of the ten great public health achievements of the 20th century), the American Medical Association, the American Dental Association, the Canadian Medical Association, the Canadian Dental Association, the Canadian Paediatric Society and the Australian Dental Association.



**WHO DISCUSSION PAPER**  
(Version dated 9 August 2021)

**DRAFT GLOBAL STRATEGY ON ORAL HEALTH**

**BACKGROUND**

1. Recognizing the global public health importance of major oral diseases and conditions, the World Health Assembly adopted resolution WHA74.5 (2021) on oral health and requested the Director-General to develop, in consultation with Member States, a draft global strategy on tackling oral diseases.<sup>1</sup> The strategy will inform the development of a global action plan on oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030.

2. The resolution on oral health and the resulting draft global strategy are grounded in the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its target 3.8 to achieve universal health coverage. They are aligned with the WHO's Thirteenth General Programme of Work (2019); the Political Declaration of the High-level Meeting on Universal Health Coverage (2019); the Operational framework for primary health care (2020); the Global strategy on human resources for health: Workforce 2030 (2016); the Global action plan for the prevention and control of noncommunicable diseases 2013–2030 (2013); the WHO Framework Convention on Tobacco Control (2003); WHA73(12) (2020) on the Decade of Healthy Ageing 2020–2030; and WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention.

**Commented [A1]:** The United States strongly supports efforts to prevent oral diseases, a critical public health issue.

Addressing oral health includes identifying and pursuing comprehensive, evidence-based strategies. These strategies can include voluntary measures, best practices, and/or regulatory measures, appropriate to each national and local context. Such strategies can also incorporate the use of public-private partnerships and other multi-sectoral collaborations.

**GLOBAL OVERVIEW OF ORAL HEALTH**

3. Oral health is the well-being of the mouth, encompassing many essential functions, including breathing, eating, speaking, smiling, working, and socializing. Experiencing good oral health, comfortably and confidently, enables an individual to support an individual's ability to achieve their full capacity and participation in society. Oral health is integral to overall health, well-being and quality of life, from birth to old age.

**Commented [A2]:** Suggest slight modifications.

**Oral Disease Burden**

4. Globally, there are estimated to be more than 3.5 billion cases of oral diseases and other oral conditions, most of which are preventable.<sup>2</sup> For the last three decades, the combined global prevalence of dental caries (tooth decay), periodontal (gum) disease and tooth loss has remained unchanged at 45%, which is higher than the prevalence of any other noncommunicable disease.<sup>2</sup>

5. Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375 000 new cases and nearly 180 000 deaths in 2020.<sup>3</sup> Noma is a necrotizing disease that is a marker of extreme poverty; it starts in the mouth and is fatal for as much as 90% of affected children.<sup>4,5</sup> Cleft lip and

<sup>1</sup> [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_R5-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R5-en.pdf)

<sup>2</sup> <http://dx.doi.org/10.1177/0022034520908533>

<sup>3</sup> <https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf>

<sup>4</sup> <https://daccess-ods.un.org/TMP/1058816.4627552.html>

<sup>5</sup> <http://www.who.int/iris/handle/10665/254579>

palate, the most common craniofacial birth defects, have a prevalence of approximately 1 in 1500 births.<sup>6,7</sup> Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting over one billion people.<sup>8</sup>

#### Social and Economic Costs of Poor Oral Health

6. The personal consequences of untreated oral diseases and conditions - including physical symptoms, functional limitations, and detrimental impacts on emotional, economic, and social well-being - are severe. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burdens. Worldwide, in 2015 oral diseases and conditions accounted for US\$357 billion in direct costs and US\$188 billion in indirect costs, with large differences between high-, middle- and low-income countries.<sup>9</sup>

7. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes, people living with disability, refugees, prisoners and/or socially marginalized groups.

#### Social, Economic and Environmental Commercial Determinants and Risk Factors of Oral Health

8. Oral diseases and conditions and oral health inequalities are directly influenced by social, economic, and environmental commercial determinants, which can include are strategies and approaches used by the private sector to promote promotion of products and choices that are detrimental or beneficial to health.

9. Oral diseases and conditions share modifiable risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease and diabetes. These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers. Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury. The risk factors for noma include malnutrition, coinfections, poor oral hygiene and poor living conditions.

#### Oral Health Promotion and Oral Disease Prevention

10. Only rarely have oral health promotion and oral disease prevention efforts targeted the social and commercial determinants of oral health at the population level. However, initiatives that address~~attack~~ upstream determinants (such as policy and regulation) can be cost-effective and have a high population reach and impact. Moreover, oral health promotion and oral disease prevention typically are not integrated into other noncommunicable disease programmes that share major common risk factors and social determinants.

11. In 2015, the WHO guideline on sugars intake for adults and children made the strong recommendation to reduce intake of free sugars throughout the life course based on the evidence of positive associations between intake of free sugars and body weight and dental caries. Nonetheless, dental public health initiatives to reduce sugar consumption are rare.

**Commented [A3]:** Please provide relevant citations and sources for this section.

**Commented [A4]:** Recommend use of term inequity versus inequality.

**Commented [A5]:** Previously agreed strategies and plans refer to social, economic, and environmental determinants. Language should acknowledge that determinants can both positively and negatively influence health and well-being.

**Commented [A6]:** The statement should be clarified or omitted. Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury. As written, the statement is imprecise and not supported by the evidence, for example, please clarify any association between chronic respiratory disease and high sugars intake. Only one of these risk factors is associated with cleft palate (harmful alcohol use). Strongly suggest providing relevant citations for this section, especially for the statement that the shared risk factors for dental caries and chronic disease are associated with cleft lip and traumatic dental injury.

Also suggest that the sentence order be swapped so that this statement appears before the listed risk factors, or that these conditions be combined into the first sentence.

Please define Noma. For example, “*The risk factors for noma (a form of gangrene affecting the face, usually caused by a bacterial infection and typically occurring in young children suffering from malnutrition or other disease) include poor oral hygiene as well as malnutrition, coinfections, and poor living conditions.*”

**Commented [A7]:** Please provide reference.

**Commented [A8]:** Is this statement accurate if considering broader public health initiatives on sugar consumption?

**Commented [A9]:** Note that the positive associations with dental caries are actually between ALL sugars and indeed all fermentable carbohydrates, not simply free sugars, and so the statement is misleading.

*Suggested revision: Dental public health initiatives that focus on reducing the frequency of consumption of fermentable carbohydrates which include free and other sugars as well as starches and that are coupled with good oral hygiene are rare.*

<sup>6</sup> <https://apps.who.int/iris/rest/bitstreams/1320658/retrieve>

<sup>7</sup> <http://dx.doi.org/10.1016/j.jormas.2021.05.008>

<sup>8</sup> <http://dx.doi.org/10.1111/edt.12389>

<sup>9</sup> <http://dx.doi.org/10.1177/0022034517750572>. Page 2 of 9

12. Millions of people do not have access to oral health promotion and oral disease prevention programmes. The use of fluorides for prevention of dental caries is limited, and essential prevention methods, such as community-based methods, topical fluoride applications or the use of fluoridated toothpaste, frequently are not available or affordable for people.

**Commented [A10]:** Consider specific mention of community-based methods such as fluoridation of the water supply.

### Oral Health Care Systems

13. Political commitment and resources for oral health care systems often are limited at the ministry of health level. Typically, the oral health care system is inadequately funded, highly specialized and isolated from the broader health care system. In most countries, universal health coverage benefit packages and noncommunicable disease interventions do not include essential oral health care. Oral health care usually is not covered in primary care facilities, and private and/or public insurance scheme coverage of oral health is highly variable between countries.

14. In many countries, insufficient attention is given to planning the oral health workforce to address the population's oral health needs. Dental training rarely is integrated within general health training systems and focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists.

15. The COVID-19 pandemic has had a negative impact on the provision of essential oral health services in most countries, leading to delays in oral health care treatment, increased antibiotic prescriptions and greater oral health inequalities. The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health care systems as part of universal health coverage efforts.

**Commented [A11]:** Recommend use of term inequity versus inequality.

## VISION, GOAL, AND GUIDING PRINCIPLES

### Vision

16. The vision of this strategy is universal oral health coverage for all people by 2030.

17. Universal oral health coverage means that every individual has access to essential, quality health services that respond to their needs and which they can use without suffering financial hardship. These include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives. Achieving the highest attainable standard of oral health is a fundamental right of every human being.

### Goal

18. The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.

**Commented [A12]:** Recommend use of term inequity versus inequality.

.../..

## Guiding Principles

### *Principle 1: A public health approach to oral health*

19. A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.

### *Principle 2: Integration of oral health in primary health care*

20. Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.

### *Principle 3: A new oral health workforce model to respond to population needs*

21. Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the-[licensing, training,](#) roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.

### *Principle 4: People-centred oral health care*

22. People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.

### *Principle 5: Tailored oral health across the life course*

23. People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.

### *Principle 6: Optimizing digital technologies for oral health*

24. Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider [and provider-to-patient](#) telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is



critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice, protection of patient data privacy, and scientific evidence.

## STRATEGIC OBJECTIVES

### Strategic Objective 1: Oral Health Governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector

25. Strategic objective 1 seeks recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national noncommunicable disease and universal health coverage agendas. Increased political and resource commitment to oral health are vital at the national and subnational levels, as is reform of health and education systems.

26. Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services. Sustainable partnerships within and outside of the health sector, and engagement with communities, civil society and the private sector, are essential to mobilize resources and address the social and commercial determinants of oral health.

### Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions

27. Strategic objective 2 calls for evidence-based, cost-effective and sustainable oral health promotion and interventions to prevent oral diseases and conditions. At the downstream level, oral health promotion supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care. At the upstream level, oral health promotion includes creating public policies and fostering community action to improve people's control over their oral health and to promote oral health equity.

28. Prevention efforts target key risk factors and including social, economic, and environmental and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco use, harmful alcohol use and unhealthy dietsfood and beverage products, as well as the use of fluorides for prevention of dental caries and human papilloma virus (HPV) vaccination for prevention of oropharyngeal cancer.

**Commented [A13]:** Prevention efforts should target key risk factors, including determinants.

**Commented [A14]:** Broader NCDs risk factors usually refer to 'unhealthy diet'. Given that the above text discusses foods high in sugars, language used here is imprecise. Foods may be healthy but high in sugars or the reverse.

### Strategic Objective 3: Primary Oral Health Care - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care

29. Strategic objective 3 seeks to increase access by the entire population to safe, effective, and affordable primary oral health care as part of the universal health coverage benefit package. Basic oral health care includes oral health promotion and prevention of oral diseases and conditions, as well as services which address oral pain, infection, trauma, dysfunction, malignant disease and referral, with agreed quality and patient-safety standards. Oral health care providers who suspect abuse or neglect should offer patients appropriate counseling, treatment, and effective means to report such cases to the relevant authority, according to the national context.

30. Oral health providers should be members of the primary health care team and work side-by-side with other health workers in tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups. Financial protection through expanded health insurance coverage - including coverage of oral health services - is one of the cornerstones of universal health coverage. Ensuring the reliable availability and distribution of essential medical consumables,



generic medicines and other dental supplies is also important for the management of oral diseases and conditions in primary health care and referral services.

**Strategic Objective 4: Oral Health Information Systems - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making**

31. Strategic objective 4 involves developing more efficient and effective integrated information systems for oral health planning, management and policy-making. At the national level, strengthening oral health information systems should include systematic collection of oral health status, risk factors and resource spending data using existing health management information systems and promising digital technologies in a way that adequately protects patient data. Monitoring systems should also be established to track implementation and impact of existing policies and programmes related to oral health.

**Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health**

32. Strategic objective 5 strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and complex clinical epidemiological surveys ~~problem description~~, rather than problem-solving. New oral epidemiology methods, including high-resolution video and multispectral imaging, have the potential to improve the quality of oral health data gathering while reducing costs and complexity. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.

**ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT**

**WHO**

33. WHO will provide a leadership and coordination role in promoting and monitoring global action on oral health, including in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations. The organization will: set the general direction and priorities for global oral health advocacy, partnerships and networking; articulate evidence-based policy options; and provide Member States with technical and strategic support.

34. WHO will continue its work with global public health partners to: establish networks for building capacity in oral health care, research and training; mobilize contributions from nongovernmental organizations and civil society; and facilitate collaborative implementation of the strategy, particularly as pertains to the needs of low- and middle-income countries.

35. By 2023, WHO will translate this strategy into an action plan for public oral health including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030. By 2024, WHO will recommend cost-effective, evidence-based oral health interventions as part of the updated Appendix 3 of the WHO Global action plan on the prevention and control of noncommunicable diseases and the WHO universal health coverage intervention compendium.

36. WHO will continue to update technical guidance to ensure safe and uninterrupted dental care, including during and after the COVID-19 pandemic and other health emergencies. WHO will, in collaboration with the United Nations Environment Programme, develop technical guidance on environmentally-friendly and less-invasive dentistry. WHO will also consider the classification of noma within the road map for neglected tropical diseases 2021–2030.

**Commented [A15]:** “Problem description” means epidemiological surveys in this context, and as drafted this objective seems dismissive of this aspect of public health. However, oral epi data (especially global) has always been sparse, which limits our ability to detect problems and trend changes early, set baselines, plan programs, etc. Rather than implying that epi surveys are a historical artifact that’s no longer necessary, suggest calling for improving data gathering through advanced imaging technologies that can be scored remotely, without the need for in-person examinations by calibrated dentist examiners. See suggested revisions.

37. WHO will help scale and sustain innovations for oral health impact in accordance with the WHO innovation scaling framework, including social, service delivery, health product, business model, digital, and financial innovations.

38. WHO will create an oral health data platform as part of WHO's data repository for health-related statistics. The institution will strengthen integrated oral health information systems and surveillance activities through the development of new standardized data gathering technologies and methods, and oral health indicators for population health surveys. WHO will promote and support research in priority areas to improve oral health programme implementation, monitoring and evaluation.

#### Member States

39. Member States have the primary role in responding to the challenge of oral diseases and conditions. Governments have the responsibility to engage all sectors of society to generate effective responses for the prevention and control of oral diseases and conditions, the promotion of oral health and reduction in oral health inequalities. They should secure appropriate oral health budgets based on intervention costing and investment cases to achieve universal oral health coverage.

40. Member States should ensure that oral health is a solid, robust and integral part of national health policies and that national oral health units have sufficient capacity and resources to provide strong leadership, training, coordination and accountability on oral health.

41. Member States can strengthen oral health care system capacities by: integrating primary oral health care as part of universal health coverage benefit packages; ensuring the affordability of essential dental medicines and consumables, and other equipment or supplies for the management of oral diseases and conditions; and prioritizing environmentally-friendly and less-invasive dentistry. Member States should also assess and reorient the oral health workforce as required to meet population needs by enabling interprofessional education and a wider team approach that involves mid-level and community health providers.

42. Member States can address the determinants of oral health and risk factors of oral diseases and conditions by: advocating for health taxes or regulation of evidence-based regulatory measures the sale and advertisement of unhealthy products, and addressing counteracting the underlying determinants that increase or reduce commercial interests that drive risks; strengthening health-promoting conditions in key settings; supporting legislation to increase the affordability of quality, fluoride toothpaste; and advocating for its recognition as an essential health product within the national list of essential medicines.

**Commented [A16]:** Consider a broader focus on determinants and acknowledge that they can influence health and wellbeing positively or negatively. “Counteracting” language is unclear.

43. Member States should improve oral health surveillance, data collection and monitoring to inform decision-making and advocacy. This includes developing and standardizing updated methods and technologies for gathering oral health epidemiological data, integration of electronic dental and medical records, strengthening integrated surveillance of oral diseases and conditions, as well as analysis of oral health system and policy data, evaluation of oral health programmes and operational research.

**Commented [A17]:** In line with suggestion above on improving data availability.

44. Member States should critically review and continuously update their oral health education and training curricula prioritizing a public health approach to oral health and reflective problem-solving and leadership skills among future oral health professionals.

#### International Partners

45. International partners have a valuable role in achieving the goal and objectives of the strategy at global, regional and national levels, including playing a stronger part in advocacy, resource mobilization, exchange of information, sharing of lessons learned, capacity-building and collaborative research.



46. Coordination is needed among international partners, including the organizations of the United Nations system, intergovernmental bodies, non-state actors, nongovernmental organizations, professional associations, patients' groups, academia and research institutions. Establishing and working efficiently as an international coalition on oral health will be a more efficient way to support countries in their implementation of the strategy.

#### Civil Society

47. Civil society has a role to encourage governments to develop ambitious national oral health responses and to contribute to their implementation. Civil society can forge multi-stakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and amplify the voices of people living with and affected by oral diseases and conditions.

48. Civil society can lead grass-roots mobilization and advocacy for increased focus within the public agenda on oral health promotion and the prevention and control of oral diseases and conditions. Civil society can also help consumers advocate with governments to request the food and beverage industry to provide healthy products; support governments in implementing their tobacco control programmes; and form networks and action groups to promote the availability of healthy food and beverages and fluoridated toothpaste, including through subsidization or reduced taxes.

#### Private Sector

49. The private sector can strengthen its commitment and contribution to national oral health responses by implementing occupational oral health measures, including through good corporate practices, workplace wellness programmes and health insurance plans.

50. The private sector should take concrete steps towards eliminating the marketing, advertising and sale of products which cause oral diseases and conditions. The private sector should also strive to improve access to and affordability of safe, effective and quality dental equipment, devices, and oral hygiene products. It should also accelerate research on affordable, safe and environmentally sound equipment and materials for oral health care.

51. Dental professionals in the private sector can support national governments in implementation of the strategy through public-private partnerships for the provision of essential oral health care, by helping to plan and implement population-wide prevention measures and by participating in oral health data collection and surveillance.

#### ACTION BY THE EXECUTIVE BOARD

52. The Executive Board is invited to note the report and to provide guidance on the draft global strategy on oral health.

**Commented [A18]:** Suggest revising. Use of 'healthy products' in this sentence may be misunderstood. The range of food and beverage products that may contribute to dental caries, for example, includes items that would in a general context be considered healthy. Also noting that civil society and consumers may also advocate with industries directly.

**Commented [A19]:** As above, recommend revising for clarity.

**Commented [A20]:** This action should be revised or reframed for clarity. It is unclear what products may be in mind here that correlate with oral diseases (in contrast to causation). Given the generality of the statement, elimination of sale may be excessive.



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## **CONSULTATION ON WHA 74.5.**

The resolution provides an opportunity to create impetus on the implementation of Oral Health Services in the broader framework of Non-Communicable Diseases (NCDs) but addressing the specific needs using the Primary Health Care (PHC) Approach. To achieve this the strategy must clearly articulate how best to strengthen all the recognised pillars of the health system using the recognised 6 building blocks, emphasizing that Human Resources for Oral Health (HROH) are primarily responsible for ensuring that blocks are employed synergistically to offer an efficient and responsive Oral Health Service.

It is important therefore to employ the resources to ensure that there is Universal Health Coverage packages that offer sufficient oral health services in an equitable manner to populations without any suffering catastrophic financial losses.

The best way forward is to develop a template logical framework for oral health, highlighting the need for standardised needs analysis, the objectives, strategies, and indicator matrix. Taking the leaf from other programs such as HIV/AIDS and Reproductive, Maternity, New-born, Child, and Adolescent Health (RMNCAH) we need to define delivery platforms, signal functions and agreed national and global targets. The means of verification (MOV) and standard monitoring and evaluation milestones should be well defined and versatile for use globally. While PHC is generally implemented based on all stages of care, the mainstay is the District Health System with defined services in the subdistrict level to preventive services in the community and specialized services and rehabilitation at higher levels. That architecture, in terms of HROH, signal functions and infrastructure must be clearly articulated in the strategy to act as an investment case and basis for health diplomacy to make maximum use of the political will available at this opportunity. We must incorporate targets and strategies to overcome HROH shortage in general and public health skills specifically that there are competent staff to implement the strategies.

A compendium of best practices in Oral Health promoting schools and other innovations from research should be shared to improve an agreed standard.

Compiled by Dr Hardwicke Matikiti

Acting Director Oral Health, Ministry of Health and Child Care Zimbabwe



Stop Caries NOW for a Cavity-Free Future

15th Sept 2021

Dr Benoit Varenne  
Dental Officer, Noncommunicable Disease Department  
World Health Organization Headquarters  
Geneva

Dear Dr Varenne,

The draft WHO Global Oral Health Strategy was circulated to members of the Alliance for a Cavity Free Future, Australian and New Zealand Chapter (ACFF ANZ) for feedback in September 2021.

The Alliance for a Cavity-Free Future is a global non-profit organisation committed to fighting against the initiation and progression of dental caries. The ACFF was formed out of this desire to effect change, by a group of like-minded dental professionals joining forces to raise awareness and combat dental caries through promoting clinical and public health action. Many of the members of ACFF ANZ are key collaborators and stakeholders on various integrated oral health projects.

The ACFF ANZ Chapter would like voice support for the WHO Global Oral Health Strategy. We believe this strategy is taking the right direction and is likely to assist with positive change in population oral health.

Yours sincerely,

Kaye Roberts-Thomson  
ACFF ANZ Chair



## The Alliance for a Cavity-Free Future

### Response to WHO consultation on 'A draft global strategy on oral health' (WHO Discussion Paper)

15<sup>th</sup> September 2021

Dear Dr Varenne,

On behalf of the Alliance for a Cavity-Free Future (ACFF), I wish to offer you many congratulations on achieving an effective consolidation of the key elements of the recent Oral Health discussions and Resolution into a concise and clear strategic form. **The ACFF agrees with and pleased to support the draft strategy.**

The fight for universal oral health is a key step in ensuring a healthier future for all and the ACFF wholeheartedly support the Vision and Goal of the WHO Oral Health Strategy. We are pleased to see many alignments between the Strategy and the Global ACFF mission and current activity streams.

We agree with the Global Overview of Oral Health elements in the draft strategy and believe that these offer a comprehensive overview. **We would however, in reference to points 4-5 (Oral Disease Burden) be keen to see due prominence given to caries and cavities explicitly within the Strategy wording (and the following Action Plan), as this is the largest and most expensive element of the oral health burden - and yet is often ignored in health policy.**

In December 2020, the ACFF 'Making Cavities History' (MCH) Taskforce undertook the task of creating a consensus on Policy Recommendations for achieving a dental cavity-free future to highlight the importance of including caries and cavities within international health and oral health discussions and policy development. This international group of 35 authors from 20 countries included CDO's, NGO representatives, public health experts and academics amongst its members. They stated that: *"The recommendations within this paper are a consensus among international representatives from across the global dental community. The authors strongly believe that if a concerted, global effort is made, dental caries can be stopped in its tracks, and we call upon policymakers to consider these recommendations so that we might feasibly create a future free from dental cavities".*

The recommendations published in February 2021 by the MCH Taskforce group fall under the following headings (full recommendations are at Annex A):

- I – Effective prevention and management of dental caries and cavities across the life course*
- II - Addressing caries and cavities risk factors across the life course to fight major non-communicable diseases*
- III - Integration of primary and secondary prevention across the life course to address the burden of cavities and caries*
- IV - Comprehensive data collection for effective prevention and management of dental caries and cavities*

The individual calls and encouragements within the MCH policy recommendations offer strong alignment to the Guiding Principles and Strategic Objectives outlined in the draft Strategy Document, with particularly noted overlap across the following areas:

**WHO Principle 1:** A public health approach to oral health- *MCH Recommendation 1/2*

**WHO Principle 2:** Integration of oral health in primary health care- *MCH Recommendation 3*

**WHO Principle 3:** A new oral health workforce model to respond to population needs- *MCH Recommendation 3*

**WHO Principle 4:** People-centred oral health care- *MCH Recommendation 1/2/3*

**WHO Principle 5:** Tailored oral health across the life course- *MCH Recommendation 2/3*

**WHO Principle 6:** Optimizing digital technologies for oral health- *MCH Recommendation 4*

In addition, many of the Strategic Objectives outlined in the draft document feature heavily throughout the MCH recommendations and the accompanying consensus report. We fully support Strategic Objective 5 – to create and update a new research agenda and innovations for better impact on oral health.

This close alignment offers opportunities for cross-referencing between the documents, and not only strengthens the case for the importance of including caries and cavities within the wider oral health and NCDs discourse, but also offers an exemplar of targeted recommendations whose implementation is already being supported. The MCH Policy recommendations have already been published in a peer-reviewed journal and widely endorsed by many international organisations, including the World Federation of Public Health Associations (WFPHA) ([view the endorsement statement here](#)).

The **ACFF “Dental Policy Lab Network”**, which will be officially launching in late September 2021, will have a stream of activity targeted towards providing locally appropriate support to encourage the implementation of the MCH recommendations and key elements of the WHO Oral Health Resolution in health systems. This Network will be well equipped to also play a role in the implementation of the WHO Strategy at the local and global levels, and as an NGO, the ACFF would be very pleased to work with WHO in this capacity to advance the Strategy and the later Action Plan.

With kind regards and best wishes for the next steps,



**Professor Nigel Pitts**

*Global Chair, The Alliance for a Cavity-Free Future  
for the Making Cavities History Taskforce*

## Annex A

# A GLOBAL CONSENSUS for Achieving a dental cavity-free future - POLICY RECOMMENDATIONS

Pitts N B, Mayne C. A Global Consensus for Achieving a Dental Cavity-Free Future. 2021. DOI: [10.18742/pub01-045](https://doi.org/10.18742/pub01-045)

Pitts N B, Mayne C. Making Cavities History: A Global Policy Consensus for Achieving a Dental Cavity-Free Future. *JDR Clinical & Translational Research*. 2021;6(3):264-267. DOI: [10.1177/23800844211020298](https://doi.org/10.1177/23800844211020298)

Alliance for a Cavity-Free Future. *Making Cavities History*. 2021. [<https://www.acffglobal.org/making-cavities-history/>]

### POLICY RECOMMENDATIONS

## I – Effective prevention and management of dental caries and cavities across the life course

Oral diseases, notably dental caries and cavities, are largely preventable. Disease prevention and management allow individuals to live a pain-free and high-quality life throughout their lives, and reduces the impact on healthcare expenditure.

### WE CALL UPON POLICYMAKERS:

- **To recognise caries and cavities** in their national non-communicable diseases (NCDs) plans at the same level as other major NCDs, such as diabetes, which share common risk factors.

- **To implement oral health education programmes** in preschools and schools for both students and parents, with the support of key stakeholders from across the healthcare spectrum, based on best practice examples from across the world, such as the Childsmile programme.

- **To implement oral health education programmes** specifically addressed at vulnerable groups, such as pregnant women, the elderly population, etc.

- **To include oral health curricula prevention and management modules** as part of the formal and lifelong training of healthcare professionals, across the spectrum.

## II - Addressing caries and cavities risk factors across the life course to fight major non-communicable diseases

Sugar consumption is one of the most common dietary risk factors across the life course towards developing an NCD, notably diabetes, cardiovascular diseases, cancer, and obesity, and results in massive public expenditures for the treatment of caries and cavities. Reduction in the intake of sugar-sweetened beverages and foods is advised globally as part of healthier dietary patterns to help reduce energy intake, the risk of obesity, and obesity-related disorders.

### WE CALL UPON COUNTRIES

- **to include oral diseases**, and in particular caries and cavities, into their national NCDs plans when targeting high sugar consumption in major NCDs. In turn, directly addressing caries and cavities will also address the major NCDs.

### WE ENCOURAGE POLICYMAKERS TO FOCUS ON:

- **Creating effective solutions**, with all stakeholders, to provide affordable and accessible healthy food and drinkable water as well as decrease the purchase of sugared food or drinks through taxation policies.
- **The importance of decreasing sugar intake** in the first two years of life as these years are crucial in determining a child's wellbeing in adulthood.
- **The implementation of oral hygiene education programmes** in primary and secondary school, including nutrition programmes modelling healthy and affordable nutrition and hygiene practices.
- **The promotion of healthy food consumption** across the life course, notably in schools and in the workplace.

### III - Integration of primary and secondary prevention across the life course to address the burden of cavities and caries

There is no general health without oral health. Therefore, a focus on prevention across the life course is key.

#### WE CALL UPON POLICYMAKERS:

- **To ensure a shift towards optimal standards of care** and preventive dental medicine, which is outcomes oriented and based on best practice implementation, and includes access to affordable future innovations in caries prevention technologies and care delivery, in discussion with all key stakeholders from across the healthcare spectrum. This should furthermore address the reduction of the environmental footprint through the reduction of the use of dental amalgam, in line with the implementation of the Minamata Convention on Mercury, and other restorative materials.
- **To ensure the implementation, access, and affordability** of proven preventive measures, such as public health use of fluoride and effective and affordable fluoride toothpaste, to promote and

preserve oral health, in discussion with all key stakeholders from across the healthcare spectrum.

- **To strengthen the interconnectivity** between oral and general health through a holistic approach which integrates oral health into general health promotion strategies as well as in academic curricula and lifelong learning for professionals.
- **To integrate equitable and affordable access to essential care** for the most common dental needs in primary care services (under Universal Health Coverage) to improve the prevention and management of NCDs as well as caries and cavities.
- **To integrate oral health policies**, and in particular the inclusion of caries and cavities prevention policies, into national health programmes as cost-effective measures and part of primary care services, as well as to translate them into national prevention programmes. The focus should be on the entire life course and range from early childhood caries to healthy ageing, in line with the WHO Decade of Healthy Ageing.

### IV - Comprehensive data collection for effective prevention and management of dental caries and cavities

The lack of data, in general, as well as the lack of consistent data on dental caries and cavities does not allow for proper decision making to ensure effective strategies in the prevention and management of dental caries and cavities.

#### WE CALL UPON POLICYMAKERS:

- **To create a sustainable public surveillance programme** for the collection of data on the prevalence and

incidence of caries and cavities across the life course, taking best practice examples as a starting point.

- **To monitor progress and evaluate the impact of policies aimed** at preventing and managing caries and cavities.
- **To use the same case definition and exchange data** on current oral health policies.
- **To establish a monitoring system** to ensure implementation of the above recommendations.



**Joint Response of ADEE, FEHDD, IFDEA and the O-Health-Edu Project team  
On the Draft for a Global Strategy on Oral Health (WHO Resolution WHA 74.5)**

The **Association for Dental Education in Europe (ADEE)**, represents more than 200 institutions dedicated to the education of Oral Health Professionals in over 50 countries. ADEE has facilitated the reestablishment of The **Forum of European Heads and Deans of Dental Schools (FEHDD)** in 2008 to provide a means of bringing together Dental School Deans, Heads and their deputies from Europe and further afield, to explore current topics of interest. ADEE is also facilitating **the International Federation Dental Educators and Associations (IFDEA)**, an initiative aimed to provide a virtual space of collaboration for the associations for Oral Health Education around the globe. ADEE is also dissemination partner for the Erasmus + project, **O-Health-Edu**, an active partnership including ten Oral Health Higher Education Institutions aimed to better understand the current state of oral health education within the EU, and to develop a suite of online tools that will support the aggregation, interrogation and presentation of oral health education program data, and curriculum documents.

Collaboratively and independently these four oral health professional associations recognizes the World Health Assembly adopted resolution WHA 74.5 (2021) as a pivotal document to orient and inspire the future development of Oral Health Education Programs. Consequently, we are responding to the call for consultation on the resolution requested from the Director General for drafting a global strategy on tackling oral diseases, as well as the development of a global action plan on oral health. ADEE, IFDEA, FEHDD and O-Health-Edu offer the following feedback on this draft document. Prior to addressing the specifics of the WHO discussion paper a brief profile of ADEE is provided for context.

ADEE, IFDEA, FEHDD and O-Health-Edu and their respective membership embrace the WHO definition of oral health as the state of well-being that encompasses numerous functions (from breathing to eating, speaking, smiling and socializing) thus enabling individuals to achieve their full capacity and participation in society, comfortably and confidently. Consequently, since our foundations such a perspective is reflected in all teaching and research activities the concept of oral health as an essential component of the patient's general health, wellbeing and quality of life, from birth to old age. ADEE consensus papers, documents and proposals for Oral Health Education have early and consistently taken into account the Agenda for Sustainable Development Goals, as well as the WHO's documents cited in the Resolution referred to the essential rapport between education, oral health and general health and wellbeing.

ADEE's profile and competencies of the European oral health professionals have progressively developed competencies, implementing learning outcomes addressing the burden of oral diseases, including its relationship with the other noncommunicable diseases, the relevance of cancers of the lip and oral cavity and its prevention, and the need for a rapid diagnosis of precancerous lesions and birth defects, with emphasis in those signalling rare diseases. In a similar manner, the association of oral health and the patient's social and economic status, as well as the commercial determinants and risk factors for the population's oral health have been developed as the knowledge-based competencies of the future oral health workforce in advocacy in prevention and oral health promotion. Most ADEE institutional members offer oral healthcare services to their populations, mostly through conventions with their public



healthcare systems. University Dental Hospitals provide not only primary dental care, but also highly specialized treatments for complex ailments. Moreover, as a part of their social engagement, most University Dental Hospitals maintain programs that provide dental treatment to vulnerable patients.

ADEE activities, congresses, formative activities and publications, all reflect the ethos of our communities of practice, to collaborate in the implementation of the Vision expressed in the Strategy: universal oral health coverage for all people in 2030. ADEE's collaborative effort is aimed to contribute to the goal of developing responses to promote oral health, reduce oral diseases as well as other oral conditions and oral health inequalities. ADEE membership's expertise has contributed for years to the research in education of the oral health workforce. Thus for these reasons the proposals of the WHO are welcome and overdue.

We wish to highlight the following key aspects be considered and reflected in the enabling of the WHO position from an oral health professional's education perspective:

1. Oral Health Professional Educators should be seen as key stakeholders in enabling this strategy and should be included from the outset at national and European, global levels so as to make such dramatic change achievable. Acknowledgement of national and local diversity in funding, education and healthcare systems will be essential to ensure equity in provision.
2. Curricula should be grounded in a competence approach, encompassing scientific evidence and best practices, and changes will take upwards of 5 years to impact graduate outturn. Realistic timetables for achieving the objectives should be set to reflect this. Ensuring the revised curricula are quality assured will be necessary and requires structural and other supports.
3. The concept of inter-professionalism is central to the success of this strategy. Implementing IPE in education and clinical practice is a step change for many professionals and will need lengthy consultation, facilitation and a long-term view to be achieved.
4. Lifelong learning will be central to enabling mind set change and a responsive workforce in a rapidly changing context. Enabling educational, clinical and sustainable practice structures to support this at a national and European, global level will be necessary.
5. Research and scientific evidence must lead the rationale debate and consensus making process. Oral health research, educational research and advancing technologies including haptics continue to shape the curriculum in many ways. Ensuring such innovations are integrated into the strategy and ways of working is critical.
6. Student wellbeing and workload will need in depth consideration, student workloads are already stretched and simply adding new skills and competence to an already busy curriculum is not the answer, thus wider professional reframing is required.

The following return to your discussion paper, the vision, goals, principles and strategic objectives to discuss these points within this context in turn:

**Proposals Vision:**

ADEE, IFDEA, FEHDD and O-Health-Edu welcome the laudable vision of the proposal to attain universal oral health coverage for all people by 2030, however we do question its possible success in such a short timeframe. Given the complexities of healthcare and education as



further highlighted by the COVID 19 pandemic, much resource investment and a change agenda must be embedded within these two service provisions. Setting achievable and realistic deadlines the majority of countries will be able to attain without further hardship is important. Perhaps a more realistic timeline for such strategic and operational change of this scale would be 2035 or 2040.

**Proposed Goal:**

Again, ADEE, IFDEA, FEHDD and O-Health-Edu very much welcome this goal which should firmly place oral health on the agenda and enable the quantifiable assessment of this over time. However, while reading the goal there seems to be misalignment in the language used in the vision. The vision states universal health will be achieved by 2030, the goal opens up to just taking stock by 2030. Such change in language albeit small is important as it implicitly implies the WHO may feel the vision is not attainable.

**Guiding Principles:**

ADEE, IFDEA, FEHDD and O-Health-Edu broadly welcome the 6 guiding principles as a means of enabling strategic change in the provision of healthcare scores and education. We make specific comment on the following:

***Principle 1: A public health approach to oral health and Principle 2: Integration of oral health in primary health care***

We agree in that the first step for addressing the public health approach to oral health must address the more prevalent and the more severe oral diseases and conditions. However, given the growing evidence that there are common causal mechanisms linking many systemic ailments to oral diseases and conditions, the draft document should signal the need for a long-term integration of oral health professionals and services within the public healthcare systems. Thus, the draft should propose starting with primary care collaboration and then progressing to the oral and general health professionals team effort to take care of the more complex patients and conditions in the hospitals.

The integration of oral care to the primary healthcare is very much welcomed, however we advise that the amount of programme change the accommodating text will require both in practice and academic environments should not be under estimated. Embedding a culture of inter professionalism will need a step change in mind sets for many professions, both in healthcare and in all the public services, and in the education environment, etc. This will need considerable re-negotiation of roles, responsibilities, accountability and thereafter education programme updating and course development. Consequently, all stakeholders will need to dedicate considerable workload, resource commitments and of course time to this endeavour.

***Principle 3: A new oral health workforce model to respond to population needs***

Again this is a laudable objective, however it will entail considerable negotiation of work practices, roles and responsibilities and potentially the demise of some oral health professions. Such negotiations at a national and regional level will need considerable time to be effectively enabled.

The resulting changes in professional role, definition and competence will need time to be quantified, qualified, documented, and broken down to meaningful learning outcomes and teaching strategies. This will then require a review of the teaching workforce to align in advance of delivering new teaching and training models. A lead in of 5 to 10 years is we feel a necessity at a minimum to make such dramatic change in both health and education sectors. We must



keep in mind that changes need to be negotiated in an inclusive manner and resulting changes in programmes will require accreditation and quality assurance, all of which is for the most part built on a 3 to 5 years cycle.

**Principle 4: People-centred oral health care and Principle 5: Tailored oral health across the life course**

Both principles are welcomed. We do remind the WHO that with regards oral health education a person centred approach has been at the core of ADEE and its members for many years. Such principles place emphasis on the importance of the social, cultural and contextual factors of healthcare and education. These in turn place emphasis on oral healthcare as being a complex system that needs a competence based approach in teaching and learning. We also remind you that the student patient relationship adds a level of complexity in oral health training as many students practice since their initial formative years on live patients. This fact makes them excellent advocates for Oral Health, as proven by the numerous charities and projects addressed to children, older and deprived patients they lead in our Faculties.

The formation of specialists in oral health dedicated to prenatal, infant, child and adolescents or to older patients has been the object of numerous research projects and consensus papers from their respective ADEE's communities of practice. These experiences lead us to remark that oral health specialities must be regulated and integrated in the health systems in order to attain the objective of integrating age-appropriate oral health strategies within the relevant health programmes across the population's life course.

**Principle 6: Optimizing digital technologies for oral health**

There is no doubt that technologies can play a key role in delivering this strategy. However, we would stress that it is important that technology is viewed as an enabler rather than a deliverer of oral healthcare. ADEE and its membership continue to embrace technologies in its teaching and practices of dentistry and to work towards standards for the use of same. Our long experience enables us to caution that while technologies provide valuable opportunities they do so at considerable upfront costs. Costs that for many countries may be better invested in upskilling or retraining staff.

**Strategic Objectives**

Each of the strategic objectives are welcomed by ADEE, IFDEA, FEHDD and O-Health-Edu with the *caveat* that national agencies are mandated to engage in a meaningful collective consultation and negotiation process not only with the public, the students and the professions but with the educators throughout the process also.

ADEE's long experience in harmonisation of Oral Health Education programs leads us to signal that the changes in professional practice result in changes in education and vice versa, thus multi stakeholder and sectorial consultation must be attained early if these objectives are to be achieved. Consequently we propose some *addenda* to the Strategic Objectives in the Draft, in order to ensure that the education of the future Oral Health Professionals is harmonized both with the WHO Global Strategy on Oral Health and with the formation of the other professionals included in the Health Workforce.



### **Strategic Objective 1: Oral Health Governance**

In order to better attain the recognition and integration of oral health in all relevant policies and public health programs (including national noncommunicable disease and universal health coverage agendas), and to implement the required educational programs, the National Oral Health Unit that constitutes the core of Objective 1 must include a representative of the Oral Health Education system.

Consequently, we proposes to modify the point 26 redaction to:

26. “Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant **public health and education services.**”

### **Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention**

In order to promote Oral Health Equity, the education of all Health professionals, including Oral Health professionals and other health workers, both already practicing and in formation, must include learning outcomes related with the evidence-based, cost-effective and sustainable oral health promotion and interventions to prevent oral diseases and conditions proposed by the National Oral Health Unit.

Consequently, we proposes to add to the point 28 redaction the following statement:

28. “Prevention efforts target key risk factors and social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries. **These preventive efforts and joint initiatives must include formative projects aimed to ensure that all the practicing members of the Health Workforce, as well as all Health students are competent to collectively address the adequate Oral Health Strategies**”

### **Strategic Objective 3: Primary Oral Health Care - Build workforce capacity**

### **Strategic Objective 4: Oral Health Information Systems - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making**

These particular objective have been the essence of all ADEE activities since its foundation. In order to attain the objective of increase access by the entire population to safe, effective, and affordable primary oral health care as part of the universal health coverage, Oral Health Education must enable the future professionals to be active members of all levels of healthcare, from primary public and private healthcare to the most specialized multidisciplinary teams. This will also facilitate the objective to enhance Oral Health Surveillance and data management, thus feeding the information systems both at a national and at a global level with relevant feedback to ensure an evidence-based policy-making. Our experience shows that interprofessional education constitutes the most effective learning experience to acquire these competencies.



Thus, to build a team workforce capacity ADEE proposes the following alternative text for point 30:

30. **“Oral health professionals must be active members of the primary health care team and work side-by-side with other health workers by applying their specific competencies to collaboratively tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups. To initiate the building of such workforce capacity, these competencies, added to the ones related with Health Surveillance and Information Systems as well as Sustainability must be developed in the adequate Interprofessional Health Education graduate and postgraduate programs.”**

#### **Strategic Objective 5: Oral Health Research Agenda**

ADEE members are the institutions that essentially carry out the Education and Research in Oral Health. Oral health related research has experienced an enormous progress in the last decades by applying the most advanced research methods and techniques and collaborating in equal conditions with all other science areas. The objective aimed to the creation and continuously updating of a new research agenda focused on public health aspects of oral health and innovation for better impact on both general oral health is then in complete agreement with ADEE's proposals and actions. However, the text on point 32 does not reflect the present state of Oral Health and Education Research as it is developed by the ADEE educational research community.

In a similar manner than interprofessional education has proven its excellence for acquiring competencies, the more successful research is nowadays interdisciplinary. Oral health research projects must be considered as an integral part of National and International Health Research programs in order to adequately address the common risk factors and causal mechanisms for many ailments that affect our populations, be the initial signs and symptoms diagnosed or treated by an Oral Health professional or by any other Health Workforce member. Other interdisciplinary research success stories in which Oral health researchers contribution has been pivotal include biomaterials, tissue regeneration, genomic-proteomics of oral/systemic diseases and craniofacial development, rare diseases, haptics, 3D and digital technologies and minimally invasive interventions.

The alternative redaction of point 32 we propose is thus:

32. **“Strategic objective 5 strives to move beyond the historical oral health research agenda that was heavily focused on dental technology and problem description, rather than problem-solving. The new oral health research agenda should reinforce its recently developed strengths, such as biomaterials, tissue regeneration, genomic-proteomics of oral and systemic diseases, craniofacial development, rare diseases, haptic, digital and 3D technologies and minimally invasive interventions. Moreover, new research initiatives must be specifically aimed to public oral health programs, population-based interventions, learning health systems, workforce models, and the public health aspects of oral diseases and conditions, such as primary health care interventions, environmentally sustainable practice, and economic analyses to identify cost-effective oral health interventions.**



**Since interdisciplinarity is a key factor in the success of numerous research projects, Oral Health objectives must be included in National and International research programs and Oral Health Professionals must be considered members of the research teams in equal conditions than the other scientists and technicians.”**

### **Role of ADEE, IFDEA, FEHDD and O-Health-Edu in the Development of the WHO’s Global Strategy on Oral Health**

As the voice of Oral Health Academic Institutions in the WHO European Region, ADEE is actively engaged in advocacy, resource mobilization, exchange of information, sharing of lessons learned, capacity-building and collaborative research to achieve the goals and objectives of the Strategy at global, regional and national level. ADEE’s contribution to the success of the WHO Global Strategy on Oral Health would be then sustained by our long history of collegiality, consensus and collaboration with global partners, including the European Union through numerous EU-funded projects, as well as student’s, professional’s, and other research and academic associations.

The O-Health-Edu ERASMUS + Project, an active partnership including ADEE and ten Oral Health Higher Education Institutions also members of ADEE, is aimed to better understand the current state of oral health education within the EU, and to develop a suite of online tools that will support the aggregation, interrogation and presentation of oral health education program data, and curriculum documents. These efforts are in line with the WHO Global Strategy, since one of its strategic objectives is to define the priorities for a strategic vision and support changes for oral health professionals’ education in 2030.

The Forum of European Heads and Deans of Dental Schools was re-established in 2008 to provide a means of bringing together Dental School Deans, Heads and their deputies from Europe and further afield to explore current topics of interest. Their meetings are part of the ADEE annual scientific meetings, and their objectives are to provide training, support and networking to improve the governance of the Oral Health Education Institutions. Their last meetings have been dedicated to themes directly related with the WHO Global Strategy, such as Diversity, Equity and Inclusion; Resilience in a time of change and the New clinical practice challenges arising from Covid in the clinical education environment.

ADEE is presently leading the International Federation Dental Educators and Associations (IFDEA), an initiative aimed to provide a virtual space of collaboration for the associations for Oral Health Education around the globe. This global open space will constitute a forum to facilitate the collaboration in the implementation of the Educational aspects of the WHO Global Strategy.

ADEE’s vast experience in the harmonization of the Oral Health Education in Europe with a Global Perspective could thus be applied to coordinate all ADEE’s various efforts and activities to collaborate in the International Coalition on Oral Health as an active partner to support countries and Oral Health Schools in the implementation of the WHO’s Global Strategy on Oral Health.



**ADEE**  
ADVANCING EDUCATION  
AND ORAL HEALTH

**FEHDD**  
FORUM OF EUROPEAN  
HEADS & DEANS  
OF DENTAL SCHOOLS



**IFDEA**

**O-Health-Edu**

This submission is made on behalf of the organisations by:

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# Australian Centre for Integration of Oral Health submission on the World Health Organization's Draft Global Strategy for Oral Health

**17 September 2021**

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## ACIOH: Who we are

The Australian Centre for Integration of Oral Health (ACIOH) is the leading national research centre in integrated oral health care and translational research - a key focus of Australia's National Oral Health Plan (2015-2024). ACIOH is a virtual centre led by Western Sydney University (WSU) in collaboration with partner universities, health services and professional organisations. WSU has a strong reputation in this area having co-established a successful interprofessional oral health research centre in 2015 ([www.cohortaustralia.com](http://www.cohortaustralia.com)).

ACIOH is the research arm of the Australian Network for the Integration of Oral Health (NIOH) which was established in 2017 as an independent group, connected through our mission to put the mouth back into the body and make oral health everyone's business. NIOH has over 120 members across universities, government agencies, not-for-profits, consumer groups, and industry within Australia.

ACIOH provides a national platform for individuals and organisations to collaborate on oral health research, generate evidence to inform policy and practice, and disseminate findings through NIOH. This approach ensures that research being undertaken is complementary and builds on existing work; and importantly avoids duplication and enhances research translation. The work being led by ACIOH/NIOH has been internationally recognised and endorsed by the World Health Organization as well as the National Interprofessional Initiative on Oral Health in the United States.

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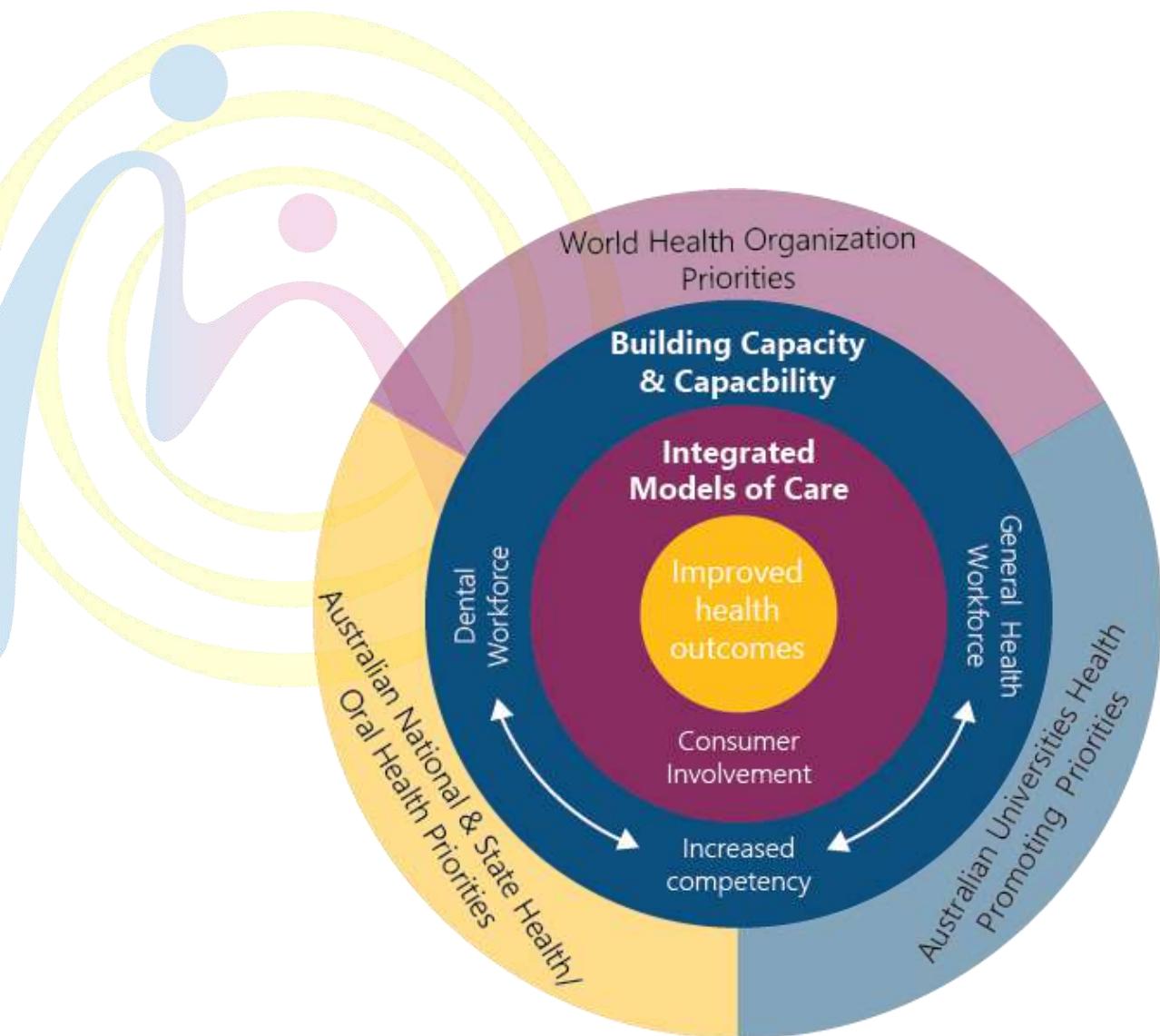
## ACIOH: What we do

The core themes of ACIOH are:

- Building capacity and capability of the broader health and dental workforce.
- Developing new integrated models of oral health care across the lifespan.

ACIOH projects focus on developing and implementing evidence-informed, culturally appropriate models of care that improve clinical practice and patient outcomes, are cost-effective for healthcare services and influence policy change.

We work closely with consumers and stakeholders from conceptualisation to implementation ensuring long-term sustainability and scalability of the models of care. There is strong focus on increasing community oral health awareness and the competency of the workforce through the development of appropriate resources, continuing professional development programs and undergraduate training.



# Consultation on the Draft Global Strategy for Oral Health

<b>Organisation Name:</b> <b>Australian Centre for Integration of Oral Health</b>	<b>Person(s) Involved in Contribution:</b> Professor Ajesh George; Professor Hanny Calache; Dr Bradley Christian; Dr Meng-Wong Taing; Associate Professor Rachel Martin; Professor Linda Slack-Smith
<b>Date:</b> 17/09/2021	<b>Contact Email:</b> bradley.christian@health.nsw.gov.au

<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
<p>The vision of this strategy is universal oral health coverage for all people by 2030.</p> 	<p>A highly appropriate all-encompassing and ambitious vision for oral health that, when achieved, has the potential to translate to meaningful gains in oral health globally. Everyone has a basic human right to oral health care and information about oral health and therefore it follows that everyone must have access to appropriate health services.</p> <p>The vision should also be about '<i>achievement of good oral health (healthy mouth) for all people by 2030</i>' rather than achievement of a '<i>universal coverage for all people</i>'. Achievement of the latter only does not necessarily imply that all people will also have good oral health. Universal oral health coverage should then be an additional guiding principle to achieving the vision of '<i>good oral health for all by 2030</i>'. Further, universal oral health coverage may not be feasible in all countries especially low-income ones; however, <i>good oral health</i> could be achieved through other strategies like improving oral health literacy and preventative behaviours.</p>
<p>The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.</p>	<p>This goal seems appropriate and we support the goal of the strategy. We suggest the following to be modified (in bold):</p> <ul style="list-style-type: none"> <li>• The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health <b>across the life-course</b></li> <li>• ...targets and indicators, based on national situations, <b>best evidence, cultural appropriateness</b> building on the guidance to be provided by the WHO...</li> </ul> <p>In addition, commercial determinants (as stated in WHO discussion paper on page 2, section 8) need also be addressed as part of this strategy. The discussion paper (page 2 section 8) states '<i>Oral diseases and conditions and oral health inequalities are directly influenced by commercial determinants, which are strategies and approaches used by the private sector to promote products and choices that are detrimental to health</i>'. Unless these commercial determinants of health are adequately addressed by the Member States, the achievement of good oral health for all by 2030, would be an unachievable goal.</p>

<p><b>Principle 1: A public health approach to oral health</b> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p> 	<p>We fully support this principle. A public health approach to oral health must also 'put the mouth back into the body'; this approach is much needed in oral health. In addition, we suggest that:</p> <ul style="list-style-type: none"> <li>• Oral health is considered by all non-dental health professionals when they are managing their own patients as oral health impacts the quality of life and the management of chronic diseases for many affected populations groups, including those who are medically compromised and those affected by disability (physical, intellectual, sensory and emotional).</li> <li>• From workforce through to education and beliefs, practices and behaviours, there are a multitude of opportunities to raise the significance of individual infection control of mouth bacteria, healthy food and habits, and fundamental access to services, particularly for the sickest and most vulnerable</li> <li>• Consider adding the following: To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts and the capacity and capability of the broader health workforce to promote oral health should be enhanced</li> <li>• Change the wording to: A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of <b>while considering impacts on the marginalised</b></li> </ul>
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>We support this principle with some considerations:</p> <ul style="list-style-type: none"> <li>• Terminology: Primary health care (PHC) vs primary care (PC) - ensure usage appropriately as reported in the WHO's Operational Framework for Primary Health Care (2020); perhaps the purpose of the principle is the integration of oral health into primary care using a primary health care approach.</li> <li>• The word 'basic' could be deleted or replaced with 'essential' to align with current literature.</li> <li>• Could add additional benefit of integration - this integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, more equitable access to comprehensive, quality health care and more streamlined and cost effective health systems.</li> </ul>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health</p>	<p>A new oral health workforce model is very much needed particularly in low-income, and rural/remote settings where access to oral health professionals may be limited.</p> <p><b>However</b>, 'A new oral health workforce model' suggests that one new model will fix all oral health issues – this is obviously not the case. We need context and needs based models; the new oral health workforce model should also include a role in the integration of oral health across all health care models.</p>

<p>workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>We suggest, revising to read as: '<b>Innovative workforce models to respond to population oral health needs and context.</b>'</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	<p>We fully support this well-articulated principle. This principle is essential as human behaviour is a major key to good oral health, and respectful caring relationships can empower the most vulnerable. Ensuring health professionals understand and practise this should be managed through best practice education. This principle should also be adopted early in all research and evidence generation activity undertaken in population oral health to ensure strategies and interventions developed are acceptable, feasible and sustainable.</p>
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Fully supported and very important principle. The principle could also add oral health strategies specific to age and cultural appropriateness.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for</p>	<p>We fully support this principle. In addition, we suggest:</p> <ul style="list-style-type: none"> <li>• Adding increasing access to care.</li> <li>• Digital technologies must also be integrated across general health for optimum outcomes.</li> <li>• Consideration on how people use the technology and the availability of technology.</li> </ul>

<p>digital oral health based on best practice and scientific evidence.</p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>We fully support this strategic objective. Oral health should be part of overall health governance.</p> <p>Paragraph 26 of the draft strategy: "Establishing national oral health units/programs in Member States should be a key advocacy activity for the WHO" - This strategy should ensure that this topic comes across clearly and flows into the planned Global Action Plan on Oral Health. This is clearly measurable outcome which will create national oral health leadership.</p> <p>We suggest adding to paragraph 26: Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, multidisciplinary, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services. Sustainable partnerships within and outside of the health sector, and engagement with communities, civil society and the private sector, are essential to mobilize resources and address the social and commercial determinants of oral health.</p>
<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>We fully support this strategic objective. Reducing the social and commercial determinants of oral health is crucial to achieving the best possible oral health for all.</p>
<p><b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>While the intent of Strategic Objective 3 aligns with Principle 2, it does not come across clearly in the title 'Primary Oral Health Care'. This strategic objective could be re-worded to read as – 'Integration into primary care' Or 'Integrated Oral Health Care'.</p> <p>The theme of integration should be reflected up front in the strategic objective, as without integration we will never be able to achieve the goal of Universal Health Coverage. 'Primary oral health care' can also be a bit confusing term to use.</p> <p>Also, in this section please be mindful of correct use of primary health care VS primary care. PHC is used in a couple of sentences in this section of the document where in fact it should be 'primary care'.</p> <p>We also recommend that primary oral health care be incorporated in tertiary professional educational programs and professional development programs post-graduation across all health professionals. The interdisciplinary approach must be prioritised to ensure sustained practice change. To</p>

	<p>enhance non-dental professional involvement in oral healthcare, interprofessional education and collaboration between non-dental and the dental profession should be promoted and supported as it is an essential step towards effective collaborative oral healthcare. In particular, the inclusion of interprofessional requirements within competency standards for non-dental health professionals is required to enhance the capacity of this workforce. Some good models exist but need to be scaled up.</p> <p>We must invest in low cost/high quality of life options for care, such as those developed for aged care facilities with risk assessments, health promoting practices, diagnosis, preventive care as required, and treatment only for pain and function.</p>
<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>We fully support this strategic objective; these should be integrated across both dental and health care systems.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>Oral health should be incorporated and considered in health research and not separated from overall health. For impact, health economics also need to be considered as cost-effective oral health interventions are recommended by 2024.</p> <p>We suggest that the word 'new' may be replaced by 'context and needs specific' research agendas. The sentence could be revised to read as: 'Create and continuously update <b>context and needs specific</b> research agendas which are focused on public health <b>and primary health care approaches</b> for better impact on oral health.'</p> <p>Also, in this section overall, the theme of evidence-informed practice, policies and programs needs to come across more clearly.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b></p>	
<p><b>Comment:</b> This is an important section of the draft global strategy. Without consideration of the role of the various stakeholders – it will be challenging to operationalise any plans or strategies.</p> <p>An issue though, is with the way the language for this section is structured – In the current form, the role of each entity sits on its own without supporting or accountability to each other. For example, the section on Member State shows that it is up to the Member States to adopt and implement such global strategies; while this may be the case – there needs to be a mechanism for accountability built into the governance roles for Member States. For a country like Australia with no national oral health body, there could be very poor uptake.</p> <p>The language for this section should be revised with a key message/theme being - WHO will work with Member States to ensure there is accountability and uptake at the national level; particularly into national level health policies and strategic plans.</p>	



## Bangladesh Dental Society

By:

Bangladesh Dental Society-BDS

To:

World Health Organization (WHO)

Bangladesh Dental Society (BDS) is the only registered national organization in Bangladesh that represents all graduating dental surgeons, having about 9500 members, which accounts for around 96 percent of all registered dentists in Bangladesh. Founded in 1977, the organization is presently governed and regulated by an elected body of 49 Executive Members. The BDS is Bangladesh's main oral health champion. The major goals of BDS are to study and promote dental science in Bangladesh, to train professionals, and to assure and deliver optimal oral health care services to the population by promoting mercury-free dentistry.

### **Comments on WHO- 'DRAFT GLOBAL STRATEGY ON ORAL HEALTH'**

#### *Global Overview of Oral Health*

#### *Social and Economic Costs of Poor Oral Health*

*6. However, in the middle-and low-income countries, the use of high quantities of mercury amalgam puts more pressure on the poor by lowering their oral health. The alternative treatment costs more than usual mercury filling. Dental technicians (quackery) tend to choose it vastly to treat people unaware of the risks of mercury amalgam.*

#### *Oral Health Promotion and Oral Disease Prevention*

BDS: An awareness-raising campaign should be launched to raise knowledge of oral health care services, particularly in poor and middle-income nations. It will minimize dental health problems and save thousands of individuals from major health problems. In addition, it has been shown that educated people are unaware of dental health concerns, indicating a lack of information about oral health in the school system. As a result, oral health-related fundamental information should be incorporated in the academic curriculum so that students may learn from their youth.

We do not agree with the comparison of the cost of mercury and alternative filling materials. The most alternative filling is now available, affordable and cost-efficient. More than 90% of dentists from Bangladesh and South Asia as a whole have already chosen alternative fillings.

#### *Oral Health Care System*

**13. In oral health care sector, lack of proper regulation or law implementation with almost zero monitoring capacity, the corruption and use of prohibited materials has increased.**

BDS office (8/2. 3rd floor, Motaleb Tower, Paribag, Dhaka-1204)

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## Bangladesh Dental Society

*15. The COVID-19 pandemic has had a negative impact on the provision of essential oral health services in most countries, leading to delays in oral health care treatment, increased antibiotic prescriptions and greater oral health inequalities. The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health care systems as part of universal health coverage efforts.*

BDS: Yes, we do agree that the pandemic is an opportunity to integrate oral health care into the overall health system through the provision of Minamata's mercury-free health care.

### ***Evolution towards Mercury-Free Dentistry***

*16. The vision of this strategy is universal oral health coverage for all people by 2030*

BDS: Dental amalgam is known as a dental filling material that contains 50% elemental mercury (Hg). Mercury is often regarded as the most dangerous heavy metal in the environment because it is associated with progressive, neurological, and renal toxins, as well as a highly persistent bioaccumulative pollutant. It is a well-known neurotoxin that can harm humans, especially children, pregnant women, lactating mothers and fetuses, damaging the brain, kidneys and other body organs. Furthermore, the use of dental amalgam results in substantial quantities of toxic mercury being released into the environment. Because of these concerns, 128 nations negotiated the Minamata Convention on Mercury, which went into effect in August 2017. In addition, as a signatory country, in 2018, the Bangladesh Dental Society (BDS) declared to phase out mercury amalgam in dental treatment of pregnant women, mothers and children. As the Minamata Convention mandated each country to minimize all incidental and intentional mercury usage and emissions, including dental amalgam, BDS has prohibited the use of mercury in dental treatment for pregnant women, mothers and children. The BDS lobbied to ban mercury amalgam and all mercury imports and seals in Bangladesh, and worked to phase out mercury amalgam in dental treatments by 2024.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'HKB'.

Prof. Dr. Humayun Kabir Bulbul  
Secretary General  
Bangladesh Dental Society (BDS)

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## **British Dental Association comments on the WHO draft *Global strategy oral health***

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and include dental students.

The BDA strongly welcomes the development of the WHO strategy and the much-needed global focus on oral health it has the potential to bring. This represents a singular opportunity to address oral diseases as part of the global disease burden, reduce oral and general health inequalities and embed oral health promotion and care into programmes for preventing noncommunicable diseases (NCDs).

It is pleasing that the strategy recognises the need for greater political commitment to addressing the burden of oral diseases, which in turn will require increased resource allocation. We support the refocusing of health systems towards oral disease prevention, which is more cost-effective than treatment and can synergise with the prevention of other NCDs and aid the reduction of inequalities. In particular, policy interventions to reduce sugar consumption must be promoted, including fiscal levers and restrictions on sales promotions, advertising and sponsorship by manufacturers of unhealthy food and drink products. A child/human rights-based approach is required, whereby governments' duty to protect health is paramount in consideration of commercial and trade freedoms.

We welcome the priority given to oral health surveillance within the strategy. This will generate evidence of the magnitude of the challenge and effectiveness of interventions, as well as providing a driver for change in itself: "What gets measured gets done".

As a member of the FDI World Dental Federation and signatory to its response to the draft strategy, the BDA supports the points raised in the FDI's submission.

In addition to the comments submitted by the FDI, the BDA suggests the following to strengthen the strategy, make it more comprehensive and facilitate its implementation:

1. The strategy should start with the wider picture, demonstrating the importance of oral health as part of general health and how it is inextricably integrated with the current global agenda (equality, environmental sustainability/SDGs, NCDs, antimicrobial resistance). Failing to set this context from the outset risks missing the opportunity to make a compelling case for urgent action, and keeps oral health in its silo.

2. From this context should follow a recognition of the serious hurdle of persuading nations to acknowledge the need for action on oral health and to put in place the building blocks to reduce oral health inequalities by developing a plan, which recognises public health, education, workforce, appropriate incentives, etc. Integration of dentistry into the heart of state-funded prevention and treatment is key; this challenge is one that can be met only by national governments working constructively with the dental profession to re-focus the provision of oral care plans to address the needs of the wider population.
3. Dental amalgam: the Minamata Convention is mentioned only once in the Background section of the strategy, without any elaboration. However, we believe it should be highlighted as a key imperative for change, as part of the “big picture” outlined in point 1 above. Business as usual in dentistry will not be able to continue if there is a sudden phase-out of dental amalgam or if phase-down is too rapid, without serious attention to prevention and alternatives, and it will lead to increased inequalities within and between countries.
4. COVID-19 is also not given sufficient prominence in the strategy; paragraph 15 understates its seismic effects on oral health care as a “negative impact”. Again, we believe this should be included in the “big picture” context and regarded as an imperative for action, not an “opportunity”. The impact on public health programmes as well as services is not mentioned in the strategy. Many countries have public health programmes that rely on face-to-face interactions, which have been completely stopped due to school or care home closures, social distancing, etc. Pandemic recovery is also interlinked with global amalgam phase-out/phase-down, as limiting the availability of this most affordable and versatile restorative material will further reduce capacity to address treatment backlogs and provide care to the most disadvantaged and vulnerable patients.
5. We support the FDI’s comments that antibiotic stewardship should be given greater prominence. Again, this should be part of the global context discussion. We agree that the increase in dental antibiotic prescribing seen in some countries during the pandemic should be urgently addressed, including through improved access to dental procedures for all with acute dental conditions, rather than relying on prescriptions.
6. General health/NCDs: as above, we support the FDI’s calls to strengthen this discussion, but also believe it should be an overarching principle within the “big picture” introduction. Oral health and general health are not separate; this should be emphasised more in the context of prevention in particular. For example, action on obesity should be re-framed as action on diet-related ill-health including oral diseases. The role of governments in prevention is crucial, not only in mitigation of caries with fluoride but also in addressing the underlying causes of poor (oral) health. Wider action to address the drivers of ill-health (poverty, education, housing, social exclusion, etc.) should be complemented by policies such as sugar levies, advertising bans, restrictions on sugary and acidic soft drinks, etc.
7. Comments on the dental workforce could be strengthened by further consideration of its size and distribution. The FDI represents over a million dentists across most countries of the world, but this compares to a total population that is approaching 8 billion. In some areas or nations, there might be one dentist for every 500-700 people; this would indicate a severe workforce shortage in many other parts of the world.

8. Whilst primary dental care is the cornerstone of this strategy, the role of specialist dental services should not be forgotten. The importance of primary care working closely with secondary and tertiary care services should be recognised and is important in workforce planning considerations.

**British Dental Association  
64 Wimpole Street  
London W1G 8YS  
September 2021**

16<sup>th</sup> September 2021

**Re: WHO Discussion Paper: Draft Global Strategy on Oral Health**  
(Version dated 9 August 2021)

Dear Sir

I am writing on behalf of the British Fluoridation Society, an expert group representing dentists, doctors and others who support the use of fluoride, including water fluoridation, to improve oral health in the community.

The Society strongly supports Para 28:

*“28. Prevention efforts target key risk factors and social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries.”*

Elsewhere in the paper the use of topical fluoride applications and fluoridated toothpaste are mentioned and again this is supported. However, there is no reference to community-based use of fluoride. Many countries have introduced water fluoridation, fluoridated salt or fluoridated milk. The evidence shows that topical application such as the use of fluoridated toothpaste supplemented by the use of one of the community systemic programmes such as water, salt or milk has the greatest effect and it is important that WHO recognise this additional benefit.

In the Consolidated report by the Director-General dated 26th April 2021 the recommendations included the following paragraph in the section on oral health on page 18:

*“– promoting community-based interventions such as water fluoridation, where technically feasible and culturally acceptable, as well as legislation to increase the*

*affordability and accessibility of effective fluoride toothpaste and advocating for its recognition as an essential health product;”*

This gives a better balance to the measures that countries can consider. It is recognised that a programme such as water fluoridation is not appropriate for all countries for a variety of reasons such as feasibility, cost etc but it recognises that such a programme can be provided to the population where it is appropriate. We feel that this is particularly important given the high potential for widening oral health inequalities if focussing solely on interventions which require a degree of behavioural change and the increasing cost and problems of delivery associated with programmes which require professional delivery or supervision.

We are also aware that in some countries there are water supplies in which the concentration of fluoride is greater than is desirable and in those areas the level of fluoride needs to be reduced to an acceptable level. That should not mean that the WHO does not support increasing the level in places where the amount of fluoride is lower than that needed to benefit oral health.

We hope that the Global Strategy can be amended to include a paragraph along the lines of that recommended by the Director-General.

Yours sincerely

A handwritten signature in black ink, appearing to read "J. Beal".

Dr John F Beal MBE, PhD, BDS, MFDS (RCS Eng), MFPH (hon), FRSPH  
Vice Chair, British Fluoridation Society

## Consultation Response feedback to the ADG

### WHO Discussion Paper: Draft Global Strategy on Oral Health

Community Dental Services CIC endorse the broad principles and strategic objectives set out in the WHO *Draft Global Strategy on Oral Health*. We are fully supportive of the tracking of measurable progress by 2030 which will enable a global response and 'call to action' for what is already widely recognised through evidence-based research as a wholly preventable disease. Comments for further exploration/consideration as part of the global strategy are summarised below:

**Vision and Universal Oral Health Coverage** - We acknowledge that inequalities in oral health provision exists globally and are fully supportive of measures outlined in the WHO vision, goal and guiding principles to specifically address this issue. The United Kingdom (UK) already has universal coverage for children and still experiences significant oral disease. We feel that universal oral health coverage will make a significant difference but could be enhanced by striving to eradicate preventable oral diseases. However, we would welcome a more targeted approach based on need i.e., social economic factors, age, health related risk factors and high-risk groups and believe this will strengthen access to universal oral health coverage.

**Oral Health Governance** - We support the need for improved political commitment to drive forward the oral health and inequalities agenda. We welcome the need for partnerships, integration of oral health within policies and public health programmes. However, we also believe strong leadership and accountability through regulatory bodies should also form the key principles underpinning governance.

**Commercial Determinants and Risk Factors** - The commercial determinants identified risk factors of oral health in the WHO strategy. We suggest that organ transplant recipients who are 2-5 times at greater risk of developing oral cavity and pharynx cancer than the general population (Liu, Q. (2014) Cancer Research UK) and people living with systemic lupus erythematosus who are 4 times as likely to develop Laryngeal than the general population are also identified as a risk group. (Cao.L, (2015) Cancer Research UK).

The WHO Global strategy on Oral Health clearly identifies that the prevalence and severity of oral health diseases and conditions is closely associated with socially marginalised groups. We would therefore welcome the WHO strategy to specifically highlight that inequality risk factors are also determinants of poor oral health i.e., Socio-economic status and deprivation including people living in deprived areas or marginalised groups including migrants, Gypsy, Roma and Traveller communities, Prisoners, Homeless people etc.

**Oral Health Promotion and Oral Disease Prevention** - The downstream model (personal, social and self-management of oral health skills amongst individuals and communities) and upstream model (policies and community action) are both essential to improve the oral health not only for the wider population but those most in need.

**Primary Oral Health Care** - We welcome the fact that WHO are supporting the integration of oral health in Primary Health Systems. We believe a holistic approach to oral health is essential to tackling oral health diseases and condition and therefore recommend this is extended beyond health to include wider industry integration and collaboration e.g., Education, Employment, Commerce and Hospitality etc.

**Oral Health Care Systems** - We support the approach on integration with broader health care systems, leading to a better understanding of population health management through shared systems and data and supporting the reduction in health inequalities. The UK are leading the way in moving towards national Integrated Care Systems (ICS) which presents an opportunity for implementation and delivery of the WHO Global strategy on Oral Health.

**Oral Health Research Agenda** – The use of public health platforms and population health data through the use of digital technologies to inform and support interventions will strengthen and shape future policies. We strongly support innovations i.e., minimal invasive interventions and environmentally sustainable practice to drive forward changes better impact oral health.

In conclusion, we are fully supportive of the WHO Draft Global Strategy on Oral Health. The vision is bold and ambitious in aiming to ensure universal oral health coverage. We would encourage further endorsement of a more targeted approach to oral health coverage for those most in need to recognise the health inequalities that presently exist across systems and globally. We welcome measures that enable progress towards tackling oral health diseases and conditions being globally tracked and monitored by 2030.

Key Actions we believe should be taken include: [\(to keep for the global action plan\)](#)

#### Early Years

- Supervised tooth brushing and fluoride application in schools and early years settings should be a national programme fully supported, funded and endorsed from government (e.g. Childsmile in Scotland targeting at least 20% of the most deprived areas with good outcomes)
- Clear guidance and evidence to MPs to support a mandate for a national water fluoridation programme

#### Older people

- Improved access to domiciliary care/external mobile dental unit clinics
- Working with whole health system promoting oral health and ensuring that OHI education is a *mandatory* requirement of health and social care teams

#### Vulnerable adults

- Mandatory OHI education for all carers and the support teams
- Increasing access to dental care /oral health via the mobile dental unit to offer care to the homeless and refugees (and other socially marginalised groups) as part of our social impact mission and to support the reduction in health inequalities

#### Wider Community Engagement

- All community hubs to have an OHI Champion to ensure the OHI model is sustainable

#### Dental services

- An increased upskilling of dental nurses gaining an OHI qualification resulting in a greater role in prevention and OH promotion

#### References

1. Liu, Q. (2014) *Increased incidence of head and neck cancer in liver transplant recipients*. Cancer Research UK  
<https://pubmed.ncbi.nlm.nih.gov/25338638/>
2. Cao, L. (2015) *Increased incidence of head and neck cancer in liver transplant recipients*. Cancer Research UK  
<https://pubmed.ncbi.nlm.nih.gov/25885411/>

World Health Organization

Dr Benoit Varenne

Avenue Appia 20

1202 Genève

September 15<sup>th</sup>, 2021

### **Response from CECDO to the Draft WHO Strategy on Global Oral Health**

Dear Dr Varenne, dear Benoit,

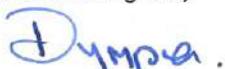
The Council of European Chief Dental Officers (CECDO) wishes to congratulate you on the global strategy on oral health as drafted by WHO's Secretariat. It describes the current picture, with the data available, for oral health worldwide and the implications for general health, wellbeing, and social and economic costs. Of particular importance, is the move towards prevention to avoid complex treatment scenarios, balanced with the need for all the public to easily access oral health care across their life course.

Only by emphasizing a public health approach, can we reorient from a predominantly treatment focus to prevention. Maintaining access to basic and/or essential oral health care where 'no one is left behind' is paramount as is clearly represented in the global strategy. Other principles on workforce, people-centered oral health care and the need for evidence-based research and interventions, are whole heartedly supported. A functional dentition across the life course, antenatal to old age, is core to mental and physical health and contributes to a person's dignity, social wellbeing, and contribution to society.

We believe that the global strategy can serve the Chief Dental Officers in the European region to strengthen the position of oral health in their countries. We forwarded the draft global strategy to our colleague chief dental officers with the urgent advice to give input to the strategy via the official channels before 17 September. In addition, a European wide CDO workshop led by CECDO - **'The Resolution on Oral Health, what does it mean for you?'** - is to take place in late October 2021. The rationale is that colleagues will consider areas where they already comply, can progress rapidly and what they still need to do. Assessing data availability and validity in each country is also important. You may appreciate that across the WHO Europe Region we have diverse systems and approaches. Such a focus will support all European member countries to work together to progress the WHO strategy. Helping each other to achieve these goals is important to us and our collegiality is a key strength. We hope that this workshop will help inform the future WHO European Region action plan.

Once again, we take the opportunity to raise our concern about the absent function for oral health at the office for WHO Europe. We expressed concern earlier to the Regional Director for Europe, Dr Hans Kluge, as CECDO believes that such a function is pivotal for bringing oral health in the European Region forward. Consideration of the interface of WHO European region with the EU commission, is also a factor for EU member states.

With kind regards,



Dympna Kavanagh, President-elect

For Mag Gabriele Sax,

President of the Council of European Chief Dental Officers

**Colegiul Medicilor Stomatologi Timiș**

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ÎNREGISTRAT CMDT

Nr. 7770 din 15.09.2021

To: Mr. Benoit Varenne

Dental Officer

World Health Organization (WHO)

20 Avenue Appia

1211 Geneva

Switzerland

Tel: +41 79 506 7236

Email: [varenneb@who.int](mailto:varenneb@who.int)

15 september

Timisoara/Romania

Subject: Web-based consultation on the WHO Draft Global Strategy on Oral Health by 2030

Dear Mr. Benoit Varenne

In regard of your call for feedback on the WHO Discussion Paper: Draft Global Strategy on Oral Health we would like to make some comments.

We are very pleased that the WHO is developing a strategy on oral health as part of the 2030 Agenda for Sustainable Development and we are very pleased that the draft is directly referring to the Minamata Convention on Mercury in the introduction. Indeed, Sustainable Development Goal 3 aims to ensure healthy lives and promote well-being for all at all ages, a goal that the Minamata Convention pursues by reducing the use of mercury in dentistry.

The draft also refers to a document (A67) in which the WHO called in 2014 on ministries of public health to implement the decisions of the Minamata Convention and reduce the use of dental amalgam. Since then, numerous dentists working mercury-free and many countries having adopted an amalgam phase-out have provided further evidence that alternatives are effective, available and affordable.

A study by the European Commission recently confirmed that phasing out amalgam is both technically and economically feasible. A legislative proposal for an EU phase out by 2030 is in preparation, and the African region has repeatedly expressed its need to end the use of

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amalgam with an agreement in the Minamata Convention to protect the environment and health.

Therefore, the WHO Strategy on Oral Health should further address the transition to mercury-free dentistry and we ask you to consider our suggestions for adopting the document (and to add the text marked in red from the attachment below).

We look forward to your cooperation.

Sincerely,

Dr.Cutui Mihaela

Vice-president Timis College of Dentists/Romania



**The text marked in red should be added to the strategy paper:**

**GLOBAL OVERVIEW OF ORAL HEALTH****Transition to Mercury-Free Dentistry**

Dental amalgam is a dental filling material consisting of 50% elemental mercury. Mercury is a developmental, neurological, and renal toxin, as well as a heavy metal and persistent bioaccumulative toxin of global concern. Because of these concerns, 128 countries negotiated a legally binding treaty, the Minamata Convention on Mercury, which entered into force in August 2017. The Minamata Convention requires each nation to reduce all incidental and purposeful uses and releases of mercury, including from dental amalgam.

**VISION, GOAL, AND GUIDING PRINCIPLES****Vision**

**16. The vision of this strategy is environmental friendly universal oral health coverage for all people by 2030.**

**17. Universal oral health coverage means that every individual has access to essential, environmentally friendly and minimal invasive, quality health services that respond to their needs and which they can use without suffering financial hardship. These include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives. Achieving the highest attainable standard of oral health is a fundamental right of every human being and the protection of the environment our duty.**

**Goal**

**18. The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce the use of dental amalgam, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.**

**STRATEGIC OBJECTIVES**

**Strategic Objective 6: Mercury-free dentistry – Promote the use of alternative filling materials and guide Member States in the transition to environmentally-friendly and minimal invasive dentistry.**

**Strategic Objective 6 includes promoting the use environmentally-friendly and minimal invasive alternatives for dental restoration and encouraging representative professional organizations and dental schools to educate and train dental professionals and students on best management practices;**

**Member states should implement plans to gradually phase out the use of dental amalgam and designate the competent authorities responsible for carrying out obligations arising from this. Insurance policies and programs should reimburse cost-effective and clinically effective mercury-free alternatives.**

**ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT****WHO**

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**34. WHO will continue its work with global public health partners to: establish networks for building capacity in oral health care, research and training; gradually phasing out dental amalgam; mobilize contributions from nongovernmental organizations and civil society; and facilitate collaborative implementation of the strategy, particularly as pertains to the needs of low- and middle-income countries.**

**Member States**

**41. Member States can strengthen oral health care system capacities by: integrating primary oral health care as part of universal health coverage benefit packages; ensuring the affordability of essential dental medicines and consumables, and other equipment or supplies for the management of oral diseases and conditions; and prioritizing environmentally-friendly and less-invasive dentistry. Member States should also assess and reorient the oral health workforce as required to meet population needs by enabling interprofessional education and a wider team approach that involves mid-level and community health providers.**

**Civil Society**

**48. Civil society can lead grass-roots mobilization and advocacy for increased focus within the public agenda on oral health promotion, the gradual phase out of dental amalgam and the prevention and control of oral diseases and conditions. Civil society can also help consumers advocate with governments to request the food and beverage industry to provide healthy products; support governments in implementing their tobacco control programs; and form networks and action groups to promote the availability of healthy food and beverages and fluoridated toothpaste, including through subsidization or reduced taxes.**





17 September, 2021

## Feedback to the Web-based consultation on the WHO Draft Global Strategy on Oral Health by 2030

### **Overall View of CREPD and the African Centre for Environmental Health:**

The African Center for Environmental Health and Centre de Recherche et d'Education pour le Développement (CREPD), representing the African Public interest opinion on dental amalgam issue, sees the occasion to develop the “*Global Strategy on Oral Health by 2030*” as an opportunity to address the most common oral health disease known as dental cavities – also known as caries – which afflict about 2.83 billion adults and children globally<sup>1</sup>, this is about 81 percent of the total of 3.5 billion people globally that experience oral diseases<sup>2</sup>.

Most importantly, we expect it adequately address the fact when reference is made to the Minamata Convention on mercury<sup>3</sup> by clearly referring to dental amalgam in the document, such things that are currently lacking.

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<sup>1</sup> according to an Institute for Health Metrics and Evaluation study published in the medical journal *The Lancet*

<sup>2</sup> according to the World Health Organization (WHO)

<sup>3</sup> The draft global strategy refers to a document (A67) in which the WHO called in 2014 on ministries of public health to implement the decisions of the Minamata Convention and reduce the use of dental amalgam.

We strongly believe it is important to address those gaps that will mislead on how the strategy will meaningfully help to achieve the SDG goal 3 as Dental amalgam currently still in use in dental caries treatments comprises 50 percent of mercury, a potent neurotoxin and certain endocrine disrupting substance with neurodevelopmental function adverse health effects including neurodevelopmental toxicity, lower IQ<sup>4</sup>. These health effects should not be ignored in the strategy just because they occur out of the oral part of the human body.

We would like to ensure that the global strategy on oral health can capture all the recent progresses across the globe to strictly control and regulate the use of dental amalgam, namely the relevant EU Directives, the FDA recommendations and the EU and African dental amalgam amendment proposals under the Minamata Convention on Mercury based on the evidence that phasing out dental amalgam in dental care is technically and economically feasible<sup>5</sup>.

Our general view is that the draft at it is now is not portraying the bigger picture for addressing the oral health diseases in a holistic and consistent way in the context of 2030 agenda, and we look forward to providing specific comments on the draft document text on the word version when it will be made available.

Otherwise, we trust that our overall view comments on the draft will help strengthen and widen the perspective of the final version of the strategy.



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<sup>4</sup> Endocrine Disruptors: from Scientific Evidence to Human Health Protection (EU, 2019)

<sup>5</sup> Assessment of the feasibility of phasing-out dental amalgam – Final report (2020)

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*Dental Health Foundation Ireland Submission*

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The Dental Health Foundation Ireland welcomes the opportunity to contribute to the WHO discussion paper for Global strategy on oral health.

Through the Vision, Goals and Guiding Principles, the WHO Draft strategy seeks universal oral health coverage within the next decade and to achieve the highest attainable standard of oral health as a fundamental right of every human being. This strategy aligns with the founding principles of the Dental Health Foundation.

The goal of this strategy is to guide Member States to develop ambitious 'national responses to promote oral health, reduce oral disease, other oral conditions and oral health inequalities' building to an action plan to achieve this vision.

The burden of oral disease effects all nations. On a global scale, 3.5 billion cases of oral disease and other oral conditions, 'most of which are preventable' is a significant warning, and a call to tackle oral diseases through this welcomed action plan on oral health.

The 5 Strategic Objectives outline specific pathways to attaining this goal and the active role that Member States, Partners and Secretariat may play.

#### **STRATEGIC OBJECTIVES**

**Strategic Objective 1: Oral Health Governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.**

*Strategic objective 1* seeks recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national noncommunicable disease and universal health coverage agendas. Increased political and resource commitment to oral health are vital at the national and subnational levels, as is reform of health and education systems.

Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services. Sustainable partnerships within and outside of the health sector, and engagement with communities, civil society and the private sector, are essential to mobilize resources and address the social and commercial determinants of oral health.

This excellent initiative places oral health on the global health agenda and the objectives of ***Smile agus Sláinte*** (National Oral Health Policy, Ireland, 2019) are aligned with it. However, there is a pressing need to improve and increase resource commitment for oral health within Ireland, to enable established policies to do the work they have mapped out to do. The Covid 19 pandemic has put pressure on Member State budgets globally for public health care initiatives, nevertheless it is crucial that future thinking includes the integration of oral health and primary health care on equal platforms towards a cross stitching of both throughout the life course.

Oral health in Ireland also requires further strengthening through leadership. Succession planning, which is a critical part of good governance, will be an important requirement for this strategy in identifying and developing future leaders.

Mr Robert Watt, Secretary-General, Department of Health (Ireland), made some very pertinent points in his opening statement at the HMI Conference 2021, *'I think it is very important to make progress and to improve performance. We need to make a change and sometimes change can be very difficult. It is inevitable if you try things for the first time that mistakes will be made and we need that culture of accepting the mistakes are made and don't have what I always call a 'gotcha' culture, but a learning culture, that we learn both from things that go well and also from mistakes. I think that it really is important because you can't deliver perfection, but you can deliver very good, 70% or whatever you are doing, very well. So, it really is, to try and have that culture of performance and change, but balanced risk-taking and accepting that things always won't go well and support our staff when things don't go well and to have that real culture of innovation. I think that is probably the biggest challenge in the public service, maybe particularly so in the health sphere, because the political media world is very unforgiving and very irrational, so it is about trying to have those really good positive norms of behaviour to encourage leaders to lead, to take sensible risks and to innovate. To echo what Paul said about devolution, we need to set frameworks and an accountability framework and then trust people to go and do the right thing. Like the best people who know how to run our hospital or the best clinicians who know how to provide the best possible care for patients, they are the people who are on the front line, who are close to patients so it is about ensuring that people have the autonomy and we have the correct culture to ensure that people can deliver and take the right decisions and it is about accepting that people won't get it right all the time'* (Health Manager 2021). Leaders with a strong moral compass, mindful of the social and economic determinants of health, their own shortcomings and the need to adopt different leadership styles to the situation must be cultivated and supported.

The recent resignation announcement of two key figures from Sláintecare (a Government of Ireland 10-year plan for healthcare services), (Professor Tom Keane, who has stepped down as Chairperson of the Sláintecare Implementation Advisory Council and Ms. Laura Magahy, who has also resigned from her role as Executive Director for the Sláintecare reform programme office), clearly demonstrates the requirement for supported leaders and resources in all areas of health promotion and protection. Professor Keane is reported as making the decision to resign having "come to conclude that the requirements for implementing this unprecedented programme for change are seriously lacking" (Bowers, 2021).

This WHO draft Strategy states that 'The COVID-19 pandemic has had a negative impact on the provision of essential oral health services in most countries, leading to delays in oral health care treatment, increased antibiotic prescriptions and greater oral health inequalities. The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health care systems as part of universal health coverage efforts'. This is supported by Blinken & Becerra 2021, who state that 'COVID-19 has exacerbated existing inequities and inequalities around the world. The goal must be to design a global health security regime that will reduce morbidity and mortality and improve well-being across all populations in all countries'. Information and surveillance systems must be designed to enable agreed indicators and outcome measures to be collected contemporaneously, with in built early warning signs. The support and development of sentinel practices is also an item to be considered. Sutton and Long, 2014, outline that health surveillance, health promotion, and disease and injury prevention and early detection are an essential and joint function of public health and primary medical healthcare.

More recently, misinformation has emerged as a considerable issue in hindering public health messaging during the pandemic. Equally, claims have been made for many years in various media in relation to water fluoridation and potential health issues. In recent years, media attention highlighting opposition to community water fluoridation has intensified, particularly via the internet and social media (Sutton et al 2015). Global collaboration is required to create and distribute content to combat the spread of misinformation on oral health related issues through communication campaigns.

The WHO Director General has called for community-based interventions such as water fluoridation to promote a healthy environment, this should be highlighted to the general public and to health care professionals. *‘— promoting community-based interventions such as water fluoridation, where technically feasible and culturally acceptable, as well as legislation to increase the affordability and accessibility of effective fluoride toothpaste and advocating for its recognition as an essential health product.’*

**Strategic Objective 2:** Oral Health Promotion and Oral Disease Prevention – Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions

*Strategic objective 2* calls for evidence-based, cost-effective and sustainable oral health promotion and interventions to prevent oral diseases and conditions. At the downstream level, oral health promotion supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care. At the upstream level, oral health promotion includes creating public policies and fostering community action to improve people’s control over their oral health and to promote oral health equity.

Prevention efforts target key risk factors and social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries.

There is a requirement for a wider integration of oral health into primary health care, and for highlighting the common risk factors between oral health and non-communicable diseases. This was recently highlighted in the Economist (2021) ‘The evidence-base shows periodontitis, which is the severe form of gum disease, has associations with diabetes, cardiovascular diseases and over 50 non-communicable diseases. Recognition of these mutual risk factors and knowledge sharing between dentistry and general health are scarce in clinical practice. Similar to general health, poor oral health is also strongly associated with lower socioeconomic status’ (The Economist Intelligence Unit Limited 2021).

It should be noted that although the annual dental check-up is an essential part of prevention and early detection of oral (or other) diseases, the Economist (2021) notes that ‘the cost of accessing a dentist is a barrier to receiving treatment early for many of the public’. Effective health promotion strategies must include the promotion of dental visiting, universal healthcare and community-based initiatives. The Economist report also indicated that ‘Research shows that preventative interventions are most effective when they combine both universal treatments delivered by healthcare

professionals with targeted prevention programmes delivered in relevant and existing community settings'.

**Guiding Principle 6 (in the draft Global Strategy on Oral Health): Optimizing digital technologies for oral health:**

This will have an important role in oral health promotion and disease prevention.

Opportunities such as the Technovation World Summit should be optimised and publicised for digital technologies for oral health. Technovation is a global tech education non-profit that empowers girls to become leaders, creators, and problem solvers. This year in 2021, a 13-year-old girl Saanvi Kaushik from Cork City, Ireland won a global award after she took inspiration from her mother working during the pandemic. She designed an app called Stellar to help children access occupational therapy services on a remote basis. Saanvi was selected as the best in the Technology category at Technovation, a global competition that saw 5,900 girls from 60 countries develop apps that help solve problems within communities (Irish Examiner 2021).

**Strategic Objective 3: Primary Oral Health Care – Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care**

*Strategic objective 3* seeks to increase access by the entire population to safe, effective, and affordable primary oral health care as part of the universal health coverage benefit package. Basic oral health care includes oral health promotion and prevention of oral diseases and conditions, as well as services, which address oral pain, infection, trauma, dysfunction, malignant disease, and referral, with agreed quality and patient-safety standards. Oral health care providers who suspect abuse or neglect should offer patients appropriate counselling, treatment, and effective means to report such cases to the relevant authority, according to the national context.

Oral health providers should be members of the primary health care team and work side-by-side with other health workers in tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups.

Financial protection through expanded health insurance coverage - including coverage of oral health services - is one of the cornerstones of universal health coverage. Ensuring the reliable availability and distribution of essential medical consumables, generic medicines and other dental supplies is also important for the management of oral diseases and conditions in primary health care and referral services.

The Dental Health Foundation suggests that interprofessional learning include oral health and public health interventions such as community water fluoridation and the use of topical fluorides.

The Discipline of Health Promotion at the National University of Ireland Galway offers a 1-year Specialist Certificate in Health Promotion – Oral Health. This course is delivered in partnership with the Dental Health Foundation and the Health Service Executive. The primary focus of the course is to provide students with professional education and training in the principles and practice of health Promotion as applied to the promotion of oral health. It is aimed particularly at practitioners who work in the oral health field (e.g., dentist, dental nurses, dental hygienists) and others in position to promote oral health (e.g., public health nurses, General Practitioners, dietitians, nurses, special needs assistants).

**Strategic Objective 5:** Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health

*Strategic objective 5* strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and problem description, rather than problem-solving. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.

The Dental Health Foundation agrees with this and recommends that substantial investment is necessary to support the oral health research agenda in Ireland. **The Irish Platform for Patient Organisations, Science and Industry (IPPOSI)** Citizens' Jury on Access to Health Information has recently published its verdict, setting out six recommendations for policymakers and expressing a strong preference for greater access to health information in Ireland.

Recommendation 1: '*We expect healthcare professionals to be able to access the health information they need to provide quality, evidence-based, real-time care to individual patients*'.

It is also important that the gap is narrowed between published research and policy. The Government of Ireland has recently launched 'Creating our Future', a welcome initiative to '*engage the Irish public to consider and imagine future areas of research that would benefit all citizens*', which the Dental Health Foundation recently highlighted as '*a wonderful opportunity for everyone to submit their ideas to this national conversation on research in Ireland on how to improve oral health for the Irish population*' (Irish Times 2021). This initiative could be replicated in Member States specifically for oral health to engage the public and broader health community in participating in the. This underscores **Guiding Principle 4** – People-centred oral health care.

#### **Commercial Determinants and Risk Factors of Oral Health**

*8. Oral diseases and conditions and oral health inequalities are directly influenced by commercial determinants, which are strategies and approaches used by the private sector to promote products and choices that are detrimental to health.*

The Dental Health Foundation advocates for research that engages in oral health promotion so that the research agenda is orientated toward public health programmes that point toward prevention in protecting oral health. That the public is empowered to improve healthy lifestyle habits.

In a paper published by Crowe et al (2019) 'Estimation and consumption pattern of free sugar intake in 3-year-old Irish preschool children' highlighted that '*a large majority of 3-year-old Irish children did not meet the WHO recommended guidelines for free sugar intake and almost none met the desired conditional recommendation*' (for dental health benefits).

Clearer messaging around consumption of natural and processed foods and drinks should come from both the public and private sectors and aimed at the community at large. People have a right to know about hidden risks in all sugars. As with misinformation mentioned above in the context of water fluoridation, the term 'healthy' in relation to food consumption has equally been diluted and overused in commercial sector messaging.

Improving Health literacy will be an essential tool in empowering the public to make informed decisions about healthy eating. It needs to be integrated into any oral health campaigns.

## Conclusion

**Smile agus Sláinte** (Oral Health Policy 2019) provides the guiding principles to transform the current oral healthcare service in Ireland over the next number of years. Unfortunately, its implementation has been delayed due to the pandemic. An overarching goal of the policy is a joined-up approach on primary care, with integrated oral and general health, and prevention. It is hoped that this can start soon engaging with all the relevant stakeholders collaborating together for successful outcomes. It is important to develop strategies that will enable all member states to keep oral health on the global agenda, as recovery from COVID-19 takes place.

The Dental Health Foundation Ireland (DHF) welcomes the opportunity to contribute to the development of the WHO Draft Global Strategy on Oral Health, in helping to tackle oral diseases and is strongly committed to the delivery of the priority areas identified in this draft Strategy, in addressing the challenges and solutions for oral health inequality. DHF has, since its establishment in 1977, been at the forefront of oral health promotion in Ireland and continually advocates for policies/strategies to promote and improve oral health.

We support a holistic approach to oral health which is underpinned by the Sustainable Development Goals. Climate change and the environment affects everyone. In the dental industry - restorative dentistry uses a lot of water, something to be considered by the oral health profession. The COP26 Climate Summit (September 2021) includes a Global Oral Health Event which may have some interesting discussions that could be considered as part of the WHO Draft Global Health Strategy.

A recent article published in the Business Section of the Sunday Independent states that economic planning that does not factor in climate costs is pointless. It quotes Jean Pisani Ferry of the Washington, Peterson Institute that it is '*high time policymakers realise climate policy is also macroeconomic policy and design strategies now*'. Acting in line with the best available science on both the climate and biodiversity crises is fundamental for human and planetary health and survival.

We welcome a strategy that will highlight the need to integrate oral and national health policy. We support the development of a focus on preventive strategies as opposed to approaches that emphasise treating existing disease. And we concur that while the Covid -19 pandemic has impacted negatively on the provision of essential oral care, it should also be seen as an opportunity to strengthen 'integration of oral health care into general health care systems.

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## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<b>Organisation Name:</b> Dental Health Services Victoria	<b>Person(s) Involved in Contribution:</b> Martin Hall
<b>Date:</b> 17/09/21	<b>Contact Email:</b> martin.hall@dHSV.org.au
<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
The vision of this strategy is universal oral health coverage for all people by 2030.	A worthy and bold vision.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	We would prefer the term inequity replace inequalities.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded	This is an essential principle and fully supported.

<p>upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>This is an essential and fully supported principle. We would like to see the inclusion of common risk approach included in this principle.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>We fully support and endorse this principle. The mid-level oral health care provider, the Oral Health Therapist, is well developed in Victoria. Beyond the mid-level oral health care provider, we would like this principle to include Dental Assistants, in particular those who have increased scope of practice as oral health educators/coaches, and within the jurisdictional regulations for the application of fluoride varnish. The oral health educator complements the oral health team with a focus on health literacy and prevention.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond</p>	<p>Essential and fully supported.</p>

<p>to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Essential and fully supported.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>Essential and fully supported.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>DHSV agrees with the establishment of a dedicated National Oral Health Unit to coordinate across sectors. This is lacking in Australia.</p>

<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>Good focus on both upstream and downstream objectives</p>
<p><b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>We like the inclusion of reporting abuse and neglect in the details of this objective. It is also good to reinforce the common risk factors; quality and safety standards also good to see.</p>
<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>We would like to see patient reported outcome measures (PROMs) included in the data to be collected. There needs to be a focus on measuring outcomes that are important to ensure person-centred care, shared decision making and direction of resources.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>More public health research is great. Minimal intervention and invasive dentistry is excellent.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b></p>	
<p><b>Comment:</b> DHSV supports and commends the WHO for its strong leadership in setting the vision, strategies, priorities and monitoring of oral health that Member States can use to reference as they also plan for the future.</p> <p>We look forward to clear, realistic, and measurable targets which DHSV can integrate into Victoria's future strategic planning for oral health.</p> <p>DHSV welcomes the WHO using its influence and resources to support Member States to address inequity in (oral) health and through advocacy, funding, health promotion and system improvements.</p>	

17. September 2021

Mr. Benoit Varenne  
Dental Officer  
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Subject: Web-based consultation on the WHO Draft Global Strategy on Oral Health by 2030

Dear Mr. Benoit Varenne

At the Seventy-fourth World Health Assembly, 42 Member States and many other countries and partners have expressed their concern about the potential environmental impact caused by the use and disposal of mercury-containing dental amalgam. Thus, representing the position of the Minamata Convention on Mercury, a legally binding treaty of 132 countries that entered into force in August 2017 and requires each country to reduce all incidental and intentional uses and releases of mercury, including from dental amalgam.

We would like to remark that phasing out or phasing down the use of dental amalgam is not considered sufficiently in the draft Oral Health Strategy as part of the Agenda 2030 for Sustainable Development, even though it's a relevant source of secondary poisoning and the SDG on Health stipulates the aim to ensure healthy lives and promote well-being for all at all ages.

The announcement to develop technical guidance on environmentally friendly and less-invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury by 2024 (when a phase-out of the use of dental amalgam has most likely already been decided), does not reflect the active role expected of WHO.

Rather, WHO should acknowledge and support the ongoing transition to mercury-free dentistry and include a detailed reflection about dental amalgam (as we are proposing in the Annex) in this global Strategy on Oral Health.

Only by doing so would WHO fulfill its responsible role and send a strong signal to the Parties to the Minamata Convention to adopt far-reaching measures to phase out the use of amalgam at the next conference in early 2022, thus making a real contribution to ensuring healthy lives and promoting the well-being of all people at all ages.

We look forward to your cooperation.

Sincerely,



Florian Schulze

Managing Director, European Center for Environmental Medicine

*Please consider our joint suggestions with the Timis College of Dentists/Romania to revise the draft Global Oral Health Strategy:*

*(The text marked in red should be added)*

## GLOBAL OVERVIEW OF ORAL HEALTH

### ***Transition to Mercury-Free Dentistry***

Dental amalgam is a dental filling material consisting of 50% elemental mercury. Mercury is a developmental, neurological, and renal toxin, as well as a heavy metal and persistent bioaccumulative toxin of global concern. Because of these concerns, 128 countries negotiated a legally binding treaty, the Minamata Convention on Mercury, which entered into force in August 2017. The Minamata Convention requires each nation to reduce all incidental and purposeful uses and releases of mercury, including from dental amalgam.

## VISION, GOAL, AND GUIDING PRINCIPLES

### ***Vision***

16. The vision of this strategy is **environmental friendly** universal oral health coverage for all people by 2030.

17. Universal oral health coverage means that every individual has access to essential, **environmentally friendly and minimal invasive**, quality health services that respond to their needs and which they can use without suffering financial hardship. These include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives. Achieving the highest attainable standard of oral health is a fundamental right of every human being **and the protection of the environment our duty**.

### ***Goal***

18. The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, **reduce the use of dental amalgam**, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.

## STRATEGIC OBJECTIVES

**Strategic Objective 6: Mercury-free dentistry** – Promote the use of alternative filling materials and guide Member States in the transition to environmentally-friendly and minimal invasive dentistry.

Strategic Objective 6 includes promoting the use environmentally-friendly and minimal invasive alternatives for dental restoration and encouraging representative professional organizations and dental schools to educate and train dental professionals and students on best management practices;

Member states should implement plans to gradually phase out the use of dental amalgam and designate the competent authorities responsible for carrying out obligations arising from this. Insurance policies and programs should reimburse cost-effective and clinically effective mercury-free alternatives.

## ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT

### **WHO**

34. WHO will continue its work with global public health partners to: establish networks for building capacity in oral health care, research and training; **gradually phasing out dental amalgam**; mobilize contributions from nongovernmental organizations and civil society; and facilitate collaborative implementation of the strategy, particularly as pertains to the needs of low- and middle-income countries.

### **Member States**

41. Member States can strengthen oral health care system capacities by: integrating primary oral health care as part of universal health coverage benefit packages; ensuring the affordability of essential dental medicines and consumables, and other equipment or supplies for the management of oral diseases and conditions; **and prioritizing environmentally-friendly and less-invasive dentistry**. Member States should also assess and reorient the oral health workforce as required to meet population needs by enabling interprofessional education and a wider team approach that involves mid-level and community health providers.

### **Civil Society**

48. Civil society can lead grass-roots mobilization and advocacy for increased focus within the public agenda on oral health promotion, **the gradual phase out of dental amalgam** and the prevention and control of oral diseases and conditions. Civil society can also help consumers advocate with governments to request the food and beverage industry to provide healthy products; support governments in implementing their tobacco control programs; and form networks and action groups to promote the availability of healthy food and beverages and fluoridated toothpaste, including through subsidization or reduced taxes.



September 17, 2021

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Sent by email: [varenneb@who.int](mailto:varenneb@who.int)

To whom it may concern,

**RE: Feedback in response to the WHO Draft Global Strategy on Oral Health Discussion Paper**

### **Background**

The Federation of Dental Hygiene Regulators of Canada (FDHRC) is pleased to provide our comments on the WHO draft global strategy on oral health discussion paper.

The FDHRC is a federation of provincial regulatory bodies which have a statutory responsibility to regulate the profession of dental hygiene within their respective provinces in Canada. The FDHRC provides national leadership on issues concerning the protection of the public with respect to the profession of dental hygiene, develops quality benchmarks for dental hygiene accreditation standards, leads the development of national entry-to-practice competencies for dental hygiene, and ensures that valid and reliable examination mechanisms exist for assessing dental hygiene competencies across Canada.

A registered dental hygienist in Canada is an educated primary healthcare professional whose work focuses on the oral health of an individual or community. As autonomous health professionals, dental hygienists work in partnership with individuals, groups, and communities, as well as care providers, professionals, and others involved in a person's circle of care to provide safe, effective, and ethical oral health care services. They provide client-centred services to prevent and treat oral disease and promote wellness through the process of assessment, diagnosis, planning, implementation, and evaluation.

There are over 30,000 registered dental hygienists in Canada, and only regulated health professionals may provide dental hygiene services in Canada.

### **FDHRC Response**

**Vision:** The FDRHC agrees with the proposed vision statements as outlined in the discussion paper. As a national federation, we agree that achieving the highest attainable standard of oral health is a fundamental right of every human being. Where countries have a strong insurance system, a strategy that includes both private insurance and public financing of services should be considered to achieve optimal results.



**Goal:** The FDHRC agrees with the goal to develop national responses to address oral health promotion and disease prevention. The inclusion of oral health targets and indicators within national health strategies are rarely included as oral health is primarily a privately funded service. The FDHRC supports the development of oral health targets and indicators within national strategies to measure the outcomes and efficacy of oral health service delivery.

**Guiding Principles:** The FDHRC supports the six guiding principles as outlined in the draft discussion paper. The role of the dental hygienist in Canada is to support a public health approach to oral health promotion and disease prevention through their broad scope of practice. Dental hygienists are positioned to be integrated into primary care and have the experience and education to assist with the development of policy and regulation that addresses social and commercial determinants of oral health at the population level. Dental hygienists should be integrated into the primary health care system as preventive therapists who contribute meaningfully to collaborative interdisciplinary health care teams.

**Strategic Objectives:** The FDHRC supports the five strategic objectives as outlined in the draft discussion paper. Dental hygiene regulators are positioned to provide input into establishing or strengthening relevant public health policies and regulations for primary oral health care. Even in developed countries such as Canada, the dental hygiene profession has not been integrated into the primary health care teams. Dental hygienists should be included in the primary health care system as preventive therapists who contribute meaningfully to collaborative interdisciplinary health care teams. Regulators also recognize the need for increased oral health research which could influence regulatory requirements, such as scope of practice, optimizing provision of care in areas with unmet needs, and continuing competence for the dental hygiene profession.

## General Comments

The FDHRC is in agreement that oral health should be integrated into health care legislation, research, policy, strategy development and program planning across the provincial health sector in consultation with appropriate stakeholders, including dental hygiene regulators. The FDHRC recommends including dental hygienists in the development of oral health promotion and disease prevention policies and regulations, as they are the experts on prevention and health promotion in oral health.

New models of service delivery that embed dental hygienists into primary health care settings as health professionals enhance the ability for teams to assess oral health, proactively identify and address disease risks, and work collaboratively with other providers. These actions have the potential to eliminate disparities and dramatically improve outcomes in oral health for a significant portion of the population.

All dental hygienists in Canada are regulated professionals. A regulatory body's job is to protect the public from unsafe practice and hold registrants of the profession accountable for the care they provide. Through legislation, standards of practice and Code of Ethics, dental hygiene health professionals maintain high standards of competency, safety and ethics, and provide the public with safe, high-quality care.



The FDHRC supports the draft global strategy on oral health and encourages WHO to consider the FDHRC as a global public health partner to assist in translating this strategy into an action plan for oral health in Canada.

Respectfully submitted,

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FDHRC Chair

## FDI World Dental Federation's submission to WHO consultation on the draft *Global strategy on tackling oral diseases*, for consideration at EB150 and WHA75

16 September 2021

***This submission was prepared by FDI World Dental Federation, and the following organizations are co-signatories:***

1. ADF - Association dentaire française
2. AIO - Italian Dental Association
3. ANDI - Associazione Nazionale Dentisti Italiani
4. Asociación Odontológica Panameña
5. Associacao Dentaria Timor Leste (ADETIL)
6. Association des chirurgiens dentistes du Burkina (ACDB)
7. Association des Chirurgiens-Dentistes du Bénin (A.C.D.B.)
8. Association marocaine de prévention bucco-dentaire (AMPBD)
9. Australian Dental Association
10. Azerbaijan Stomatological Association
11. Bahamas Dental Association
12. Bangladesh Dental Society
13. British Dental Association (BDA)
14. Bulgarian Dental Association (BgDA)
15. Bundeszahnärztekammer e.V. (German Dental Association)
16. Cercle des Médecins-Dentistes du Grand-Duché de Luxembourg
17. Chambre Syndicale Dentaire, Belgium
18. Chinese Stomatological Association
19. Chinese Taipei Association for Dental Sciences
20. Colegio de Cirujano Dentistas de Chile
21. Colegio de Cirujanos Dentistas de Costa Rica
22. Colegio de Odontólogos de Bolivia
23. Commonwealth Dental Association
24. Cyprus Dental Association
25. Danish Dental Association
26. Dental Association of Seychelles
27. Dental Association of Thailand
28. Dental Chamber of Kosovo
29. Egyptian Clinical Dental Society
30. Ethiopian Dental Professional's Association (EDPA)
31. Fiji Dental Association
32. Finnish Dental Association
33. Hong Kong Dental Association
34. Indonesia Dental Association
35. International Diabetes Federation (IDF)
36. Irish Dental Association
37. Japan Dental Association
38. Kenya Dental Association
39. Korean Dental Association
40. Malaysian Dental Association
41. Mexican Dental Association (Asociación Dental Mexicana)
42. Mongolian Dental Association
43. NCD Alliance
44. Non-communicable Diseases Alliance Kenya
45. Norwegian Dental Association
46. OMD - Portuguese Dental Association
47. Philippine Dental Association
48. Polish Dental Society
49. Romanian Dental Association of Private Practitioners (RDAPP)
50. Russian Dental Association
51. Samara State Medical University
52. Serbian Dental Society
53. Slovenian Dental Association
54. SmileTrain
55. Société de Médecine Dentaire, asbl
56. South African Dental Association
57. Sri Lanka Dental Association
58. Stomatological Society of Greece
59. Tanzania Dental Association
60. The Armenian Dental Association
61. Tunisian Dental Syndicate for Private Practice
62. Turkish Dental Association
63. Ukrainian Dental Association
64. VVT - Verbond der Vlaamse Tandartsen
65. Zimbabwe Dental Association

To the attention of  
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FDI World Dental Federation (FDI) — representing over one million dentists and close to 200 national dental associations — and the aforementioned organizations thank the World Health Organization (WHO) for preparing the draft *Global strategy on tackling oral diseases* (hereinafter “*Global strategy*”) following the request made by Member States on the recent resolution on Oral health ([WHA74.5](#)). We commend WHO for this document to advance the effective integration of oral health within health systems at the national, regional, and global levels; and we strongly welcome the opportunity to comment on the current draft.

The implementation of the *Global strategy* represents a historic opportunity to tackle oral diseases as part of the global disease burden, to reduce oral and general health inequalities, and to ensure that oral health promotion and oral healthcare are fully embedded into strategies addressing noncommunicable diseases (NCDs) and aiming at Universal Health Coverage (UHC). **We have reviewed the current draft and share the following comments and suggestions for consideration.**

### **Strengths of the current draft**

**Overall, we are extremely pleased to see that the *Global strategy* aligns with FDI’s roadmap – [Vision 2030: Delivering Optimal Oral Health for All](#).** In particular, the vision of the *Global strategy*, “universal oral health coverage for all people by 2030”, is fully reflected in pillar 1 of FDI’s Vision 2030, “Universal coverage for oral health”, with the associated target of: “By 2030, essential oral health services are integrated into healthcare in every country and appropriate quality oral healthcare becomes available, accessible, and affordable for all.”<sup>1</sup>

**We commend the language and structure of the *Global strategy*** for being clear and logical. It provides background on the nature of the document and explains its purpose of informing the implementation-oriented *Action plan for public oral health* to be approved in 2023, together with a progress monitoring framework and measurable 2030 targets.

**The *Global strategy* complements the resolution on Oral health. It recognizes that cleft lip and palate contributes to the burden of oral diseases, and the role that adequate exposure to fluoride plays in the prevention of tooth decay (dental caries) – the most prevalent disease worldwide. It mentions different fluoride delivery mechanisms and recognizes them as *essential prevention methods*, including community-based fluoridation *where appropriate*<sup>\*</sup>, topical fluoride applications, and use of fluoridated toothpaste. The**

\* For instance, water fluoridation is an effective and safe way to systematically protect oral health in populations with a moderate to high risk of dental caries, thus reducing oral health inequalities. The recommended level of fluoride needs to be provided and therefore, fluoridation needs to be accompanied by quality control measures and regular monitoring. There might be regions with water naturally rich in fluoride, or where fluoride is already available through other sources (e.g., through fluoridated milk, salt, or dietary supplements). Source: FDI. *Promoting Oral Health through Water Fluoridation*. FDI Policy Statement adopted by the FDI General Assembly: September 2014, New Delhi, India. Original version adopted by the FDI General Assembly: November 2000, Paris, France. New Delhi: FDI World Dental Federation; 2014. Available from: <https://www.fdiworlddental.org/promoting-oral-health-through-water-fluoridation>.

*Global strategy* also complements the resolution by acknowledging the lack of political commitment and resources given to oral health within national health systems until now, and therefore the need to allocate sufficient national budget for oral diseases prevention and control.

**Oral health promotion, oral disease prevention, and basic oral healthcare are also presented as essential health services that should be part of countries' UHC benefit packages.** Coverage of essential oral health services varies tremendously between countries (and even between high-income countries). For instance, in the European Union, only the national health systems of Croatia, Germany, and Slovakia cover more than half of the countries' total oral healthcare expenditure. This demonstrates the too often isolation of oral health within health systems, separating the mouth from the body at the health system level and underestimating the impact of oral health on general health. Synergies to reduce overall health-system costs by early and cost-effective oral health interventions and referrals for other NCDs are a missed opportunity now picked up by the *Global strategy*.

**It is very positive to see that the definition of “universal oral health coverage” within the vision of the *Global strategy* refers to the three core elements of UHC** – ensuring the quality, equitable access, and financial protection for a wide range of health services (i.e., health promotion, prevention, treatment, and rehabilitation) that are people-centered (responding to individuals' evolving needs across their life course). Primary health care (PHC) is the cornerstone of UHC and key to ensuring the accessibility and affordability of essential oral health services for all. **The focus on PHC under both the *Global strategy*'s guiding principles and the strategic objectives** is most welcome to guide national implementation and reduce oral health inequalities.

**Another welcomed focus within the *Global strategy* is the need for a wider team approach in dentistry**, increasing access to oral health services, especially in low- and middle-income countries where there are often shortages of oral health workers. 69% of the world's dentists only serve 27% of the global population, and there are risks of simultaneous over- and undersupply of oral healthcare. We need enough health workers who are competent in delivering oral health interventions, and geographically distributed in accordance with populations' needs. Dental teams, and thus oral healthcare outreach, can be reinforced by building a strong cadre of other oral health workers (such as dental hygienists) and non-physician healthcare providers (such as community health workers, nurses, and other allied health workers) to deliver adequate oral healthcare within their scope of practice, especially at the PHC level.<sup>2</sup>

By recognizing the important role of oral health promotion and oral disease prevention for populations' health, and in line with FDI's Vision 2030, **the *Global strategy* rightly acknowledges the need to reorient health systems towards population-wide prevention rather than individual treatment interventions where possible**. The focus on addressing upstream determinants (social and commercial) to reduce oral health inequalities and oral healthcare costs is crucial, especially through public policies and regulation aiming to reduce sugar consumption and increasing access to adequate levels of fluoride.

There is also a **commended focus on enabling individuals to achieve optimal oral health by increasing oral health literacy efforts** (including through digital solutions), leading to increased capacity for individuals to self-manage and make decisions about their oral health. In terms of shared risk factors with other NCDs, the **explicit mention of other forms of tobacco use than smoking (“betel quid and areca nut use”) and human papilloma virus (HPV) is very timely**, given their association with increased incidence of oral cancers.<sup>3,4</sup> **Lack of breastfeeding** is also mentioned as a common NCD risk factor that needs to be addressed, as it is linked, for example, with a higher risk of developing early childhood caries and obesity.<sup>5</sup>

Research and surveillance should be supported in parallel to these efforts through the development and integration of national information systems that include oral health data and indicators. We therefore **strongly welcome the prioritization of oral health information systems and oral health research as strategic objectives of the *Global strategy*, and the announcement of an oral health data platform.** The standardization of oral health indicators will be a crucial step to allow monitoring of progress in oral health across countries and support research. The scope of oral health research will need to span across health, behavioural, and social science disciplines to better understand both the complexity of clinical associations between oral and general health, and the challenges in implementing dental public health interventions and integrating oral health services.

Two major strengths of the *Global strategy*, include **the recognition of the role of civil society in the oral health response and the fact that oral health is considered a fundamental human right.** We agree with the need to amplify the voices of people living with and affected by oral diseases and conditions. Their experience and expertise in terms of identifying real gaps in meeting people's oral health needs is a powerful asset in ensuring that health and social services are effective and relevant to the beneficiaries they are intended to serve. Therefore, we need more than amplifying their voices, ensuring both health workers and people living with oral diseases and other NCDs are meaningfully engaged in decision-making and policymaking, care delivery, and advocacy efforts.

#### **Barriers to be addressed by the current draft**

The biggest challenge in the oral health response is the lack of implementation and integration within national health systems, which is somewhat implied by the *Global strategy* when recognizing the lack of political leadership and financing that has been allocated to oral health. **The *Global strategy* remains a very high-level document without providing specific guidance nor indicators or targets for the achievement of its strategic objectives, beyond the guiding principles.** We understand the rationale behind this is that the 2023 *Action plan for public oral health* will focus more on identifying strategies for national implementation and integration, proposing measurable 2030 targets and a progress monitoring framework for accountability. However, we find the *Global strategy* could be improved by addressing more specifically the current challenges faced by populations, the oral health community, and health systems (see general and specific comments hereinafter).

When considering the economic costs of poor oral health, **it is important to highlight the weight that out-of-pocket payments have specifically in oral healthcare within health systems.** In low- and middle-income countries, coverage of oral health services is often very low or non-existent, exposing households to a higher risk of catastrophic health expenditure if they receive dental treatment, or even entirely precluding access to oral healthcare.<sup>6</sup> **More specific reference to this is needed, as well as to the complexity of payment systems for oral health workers** to promote a focus on preventive interventions and ensure the effective integration of oral health services within national UHC benefit packages.

Currently, **the *Global strategy* only links oral health with NCDs by recognizing the common risk factors of oral diseases and other NCDs.** However, the associations between oral health, NCDs, and general health go beyond sharing risk factors. Oral diseases often manifest together with other NCDs in the form of comorbidities. For instance, periodontal (gum) disease is the sixth most prevalent disease worldwide, affects the alveolar bone leading to tooth loss, and often manifests as a common complication of diabetes. It can also affect blood glucose control increasing the risk of diabetes.<sup>7</sup> Higher prevalence of hypertension, a risk factor for cardiovascular complications, has also been observed in people with poor periodontal health,<sup>8</sup> and oral bacteria has been linked with the development of dementia, cardiovascular disease, and systemic infection.<sup>9,10</sup> Moreover, good oral health can positively impact NCD treatment outcomes.<sup>11,12,13</sup> Given these

strong associations between oral health and NCDs, when talking about oral health promotion and oral disease prevention, **the *Global strategy* should also acknowledge poor oral health as a risk factor for NCDs beyond oral diseases; and the case for interprofessional collaboration between oral health and non-oral health workers should be made more explicitly.**

In line with this, **we strongly welcome the inclusion of a guiding principle on the need for a new oral health workforce model, but this needs to encompass issues beyond education and resource planning.** As reiterated in pillar 3 of Vision 2030 (*Building a resilient oral health workforce for sustainable development*), strategies around intra- and inter-professional collaboration are key to ensure wider access to oral healthcare and integration of medical and oral health services, especially in light of the associations between oral health and NCDs mentioned above. For instance, oral health workers can have a role increasing access to NCD prevention (e.g., tobacco cessation support, dietary advice),<sup>14</sup> screening (e.g., for oral cancers, diabetes, and hypertension),<sup>15,16,17</sup> and care (e.g., contributing to optimal diabetes management).<sup>18</sup>

Another aspect that would require more specificity is the issue of retention and distribution of the oral health workforce, this is not an issue only between countries, but also within countries (i.e., between urban and rural areas), having health districts with no availability of oral health services at all. Thus, **given the complexity around optimizing the oral health workforce to increase access to oral health promotion, oral healthcare, and other NCD services, we urge WHO to consider the inclusion of a strategic objective specifically on *Oral Health Workforce*, addressing challenges around education, planning, and collaboration.**

We commend the *Global strategy* for recognizing the disruption caused by COVID-19 on essential oral health services and its impact on increasing antibiotic prescriptions. Indeed, dentistry has a role in antimicrobial resistance (AMR), including through antibiotic stewardship – dentists currently prescribe up to 10% of antibiotics worldwide.<sup>19</sup> However, the role of dental teams in infection prevention and control, and antibiotic stewardship is not widely recognized by WHO, for instance, in the Global action plan on antimicrobial resistance. This leads to a lack of engagement of dentists in AMR multisectoral efforts. **The *Global strategy* offers an opportunity to link AMR efforts and the role of dentistry beyond the context of COVID-19. We therefore urge WHO to consider and include this as part of an additional guiding principle on sustainability.**

Sustainability has indeed become an increasingly relevant issue for dentistry. The imperative of reducing waste of resources by promoting prevention, is both a commitment and challenge for the oral health profession. A good example of this is the Minamata Convention on Mercury calling for the phase down of use of dental amalgam. The Minamata Convention is a legal instrument bringing the opportunity to invest in prevention and promote less invasive dentistry, find alternatives to dental amalgam that are accessible, affordable, durable, and environmentally friendly, as well as improve waste management. **The *Global strategy* should better reflect on the role that sustainability plays in the oral health response by adding sustainability as a guiding principle**, which is already guiding the oral health research agenda and WHO and Member States' roles, and it reinforces the strategic objective on *Oral Health Promotion and Oral Disease Prevention*.

## Specific comments, recommendations, and reserves

Section		Para	Comment
Background	<i>Nature and purpose</i>	1	<p>It is concerning to see that the <i>Global strategy</i> does not include a specific timeframe; however, it will inform the 2023 <i>Action plan for public oral health</i> and its 2030 targets. Having a specific timeframe supports monitoring and accountability efforts and leaves the door open for a revised <i>Global strategy</i> after 2030 based on the lessons learnt from the implementation of the future action plan and 2030 targets. <b>We therefore recommend that the <i>Global strategy</i> outlines a specific timeframe from the year of its adoption (scheduled for 2022) to 2030.</b></p>
	<i>Supporting documents and processes</i>	2	<p>The <i>Global strategy</i> is strongly aligned with other WHO and UN documents and processes not mentioned in the strategy's background. For instance, the <b>Global Action Plan for Healthy Lives and Well-being for All</b> supports the achievement of the health-related Sustainable Development Goal targets; the <b>Global Strategy on Digital Health 2020–2025</b> is relevant given that optimizing digital technologies for oral health is one of the strategy's guiding principles; and given the strong reference made to the social determinants of oral health, <b>WHA74.16 (2021) on Social determinants of health</b> should be also included, although this resolution was adopted in parallel with the WHA74.5 (2021) on Oral health.</p>
Global Overview of Oral Health	<i>Definition of oral health</i>	3	<p>We strongly welcome the holistic and life-course approach of the definition of oral health, which aligns well with <i>FDI's definition of oral health</i><sup>†</sup>. However, to fully align with <i>FDI's definition of oral health</i>, <b>we urge WHO to define oral health as both “the health and well-being of the mouth”</b>, including the execution of many functions with confidence and without pain, discomfort, and disease. <i>FDI's definition of oral health</i> was overwhelmingly approved in 2016 by FDI's General Assembly, formed by close to 200 national dental associations from over 130 countries.</p>
	<b>Oral Disease Burden</b>	4	<p>When talking about the burden of the main oral diseases, <b>we urge WHO to highlight that dental caries alone are the most prevalent condition among NCDs (or any other disease group)</b>, to show the magnitude of this single oral disease.<sup>20</sup> It is then important to show the percentage of people affected by the main oral diseases altogether (almost half of the world's population) and how their collective prevalence remains unchanged.</p>

<sup>†</sup> FDI's definition of oral health (2016): “Oral health is multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex.” Source: Glick M, Williams D, et al. A new definition for oral health developed by the FDI World Dental Federation opens the door to a universal definition of oral health. *Int Dent J*. 2016;66(6): 322–324. Available from: <https://doi.org/10.1111/idj.12294>

		<p>We strongly welcome the reference to cancers of the lip and oral cavity, noma, and cleft lip and palate under the <i>Oral Disease Burden</i> section, demonstrating that within the field of oral health there are serious inequalities and devastating conditions. Specifically, we ask for:</p> <ul style="list-style-type: none"> <li>• <b>Clarification that noma (cancrum oris) “is a non-contagious necrotizing disease”</b> to fight misconceptions about this disease and also specify the causative agent of noma remains unknown and that there is no global data on its prevalence / incidence since the 1990s as this is relevant when talking about the burden of oral diseases and shows the lack of prioritization and (oral) health surveillance capacity.<sup>21</sup></li> <li>• <b>The global prevalence of cleft lip and/or palate is reconsidered to be “of approximately 1 in 700 live births with considerable ethnic and geographical variation”</b> as this is the estimated prevalence when considering the collective burden of cleft lip, cleft palate, and cleft lip and palate.<sup>22</sup> Moreover, it is important to note that cleft lip and/or palate as severe birth defects, leading to high rates of infant mortality in rural and poor settings when there is no timely access to quality surgery.<sup>23</sup></li> </ul>
	<p>New</p>	<p><b>We urge WHO to consider an additional paragraph under the <i>Oral Disease Burden</i> section which considers the comorbidity of oral diseases and other NCDs,</b> to highlight the association between oral health and NCDs beyond shared risk factors. For instance, this new paragraph can mention several associations between oral diseases and other NCDs in line with the WHO resolution on Oral health. It can also stress the two-way relationship between periodontal disease and diabetes and include the global prevalence of periodontal disease among people living with diabetes. It can also mention that, for people living with diabetes, there is strong evidence that good periodontal health leads to improved blood glucose control, reduces the likelihood of hospitalization, and lowers the cost of treating diabetes.<sup>24</sup></p>
<p><b>Social and Economic Costs of Poor Oral Health</b></p>	<p>6</p>	<p><b>A stronger emphasis could be made on the higher proportion of out-of-pocket payments and catastrophic health expenditure</b> that is associated with oral healthcare, often leading people not to seek care when needed.</p>
	<p>7</p>	<p><b>Older people should be mentioned</b> among the vulnerable members of societies being disproportionately affected by oral diseases and conditions and having poor access to oral health services.<sup>25</sup></p>
<p><b>Commercial Determinants and Risk Factors of Oral Health</b></p>	<p>8</p>	<p><b>We welcome the explicit mention of commercial determinants of health</b> in the <i>Global strategy</i>, and their role in the oral disease burden and in exacerbating health inequalities. <b>We suggest referring to all upstream determinants of oral health under this section</b>, and therefore add the following sentence at the end of this paragraph: “Together with the wider social and economic determinants of health,</p>

			commercial determinants are upstream drivers of poor oral health among populations globally".
	9		<p><b>We strongly welcome the explicit mention of betel quid and areca nut use, lack of breastfeeding, and HPV as shared risk factors for oral diseases and other NCDs;</b> however, we suggest the following edit: "These risk factors include all forms of tobacco use (including smoking and smokeless tobacco use such as betel quid and areca nut use), harmful alcohol use, [...]." This way we are <b>specifying smoking and smokeless forms of tobacco use</b>, and by using the term "smokeless tobacco" (and not just "betel quid and areca nut use"), we are also encompassing other forms of smokeless tobacco use that have been associated with a higher incidence of oral cancers, such as toombak, snus, etc.<sup>26</sup> The following sentences must also be clarified:</p> <ul style="list-style-type: none"> <li>• "Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury." It is very positive to see an implicit reference to <b>the role of primary prevention in orofacial clefts, and alcohol as a risk factor for traumatic dental injury</b>, showing the health and social implications of alcohol use – <b>these points should be made more explicitly in the <i>Global strategy</i></b>.</li> <li>• "The risk factors for noma include malnutrition, coinfections, poor oral hygiene and poor living conditions." It would be more accurate to say: <b>"Noma is a complex and multifactorial disease with unknown causative agent</b>, the risk factors associated with noma include malnutrition, coinfections, poor oral hygiene and poor living conditions."</li> </ul>
Oral Health Promotion and Oral Disease Prevention	10		<p><b>We fully align with this paragraph and suggest specifying "(public policy and regulation)"</b> as the evidence on the effectiveness of self-regulation alone is weak. We also suggest <b>mentioning here that, given associations between oral health and NCDs, poor oral health should also be considered as a risk factor</b>; and thus, the importance of integrating oral health promotion and oral disease prevention into other NCD programmes.</p>
	11		<p><b>We fully align with this paragraph and suggest specifying a few examples of public health initiatives to reduce sugar consumption</b>, such as taxation of sugary drinks, implementation of clear nutrition labelling, regulation of all forms of marketing and advertising of food and beverages high in sugar to children, improvement of the food environment in public institutions (i.e., schools, hospitals, public buildings, and workplaces), and increasing awareness and access to clean water.</p>
	12		<p>We strongly welcome this paragraph, recognizing the role of fluorides in the prevention of dental caries. <b>We suggest specifying the benefits of community-based methods (e.g., fluoridation) where appropriate</b>, mentioning the cost-effectiveness of these interventions and the need to accompany these interventions with regular monitoring.</p>
Oral Health Care Systems	13		Isolation of oral health services within health systems needs to stop and this paragraph describes the

			<p>current situation. A health system reform would require a change of mindset for both public and private health sectors. For instance, oral healthcare is often covered by a separate insurance policy if at all. This is to reflect the existing separation that is made between health services. <b>This should be more clearly reflected in this paragraph, that oral health services are often considered a separate complementary health service, rather than part of a country's essential health services.</b> Moreover, when talking about primary care facilities, <b>we suggest mentioning the impact that improving referral mechanisms</b> as part of integrating oral health services at the PHC level can have on increasing access to basic care and facilitating access to specialized care when needed.</p>
	14	<p><b>This paragraph needs further elaboration if it aims to describe the challenges to optimize the oral health workforce within healthcare systems.</b> The oral health workforce needs to adapt and respond to the population's evolving needs (rather than just address needs). Current planning strategies rarely focus on the retention and continued education of oral health workers and ensuring a needs-based distribution of oral health workers within countries. Engaging a wide range of oral health workers is key to increase coverage of oral health services across communities, and for that, the different oral health professions need a defined scope of practice and access to education that encourages intra-professional collaboration and clear referral mechanisms.</p>	
	15	<p>Reference to the impact that COVID-19 has had in disrupting access to essential oral health services is key. FDI has referred to the impact of lockdowns on people's oral health as being a <i>dental disaster</i>.<sup>27</sup> This reiterates again the essentiality of oral health services (including oral health promotion). Therefore, <b>this paragraph must also refer to the need for health emergency planning to include prevention strategies and development of digital health solutions</b>, such as mobile dentistry interventions. <b>It is also promising to see recognition of the role that dentistry plays in AMR stewardship, given the increased rate of antibiotic prescriptions during the pandemic.</b> This should be mentioned more generally in the <i>Global strategy</i> (further down, we are suggesting adding a new guiding principle on sustainability).</p>	
	<b>Vision, Goal, and Guiding Principles</b>	<b>Vision</b>	<p>16</p> <p>We fully align with the strategy's vision which strongly resonates with Vision 2030's pillar 1 "Universal coverage for oral health". <b>We ask WHO to maintain this as it is.</b> A focus on oral health as an essential element of UHC will ensure equitable access to quality services and full integration of oral health within health systems, supporting the oral health workforce in the process.</p>

		17	<p><b>We strongly welcome the recognition of oral health as a fundamental human right.</b> The description of the strategy's vision includes the three elements of UHC (quality, accessibility, and affordability) and asks for the oral health response to be needs-based. <b>We welcome reference to the wide range of services that universal oral health coverage should encompass, including prevention and rehabilitation.</b> Rehabilitation should not be forgotten in the context of oral healthcare, as this is an essential service. For example, for people undergoing oral surgery in the context of a cleft, noma, or other complications.</p>
	<b>Goal</b>	18	<p>Currently, the <i>Global strategy</i> only provides very high-level guidance to Member States to strengthen their national oral health responses. It is more accurate to say that the goal of the <i>Global strategy</i> is to define the guiding principles, strategic objectives, and different stakeholder roles that will inform the 2023 Action plan for public oral health. Otherwise, the <i>Global strategy</i> needs to be more specific and implementation-oriented.</p>
<b>Guiding Principles</b>	<b>Principle 1: A public health approach to oral health</b>	19	<p><b>We fully align with this principle</b> shifting the focus of the oral health response towards prevention. We welcome its population-wide approach, and reference to work across sectors. <b>A reference to working with fiscal actors (i.e., ministries of finances) could be made</b> as part of taxing unhealthy commodities and providing subsidies that incentivize healthy diets.</p>
	<b>Principle 2: Integration of oral health in primary health care</b>	20	<p><b>We fully align with this principle</b> as integration of oral health services within PHC and NCD prevention, detection, and control efforts is essential to achieve optimal oral health for all. We suggest clarifying what is meant by "related conditions" as this is not explained in the <i>Global strategy</i>. As suggested earlier, it can be included under the <i>Oral Disease Burden</i> section by describing the oral disease comorbidities.</p>
	<b>Principle 3: A new oral health workforce model to respond to population needs</b>	21	<p><b>This principle needs a more ambitious scope to optimize the oral health workforce.</b> A new model also needs to consider retention and geographical distribution of oral health workers according to the populations' needs. As outlined in the cross-cutting pillar of Vision 2030 (<i>Enabling a responsive and resilient profession: the case for educational reform</i>), a new oral health workforce model must support intra- and inter-professional education to strengthen collaboration and to allow the full integration of oral health services within health systems and at the PHC level. It should also be clarified that oral health workers can play a leading role in providing oral health training to non-oral health workers, better aligning with the education and training needs of health workers.</p>
	<b>Principle 4: People-centred oral health care</b>	22	<p><b>We fully align with this principle</b>, and it can be reinforced by including in the definition of people-centred, that <b>this also involves for people to be treated holistically and not with a disease-specific approach</b>, putting people and not diseases at the centre of health systems, and breaking down the silo</p>

			between oral health and general health.
	<b>Principle 5: Tailored oral health across the life course</b>	23	<b>We fully align with this principle</b> , especially in the context of how maternal, newborn and children health (MNCH) and other population/age-specific programmes could be leveraged. However, it can be reinforced by <b>specifying that oral health services, included within UHC benefit packages, should not be exclusive to a specific population group only</b> (e.g., in some countries, oral healthcare is only covered for children). <sup>28</sup>
	<b>Principle 6: Optimizing digital technologies for oral health</b>	24	<b>We fully align with this principle</b> and agree that digital technologies are key to making oral health services available at the PHC level and that governance for digital health needs to be reinforced in parallel. We welcome the wide range of uses described for digital oral health and <b>suggest adding reference to the need to educate oral health workers and primary care providers on digital and technological advances</b> .
	<i>Suggested additional principle: Sustainability</i>	New	Sustainability is an essential element to consider in the oral health response, prioritizing prevention, and ensuring dentistry reinforces other efforts to achieve sustainable health systems. <b>Under this new guiding principle that we urge WHO to consider, important issues around AMR and the phase down of use of dental amalgam can be covered</b> , guiding the strategic objectives on oral health promotion, prevention, and the oral health research agenda, as well as WHO and Member States' responsibilities towards sustainability in dentistry.
<b>Strategic Objectives</b>	<b>Strategic Objective 1: Oral Health Governance</b>	25-26	<b>We fully align with this strategic objective</b> , with the ultimate goal being that oral health services are recognized, integrated, covered, and well-resourced as an essential health service. We also appreciate the importance of working across stakeholders to maintain political and resource commitment and address upstream determinants. Regarding the national oral health unit, we suggest the following edit: "A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services and <b>should address both preventive and curative efforts</b> ."
	<b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b>	27-28	<b>We fully align with this strategic objective</b> and, given equal access to promotive and preventive services remains a challenge, we suggest the following edit: "Strategic objective 2 calls for evidence-based, cost-effective, <b>population-wide</b> and sustainable oral health promotion and interventions to prevent oral diseases and conditions.". Also, regulatory policies are key to restrict access to unhealthy commodities, but <b>the Global strategy should also refer explicitly to promotive public policies</b> , for instance, to increase access to healthy diets – such as setting market incentives, subsidies to buy fresh fruits and vegetables, etc. It is important to stress under this section that <b>only a combination of policies will ensure the success of oral health promotion and oral disease prevention efforts</b> .

	<b>Strategic Objective 3: Primary Oral Health Care</b>	29-30	<p><b>We fully align with having PHC as both a strategic objective and a guiding principle</b> to ensure access to oral health services for all, and we commend the mention of referrals in this process, the importance of financial protection, and access to essential consumables and medicines for oral health. Ensuring oral health workers are also part of primary care teams is an essential step. We, however, ask WHO to have a separate and specific strategic objective on <i>Oral Health Workforce</i>, addressing the challenges around health workforces' education, planning, and collaboration and specifying what is meant by: "[...] work side-by-side with other health workers in tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups".</p>
	<b>Strategic Objective 4: Oral Health Information Systems</b>	31	<p><b>We fully align with this strategic objective</b> – having strong health information systems for oral and general health is a key element of health systems. For instance, without a strong oral health information system, Member States cannot implement a needs-based approach to oral health workforce planning. Existing surveillance instruments need to be reinforced by including oral health modules and WHO should help identify standardized oral health indicators. For instance, WHO's <b>STEPwise Approach to NCD Risk Factor Surveillance (STEPS)</b> has a module on oral health that can be mentioned in the <i>Global strategy</i>.</p>
	<b>Strategic Objective 5: Oral Health Research Agenda</b>	32	<p><b>We fully align with this strategic objective</b> – the scope of the oral health research agenda needs to span across health, behavioural, and social science disciplines to better understand both the complexity of clinical associations between oral and general health, and the challenges in implementing dental public health interventions and integrating oral health services. We strongly welcome the mention of cost-effectiveness analyses, and <b>we suggest for "alternative dental restorative materials" to be replaced by "dental restorative materials that can fully replace dental amalgam"</b> for clarification.</p>
	<i>Suggested additional strategic objective: Oral Health Workforce</i>	New	<p><b>We urge WHO to consider the addition of a new strategic objective on oral health workforce specifically</b>, in line with the guiding principle: <i>A new oral health workforce model to respond to population needs</i>. This will help address the different challenges affecting the oral health workforce, such as education, retention, geographical distribution, planning, and intra- and inter-professional collaboration. <b>It needs to be specified how oral health workers can help address shared risk factors</b> (e.g., via tobacco cessation support, dietary advice, etc.) <b>and support general health check-ups</b> (e.g., performing screenings for oral cancer, diabetes, and hypertension). Also, non-oral health workers can be trained to deliver brief oral hygiene interventions performing a risk assessment and referring patients to a dentist when relevant.</p>
<b>Role of Member States,</b>	<b>WHO</b>	33-38	<p>We commend the roles and work of WHO in the oral health response, and welcome the commitments made under the <i>Global strategy</i>, including around collaboration with global public health partners. <b>We ask WHO to consider and reflect on the collaboration with regional WHO offices for the</b></p>

Partners and Secretariat			<p><b>implementation of this strategy. We look forward to the announced oral health data platform, and we suggest adding more information on this</b> – for instance, whether this will help promote standardized indicators on oral health, obtain global analyses and report on the oral health status, and monitor progress made by Member States integrated oral health within their national health systems. We ask WHO to coordinate the upcoming 2030 targets and cost-effective interventions on oral health with efforts around the NCD implementation roadmap 2023-2030 for a unified NCD response, and to classify noma as a neglected tropical disease (NTD) within the road map for NTDs 2021–2030 to bring attention to this neglected disease increasing access to noma prevention and care to those who need it.</p>
Member States	39-44		<p>We welcome the whole-of-government and whole-of-society approach to Member States' roles and responsibilities in the oral health response, and the importance for them to allocate resources and surveillance capacity to oral health services and the oral health workforce. <b>We also welcome the request for Member States to recognize fluoride toothpaste as an essential product within national essential medicines lists. We ask WHO to replace “advocating for health taxes or regulation of the sale and advertisement of unhealthy products [...]” to “implementing health taxes or regulation of the sale and advertisement of unhealthy products [...]”, and “advocating for its [fluoride toothpaste’s] recognition as an essential health product within the national list of essential medicines” to “recognizing it [fluoride toothpaste] as an essential health product within the national list of essential medicines”.</b> <b>Member States should also be responsible for including dentistry in AMR efforts and develop country-wide emergency plans that ensure the uninterrupted provision of essential oral health services.</b></p>
International Partners	45-46		<p><b>We align with this section</b> but the mentioning of <b>collaboration of international partners with national actors to ensure implementation</b> at the regional and national levels should be added.</p>
Civil Society	47-48		<p>We welcome the recognition of civil society in the oral health response, including the role of people living with and affected by oral diseases, as well as how they can help assess progress. <b>This section could be strengthened further though.</b> For instance, the second paragraph can read as follows: “Civil society can lead grass-roots mobilization and advocacy for increased focus within the public agenda on oral health promotion and the prevention and control of oral diseases and conditions and <b>ensure Member States are accountable for their commitments. Civil society can denounce industry interference and directly advocate public policy and regulation</b> against unhealthy commodities, support governments in implementing risk factor programmes (including on tobacco control) and promote the availability of healthy products and fluoridated toothpaste (for instance, through subsidization or reduced taxes)”. <b>It is important to specify that by engaging people living and affected by oral diseases (not just amplifying their voices), WHO and Member States can identify the real gaps in meeting people's needs</b>, making oral health services effective and relevant to the beneficiaries they</p>

			are intended to serve. And the same applies with health workers, by engaging them, WHO and Member States can identify the real challenges faced by the workforce and affecting retention rates and planning outcomes.
	<i>Suggested addition: Academia</i>	New	If research is a strategic objective of the <i>Global strategy</i> , a specific stakeholder mentioned here should be academia (as it has been mentioned in WHO's discussion paper on draft recommendations for the prevention and management of diabetes over the life course, including potential targets, dated as of 17 August 2021). The following can be added under academia: "Consolidate and expand the evidence base on oral diseases causes and associations with NCDs and general health, health outcomes from oral health treatments, oral health inequalities, and cost-effectiveness analyses; and on interventions at the individual, community and societal level." "Engage health sciences with social scientists to consolidate and expand the evidence base on behavioural change interventions for oral health promotion and oral disease prevention."
	<b>Private Sector</b>	49-51	<b>We welcome the different ways in which the private sector can contribute to the oral health response</b> , by promoting good oral health in the workplace; disengaging from industry interference and supporting access to essential products; and the role of dental private practice.

We urge WHO to develop a *Global strategy* that is robust, time-bound, and implementation-oriented encompassing more ambitiously all the different areas that require reform in national health systems for oral health to become an integral element of NCD and UHC strategies.

The *Global strategy* would benefit from a more comprehensive description of all the implications that the associations between oral health, NCDs, and general health have for health systems. The importance of optimizing the oral health workforce to achieve the vision and goal of this *Global strategy* calls for a specific strategic objective on *Oral Health Workforce*. *Sustainability* should be also included as a guiding principle given the implications it has across the different strategic objectives of this *Global strategy*, and the responsibility that WHO and Member States have towards promoting and implementing a sustainable oral health response.

We stand ready to support WHO and Member States with the development and implementation of the *Global strategy*, the subsequent 2023 *Action plan for public oral health* (including its monitoring framework and 2030 targets), and the NCD “best buys” and other recommended interventions on oral health management, reinforcing the Global action plan for the prevention and control of NCDs 2013–2030 and its upcoming implementation roadmap 2023–2030.

***On behalf of FDI and the co-signing organizations, we remain at your disposal for any questions or further information at [advocacy@fdiworlddental.org](mailto:advocacy@fdiworlddental.org).***

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La Federación Española (HIDES) en representación de los Higienistas Dentales de España y como única entidad española miembro de la (IFDH) International Federation of Dental Hygienists y de la (EDHF) European Dental Hygienist Federation, agradece la oportunidad que se nos brinda para colaborar en la elaboración de las distintas estrategias para combatir las enfermedades bucodentales.

Entendiendo, que la profesión de Higiene Dental surge para abordar las necesidades de la salud oral de la población y al hilo de la situación sanitaria mundial de la COVID-19, La Federación Española de Higienistas Bucodentales(HIDES) quiere hacer hincapié en:

1. La necesidad mundial del cuidado oral de la población envejecida, es decir, la tercera edad, nuestros mayores.

Llegada una edad, la persona necesita un cuidado y atención especial.

Como profesionales de la salud bucodental y teniendo en cuenta que este target poblacional es además un paciente polimedicado, entendemos que debe primar la estrategia de preservar el cuidado de la salud oral de nuestros mayores con el fin de mantener el cuidado de su salud en general.

Para ello se deberían dotar los centros de cuidados de mayores de higienistas dentales, como responsables del cuidado oral de los usuarios, evitando sin duda que situaciones tan dramáticas como las vividas recientemente se repitan.

2. Se requiere incrementar el cuidado en la salud oral de los enfermos con alteraciones neurológicas. pacientes con enfermedades neurodegenerativas como Parkinson y Alzheimer, son incapaces de mantener una higiene oral adecuada
3. Dada la gravedad y secuelas, aún por valorar de la COVID-19 es fundamental la labor que los higienistas bucodentales pueden llevar a cabo como educadores sanitarios en pacientes afectados por la disfagia o con los posibles efectos adversos de esta devastadora enfermedad que ha asolado al planeta.

Por todo ello, entendemos que la Federación Española de Higienistas Bucodentales, debe formar parte del posible grupo de trabajo que lleve a cabo la elaboración del plan de estrategias mundial para el cuidado de la salud bucodental, teniendo en cuenta la importante necesidad de formar al



colectivo adecuadamente y sobre todo la necesidad de equipara en nuestro país nuestra formación al resto de países europeos.

Al mismo tiempo, requerimos incrementar la figura del higienista dental en la sanidad pública, esa sería la manera más equitativa de garantizar la calidad de servicio en el cuidado de la salud oral.

Madrid, 17 de septiembre de 2021

**Eva López de Castro**-Vicepresidenta HIDES

*Delegada Internacional*



**Res: Asamblea Mundial de la Salud. Resolución WHA74.5 (2021).  
Propuestas. Madrid, ( España), 15 de septiembre de 2021,**

**World Health Assembly. Resolution WHA74.5 ( 2021).**

**Proposals. Madrid, ( Spain). September, 15th 2021**

**PROYECTO DE ESTRATEGIA MUNDIAL SOBRE SALUD BUCAL  
WORLD STRATEGY PROJECT ON ORAL HEALTH**

The **UNION OF PROFESSIONAL COLLEGES OF DENTAL HYGIENISTS OF SPAIN**, addressed in Madrid, Paseo de la Castellana nº 143 ( 28046 Madrid) represented by its President Ms. Soledad Archanco Gallastegui, with e-mail for notifications:

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presents the following PROPOSALS referred to the Resolution WHA74.5 ( 2021) approved by the Executive Council of WHO, in January 2021.

The resolution WHA74.5 ( 2021), otustands

***“ the worrying charge and the human and economic cost of oral diseases and pretends to create lines to face poor oral health both in a national and international level focusing in prevention and multisectorial action”***

In the search of these **prevention measures**, the main collective of sanitary professionals who , in Spain must propose and implement those prevention measures are the **DENTAL HYGIENISTS** who are in charge of

***“Safeguarding the promotion of health and oral sanitary education. The gathering of data, realization of health tests and advising on hygienic and preventive measures as well as cooperation in epidemiologic research.”***

In Spain the main organization which represents dental hygienists and which possesses the highest knowledge on the matter and of prevention needs that the Project intends to cover is the **UNION OF PROFESSIONAL COLLEGES OF DENTAL HYGIENISTS OF SPAIN**

The importance of this Organization in the defence of oral health of the Spanish population is recognised by being present in the consultive Organ of the Ministry of Health in Spain ( Order SCB/93/2019, February 4th, by which the Comitee of Sanitary and Social Professions is created)

From the **UNION OF PROFESSIONAL COLLEGES OF DENTAL HYGIENISTS OF SPAIN**, willing to add to this **open consultation of the WORLD HEALTH ASSEMBLY ( WHA)** the knowledge obtained by our training, experience and representativity, we propose the following measures which would complement the cover in the sanitary field referred to oral health, with a low cost and with the necessary preventive character.

## **INTRODUCTION**

By observing the outlook of oral care programs( even in the same country) we have verified how by the mere fact of living some kilometers away north/south/east or west there is a great inequality regarding the covering and benefits that are obtained.

Furthermore not all countries have oral health programs or they are not well established. In those places where resources are scarce, it is necessary to carefully measure the use of resources to guarantee the access to quality oral health attention for everyone. This will include a sufficient number of competent sanitary professionals in the realization of preventive interventions, the availability of time of treatments and the access to odontological materials which are affordable, safe and efficient.

And if what has been mentioned is applied to just one country, What can be expected of national policies around the world?. Poor and deprived populations in the world are those who suffer a higher amount of oral morbility, whose distribution exposes in every country well defined risk profiles that are related with life conditions, certain enviromental and behavioral factors, oral health systems and the application of preventive programs on the matter.

## **PRECEDENTS**

- The main oral health issues are: cavities, periodontopathies, oral cancer, HIV oral manifestations, oral trauma, cleft lip and palate and noma (

serious gangrenous condition which starts in the mouth and affects mostly to children). Fortunately most oral health issues are preventable and can be treated in their initial stages. Worldwide it is estimated that there are over 3.500million cases of diseases and other oral illnesses and that most of them are preventable

- Equally we must take oral health into account as an important risk factor in the appearance of certain non transmissible systemic alterations/diseases such as: adverse outcome of pregnancy (premature labour and low birth weight) cardiovascular conditions (bacterian endocarditis, stroke, isquemic cardiopathy and arterosclerosis), respiratory (bacterian pneumonia, bronchitis and chronic obstructive lung condition) and diabetes mellitus
- The uneven distribution of the oral health professionals and the lack of adequate health centres in most countries imply that the access to primary services of oral health is frequently low. Generally speaking, following a study among adults who manifested the need of oral health services, the access to it varies from 35% in low income countries, 60% in mid-low income countries, 70% in mid- high income countries and 82 % in high income countries. In addition to this, even in high income environments the odontological treatment is expensive and represents on average the 5% total expense of health care and 20% of direct expenses of patients.<sup>6</sup>
- Oral care professionals must confront the important set out challenges by the need to reduce the waste of resources, including human resources, time equipment and odontologic material. 69% of worldwide odontologists attend just the 27% of the planet's population therefore there are simultaneous risks of excessive attention in certain places and non- sufficient in others.<sup>(7)</sup>
- Regarding the profession of dental hygienist in relation with the general population and the number of dentists, significant statistic data have not been found because the profession, its functions and degrees vary considerably from one country to another.

## PROPOSALS

The amount of morbility due to oral diseases and other non-transmissible ones can be reduced through **public health interventions directed towards the most common risk factors**. Among these interventions we can highlight:

- Encouragement of a balanced diet low in free sugars, in which many fruits and vegetables must be included and in which the main drink is water.
- Interruption of tobacco consumption in all its forms particularly chewing of Areca nut.

- Encouragement of the use of protection equipment when practising sports and Bycicle and motor bike riding ( to reduce the risk of facial traumatism.
- Encouragement of an active life.
- Enough exposure to fluoride is an essential factor for cavity prevention.

(4)

### **Specific interventions of oral health:**

The primary intervention in the field of health has proved a minor incidence in the development od periodontal diseases, cavities, etc, and its association with others on a systemic level.

Equally it implies a reduction in sanitary expense and an improvement in life quality of people. The precise proposed actions are :

- 1.- Encouraging governments to increase the oral heath service budgets and preventive programs,particularly in primary attention, hospital attention, geriatrics , private health insurances etc...
- 2.- Implementation of identical national and international strategies in those countries with a similar economic, social and cultural profile. Equal in actuations and activities to develop inside the planning for promotion and prevention integrated in oral health morbility.
- 3.- Implementation of a service of oral health attention in primary attention in all the countries and hospital care o health teams for non transmissible illnesses. Tightening of links with other sanitary professionals would create a priceless forum for early intervention and the significant reduction of costs, which would as well reduce the sanitary attention making it more affordable.
- 4.- Updating of computering systems with identical indicators for the gathering of oral health data which provides periodic data about coverage, provided assistance and economic cost.
- 5.- Prevention as a response to sanitary policies which are in conflict with governmental budgets. Being aware that prevention means institutional, laboral, family and personal saving.
- 6.- Adoption of a steady plan in order to reduce the consumption of sugar in feeding considering it a comercial determinant on health. Reducing the sugar intake through an efficient tax strategy on beverages and other sugared products including the warning “ high sugar content” in the labelling of such products.
- 7.- Encouraging and supporting programs to help people stop smoking, which nowadays are developed by members of oral attention teams.
- 8.- Integrating the figure of the dental hygienist as one of the main professionals implied in prevention, data gathering and primary attention.Conforming and working in multidisciplinary teams( pediatrics, maternity,non transmissible illnesses health teams: hospitalized, external

patients, geriatrics , special needs patients, physical or psychical disabilities, oncological patients, emergency patients, etc..)

9.- Promoting and developing the figure of the dental hygienist as the sanitary profesional able to prevent dental cavity ( the most prevalent worldwide pathology) (8) and periodontal diseases, through sanitary education, fluoride applications and dental tartrectomy.

10.- Dental hygienists have the potential to prevent oral diseases and other non oral diseases, and to cooperate with other professionals with a synergic aim, coordinating common work with midwives, community nurses, pediatric nurses, social workers, occupational therapists and educators. Benefits from global work among the different health fields have been shown already evident, always from the belief that health is only one and there are no "different types of health" ( oral, cardiovascular, metabolic,etc..)

11.- Conducting audiovisual communications able to educate, to make conscious and lead to develop healthy habits and lifestyle in the population. Modifying behaviours and adquiring new habits is difficult but the awareness and transformation of the world population towards a Universal Health Cover can be in the mid and long term of great use not only for oral health but for health in general.

12.- Use of social networks to encourage healthy lifestyles among the youngsters

The previous proposals are the ones that the dental hygienists from Spain, through the **UNION OF DENTAL HYGIENISTS PROFESSIONAL COLLEGES** presents to the WHO for its analysis and implementation, offering our cooperation for the implementation of such measures.

*Madrid, ( Spain) September 15th-2021*

**UNION OF DENTAL HYGIENISTS PROFESSIONAL COLLEGES OF SPAIN**  
**SOLEDAD ARCHANCO GALLASTEGUI**  
**PRESIDENT**

September 10, 2021

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**Re: Draft Global Strategy on Tackling Oral Diseases.**

via email: [varenneb@who.int](mailto:varenneb@who.int)

The International Association for Dental Research (IADR), which represents over 10,000 researchers around the world with a mission to drive dental, oral and craniofacial research for health and well-being worldwide, appreciates the opportunity to share our thoughts on the Draft Global Strategy on Tackling Oral Diseases being developed by the World Health Organization (WHO). IADR applauds the WHO on both the approval of the Oral Health Resolution during the World Health Assembly 74 (WHA74) as well as the development of this draft global strategy on tackling oral diseases. We also support the development of the global strategy to inform the development of a framework for tracking progress with clear measurable targets. To respond to this request for comments, IADR engaged its Science Information Committee and its Board of Directors.

Paragraph 9 of the Commercial Determinants and Risk Factors of Oral Health section of the draft report, addresses human papilloma virus as a risk factor for oropharyngeal cancers. This is true, as studies have shown that the incidence of HPV-related oropharyngeal cancers is rapidly increasing and currently exceeds (United States<sup>11</sup>) or is predicted to exceed that of HPV-related cervical cancer<sup>12</sup>. Unfortunately, there is no further mention of preventing HPV-related oropharyngeal cancers in the document. Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention, Paragraph 28 should include national HPV vaccination programs for girls and boys to reduce oropharyngeal cancers as well as screening programs to mitigate outcomes.

A public health approach to disease prevention and health promotion has emerged as the dominant strategy for combating noncommunicable diseases worldwide<sup>1</sup> and therefore is also applicable to oral diseases. The WHO Global Oral Health Programme has adopted this approach as the best means of promoting oral health and reducing inequalities within and between countries<sup>2</sup>. In paragraph 12 of the Oral Health Promotion and Oral Disease Prevention section of the draft report it is called to attention that essential prevention methods, such as community-based methods, topical fluoride applications or the use of fluoridated toothpaste, frequently are not available or affordable for people. In an effort to set measurable targets for Member States, IADR would support the explicit definition of the community-based methods that are most effective for the prevention of oral diseases as well as the most economical mechanisms. Community water fluoridation is a safe and effective, evidence-based intervention for the prevention of dental caries. Studies have shown that community water fluoridation

is the simplest way to maintain a constant low dose of fluoride in the oral cavity, through drinking fluoridated water or ingesting meals prepared with fluoridated water<sup>3,4</sup>. Additionally, a systematic review by the US Community Preventive Services Task Force (CPSTF) found that water fluoridation is cost saving and is a safe and effective way to prevent and control dental caries<sup>5</sup>. Additionally, the United Kingdom's National Institute for Health Research, Cochrane Oral Health Group, and the National Health and Medical Research Council, Australia have all conducted scientific reviews by expert panels and concluded that community water fluoridation is a safe and effective way to promote good oral health and prevent decay<sup>13-15</sup>. The WHO has previously recommended a concentration of 0.5 to 1.5 mg/L of to achieve caries prevention while minimizing the risk of dental fluorosis<sup>16</sup>. Countries have decided on the concentration of water fluoride appropriate for their context. Therefore, IADR supports the inclusion of community water fluoridation within the draft strategy as a recommendation of a measurable target for the prevention of oral diseases.

The Minamata Convention on Mercury is a multilateral, legally-binding, environmental agreement that addresses specific human activities which are contributing to widespread mercury pollution. This agreement includes an approach to phase down the use of dental amalgam for the treatment of dental caries. With 133 Parties to the Minamata Convention, including middle- and lower-income countries (LMICs), it is imperative that the draft resolution contain a specific paragraph within the Strategic Objectives section that specifically addresses the use of dental amalgam. IADR supports the inclusion of language that is supportive of the phase down of dental amalgam within Strategic Objective 3. This language should call for further research into dental amalgam alternatives and include guidance to setting national objectives and a timeline that is targeted at caries prevention and health promotion. Additionally, in resource limited settings, a premature phase out approach in lieu of a country specific and nationally contextual phase down approach may serve to widen oral health inequalities<sup>6</sup>.

In Guiding Principles 2 and 3, the global strategy addresses the need for the integration of oral health in primary health care and a new oral health workforce model that is responsive to population needs. It is important to note, that in several countries, for instance Mexico, primary health care is mainly provided by nurses<sup>8,9</sup>. However, during basic training in nursing schools, educational preparation to address oral health needs is limited across nursing career curricula<sup>10</sup>. Consequently, it will be challenging for those countries to successfully incorporate oral health into primary health care practices. Therefore, the main activities of primary care that may be mainly aimed at the mother-child binomial, will continue to lack oral health promotion and education, which is essential during child development. IADR supports inclusion within the global strategy, a call for the integration of oral health prevention and the basic description of oral health problems during the life course within the nursing career curriculum.

As part of the Strategic Objectives, the draft report outlines the oral health research agenda. It identifies the need to create a research agenda that is oriented towards public health programs, population-based interventions, learning health systems, workforce models, digital technologies, the public health aspects of oral diseases and conditions, and economic analyses to identify cost-effective interventions. However, paragraph 32 in Strategic Objective 5 incorrectly states that “the historical oral health research agenda [that] has focused heavily on dental technology and problem description, rather than problem-solving.” This is simply not true and belies the very definition of research. Our current preventive approaches have been built on decades of research into the basic biologic mechanisms of oral diseases. Rather than discard any current research agenda, IADR supports a clear call for the enhancement of the research agenda with an emphasis on the expansion of the current research interest in dental technologies to include a more public health lens. There is the capacity to continue to investigate appropriate dental technologies for treatment and prevention whilst addressing all the other components and foundational

biologic aspects of oral disease. As others have said, our research agenda must span from the molecular to the societal. With emerging technologies such as artificial intelligence, augmented reality, regenerative dentistry, and CRISPR, added to the lessons learned from the COVID-19 pandemic that inspired the increased need for teledentistry, we would be remiss to neglect this important aspect of the oral health research agenda.

Noma (Cancrum oris) is highlighted in several sections of the draft global strategy including references in the Oral Disease Burden, Commercial Determinants and Risk Factors of Oral Health as well as outlined as one of the roles of the WHO to consider the classification of noma within the road map for neglected tropical diseases 2021–2030. IADR applauds the WHO for their acknowledgement of the impacts of noma as well as the identification of noma as a marker of extreme poverty exacerbated by socioeconomic disparities. IADR supports the inclusion of noma in the oral disease research agenda as it continues to be poorly understood<sup>17,18</sup> and would therefore benefit exponentially from a research agenda that is inclusive of studies ranging from the foundational biologic aspects of the disease to population-based research.

Orofacial cleft (OFC) is one of the most common congenital malformations and includes 3 subgroups: cleft lip (CL), cleft palate (CP), and cleft lip and palate (CLP). The causes of OFC are complex, including genetic predisposition and environmental risk factors. The average prevalence of cleft lip with or without cleft palate was 7.75 per 10,000 live births in the United States and 7.94 per 10,000 live births internationally<sup>7</sup>. It is most prevalent in Asian regions with 19.05 per 10,000 live births in Japan being the highest rate globally<sup>7</sup>. It is therefore important the special emphasis be placed on research associated with the fundamental aspects of OFC. IADR supports the inclusion of OFC in Strategic Objective 5 with a clear call for the incorporation of OFC in the research agenda and specific measurable targets for Member States to assess their progress towards this objective.

IADR appreciates the opportunity to provide comments on the Global Strategy on Oral Health being developed by the WHO. IADR stands ready to work with the WHO and the Division of UHC/Communicable and Noncommunicable Diseases to further define the global strategy. If you have any further questions, please contact Dr. Makyba Charles-Ayinde, Director of Science Policy, at [mcayinde@iadr.org](mailto:mcayinde@iadr.org).

Sincerely,



Christopher H. Fox, DMD, DMSc  
Chief Executive Officer



Eric C. Reynolds, AO, FICD, FTSE, FRACDS  
President, IADR

<sup>1</sup>Global strategy for the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2000.

<sup>2</sup>Petersen PE. (2003). The World Oral Health Report 2003. Continuous improvement of oral health in the 21st century the approach of the WHO Global Oral Health Programme. *Community Dentistry and Oral Epidemiology* 31 Suppl 1:3-24.

<sup>3</sup>Cury JA, Tenuta LM. (2008). How to Maintain a Cariostatic Fluoride Concentration in the Oral Environment. *Adv Dent Res.* **20**(1): p. 13-6.

<sup>4</sup>Lima CV, Tenuta LMA, Cury JA. (2019). Fluoride Increase in Saliva and Dental Biofilm due to a Meal Prepared with Fluoridated Water or Salt: A Crossover Clinical Study. *Caries Res.* **53**(1): p. 41-48.

<sup>5</sup>Ran T, Chattopadhyay SK. (2016). Economic Evaluation of Community Water Fluoridation: A Community Guide Systematic Review. *Am J Prev Med.* **50**(6): p. 790-6.

<sup>6</sup>Aggarwal, V.R., Pavitt, S., Wu, J. et al. (2019). Assessing the perceived impact of post Minamata amalgam phase down on oral health inequalities: a mixed-methods investigation. *BMC Health Serv Res* **19**, 985. <https://doi.org/10.1186/s12913-019-4835-1>.

<sup>7</sup>Tanaka SA, Mahabir RC, Jupiter DC, Menezes JM. (2012). Updating the epidemiology of cleft lip with or without cleft palate. *Plast Reconstr Surg.* **129**(3):511e-518e. doi: 10.1097/PRS.0b013e3182402dd1. PMID: 22374000.

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<sup>10</sup>Bhagat V, Hoang H, Crocombe LA, Goldberg LR. (2020). Incorporating oral health care education in undergraduate nursing curricula - a systematic review. *BMC Nurs.* **14**;19:66. doi: 10.1186/s12912-020-00454-6. PMID: 32684840; PMCID: PMC7359291.

<sup>11</sup>Van Dyne EA, Henley SJ, Saraiya M, Thomas CC, Markowitz LE, Benard VB. (2018). Trends in Human Papillomavirus-Associated Cancers — United States, 1999–2015. *MMWR Morb Mortal Wkly Rep.* **67**:918–924. DOI: <http://dx.doi.org/10.15585/mmwr.mm6733a2>

<sup>12</sup>Gouglas S, Mouchtaropoulou E, Besli I, Vrochidis P, Skoumpas I, Constantinidis I. (2021). HPV-Related Oropharyngeal Cancer and Biomarkers Based on Epigenetics and Microbiome Profile. *Frontiers in Cell and Developmental Biology.* **8**: 1677. DOI=10.3389/fcell.2020.625330.

<sup>13</sup>McDonagh MS, Whiting PF, Bradley M, et al. (2000). A Systematic Review of Public Water Fluoridation. University of York, York: NHS Centre for Reviews and Dissemination; <https://www.nhs.uk/Conditions/Fluoride/Documents/crdreport18.pdf>. [Accessed : September 3, 2021]

<sup>14</sup>Iheozor-Ejiofor Z, Worthington HV, Walsh T, O'Malley L, Clarkson JE, Macey R, Alam R, Tugwell P, Welch V, Glenny A-M. (2015). Water fluoridation for the prevention of dental caries. *Cochrane Database of Systematic Reviews* Issue 6.

<sup>15</sup>Australian Research Centre for Population Oral Health. (2006). The use of fluorides in Australia: Guidelines. *Aust Dent J.* **51**:195-199. DOI: [10.1111/j.1834-7819.2006.tb00427.x](https://doi.org/10.1111/j.1834-7819.2006.tb00427.x).

<sup>16</sup>World Health Organization. (2004). Fluoride in Drinking Water: Background Document for Development of WHO Guidelines for Drinking Water Quality. [https://www.who.int/water\\_sanitation\\_health/dwq/chemicals/fluoride.pdf](https://www.who.int/water_sanitation_health/dwq/chemicals/fluoride.pdf). [Accessed: September 3, 2021].

<sup>17</sup>Farley E, Ariti C, Amirtharajah M, Kamu C, Oluyide B, Shoaib M, Isah S, Adetunji AS, Saleh F, Ihekweazu C, Pereboom M and Sherlock M. (2021). Noma, a neglected disease: A viewpoint article. *PLoS Negl Trop Dis* **15**(6):e0009437. <https://doi.org/10.1371/journal.pntd.0009437>.

<sup>18</sup>Burki T. (2016). Facing Noma. *The Lancet Infectious Diseases.* **16**(11):P1231. [https://doi.org/10.1016/S1473-3099\(16\)30420-0](https://doi.org/10.1016/S1473-3099(16)30420-0)

## **Feedback on the DRAFT GLOBAL STRATEGY ON ORAL HEALTH**

Submission on behalf of Iran's Research Institute for Dental Sciences (RIDS)

Website: (<http://sbmu.ac.ir/index.jsp?siteid=394>)

We are writing on behalf of Iran's Research Institute for Dental Sciences (RIDS), one of the two nationally funded dental research centres in Tehran, Iran. The RIDS is affiliated with Shahid Beheshti University of Medical Sciences (SBMU) and has been supporting public health research and implementation of national dental health surveys. It is great pleasure to confirm that we have found many of the recommendations in this draft relevant to oral health problems in Iran. Specifically, we welcome the recommendations made in association with third guiding principle of the draft, which put emphasis on developing 'A new oral health workforce model to respond to population needs' (article 21). In this submission, we initially share the experience of training dental workforce in Iran and provide feedback for development of the draft especially in line with the developments of dental workforce.

### **Iranian experience of dental workforce**

We are pleased that the WHO draft recognised the limitation of the historical model of training dental workforce, which 'focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers' (Article 14). Such limitations have also been recognised in Iran. To overcome the barriers to dental care especially in the more deprived and remote areas, Iran's Ministry of Health commenced training dental auxiliaries (i.e. dental therapists) in the 1980s with the backing of parliamentary legislation. This national initiative involved training locally recruited dental hygienists, who were undergoing a 2-year programme after graduation from high school. The graduate of this programme were then employed by publicly funded primary care network to serve their local communities in remote and deprived areas. A wide range of dental treatments was provided by these health care workers including dental extractions, fillings, dentures, and preventive interventions such as fluoride varnish and fissure sealants. This seemingly successful initiative, however, was suspended in less than a decade due to restructuring of the ministry of health. Following this, the graduates of the dental hygiene programme, who used to work within primary care, were admitted to dental schools to become licensed dentists. With the suspension of this programme, dentists who work in the private sector, again, became the main provider of dental care. In the 2000s, health authorities attempted to address the shortcoming of dental workforce by increasing the number of dental schools, which multiplied the number of dentists working in private sector. It is widely agreed that the increase in the number of dentists who are predominately based in metropolitan areas of large cities could not successfully address access to dental care in the areas where the care is needed the most. On the positives, Iran currently implements a national oral health

programme for children, which is mainly founded on application of fluoride varnish by community health care workers within primary care. Despite its limitations, it is recognised that millions of children have benefited from this preventive intervention. Given the strength of evidence to support fluoride varnish, it is believed that this programme played a role in prevention of child dental caries.

## **Reflections and recommendations for WHO draft**

To summarise, we are pleased that the WHO draft emphasised on ‘A new oral health workforce model to respond to population needs’ (Article 21). On reflection, we would like to highlight some lessons we learnt from the experience of training dental workforce in Iran.

- 1- Integration of dental care within primary care may be facilitated by training mid-level care providers such as dental hygienists as well as by shifting some dental tasks to community oral health care workers.
- 2- Developing a new oral health workforce, which does not merely rely on highly skilled providers (i.e. dentists) for delivering basic dental treatments, is relevant and potentially beneficial for developing countries where the resources are scarce.
- 3- In addition to political will, revisiting dental workforce requires advocacy with stakeholders including the current providers of dental care and recipients of care.
- 4- Increase in the number of dentists to work in private sector does not necessarily lead to better access to dental care in areas where the care is needed.
- 5- Community based prevention programmes such fluoride varnish and giving advice on diet should be emphasised along with the integration of dental care within primary care.
- 6- While there are examples of using mid-level providers and community health workers even at national level, there is a significant lack of evidence about the efficacy and effectiveness of such initiatives.

**From:** ali kazemian  
**Sent:** Thu, 16 Sep 2021 17:10:32 +0000  
**To:** VARENNE, Benoit  
**Subject:** [EXT] FFeedback about WHO draft global strategy on oral health

Dear Dr. Varenne,

On behalf of the Iranian Association of Community Oral Health, I would like to thank you and your colleague at the WHO dental office for developing the WHO DRAFT GLOBAL STRATEGY ON ORAL HEALTH. We, members of IACOH, enthusiastically read the draft. It is such a precious document, and can be a milestone in the recent opportunity window for global oral health. There are many important valid points through the text that need to be echoed worldwide.

Just in order to suggest some issues to be reconsidered for finalizing the resolution, we would like to share the following ideas:

- We think ADDED SUGAR worth being addressed in the "Strategic Objectives" (S.O.) section. It could be added as a crucial area of interest in S.O. 1 and/or 5. Moreover, programs targeting control of sugar consumption at schools or workplaces could be included in S.O. 2 (p. 27) as midstream interventions.
- The importance of attention to SOCIAL MEDIA could be included in the 'Principle 6: Optimizing digital technologies for oral health'. Banning or controlling advertisement of sugar-added products could be included in S.O. 2 (p. 28).
- Except for paragraph no. 51, the resolution is almost silent about the dental profession. Having considered the possible convincing reasons for that, we think maybe adding some suggestions for redefinition of possible roles of dentists in healthcare system could be helpful. (Tobacco cessation and/or covid-19 vaccination are some possible examples).
- Supervised tooth-brushing could be suggested in S.O. 2 (p. 27) as an example of possibly effective midstream interventions.
- In addition to the emphasis on educating oral health providers and integrating them in primary healthcare team in S.O. 1 (p.25) and S.O. 3 (p.30), we suggest to highlight promoting oral health literacy of all health workers and medical and pharmacy students.
- Furthermore, reforms in dental care PAYMENT system may be included in the resolution- for example in Principle 1 or 4, or S.O. 2.

I appreciate the efforts made in developing this valuable resolution. Hope all these attempts result in substantial improvements in global oral health.

Kind regards.

Ali Kazemian

DDS, PhD.

President of Iranian Association of Community Oral Health

Chair and assistant professor at the Department of Community Oral Health,

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0098-9155033050

**To:**

VARENNE, Benoit



ISO/TC 106 – Dentistry

2021-08-26

**Comment on the DRAFT GLOBAL STRATEGY ON ORAL HEALTH from the International Standards Organization’s Technical Committee 106 – Dentistry (ISO TC 106 – Dentistry)**

The International Standards Organization’s Technical Committee 106 – Dentistry, very much welcomes the resolution of WHA 74.5 (2021) on Oral Health. In our view, this is an important step forward to improve oral health worldwide. Also, the DRAFT GLOBAL STRATEGY ON ORAL HEALTH is applauded and the following comments are meant to add supplementary information from our point of view.

**BACKGROUND:**

The dental health care systems around the world are very different. The DRAFT document mainly addresses the situation in Lower middle-income countries (LMIC). It is acceptable to draw attention to such areas of the world, as these countries suffer most from oral health inequities. However, this should be clearly stated at the beginning of the document, to gain broad acceptance. Furthermore, objectives relevant for all countries, such as rare diseases with orodental manifestations, should be included.

**ORAL HEALTH CARE SYSTEMS:**

In point 2 of the “Background”, reference is made to the Minamata Convention. This also is relevant for the present and future health care system, and it should be mentioned as a separate subparagraph after point # 14 that the WHA 74.5 (2021) has explicitly referred to an amalgam phase down which will have a distinct influence on the healthcare system of countries. Special emphasis has been placed on Amalgam separators in the Minamata Convention, which are of key importance for minimizing mercury efflux into the environment during amalgam removal. ISO has developed an international standard for such devices. So-called alternative materials, also mentioned in the Minamata Convention as an important aspect for reducing the need of mercury, have ISO standards available for quality control.

**VISION, GOAL, AND GUIDING PRINCIPLES:**

We believe the sequence of the “Guiding Principles” should be changed: Prevention should lead, as it is the most important principle for (largely) preventive diseases. The second, should be the integration of oral health “services” (this term should be included here) in primary health care. This should be followed by principle three: a public health approach to oral health, which is the method proposed to achieve the first two principles. The importance of fluoride preparation has been stressed and quality control for fluoride preparations through ISO Standards should be included in this document.

**STRATEGIC OBJECTIVES:**

Strategic Objective 5 (point 32): "Strategic objective 5 strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and problem description, rather than problem-solving." This is not correct: all research objectives are directed to problem solving, this is the basic philosophy of research. Instead, it should be stressed that research on oral public health should be further supported within Academia. It is obvious that the goals of this project cannot be reached without Academia. Therefore, a clear statement on the need of research and on the importance of Academia in this respect as an independent player in this scene is needed, which needs adequate funding. Also standards for quality control are based on sound technology and research.

Additionally, rare diseases with orodental manifestations should be included as part of the strategy. These are non-preventable and non-communicable diseases and more than 900 rare diseases present with orodental manifestations. Most of the affected patients suffer from diagnostic wandering to inappropriate to insufficient care. This is due to the lack of knowledge among health professionals, interactions to strengthen with dedicated reference centers and inappropriate recognition and funding for patient care by states and health systems. This leads indeed to inequity and additional handicap for patients.

#### ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT:

We believe that while not explicitly mentioned here, reference should be made to Academia, and the International Association for Dental Research as an important stakeholder, which is a liaison partner of WHO and which represents worldwide international and interdisciplinary research in the oral health field. Consideration should also be made to the Technical Committee 106: Dentistry of the International Standards Organization to be included as a stakeholder, who can efficiently contribute to the above-mentioned objectives as has been delineated above.

# THE *LANCET* COMMISSION ON ORAL HEALTH

## Response to WHO Consultation on the Draft Global Strategy on Oral Health

### *The Lancet Commission on Oral Health*

1. Following the publication of the *Lancet Oral Health Series* ([www.thelancet.com/series/oral-health](http://www.thelancet.com/series/oral-health)) and the growing recognition of the global public health importance of oral diseases, The *Lancet* established a new Commission on Oral Health in 2020.<sup>1</sup> Twenty-seven leading researchers, policy makers, civil society advocates and clinicians from 16 diverse countries have been appointed as Commissioners to work together to raise the political and policy profile of oral health and to make recommendations on policy and oral health system reform to improve population oral health and reduce oral health inequalities.
2. As a Commission we are delighted to have this opportunity to comment on the *WHO Draft Global Strategy on Oral Health*. We are very pleased to see that after many years of neglect, oral health is now becoming a priority at WHO and welcome its inclusion within the broader noncommunicable disease (NCD) and Universal Health Coverage (UHC) agendas. In our response we will first highlight the positive features of the draft *Strategy* and then will outline some general suggestions on changes we recommend and then finally, we will give specific comments on each section of the document.

### *Positive feedback on draft*

3. Overall, the document provides a **compelling case for strategic action** on global oral health. We very much welcome the **strong public health approach** that has been adopted across the different sections of the draft document.
4. In the *Global Overview of Oral Health*, it is good to see a **holistic definition of oral health** presented that recognises the **essential core functions** that are encompassed within oral health and recognition that oral health is **integral to overall health and**

<sup>1</sup> [In order to avoid a potential conflict of interest Dr Varenne \(WHO\) who is also a member of the Commission, was not part of developing this response to the public consultation process.](#)

**well-being across the life course.** We are also very pleased to see recognition placed on the **wider social and economic burden of oral diseases** and the need to **tackle oral health inequalities**. We commend the emphasis placed on highlighting the underlying importance of **the commercial determinants** and **common risk factors** of oral diseases and, in particular, the need to **reduce free sugar intakes**. We also support the recognition placed on highlighting the need for **reform of oral health care systems** and endorse the importance of ensuring that oral health services are **responsive to population oral health needs** and are **better integrated with general health care** as part of **universal health coverage**. We entirely endorse the need to train a **broader dental team** including **community oral health workers and a range of mid-level providers** rather than **only relying on training highly specialised dentists**.

5. The *Vision and Goal* presented in the draft *Strategy* provide a useful and innovative forward view for oral health, and the *Guiding Principles* outline an ambitious set of **underlying principles to guide future strategic action** at the national level. We particularly commend the emphasis placed on **public health approaches, integration** and **developing a global oral health workforce** that is **responsive to population oral health needs**.

6. The *Strategic Objectives* highlight a useful and ambitious set of priorities including **governance, health promotion and prevention, primary oral health care, information systems and research**. These are all fundamentally important priorities that need to be addressed at a national level. We also welcome that an overview has been presented on the **role of WHO, member states, international partners, civil society and the private sector** in moving the oral health agenda forwards in a meaningful and sustained fashion. Only through true **partnership working across sectors and agencies** can change be achieved. We particularly welcome the importance placed on the important role that **civil society** can play in **advocating policy development**. Unlike other areas of health such as maternity care, mental health, and sexual health, civil society organisations and patient groups have been largely **ignored or excluded from oral health policy development**. It is essential that the population and patients are given more of an **opportunity to voice their views** on how oral health services and policies are developed in the future.

### **General suggestions and recommendations**

#### *7. Greater recognition needed on the social determinants of oral diseases*

We are concerned that insufficient emphasis has been placed on the **social determinants of oral diseases** specifically in relation to **oral health inequalities**. In paragraphs 8 and 9 a brief sentence highlighting the importance of social determinants would link well with the *Strategic Objective 2 on Oral Health Promotion and Oral Disease Prevention* (paragraph 27 and 28).

#### *8. Bolder approach needed on commercial determinants*

Although we are delighted that the **commercial determinants** of oral diseases have been recognised, we recommend that stronger and clearer language is used to highlight **commercial activities** used to undermine efforts to **reduce free sugars** consumption.

We also suggest that any mention of 'unhealthy foods' be replaced with explicit reference to 'free sugars'. (See below further specific suggestions on text in relation to free sugars).

#### *9. A more balanced emphasis needed on Universal Health Coverage*

Although we recognise the strategic importance of **Universal Health Coverage** within WHO, we are concerned that **too much emphasis has been placed on UHC** in the draft strategy, particularly in relation to the *Vision, Goal and Guiding Principles*. We note that in the World Health Assembly Oral Health Resolution **eight priorities were identified** with UHC being highlighted as only one of these. Presenting the *Vision and Goal* only in terms of UHC **risks this Strategy gaining less traction** with national governments who do not recognise UHC as a top priority. Placing more emphasis on the **Sustainable Development Goals** (eg SDG 3, SDG 5, SDG 6 and SDG 10) in the *Vision, Goal and Guiding Principles* section could help strengthen the potential buy-in from a wider range of member states and also help to locate the *Strategy* within broader policy developments. We are also concerned that improving access to oral health services alone, although very important, will **not have much impact on tackling oral health inequalities** in the **absence of upstream public policies addressing the social and commercial determinants** of oral diseases.

We also note that throughout the draft strategy **various different terms are used interchangeably to describe oral health services** eg 'basic oral health services' (para 20), 'essential oral health care' (para 21), 'primary oral health care' (para 29) and 'basic oral health care' (para 29). It is unclear if these different terms are being used for a specific purpose or not. The **use of precise and consistent terminology** might help to avoid confusion.

#### *10. More emphasis needed on ageing population*

Although a life-course approach is part of the *Guiding Principles* we are concerned that **insufficient focus** has been placed on the **challenges and potential opportunities** presented by **ageing populations**. In many parts of the world including WPRO, EURO and PAHO WHO regions **ageing is a critical public health and social issue**. Moreover, the number of individuals 60 years and older is **growing fastest in LMIC**. Oral health care systems and policy frameworks therefore **need to address the oral health needs and challenges of ageing populations**. The *Strategic Objectives* in this *Strategy* therefore needs to highlight this important issue.

#### *11. Expansion of role of civil society and community action*

Although we very much welcome the inclusion of **Civil Society** in the final sections of the *Strategy*, we would like to see greater emphasis placed throughout the document on the need and value of **actively engaging with civil society organisations, community groups and patient representatives** in the development and reform of oral health services and policy frameworks. Actively engaging in **true partnership** with civil and community organisations and **co-designing/co-producing new models of care** provide an ideal opportunity to develop **more responsive and sustainable solutions**.

## Specific suggestions/edits

Section/Topic	Para	Specific comments
Global Overview of Oral Health	6	The impact of oral diseases has been shown to have wider impacts on the family, community and health care system. We suggest adding the following text to the first sentence of para 6: <i>'.....are severe and have the potential to affect families, communities, and the wider health care system.'</i>
	7	Socio-economic inequalities in oral health are socially graded across the social hierarchy in a consistent stepwise fashion. The social gradient has profound implications for policy and highlights the limitation of only adopting a high-risk approach to reduce inequalities. Universal approaches that are responsive to levels of need (proportionate universalism) offer the greatest potential to reduce health inequalities. We recommend adding 'social gradient' to the end of the first sentence of para 7 to highlight this issue: <i>'.....oral diseases and conditions (social gradient).'</i> In addition to socio-economic inequalities it is also important to stress the ethnic inequalities in oral health that exist across the globe. We therefore recommend adding the following text to para 7: <i>'.....prisoners, those from ethnic minorities and/or other socially marginalized groups.'</i>
Commercial determinants and risk factors of oral health	8	We strongly recommend that the social determinants of oral health are highlighted in this section. This would link to the later text in paras 27 and 28. We suggest that the title of this section is changed to: <b>'Social and Commercial Determinants and Risk Factors of Oral Health'</b> . We also suggest that the following text is added to para 8: <i>'Oral diseases and oral health inequalities are directly influenced by social and commercial determinants. The commercial determinants are strategies and approaches.....'</i>
Oral Health Promotion and Oral Disease Prevention	10	We welcome the importance of adopting upstream interventions and suggest that this text could be slightly strengthened with the following minor edits to the second sentence in paragraph 10: <i>'..... (such as policy and regulation) are usually more cost-effective and have a high population reach and greater impact on inequalities.'</i>
	12	It would be useful to specifically mention water fluoridation in para 12 and to highlight the inequalities agenda. We therefore suggest the following minor edits:

			‘....such as fluoridation of public water supplies and other community-based methods....., particularly those living in LMICs or from socially marginalized groups.
	Oral Health Care Systems	13	One of the major challenges of oral health care systems globally is the fact that the majority of providers (80-90%) are private practitioners whom Governments have a limited ability to control/influence. We recommend that this point is highlighted in para 13 as follows: ‘Typically, the oral health care system is inadequately funded, <b>mainly delivered by independent private providers</b> , highly specialized .....
<b>Vision, Goal and Guiding Principles</b>	Vision	17	As highlighted above in our general comments (see point 9 above) we are concerned that too much emphasis is placed on UHC in this vision statement. Although oral health promotion is mentioned we are concerned that many people may interpret this vision statement solely in terms of improving access to oral health services, which alone will not ‘enable all people to enjoy the highest attainable state of oral health.’ We therefore recommend that specific mention is also made of public health policy measures to address the social and commercial determinants of oral health.
<b>Guiding Principles</b>	Principle 1: A public health approach to oral health	19	To strengthen this important first principle we recommend the addition of the following text in the third sentence: ‘....expanded upstream actions <b>on social and commercial determinants</b> involving a broad.....’
	Principle 2: Integration of oral health in primary health care		The compartmentalisation and isolation of oral health is clearly a major challenge that needs to be addressed urgently. Although we fully acknowledge the importance of integrating oral health in primary health care, the integration agenda has a far broader and more comprehensive scope beyond the confines of primary health care. We therefore recommend that this important principle of integration is broadened in focus to highlight both vertical and horizontal aspects and also highlights opportunities for integration of oral health in various policy frameworks.
	Principle 4: People-centred oral health care	22	An important but missing aspect of ‘people-centred oral health care’ is ‘cultural competency’ - providing high quality care to diverse communities from different cultural backgrounds. We therefore recommend the following edit to the opening sentence of para 22: ‘People-centred and <b>culturally competent</b> oral health care.....’
<b>Strategic Objectives</b>	Objective 2: Oral health promotion and oral disease prevention	Heading	We recommend a minor edit in the title text of Objective 2 as follows: ‘....Enable all people to achieve the best possible oral health and <b>address the social and commercial determinants</b> ....’
		27	Amongst many of our clinical community confusion often remains over the precise meaning of ‘oral

		28	<p>health promotion' and its relationship with 'oral health education and prevention'. We recommend that some minor edits are made to para 27 to avoid creating further confusion on this point:</p> <p>'At the downstream level, <b>oral health education</b> supports the development.....'</p>
		28	<p>Similar minor edits are also suggested for para 28:</p> <p><b>'Oral health promotion interventions target social and commercial determinants and risk factors of oral diseases and other oral conditions'</b></p>
		28	<p>In line with WHO guidelines on sugars we recommend editing the text in para 28 as follows:</p> <p><b>'.....harmful alcohol use and <b>limiting free sugars intake to less than 10% of total energy and ideally even further to less than 5%</b>, as well as the <b>encouragement</b> of use of fluorides for prevention of dental caries.'</b></p>
Objective 3: Primary Oral Health Care		30	<p>It is unclear what exactly is meant in para 30 in terms of '...supporting general health check-ups.'</p>
		30	<p>Does this mean that oral health providers should undertake 'general health check ups' or are they meant to be supporting other health workers, if so, how? The evidence base for both these options is perhaps rather limited. We suggest deleting these words from the sentence.</p>
		30	<p>To highlight the importance of essential medicines we recommend that the final sentence in para 30 should become a separate point.</p>
Objective 4: Oral health information systems		31	<p>Very often health surveillance and information systems do not include marginalized and disadvantaged communities in their data collection processes. We therefore suggest a minor edit to para 31:</p>
		31	<p><b>'Strategic objective 4 involves developing more efficient, effective and <b>inclusive</b> integrated information systems for.....'</b></p>
Objective 5: Oral health research agenda		32	<p>We welcome the emphasis placed on strengthening public health research but recommend the following additional elements to para 32:</p>
		32	<p>'The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, <b>implementation sciences</b>, workforce models, digital technologies, and the public health aspects of oral diseases and <b>inequalities</b>. <b>Research priorities include upstream integrated interventions</b>, primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.'</p>
Role of Member States, Partners and Secretariat		Heading	<p>The term 'secretariat' is used, but in the operational paragraphs only WHO is mentioned. Suggest more consistent terminology is used.</p>
WHO		38	<p>The mention of the 'institution' is confusing – we assume this refers to the WHO Global Health</p>

		Observatory. If it is another, new institution, it would require more details.
Member States	39	To highlight the importance of understanding community oral health needs we recommend a minor edit to para 39 as follows: '...They should secure appropriate oral health budgets based on the assessment of community oral health needs, intervention costing and investment cases to achieve universal oral health coverage.'
	42	We recommend strengthening and expanding the text on actions needed to reduce free sugar intakes. Our edits are based on text from the WHO Fact Sheet on Sugars and Dental Caries. ( <a href="https://www.who.int/news-room/fact-sheets/detail/sugars-and-dental-caries">https://www.who.int/news-room/fact-sheets/detail/sugars-and-dental-caries</a> )
		Based upon WHO FCTC guidelines, ( <a href="https://www.who.int/fctc/guidelines/article_5_3.pdf">https://www.who.int/fctc/guidelines/article_5_3.pdf</a> ) we also suggest adding some text to alert Member States on the commercial activities that may be used to undermine policies to reduce sugars intakes.
		Our suggested revised text for para 42 is: 'Member States can address the determinants of oral health and risk factors of oral diseases and conditions by implementing key policies including: taxation of sugar-sweetened beverages and foods with high free sugar content; implementing clear nutrition labeling, including the information on sugars contained in a product; regulating all forms of marketing and advertising of food and beverages high in free sugars to children; improving the food environment in public institutions, particularly schools, through regulating sales of foods and beverages high in free sugars; and prioritizing awareness and access to clean water as a drink that is 'safe for teeth'. Member states should be alert to commercial and other vested interests activities to undermine or subvert efforts to control free sugars consumption and should act to protect these policies from undue influence. Other important strategies include strengthening health-promoting conditions in key settings; supporting legislation to increase the affordability of quality, fluoride toothpaste; and advocating for its recognition as an essential health product within the national list of essential medicines.'
International partners	45	Who exactly are 'international partners'? The term is not clearly defined nor are examples of organisations provided. We think that the family of UN organizations should be targeted, particularly UNICEF as the agency in charge of child health and welfare. Development partners such as government development agencies (USAID, GIZ, etc) should be mentioned as their bi-and multilateral support to health is an important contribution to overall development, even though their investment in NCDs is still below target.

Civil society	48	As mentioned in our general recommendations (see point 11 above) although we are very pleased to see the importance of civil society in the draft strategy we feel that para 48 could be strengthened to highlight the opportunities for intervention co-design/co-production. We therefore recommend the addition of the following final sentence to para 48: <i>'Actively engaging in true partnership with civil and community organisations and co-designing/co-producing more innovative new approaches to oral health care provide an ideal opportunity to develop more responsive and sustainable models of care.'</i>
Private sector	49	We suggest moving this opening sentence to further down in the section.
	50	This is a very important point but the current text needs to be strengthened and better aligned with para 42. We also suggest separating the food/beverage industries from other private sector stakeholders that are part of oral healthcare.
	51	The use of the term 'public-private partnership' is confusing. This term is commonly used in the context of the public sector working with private commercial entities. When it comes to private dental practitioners supporting national governments in the implementation of the strategy, perhaps a better term to use would be 'collaborative working'.

### 11. Conclusions

In conclusion we would like to congratulate WHO for their excellent *draft Global Strategy on Oral Health*. The strategy document outlines an ambitious and bold vision for global oral health and we hope our comments are helpful in finalizing the document. The *Lancet* Commission on Oral Health looks forward to engaging and working with WHO in the coming months and years in moving the oral health agenda forwards.

Please contact Professor Richard G Watt ([r.watt@ucl.ac.uk](mailto:r.watt@ucl.ac.uk)) if you require any additional information on this *Lancet* Commission response. Further information on the *Lancet* Commission on Oral Health is available at: [www.ucl.ac.uk/epidemiology-and-public-health/research/dental-public-health/lancet-commission-oral-health](http://www.ucl.ac.uk/epidemiology-and-public-health/research/dental-public-health/lancet-commission-oral-health).



## **Feedback from MSF on WHO consultation on the draft global strategy on oral health**

17 September 2021

### **OVERALL COMMENTS**

Médecins Sans Frontières (MSF) welcomes the draft global strategy on oral health. It recognises that **the burden of oral diseases disproportionately affects the most marginalised and vulnerable communities**. We are particularly glad to read that efforts will be intensified to control noma.

**Noma is a preventable and treatable disease** and should not exist anymore. If cases are detected early, it can be treated easily with a short course of antibiotics and wound dressing. Noma can also be prevented when communities have better access to a balanced diet, good oral hygiene, health care and routine vaccination.

**The oral health strategy represents a historic opportunity to make change happen for people at risk of, affected by, or who have survived noma. Additional resources are required to end the neglect of noma and facilitate the integration of noma prevention and treatment activities into existing public health programmes.**

MSF recommends that the World Health Organization recognise noma as **a neglected tropical disease (NTD)** of highest importance.

## GLOBAL OVERVIEW OF ORAL HEALTH

### Oral Disease Burden

#### Suggested additions

5. Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375 000 new cases and nearly 180 000 deaths in 2020. Noma is a **rapidly progressing** necrotizing disease that is a marker of extreme poverty; it starts in the mouth and is fatal for as much as 90% of **people** affected **with one model estimating 140,000 new cases annually, noma is not contagious**. Cleft lip and palate, the most common craniofacial birth defects, have a prevalence of approximately 1 in 1500 births. Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting over one billion people.

#### Comment

We suggest specifying that noma is a 'rapidly progressing' disease because time management is crucial in the treatment of its early stages.<sup>i</sup> While fewer cases of adults with acute noma have been reported in scientific literature, we strongly recommend writing 'people' instead of 'children' to avoid framing it as a paediatric disease. Including its estimated global incidence<sup>ii</sup> gives a sense of the burden noma poses and specifying that the disease is not contagious can contribute to tackling misconceptions and stigmatisation.

### Social and Economic Costs of Poor Oral Health

#### Suggested additions

6. The personal consequences of untreated oral diseases and conditions – including physical symptoms, functional limitations, **stigmatization, discrimination**, and detrimental impacts on emotional and social well-being, **and the ability to pursue a dignified livelihood** – are severe. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burdens. Worldwide, in 2015 oral diseases and conditions accounted for US\$357 billion in direct costs and US\$188 billion in indirect costs, with large differences between high-, middle- and low-income countries.

#### Comment

Studies have shown that noma survivors face stigmatisation and discrimination with excessive questions about their physical appearance, a lack of access to education, difficulties finding jobs, limited marital prospects, and bullying.<sup>iii</sup> This makes the direct and indirect costs of noma even higher given the inability of affected people to contribute to and participate in their communities, and the lack of productivity caused by their exclusion from society.

### Commercial Determinants and Risk Factors of Oral Health

#### Suggested additions

9. Oral diseases and conditions share modifiable risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease and diabetes. These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the

human papilloma virus for oropharyngeal cancers. Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury. **The aetiology of noma is unknown but its** risk factors include malnutrition, coinfections, **vaccine preventable comorbidities**, poor oral hygiene and poor living conditions.

#### Comment

Mentioning the knowledge gaps in terms of aetiology is key as the topic has been neglected by research but could provide important insights on prevention, treatment, and elimination of the disease. Specifying ‘vaccine preventable comorbidities’ as one of the risk factors highlights the potential to control the disease through existing public health programmes.

### **Oral Health Promotion and Oral Disease Prevention**

#### Suggested addition

10. Only rarely have oral health promotion and oral disease prevention efforts targeted the social and commercial determinants of oral health at the population level. However, **cross-cutting** initiatives that tackle upstream determinants (such as policy and regulation) can be cost-effective and have a high population reach and impact. Moreover, oral health promotion and oral disease prevention typically are not integrated into other noncommunicable disease programmes that share major common risk factors and social determinants.

#### Comment

There are numerous cross-cutting initiatives that should be incorporated into existing health structures and health systems to strengthen efforts to control noma. This includes integration with primary health care assessments, malnutrition surveys, vaccination campaigns and existing strategies that are implemented to control neglected tropical diseases. In addition, cross-cutting initiatives to ensure adequate nutrition, improved access to health care and socioeconomic status will eliminate the underlying determinants of noma and several other diseases.

#### Addition of a specific paragraph on noma

**As noma is easily preventable and reversible in its early stages, the costs of delayed treatment, including surgery and rehabilitation, are significantly higher than its prevention. Efforts at the community level to scale up preventive activities and detect people with acute noma, as well as noma survivors, are crucial. Noma is neglected in the global health community. There is a lack of knowledge among health care workers, even in countries with a high burden of the disease.**

#### Comment

Highlighting specific challenges of health promotion and prevention of noma is essential when the nature of the disease itself – rapidly progressing, causing high mortality and morbidity, disfiguring its rare survivors and leading to stigmatisation and discrimination – is the major obstacle to control, eliminate, and eradicate it. However, its prevention can easily be integrated with programmes targeting malnutrition, vaccination and oral hygiene and improved by implementing systematic oral screenings for people at risk and using monitoring tools like the WHO-approved District Health Information Systems.



## VISION, GOAL, AND GUIDING PRINCIPLES

### Vision

#### Suggested addition

17. Universal oral health coverage means that every individual has access to essential, quality health services that respond to their needs and which they can use without suffering financial hardship. These include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives. Achieving the highest attainable standard of oral health is a fundamental right of every human being. **Noma is a marker of oral health inequalities, and its elimination is an indicator for the realisation of human rights and Sustainable Development Goals.**

#### Comment

MSF welcomes the recognition of oral health as a fundamental and universal right. The close interconnections with other human rights and Sustainable Development Goals can make the elimination of noma an indicator of the strategy's success. Human rights at stake for individuals at risk of or with noma intersects with the rights to food, water and sanitation, health, adequate housing, education, life, freedom of expression, the right of children with disabilities to a full and decent life; and the right to equality and non-discrimination<sup>iv</sup>. On the same note, the elimination of noma intersects across the realisation of the Sustainable Development Goals, including SDG 1 (No poverty), SDG 2 (Zero hunger), SDG 3 (Good health and well-being), SDG 6 (Clean water and sanitation).

### Goal

#### Suggested addition

The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030. **In the particular case of noma, a global response, is needed aimed at the elimination and eradication of the disease.**

#### Comment

Noma primarily affects populations living in tropical and sub-tropical areas, specifically low-income settings in Africa and Asia, though cases have also recently been reported among vulnerable populations in other regions (Middle East, South America, North America and Europe). A global and immediate response is needed to identify people at risk of, affected by, or who have survived the disease.

### Guiding Principles

#### Suggested additions



20. Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable **and neglected tropical** disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, **reducing mortality and morbidity of noma** and more equitable access to comprehensive, quality health care.

Comment

Integration with existing neglected tropical disease programmes should be mentioned in the guiding principles as its potential benefits can be life-saving and limit the irreversible, life-threatening, tissue damage caused by noma in its later stages.

## STRATEGIC OBJECTIVES

**Strategic Objective 1: Oral Health Governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector**

Suggested addition

25. Strategic objective 1 seeks recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national noncommunicable disease, **neglected tropical disease** and universal health coverage agendas. Increased political and resource commitment to oral health are vital at the national and subnational levels, as is reform of health and education systems.

Comment

Recognition and integration with national neglected tropical disease agendas should be mentioned in the strategic objectives as their benefits can be life-saving and limit the irreversible, life-threatening, tissue damage caused by noma in its later stages.

Suggested additions

26. Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease, **neglected tropical disease** structures and other relevant public health services. Sustainable partnerships within and outside of the health sector, and engagement with communities, civil society and the private sector, are essential to mobilize resources and address the social and commercial determinants of oral health. **To help bridge the knowledge gap on noma and improve the early detection, diagnosis and management of cases at the primary care level, national noma control programmes should be implemented or strengthened in countries affected by the disease.**

Comment

The implementation of National Noma Control Programmes in ten priority countries since 2013 and the 2020 'Step-by-step guide to develop national action plans for noma prevention



and control' have shown that dedicated focal points at country level significantly strengthen noma prevention and control activities.<sup>v</sup>

**Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions**

Suggested addition

28. Prevention efforts target key risk factors and social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable **and neglected tropical** disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries.

Comment

Integration with neglected tropical disease prevention efforts should be mentioned in the strategic objectives as their benefits can be life-saving and limit the irreversible, life-threatening, tissue damage caused by noma in its later stages.

**Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health**

Suggested addition

32. Strategic objective 5 strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and problem description, rather than problem-solving. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions. **Noma research should address key areas including disease burden and distribution, pathogenesis and the efficacy of public health interventions.**

Comment

Mentioning the knowledge gaps is key as the topic has been neglected by research, but could provide important insights on prevention, treatment, and elimination of the disease.

**ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT**

**WHO**

Suggested addition

36. WHO will continue to update technical guidance to ensure safe and uninterrupted dental care, including during and after the COVID-19 pandemic and other health emergencies. WHO will, in collaboration with the United Nations Environment Programme, develop technical



guidance on environmentally-friendly and less- invasive dentistry. WHO will also consider the classification of noma within the road map for neglected tropical diseases 2021–2030 **and its inclusion in the WHO neglected tropical disease list with the aim of facilitating the integration of activities relating to noma with existing public health programmes.**

#### Comment

The oral health strategy represents a historic opportunity to make change happen for people at risk of, affected by, or who have survived noma. Additional resources are required to end the neglect of noma by raising awareness and facilitating the integration of noma prevention and treatment activities into existing public health programmes. MSF recommends that the World Health Organization recognise noma as a neglected tropical disease (NTD) of highest importance.

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<sup>i</sup> World Health Organization Regional Office for Africa. Information brochure for early detection and management of noma. 2017. Available from <https://apps.who.int/iris/handle/10665/254579>

<sup>ii</sup> World Health Organization. The World health report : 1998 : Life in the 21st century : a vision for all : report of the Director-General. World Health Organization. Available from <https://apps.who.int/iris/handle/10665/42065>

<sup>iii</sup> Wali IM, Regmi K. People living with facial disfigurement after having had noma disease: A systematic review of the literature. *J Health Psychol.* 2016;September(22):1243–55. DOI: [10.1177/1359105315624751](https://doi.org/10.1177/1359105315624751).

<sup>iv</sup> Study of the Human Rights Council Advisory Committee on severe malnutrition and childhood diseases with children affected by noma as an example. Human Rights Council Advisory Committee. 19/7 The right to food. UN. Doc. A/HRC/RES/19/7 1, 50. Available from <https://daccess-ods.un.org/TMP/3896238.80386353.html>

<sup>v</sup> World Health Organisation (WHO), World Health Organization. A step-by-step guide to develop national action plans for noma prevention and control in priority countries. 2020. Available from <https://apps.who.int/iris/handle/10665/337203>

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

**Organisation Name:** National Oral Health Promotion Steering Group, Australia

**Date:** 14/09/2021

**Person(s) Involved in Contribution:**  
Health Promotion Representatives from each State and Jurisdiction across Australia

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For consultation details on the WHO website please click [here](#)

Key Areas of the Draft Global Strategy for Oral Health	Stakeholder Comment
The vision of this strategy is universal oral health coverage for all people by 2030.	Yes, we support this vision
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	<p>Yes, we agree.</p> <p>We support the inclusion of oral health promotion and a focus on reducing oral health inequalities as important aspects to improving overall oral health.</p>
GUIDING PRINCIPLES – PAGE 4 of Draft Strategy	
<p><i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	<p>Yes, we agree.</p> <p>It is time for oral health to be included as a key component of public health strategies.</p>
<p><i>Principle 2: Integration of oral health in primary health care</i> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary</p>	<p>Yes, we agree.</p> <p>Without integration of oral health into general health strategies, general health and public health strategies will be undermined by the impact of poor oral health.</p>

<p>health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Yes, we agree.</p> <p>Optimal utilisation of the oral health workforce is critical for achieving universal oral health coverage.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	<p>Yes, we agree.</p> <p>Universal oral health will not be achievable without adopting a consumer-centred approach which caters for individual needs and diverse contexts.</p>
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects</p>	<p>Yes, we agree.</p>

<p>may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Tailored, age-appropriate strategies and interventions are the most effective way to fully maximise resource and achieve outcomes</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b></p> <p>- Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>Yes, we agree.</p> <p>Telehealth and digital technologies provide novel pathways to addressing oral health needs.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>Yes, we fully support this.</p> <p>Oral health needs to be included in the general health agenda</p>
<p><i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>Yes, we agree.</p> <p>Treatment and reducing disease burden is not possible without a promotion and prevention focus</p>
<p><i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>Yes, we agree.</p>

<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>Yes, we agree.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>Yes, we agree.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.</p>	
<p><b>Comment:</b>  The National Oral Health Promotion Steering Group is committed to supporting any strategies aimed at improving oral health outcomes.</p>	

## NCD Alliance Advocacy Briefing

### WHO NCD consultations, September 2021

This document covers a summary of the contributions of civil society organisations within the global NCD movement to the ongoing web-based consultations in preparation for the 150th session of the WHO Executive Board ([EB150](#)) and the 75th World Health Assembly (WHA75).

The document also outlines NCD Alliance's response to the discussion paper on the development of an Implementation Roadmap 2023-2030 for the prevention and control of NCDs.

#### **EB150 agenda items, consultations, and respondents**

Issue	Consultation deadline	Consultation documents	Response submitted by NCD civil society organisations:
1. Development of an implementation roadmap 2023-2030 for the global action plan for the prevention and control of NCDs 2013-2030. Decision WHA74(10)	17 Sept	<a href="#">WHO Discussion paper for an open discussion forum from 6 to 17 September 2021</a>  <a href="#">Implementation roadmap 2023-2030 for the global action plan (who.int)</a>	NCDA response - please see below.
2. Diabetes – recommendations for global targets and monitoring Resolution WHA74.4	17 Sept	<a href="#">Recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes (who.int)</a>	<a href="#">IDF</a>  <a href="#">International Society of Nephrology</a>
3. Oral Health – Global Strategy Resolution WHA74.5	17 Sept	<a href="#">Global strategy on tackling oral diseases (who.int)</a>	<a href="https://www.fdiworlddental.org/sites/default/files/2021-09/FDI_Submission_WHO_Draft_Global_Strategy_Oral_Diseases_FINAL_web.pdf">https://www.fdiworlddental.org/sites/default/files/2021-09/FDI_Submission_WHO_Draft_Global_Strategy_Oral_Diseases_FINAL_web.pdf</a>
4. NCDs in humanitarian emergencies – recommendations for health systems Annex 9 document EB148/7, resolution A/RES/73/2	No CS consultation	Not yet available: Recommendations on resilient health systems and health services and infrastructure to treat people living with NCDs and to prevent and control their risk factors in humanitarian emergencies	[Civil society request for consultation at informal meeting on 3 September]
5. Neurology and Epilepsy – Global Action Plan Resolution WHA73.10	15 Aug	<a href="#">Discussion-paper_epilepsy-and-other-neurological-disorders_050321.pdf (who.int)</a>	OneNeurology initiative, including EFNA, WSO, ADI <a href="#">OneNeurology-Partnership_synopsised-comments-on-the-draft-GAP.pdf</a>
6. Alcohol – Global Action Plan Decision EB146(14)	3 Sept	<a href="#">Global alcohol action plan: First draft (July version) (who.int)</a>	NCDA: <a href="#">New submission - WHO Global Strategy on the Harmful Use of Alcohol (GAS)   NCD Alliance</a>  <a href="#">Movendi International</a> <a href="#">Global Alcohol Policy Alliance</a>

			<a href="#">World Cancer Research Fund Intl, McCabe Centre World Heart Federation, TGI</a>
7. Obesity – recommendations for global targets (expected resolution) Resolution WHA74.4	17 Sept	<a href="#">Draft recommendations for the prevention and management of obesity over the life course, including potential targets (who.int)</a>	World Obesity Federation: <a href="#">WOF comments on WHO obesity recommendations 07092021.pdf</a>
8. Global Coordination Mechanism – draft workplan Decision WHA74(11)	17 Sept	<a href="#">Web-Based Consultation- GCM/NCD Workplan 2022-2025 (who.int)</a>	NCDA

### **NCDA comment on the Implementation Roadmap and NCD initiatives**

We welcome the initiative to develop an implementation roadmap for the final years of the Global Action Plan on NCDs. In particular, it is essential to extend the 2025 targets through to 2030 to support Member States to implement priority measures according to needs of their populations of people living with NCDs and at risk of NCDs, and to tailor to their local context – mobilise and optimize the allocation of resources.

#### **Key messages - Cross-cutting priorities across NCD initiatives and the implementation roadmap**

- 1. Strengthen the case for urgent action and investment in light of lessons learned during the COVID-19 pandemic - link NCDs to health security, health systems resilience and economic stability**

Please see the evidence collected and recommendations presented here: [Resilience and recovery from COVID-19 | NCD Alliance](#)

- 2. Demonstrate that initiatives are mutually reinforcing and quantify the co-benefits across all NCDs beyond the '4x4'**

As an overarching comment, It is important to clearly demonstrate to governments how the current suite of NCD initiatives, strategies, action plans and recommendations are inter-related, consistent and mutually reinforcing, e.g.

- How do all of the initiatives in development, including the implementation roadmap, deliver on the mandate from the UN High Level meeting (2018) political declaration to shift to a '5x5' agenda including mental health, neurological disorders and measures to reduce premature mortality from air pollution?
- How will the Alcohol Action Plan deliver quantifiable, cost-effective benefits across Cancer, CVD, diabetes, oral health, obesity, neurology and mental health?
- The necessity of increased policy action on diet and particularly sugar across diabetes, oral health and obesity – and many associated complications and comorbidities, e.g. CVD, stroke, chronic kidney disease, liver disease (e.g. NAFLD), diabetic retinopathy, dementia, etc.
- How will the targets proposed for diabetes and obesity deliver benefits across other NCDs and mental health – by considering comorbidities and complications – as well as benefits to

reducing vulnerability to COVID-19 and future epidemics. We have seen that diabetes and obesity are common comorbidities of COVID-19 worldwide – and that people living with multiple chronic conditions are at even higher risk.

- How will the future Global strategy on tackling oral diseases as part of the NCD and UHC responses contribute to the development of an NCD implementation roadmap? The current draft aims to address common NCD risk factors, as many other NCD documents, and should be part of the “ALIGN” section.

### **3. Put people living with NCDs at the heart of all NCD initiatives**

NCDA very much welcomes the approach deployed by WHO to the development of the Global Diabetes Compact to engage people living with diabetes. We call for this approach to be replicated across the other initiatives under consideration and offer support to connect with people with lived experience, e.g. neurology, obesity, oral health and alcohol-related conditions. Please also note in this context, that importance of a coherent approach with the commitment to engage people living with disabilities was also highlighted in the resolution on follow up to the Disability Action Plan adopted at WHA74.

We invite WHO to consider endorsing the principles and core strategies of the Global Charter of Meaningful Involvement of People Living with NCDs: [Global Charter | Our Views, Our Voices \(ourviewsourvoices.org\)](https://ourviewsourvoices.org/)

### **4. Clearly identify barriers to NCD policy adoption and implementation**

The discussion paper on the implementation roadmap mentioned critical barriers to uptake of recommended, cost-effective NCD policies and interventions. Can these barriers be articulated by WHO? NCD Alliance published an assessment of the barriers to NCD policy action, here: [Bridging the Gap on NCDs: From global promises to local progress - Discussion paper | NCD Alliance](https://ncdalliance.org/resource/bridging-the-gap-on-ncds-from-global-promises-to-local-progress/)

### **5. Protect against harmful industry interference (alcohol, ultra-processed food and drinks, etc.)**

A major barrier to adoption and implementation of recommended NCD policy interventions, particularly with regard to prevention measures, is interference by health harming industries. An independent academic assessment has collected over 800 examples from all regions in the context of tactics adopted by industries to exploit policy influence during the COVID-19 pandemic, where the vast majority of examples reported pertain to the (junk) food and alcohol industries: [Signalling Virtue, Promoting Harm - Unhealthy commodity industries and COVID-19 | NCD Alliance](https://ncdalliance.org/resource/signalling-virtue-promoting-harm-unhealthy-commodity-industries-and-covid-19/)

NCD Alliance has noted increasing calls to WHO over recent years from member states, to develop guidance to identify, prevent and mitigate conflicts of interest and interference from health harming industries in policy-making progresses. We call on WHO to provide this much-needed guidance to governments and stand ready to support with civil society experience and best practice examples.

### **6. Expand and strengthen the 'Best Buys' and recommended interventions for both NCD prevention and care**

We fully support a mandate to review and strengthen Appendix 3 to the Global Action Plan, in addition to developing recommended interventions for Oral Health. We call on WHO to improve the cost-benefit methodology to strengthen the investment case, including assessment of the costs of complications and multi-morbidity beyond the ‘5x5’ and the economic value of addressing NCDs to improve resilience to

epidemics. We also call on WHO to urgently update the recommended interventions with measures to reduce air pollution and to improve mental health. Appendix 3 should be continually reviewed to keep pace with the evidence base of impactful and cost-effective policy interventions.

**7. Set clear, measurable, time bound, feasible & ambitious global targets and ensure this is supported with improved monitoring, reporting and accountability, at global and national levels, and technical guidance and support in that regard at regional and national level.**

Accountability remains a significant gap in the NCD response, as identified here: [Bridging the Gap on NCDs: From global promises to local progress - Discussion paper | NCD Alliance](#) WHO should work more closely with other global health institutions, notably IHME, to make data publicly available and closer to real-time, to allow for independent analysis and accountability, e.g. the NCD Countdown 2030 collaboration and similar exercises at regional and national levels. We ask WHO to consider creating a mechanism to formally submit civil society shadow reports, as has been successful at catalysing policy action in the field of HIV/AIDS.

**8. Demonstrate how the implementation roadmap relates to the draft Roadmap on Building an NCD ready workforce**

We welcome the workforce considerations and potential targets reflected in the Obesity proposal and request that an assessment of workforce needs consistently reflected across the other NCD proposals, in order to support member states in their decision-making.

**9. Increase national resources – especially workforce, financial, access to medicines, supply chain strengthening with benefits across all NCDs, as well as COVID, communicable diseases.**

Investment remains the Achilles' heel of the NCD response, as also outlined in the 'Bridging the Gap' analysis (NCDA, 2020). We call on the NCD community to come together to catalyse mobilization of additional resources, including via the Multipartner Trust Fund of the UN Interagency Taskforce. We look forward to a second Global NCD Financing Dialogue in 2022/23 as an opportunity to secure concrete commitments from international financial institutions and Ministries of Finance for the NCD response, and universal health coverage for people living with NCDs and mental health conditions.

**10. WHO/UNIATF support and dismantling of disease siloes - importance of financial, technical, data, investment case support to national governments, as well as WHO and regional offices.**

There is also a clear recognition that WHO and the Taskforce are under-resourced to deliver on the very wide mandate to respond to government requests for technical guidance on prevention and care for NCDs. There is an urgent need within WHO and global health more broadly to dismantle 'disease siloes' and consider the epidemiological reality that most people living with chronic conditions (including HIV, TB and MNCH conditions) are living with more than one, and very often with multiple NCDs due to the same risk factors and bidirectional relationships. We support the initiatives to secure more sustainable and flexible financing for WHO and call for these to be more responsive and better aligned with the Global Burden of Disease and status of NCDs as the world leading causes of premature death and disability worldwide.

Please see: <https://ncdalliance.org/resources/policy-brief-from-silos-to-synergies-integrating-noncommunicable-disease-prevention-and-care-into-global-health-initiatives-and-universal-health>

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<b>Organisation Name:</b> Nepean Blue Mountains Local Health District, Oral Health Services	<b>Person(s) Involved in Contribution:</b> Tanya Mahony
<b>Date:</b> 14 <sup>th</sup> September 2021	<b>Contact Email:</b> <a href="mailto:tanya.mahony@health.nsw.gov.au">tanya.mahony@health.nsw.gov.au</a>
<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
The vision of this strategy is universal oral health coverage for all people by 2030.	Agree with this statement.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	This statement needs to include linking between oral health to overall health, well-being and quality of life – with appropriate training being provided within general health teaching.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and	Nil further comments.

<p>coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>Excellent point raised regarding the increase chance of prevention, early detection and control of related conditions, both dental and general health conditions. This will also be affected by an individual's access to oral health/primary health care.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Are Oral Health Therapists/Dental Hygienists included in these mid-level oral health care providers, or does this also refer to medical general practitioners (GPs), as they will also play an integral role in responding to population needs. Some people often seek a medical GP as their first point of contact, even when the concern is of dental origin, therefore reassessing their roles within the community will assist with access and education.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions.</p>	<p>No further comments.</p>

<p>In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Very valid point! Nil further comments to expand this.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>Nil further comments; however, this is important given the changes implemented to public oral health during the recent COVID-19 pandemic.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health,</p>	<p>If this is referring to the oral health sector working alongside other medical disciplines through sustained partnerships, it is very important to consider especially with both the</p>

strengthen leadership and create win-win partnerships within and outside of the health sector.	private and public sectors. There is the need to link oral health with general health and promoting the need for routine dental care/check-ups.
<b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	The development of state-wide funded health promotion programs that do not just cover oral health, but the link it has with general health (eg. blood pressure concerns and periodontal diseases). An example of this would be the New South Wales Primary School Mobile Dental Program as a state funded program in Australia.
<b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	Nil further comments.
<b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	Research and project evaluation will play an important role in determining the impact these systems and policies have on the general community.
<b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	Research and project evaluation will play an important role in determining the impact these systems and policies have on the general community.
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b>	
<p><b>Comment:</b></p> <p>WHO – nil comments.</p> <p>Member states – nil comments.</p> <p>International partners – will this occur in conjunction with member states?</p> <p>Civil society – excellent points raised regarding providing healthy products, which should be included with member states.</p> <p>Private Sector – nil further comments that have not already been raised.</p>	

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

**Organisation Name:** National Oral Health Promotion Steering Group, Australia

**Date:** 14/09/2021

**Person(s) Involved in Contribution:**  
Health Promotion Representatives from each State and Jurisdiction across Australia

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For consultation details on the WHO website please click [here](#)

Key Areas of the Draft Global Strategy for Oral Health	Stakeholder Comment
The vision of this strategy is universal oral health coverage for all people by 2030.	Yes, we support this vision
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	<p>Yes, we agree.</p> <p>We support the inclusion of oral health promotion and a focus on reducing oral health inequalities as important aspects to improving overall oral health.</p>
GUIDING PRINCIPLES – PAGE 4 of Draft Strategy	
<p><i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	<p>Yes, we agree.</p> <p>It is time for oral health to be included as a key component of public health strategies.</p>
<p><i>Principle 2: Integration of oral health in primary health care</i> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary</p>	<p>Yes, we agree.</p> <p>Without integration of oral health into general health strategies, general health and public health strategies will be undermined by the impact of poor oral health.</p>

<p>health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Yes, we agree.</p> <p>Optimal utilisation of the oral health workforce is critical for achieving universal oral health coverage.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	<p>Yes, we agree.</p> <p>Universal oral health will not be achievable without adopting a consumer-centred approach which caters for individual needs and diverse contexts.</p>
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects</p>	<p>Yes, we agree.</p>

<p>may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Tailored, age-appropriate strategies and interventions are the most effective way to fully maximise resource and achieve outcomes</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b></p> <p>- Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>Yes, we agree.</p> <p>Telehealth and digital technologies provide novel pathways to addressing oral health needs.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>Yes, we fully support this.</p> <p>Oral health needs to be included in the general health agenda</p>
<p><i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>Yes, we agree.</p> <p>Treatment and reducing disease burden is not possible without a promotion and prevention focus</p>
<p><i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>Yes, we agree.</p>

<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>Yes, we agree.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>Yes, we agree.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.</p>	
<p><b>Comment:</b>  The National Oral Health Promotion Steering Group is committed to supporting any strategies aimed at improving oral health outcomes.</p>	

# Oral Health Promotion Research Group – Ireland



## Submission

To varenneb@who.int

W.H.O. Discussion Paper

Version dated 9<sup>th</sup> August 2021

Draft Global Strategy on Oral Health

World Health Organisation,  
20 Avenue Appia,  
1211 Geneva 27,  
Switzerland.

From : Oral Health Promotion Research Group Ireland

Chair: Naomi Bergin  
Secretary: Rose Bradley Molloy

## **Introduction:**

The Oral Health Promotion Research Group (Irish Link) was set up in 2003 as an all-Ireland, multiagency collaborative venture to foster and promote evidence based Oral Health Promotion Research & Practice and ensure a Common Risk Factor Approach to Oral / Health Promotion within the field of Population Health in Ireland.

## **Historical Policy Background**

In 1995, the first Irish Health Promotion Strategy “Making the healthier choice the easier choice” set out how health promotion can be effective in improving health and well being and in addressing the causes of ill-health in the community. Oral Health was included as an integral part of this strategy which aimed at improving the level of oral health in the population overall through oral health promotion programmes.

In July 2000, the Department of Health & Children published “The National Health Promotion Strategy 2000 – 2005 which identified strategic aims and objectives to contribute to the overall health improvement of the Irish population. Again, oral health was included in this strategy and had several key strategic objectives including:-

- Promoting the use of fluoride toothpaste among lower socio-economic groups.
- Educating parents on the need to supervise oral hygiene and ensure the appropriate use of a pea size amount of fluoride toothpaste.
- Prioritize oral health promotion initiatives for Special Needs Groups.

## **Key achievements from these two Policies / Strategies**

1. Establishment of the Specialist Certificate in Health Promotion (Oral Health) offered by the Dental Health Foundation and the National University of Ireland (N.U.I) Galway and the Health Services Executive.

This course has been running now for the past 22 years. This has resulted in a sizeable group of trained oral health promoters including dentists, dental hygienists, dental nurses and primary care staff.

2. The setting up of the “Forum on Fluoridation” and the “Irish Expert Body on Fluorides and Health”. These bodies have overseen major research into the effects of water fluoridation in Ireland and instigated oral health promotion programmes, improvements in technical knowledge and facilities and education of professionals & the public.
3. Development of various oral health education initiatives through the Health Services Executive and the Dental Health Foundation.
4. The inclusion of Oral Health within National Research programmes funded by the Health Research Board (H.R.B.) including a “Guideline Development Project” run by the Oral Health Services Research Centre in Cork, and “SmartStart” – a programme for preschools run initially as a cross border initiative and now being rolled out across all preschools facilities in Ireland.

## **Key Issues outstanding from these two Strategies / Policies since 1995**

1. The 1995 Health Promotion Strategy allowed for the appointment of 30 dental auxiliary personnel by the then Health Boards (i.e. one person from each Community Care Area) who would be “assigned specifically to Oral Health Promotion and with a particular emphasis on Special Needs Groups”

In practice, these appointments did not take place as envisaged. In one area (North Eastern Health Board (N.E.H.B.) Oral Health Education Officers were appointed specifically to develop oral health promotion across the area. Two of these have now retired and it is not known if they will be re-appointed. In nearly every other area, dental nurses or hygienists were appointed into these posts, but with a mainly clinical brief, rather than oral health promotion. In practice, if an area is short staffed, these personnel will be sent back to work in dental clinics as chairside operators.

**Thus, Ireland has no dedicated Oral Health Education Officers, unlike Health Promotion Officers who are appointed with a career pathway, in nearly every HSE area.**

This lack of dedicated staff is not only a hindrance to the establishment and development of oral health education initiatives across Ireland but also there is no career outlet for the hundreds of trained staff who have completed the Specialist Certificate in Health Promotion (Oral Health) NUIG/HSE/DHF).

### **Current Oral Health Policy**

In 2019, the Department of Health published “Smile agus Sláinte”, an Oral Health Policy which aimed to transform Irelands current oral healthcare service from 2019 – 2027. It follows “SláinteCare” – the Departments long term vision for building a better health care service and the SláinteCare Implementation Strategy (2018). All of these policies emphasise the same ideals; a primary care focus, integrated general and oral health, prevention, supports to enable everyone to achieve their own personal best oral /health and to reduce inequalities across the entire population. “Smile agus Sláinte” also adopts a “life-course approach” to support prevention and care from birth to old age, and a Common Risk Factor Approach (C.R.F.A.) which presupposes joint, interagency working across many sectors to address risk factors common to both general and oral health.

Forty one actions have been identified in “Smile agus Sláinte”. Nine priorities were identified for the first three years (2019 – 2021/2). There are 3 strategic strands:

1. Oral Health Promotion and Protection Programmes.

It envisages that a re-orientated public dental health service will have a Community Oral Healthcare Services function and will lead delivery of specific oral health promotion programmes.

2. Oral Health Care Service Provision.

The biggest change here is that children will no longer be screened, examined and treated within the public dental service but will be seen by a general dental practitioner (GDP). Vulnerable people will also be able to access local dental care from a GDP.

The public dental service will see vulnerable people who cannot receive care from a local GDP and will access the needs of those living in residential care.

3. Evaluation of Oral Health.

It is planned that oral health will be evaluated across the life course at ages 5, 12, 15 – 19, 35 – 44 & 65 +. This will take place within the general dental practice in the main.

“Smile agus Sláinte” focussed on dentists and dental technicians in **WORKFORCE PLANNING**. Although there was no mention of Oral Health Promoters, nonetheless it was stated that expanding dental auxiliaries scope of practice and ensuring direct access for the public to them could facilitate better access to oral health care services.

### **DRAFT Global Strategy on Oral Health W.H.O. 2021.**

#### **Key issues identified in this strategy relevant to Oral Health Promotion.**

1. The strong and consistent relationship between **socioeconomic status** & the prevalence and severity of oral diseases and conditions. The poor and vulnerable, people with disabilities, refugees and socially marginalised groups are all disproportionately affected by oral diseases and conditions.
2. **Commercial determinants** of health directly affect oral health through approaches made by the upstream commercial sector to promote products and choices not conducive to health.
3. Oral Health Promotion **is not integrated into** other N.C.D. programmes that share Common Risk Factors and Social determinants.
4. **Dental Public Health** initiatives to reduce sugar consumption are rare.
5. Workforce planning rather than focussing on dentists **should** focus on **community oral health workers & mid level providers**, such as dental assistants, dental nurses, dental therapists and dental hygienists.

The VISION of the Draft “W.H.O. Global Strategy on Oral Health is;

Universal Oral Health coverage for all people by 2030.

This means that every individual has access to essential, quality health services that respond to their needs and which they can use without financial hardship.

The GOAL of the Draft W.H.O. Global Strategy on Oral Health is to;

Guide member states to develop **ambitious** national responses to promote oral health, reduce oral diseases, make progress on the path to universal oral health coverage for their populations.

## Strategic Objectives

1. Oral Health Governance – improve political and resource commitment to oral health, strengthens leadership and create win – win partnerships within and outside of the health sector.

## OHPRG Comments

With the publication of the *Smile agus Sláinte*, the new Oral Health Policy, Oral Health is aligned with *SláinteCare* the National Health Strategy which aims to provide universal oral healthcare through primary care providers such as general dental practitioners, and their teams. Unfortunately, in Ireland, there was little consultation with General Dental Practitioner Groups about this and it will require dedicated funding and co-operation from the states almost 2,000 odd dentists working in private practice. Rarely do these dentists and their teams work within primary care facilities & this needs to change, to encourage them to become part of the wider primary care network.

There is a National Oral Health Office?, although it is established by the Department of Health and staffed by mainly HSE personnel. This needs to be expanded to include all stakeholders including general dental practitioners, dental public health representatives and oral health promotion participators.

## **Objective 2: Oral Health Promotion and Oral Disease Prevention – enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseased and conditions.**

## OHPRG Comments

Although the “Making every Contact Count” approach to health promotion is laudable and should be followed by all healthcare workers, there needs to be a dedicated integrated workforce of Oral Health Promotion personnel, similar to the Health Promotion Departments of most HSE services. The Specialist Certificate in Health (Oral Health) will continue to train oral and general healthcare staff to the highest level in Oral Health Promotion but these graduates need an outlet for their work and a career structure they can follow like that of Health Promotion Officers. Indeed, many graduates have gone on to join Health Promotion Departments but none has the specific task of designing, co-ordinating, implementing and evaluating oral health promotion initiatives within a C.R.F.A.

**Objective 3: Primary Oral Healthcare – Build workforce capacity and ensure financial protection and essential supplies is integrated primary oral health care.**

**OHPRG Comments**

The objective to ‘increase access by the entire population to safe, effective, and affordable primary oral health care’ is currently undermined in the Irish setting due to the increasing shortage of dental surgeons available for recruitment in the country and an acceptance by individuals to pay out of pocket where they can for oral healthcare, widening inequalities. The HSE Dental Service, which provides primary oral health care for children and adults with special care needs , has developed enormous backlogs due to Covid and now is experiencing a shortage of dentists and having great difficulty recruiting staff. At the same time large numbers of dentists have resigned from the medical card scheme (DTSS) which provides care for those on lower incomes. The remaining practices are also experiencing recruitment difficulties. This shortage of dentists is directly impacting on patient’s ability to access care with a disproportionate impact on those in the lower socioeconomic groups. Any workforce planning for Ireland needs to urgently address the current shortage of dentists and the professions complimentary to dentistry in the country.

Basic oral health care in this objective includes oral health promotion and prevention of oral diseases and conditions as well as services. All oral health care providers should be members of the primary health care teams and work side by side with other health care workers. Financial protection through expanded health insurance or funded care.

What is needed in Ireland is an expanded oral health care workforce to include oral health promoters, dental therapists who could work with GDP’s to treat children and expanded duty dental nurses and hygienists who could work alongside other primary health care workers in promotion and prevention programmes. Dental Hygienists should be able to be accessed directly by the general public as they are in other countries. Legislative change is urgently required.

**Objective 4: Oral Health Information Systems – enhance oral health surveillance and information systems to provide timely and relevant feedback to decision makers for evidence based policy making.**

**OHPRG Comments**

This objective should be met through the implementation of “Smile agus Sláinte”, although considerable resources will be needed to ensure that the envisaged clinical surveillance programme can be put in place. Links between the Dental Public Health Departments of the dental schools and the public (Community) Dental Service must be strengthened and fostered.

**Objective 5: Oral Health Research Agenda – Create and continuously update a new Research Agenda focussed on public health aspects of oral health and innovation for better impact on oral health.**

**OHPRG Comments**

This objective strives to move the research agenda towards public health programmes, population based interventions, workforce models, digital technologies and primary care interventions.

Currently, there is no specific budget allocation for oral healthcare research in Ireland or a rolling epidemiological programme or surveillance. In fact, there is no established “research agenda” as such, apart from individuals within dental schools or the HSE or G.D.P. who elect to carry mostly clinical research. Whatever ‘Research Agenda’ might be developed in Ireland, it needs to be transparent and open to both health professionals and the public.

In conclusion, the Oral Health Promotion Research Group (O.H.P.R.G.) supports this draft global strategy on oral health and in particular the vision of universal oral health coverage for all the citizens of Ireland by 2030. It is hoped that the implementation of “Smile agus Sláinte” will help towards this very ambitious global strategy.

15<sup>th</sup> September 2021

Signed:

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# Orthodontic Society *of* Ireland

SUBMISSION IN RESPONSE TO THE INVITATION FOR FEEDBACK  
on

**DRAFT GLOBAL STRATEGY ON ORAL HEALTH**  
(WHO Discussion Paper version dated 9 August 2021)

SEPTEMBER 2021

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## Introduction

**The Orthodontic Society of Ireland** would like to offer congratulations to the WHO for passing Resolution WHA74.5. On behalf of our members, I would like to offer our thanks to our international colleagues who have worked so hard to pass this landmark WHO Resolution to put Oral Health on the Global Health agenda to tackle the growing burden of non-communicable chronic diseases (NCD's) and for developing these strategic objectives to guide clinicians and policy makers. We are grateful for this opportunity to support the resolution and offer our insights and would like to offer our commitment to engage with other stakeholders in Ireland.

### Strategic Objective 1: Oral Health Governance

The Strategic Objectives outlined in the WHO Resolution are aligned with the guiding principles of Ireland's 2019 Oral Health Policy, *Smile agus Slainte*, which also promotes preventative strategies to reduce the burden of disease. The Lancet series on the Global public health burden of oral diseases. (Peres, 2019; Watt, 2019; Watt 2019) highlighted that a treatment orientated focus in dentistry does not improve health or reduce the burden of disease and advocated for radical change and the need for both upstream and downstream interventions to effect change.

Individually and collectively, Irish people responded to the Covid -19 pandemic to reduce the burden of disease to protect their own health and the health of their families and communities. Authors have highlighted the opportunity for this paradigm shift to "act as a catalyst" to address the common risk factors using similar public health tools to reduce the burden of NCD's globally. (Lancet 2020)

The concept that our lifestyles and health behaviours are directly associated with the burden of disease is not new. The World Health Organisation (WHO) reports on the Global Burden of Disease Reports (2019) show that lifestyles and habits significantly contribute to mortality and quality of life. As with Covid-19, flattening the curve of these preventable diseases will require a paradigm shift at both individual and societal levels and in the organisation and delivery of healthcare services.

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Reicher (2000) described the two psychologies of health behaviour in response to coronavirus; whether public health messages were patriarchal and drove fear and compliance or if they were constructive and created meaning that influenced positive health behaviours. Strategies to improve health are most successful when they empower and engage people rather than being perceived to blame and shame.

Most of the literature on prevention in the past has focused on the cost savings of prevention, rather than the broader health benefits. (Vernazza, 2021) Dental practice in Ireland has high fixed costs and current "fee per item" models of funding, which creates difficulty to quantify or charge for "advice." There are significant barriers to health promotion and health education in the clinical setting. (PPE, communication, operational cost, access.) Smile Agus Slainte prioritises prevention and new models of care.

### **Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention**

Tooth decay remains the most common chronic disease in children in Ireland with many common risk factors for other chronic diseases. (SmileAgusSlainte, 2019). By the age of 5, about 25% of Irish children have had tooth decay. This may be the first sign that a child will be vulnerable to other chronic diseases throughout their life. Emerging concepts in immunology outline the prolonged, dysregulated and maladaptive inflammatory response in patients with NCD's. (Egger, 2017) This is evidenced by an orthodontic study that measured a statistically significant difference in the rate of tooth movement in obese adolescents compared to a control group. The authors determined that inflammatory markers and a pre-existing inflammatory state in the obese adolescents, sped up tooth movement. (Saloom, 2017)

Traditional training has focused on what the dental profession should do to reduce dental decay in high-risk children, rather than patient focused self-management interventions to reduce the long term risk of other NCD's. (Whelton, 2009)

Health Behaviour is complex. It can be influenced by the medial, proximal and distal determinants of disease; genetics, culture, parenting, influences, perceptions, feelings and attitudes. (Acheson, 1998)

The HBSC (2018) report on health behaviours in school aged children in Ireland highlights a statistically significant difference between adolescents of different socio-economic groups

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in positive health behaviours (eating fresh vegetables and tooth brushing) but no difference in negative health behaviours such as sugar and soft drink consumption. The health belief model outlines why some people don't engage in preventative health behaviour; People have different perceptions of threat and of the influence their behaviour has on outcomes. (Michie,2014)

A key emergent theme is in thinking of healthcare in the positive domains of health improvement rather than the management of disease. WHO described health as "a resource for everyday life; it is a positive concept, emphasizing social and personal resources." (WHO,2020)

Orthodontics is in the domain of positive health as the branch of dentistry that specialises in the growth and development of the teeth and jaws and the elective correction of malocclusion. Healthy adolescents visit their orthodontist more than any other health practitioner as their patient journey may extend over several years.

Many children in Ireland do not regularly attend a general dental practitioner. Young people may seek or desire to have orthodontic treatment, and this creates an ideal setting to promote positive health messages throughout the treatment journey. The orthodontic profession in Ireland promotes that good oral health is established prior to active treatment and supported during and following orthodontic treatment. This not only reduces risks during orthodontic treatment but can improve both the long term benefits of orthodontic treatment and long term dental health.

Self-Management is defined as "the active participation by people in their own care" (Egger, 2017) Self-management is most relevant in active prevention and in the management of chronic diseases and long-term care.

Orthodontic outcome relies on many patient factors, in addition to professional factors. (Banks, 2004; Joury, 2009, 2011) Whilst much of the orthodontic literature describes the patient's role in their own care as "compliance," the health behaviour literature suggests that health behaviour change is not strongly influenced by persuasion or direction. (Schwarzer, 2020) In 2011 the NHS estimated that 20% of the orthodontic budget was spent on failed treatments. Self-efficacy, intention and social influences are potential psychosocial determinants of oral health behaviour in adolescents. (Abel 2016) Understanding this and building self efficacy and self-determined goals in the orthodontic

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setting not only improves the orthodontic outcome of young people but, in theory, can also improve self management of their general health. Health behaviours do not occur in isolation, but cluster. (Conry, 2011) Broaden and Build Theory supports this understanding that positive health behaviours can be practiced, developed and shared.

(Frederickson,2001)

Many young people first experience health care through dental or orthodontic care. It's something that is tangible to them and a valuable starting point in active self-management. The emerging evidence in health behaviours and positive psychology outlines the important role the orthodontic profession can play in supporting young people to build their self-efficacy and self management of their own health. Irish researchers have explored the benefits of positive psychology coaching (Burke, 2017) and motivational interviewing to support orthodontic care. (Rigau-Gay, 2020)

### **Strategic Objective 3: Primary Oral Health Care**

Poor investment has led to high numbers of dentists withdrawing from public dental schemes in Ireland and poor access to publicly funded dental and orthodontic treatment. The Orthodontic Society of Ireland recognises the need for primary dental care for all children and effective pathways and communication between general and specialist practitioners to promote oral health and deliver active treatment.

A report by Deloitte also determined that current models of healthcare are not sustainable. Across Europe, healthcare systems are struggling to meet workforce demands with shortages of highly skilled staff and health care professionals are "crippled by burnout workforce buckling under the strain of a heavy workload, poor work-life balance and declining morale and wellbeing." (Deloitte, 2017) The field of positive organisational scholarship defines the building blocks to create healthier workplaces for staff and deliver better outcomes for patients. (Cameron, 2003)

### **Strategic Objective 4: Oral Health Information Systems**

The global pandemic has shown a surge in public interest in understanding science related to their health, the use of technologies to monitor and support health and an understanding of the benefits of "trusted sources" of health information.

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Health technology can support practitioners in engaging with patients remotely and in a way that is meaningful to them. It can be used to improve the use of clinical time and personalise care. Adolescents are "digital natives." Irish research shows they are most motivated by information that is visual. In one collaboration with SpunOut.ie, RCSI and IADT, researchers demonstrated that, "online animations provide an accessible means of translating empirical research findings into meaningful public health outputs. They offer a cost-effective way to provide targeted online information." (Coughlan, 2021) Researchers in Scotland have recently published their findings on the benefits of co-creating content on a common source(Wikipedia) to build a trusted source. (Tan, 2021)

Developing resources require engagement with the profession, educators and young people and investment, but this can also support clinicians by improving efficiency in clinical time and allow visits to be more personalised.

Digital technologies are often described as "disruptive." This force for change is often positive and should be used to promote oral health, so the orthodontic profession in Ireland, along with our colleagues in EFOSA are concerned about the increasing trend for orthodontic treatment to be marketed "direct to consumer" without a physical examination, diagnosis or delivery of care by a registered dentist or orthodontist. To support optimal oral health during orthodontic treatment, we rely on legislation and regulation to control the qualifications and standards that are required to advertise, prescribe, manufacture and deliver custom devices providing orthodontic tooth movement to the general public.

### **Strategic Objective 5: Oral Health Research Agenda – C**

The Orthodontic Society of Ireland is committed to delivering excellence in patient care and respect and value researchers and colleagues who provide the evidence and clinical guidelines for best practice and provide our continuing education.

As clinicians, we understand that outcome is influenced by broad range of individual patient and practitioner factors that RCT's does not always capture; Large scale RCT's can be expensive to set up and generate a normal distribution of treatment outcomes. Patient centred research, participatory research and systems thinking can support a better understanding of patient factors in improving treatment outcome and health. (Brocklehurst 2020)

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**Public Health Association  
AUSTRALIA**

# **Public Health Association of Australia submission on the World Health Organization's Draft Global Strategy for Oral Health**

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**17 September 2021**

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## Preamble

### The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, behavioural, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.



**Public Health Association  
AUSTRALIA**

### Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

### Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

## Consultation on the Draft Global Strategy for Oral Health

<b>Organisation Name:</b> <b>Public Health Association of Australia</b>	<b>Person(s) Involved in Contribution:</b> <b>Oral Health Special Interest Group</b>
<b>Date:</b> 17/09/2021	<b>Contact Email:</b> <a href="mailto:phaa@phaa.net.au">phaa@phaa.net.au</a>

<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
The vision of this strategy is universal oral health coverage for all people by 2030.	We recognise this goal is ambitious, however, the vision is critical to raise the profile of oral health being integral to general health and well-being, and the necessity of its inclusion in universal healthcare coverage.  We suggest the term 'oral' be removed from, 'universal oral health coverage'.  Alternatively, we suggest the following wording: 'The vision of this strategy is universal healthcare coverage for all people by 2030 including oral health'.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	We strongly commend the development of the strategy.  We suggest the terminology 'oral health inequalities' be replaced with 'oral health inequities' to reflect that these differences are largely avoidable and unfair.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health	We support a public health approach to oral health, recognising that it should take a population approach by implementing universal initiatives, and by creating culturally safe models of care for populations at most risk to oral diseases. Universal access to healthcare including oral health should be proportionate based on individual risk and health needs.  As an example, one of the most important universal preventive interventions for dental caries has been

<p>requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	<p>community water fluoridation, which should be expanded, wherever possible.</p> <p>In recent times, interventions to reduce sugar consumption, through the implementation of a healthy levy (tax) on sugar sweetened beverages (SSBs) have been implemented or forthcoming in at least 20 jurisdictions including Mexico, France, Chile, Finland, the United Kingdom, South Africa, Portugal and several US cities. This is likely to have a long-term impact on reducing the incidence of dental caries and other non-communicable diseases including diabetes and obesity.</p> <p>We prefer the principle to strengthen the importance of prevention and suggest the following wording: 'A public health approach to oral health and prevention of oral diseases across the life-course'.</p>
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>We support the integration of oral health in primary healthcare. It is imperative that the promotion of oral health and the prevention of oral disease should be a core responsibility of all primary healthcare providers. There is emerging strong evidence that primary healthcare providers are well positioned to provide early anticipatory guidance for oral disease prevention.<sup>1</sup></p> <p>Similarly, we recognise the importance of oral health providers integrating and partnering with general primary health care as appropriate, including through the adoption of a common risk factor approach to non-communicable diseases. Oral healthcare providers are well-positioned to undertake preventive interventions for chronic conditions such as diabetes and obesity, which share common risk factors with oral health.<sup>2-3</sup></p> <p>We reject the use of the term 'basic oral health services', rather, we propose the term 'essential oral health care', which is articulated by Benzian and colleagues (2020).<sup>4</sup></p> <p>We also wish to add that aged care systems should be part of universal healthcare coverage efforts, and as such, oral health play an important role from the first 2000 days of life to healthy ageing and aged care.</p>

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<sup>3</sup> Yonel, Z., Batt, J., Jane, R. et al. The Role of the Oral Healthcare Team in Identification of Type 2 Diabetes Mellitus: A Systematic Review. Curr Oral Health Rep 7, 87–97 (2020). <https://doi.org/10.1007/s40496-020-00250-w>

<sup>4</sup> Benzian H, Beltrán-Aguilar E, Mathur MR, Niederman R. Pandemic Considerations on Essential Oral Health Care. Journal of Dental Research. 2021;100(3):221-225. doi:10.1177/0022034520979830

<p><b>Principle 3: A new oral health workforce model to respond to population needs -</b> Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>We recognise that each country has their own different capacities to engage and leverage the expertise of the oral health workforce. However, the broader goal to achieve universal healthcare coverage, that includes oral health, must include all primary healthcare providers.</p> <p>There are many different oral health workforce models that are appropriate to the country context, which can adapt, and change based on the needs of the population. The discussion paper highlights the weaknesses of developing an oral health workforce dominated by highly specialised oral health workforce of dentists, and strongly support the principle for the expansion of 'mid-level' oral healthcare providers. An example of this is the establishment and recognition of the oral health therapist workforce. We reject the use of the term 'mid-level' for its inherent deficit language.</p> <p>We do not believe the reorientation of essential oral healthcare services is solely the role of oral healthcare providers and community oral health workers. And vice versa, oral healthcare providers and community oral health workers can play an important role in the promotion of general health and wellbeing.</p> <p>Primary healthcare workers, including medical practitioners, nurses, pharmacists, and community health workers are well established within the primary healthcare system, and more readily accessible with disadvantaged and remote communities than oral healthcare providers. However, major reforms are necessary to upskill primary healthcare workers in oral health. Alongside the focus on education and training, regulatory bodies should also be adaptive and respond to support the oral health needs of the population.</p> <p>We believe Principle 3 should read: 'Health workforce models, including oral healthcare providers and community oral health workers, should respond to population needs.'</p>
<p><b>Principle 4: People-centred oral health care -</b> People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-</p>	<p>We support this principle.</p>

<p>management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>We support this principle with a revision: 'Tailored culturally safe anticipatory oral healthcare across the life course'.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>We support this principle, however, caution that its adoption has the potential risk to disproportionately affect populations unable to access digital technology. Globally, the provision of oral health services has been treatment-dominated, with increasing use of highly technical digital technology, but it has not successfully tackled the global burden of oral diseases.<sup>5</sup></p> <p>We suggest the following revision be considered 'Optimizing digital technologies for oral health to increase timely access to universal healthcare, including oral health, and the reduction of oral health inequities'.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>We support this objective.</p> <p>We suggest the inclusion of an operative paragraph to address private sector interference. For example, countries should maximise the role of private sector in full alignment of the Framework of Engagement with non-State actors (FENSA) and devise clear rules and rigorous approaches for engagement, which prevent, identify, and manage real or potential conflicts of interest and ensure that such</p>

<sup>5</sup> Watt RG, Daly B, Allison P, Macpherson LMD, Venturelli R, Listl S, Weyant RJ, Mathur MR, Guarnizo-Herreño CC, Celeste RK, Peres MA, Kearns C, Benzian H. Ending the neglect of global oral health: time for radical action. Lancet. 2019 Jul 20;394(10194):261-272. doi: 10.1016/S0140-6736(19)31133-X.

	<p>engagements directly support specific objectives of national NCD responses.</p> <p>This statement is in line with similar discussion papers on the implementation of a road map 2023-2030 for the Global Action Plan for NCDs, Global Action Plan on Alcohol, and Global Action Plan on Obesity.</p>
<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention -</b> Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>We support this objective.</p> <p>For operative paragraph 28, We suggest taxes on sugar-sweetened beverages (SSBs) should be specifically noted.</p> <p>The evidence that a health levy (tax) on SSBs will effectively reduce consumption is strong, increasing, and consistent. This should be included as one policy as part of a comprehensive strategy of evidence-informed actions to address unhealthy diets and diet related ill-health.</p> <p>Over-consumption of sugar is a major contributor to obesity, diabetes and tooth decay. SSBs are a major source of sugar in the diet, and its consumption is increasing in most countries, especially amongst children and adolescents.</p> <p>Based on reasonable and increasing evidence in terms of both reducing SSB consumption and revenue raising, WHO recommends an appropriately designed levy on SSB, with the aim of raising the retail price of SSB by 20% or more.<sup>6</sup></p> <p>In Australia, modelling suggests a 20% health levy (tax) on SSB would raise an estimated AUD\$400 million a year and reduced annual health expenditure by up to \$29 million.<sup>7</sup></p> <p>A study in the United States estimated a \$0.01/ounce sugary beverage tax could save US\$23 billion in healthcare costs alone over 10 years,<sup>8</sup> and simulations showing how taxes would avert obesity and diabetes in the United Kingdom and</p>

<sup>6</sup> World Health Organization. Fiscal policies for diet and prevention of noncommunicable diseases. Technical Meeting Report. 5-6 May 2015, Geneva, Switzerland. Geneva: World Health Organization; 2016.

<sup>7</sup> Veerman JL, Sacks G, Antonopoulos N, Martin J. The Impact of a Tax on Sugar-Sweetened Beverages on Health and Health Care Costs: A Modelling Study. PloS one. 2016;11(4):e0151460.

<sup>8</sup> Long MW, Gortmaker SL, Ward ZJ, Resch SC, Moodie ML, Sacks G, Swinburn BA, Carter RC, Wang YC (2015). Cost-effectiveness of a sugar-sweetened beverage excise tax in the U.S. American Journal of Preventive Medicine 49(1):112-123.

	Mexico indicate there would be savings in other countries as well. <sup>9,10,11</sup>
<i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	We support this objective, with a suggested revision: 'Embed Oral Health in Primary Health Care'.
<i>Strategic Objective 4: Oral Health Information Systems</i> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	We support this objective.
<i>Strategic Objective 5: Oral Health Research Agenda</i> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	<p>We support this objective and wish to emphasise the importance for focusing on translational research that assesses economic and political feasibility of implementation.</p> <p>Furthermore, this objective should be linked with advancing sustainable dentistry in achieving the World Health Organization's Sustainable Development Goals.</p> <p>We also note the FDI World Dental Federation have developed research goals centred on<sup>12</sup>:</p> <ol style="list-style-type: none"> <li>1. Preventive care</li> <li>2. Operative care</li> <li>3. Integrated care</li> <li>4. Ownership of care</li> </ol>

**ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.**

<sup>9</sup> Sánchez-Romero LM, Penko J, Coxson PG, Fernández A, Mason A, Moran AE, et al. (2016) Projected Impact of Mexico's Sugar-Sweetened Beverage Tax Policy on Diabetes and Cardiovascular Disease: A Modeling Study. PLoS Med 13(11): e1002158. doi:10.1371/journal.pmed.1002158

<sup>10</sup> Briggs AD, Mytton OT, Kehlbacher A, Tiffin R, Elhussein A, Rayner M, Jebb SA, Blakely T, Scarborough, P (2016). Health impact assessment of the UK soft drinks industry levy: a comparative risk assessment modeling study. Lancet Public Health 2(1):e15-e22.

<sup>11</sup> Afshin A, Micha R, Webb M, Capewell S, Whitsel L, Rubinstein A, Prabhakaran D, Suhrkne M, Mozaffarian D (2017). Effectiveness of Dietary Policies to Reduce Noncommunicable Diseases. Disease Control Priorities (third edition).

<sup>12</sup> FDI World Dental Federation. Sustainability in Dentistry. n.d. Available from <https://www.fdiworlddental.org/sustainability-dentistry>.

**Comment:**

WHO

We request consideration of a commitment of the WHO to expand the Oral Health Unit – especially during this period of the global oral health strategy development and the associated stakeholder communication and coordination tasks.

Member States

We strongly support the clear and concrete description of the actions needed by Member States to bring about improved oral health and prevention of oral diseases. For paragraph 42, we suggest to specifically include the role of taxation of sugar-sweetened beverages (SSBs). i.e. '...advocating for health taxes or regulation of the sale and advertisement of unhealthy products (including a health levy of sugar sweetened beverages), and counteracting...'

International Partners

We strongly support the paper's identification of the importance of international and national professional associations including the FDI World Dental Federation, the World Medical Association and the International Council of Nurses to bring about the workforce change required to integrate oral health within primary healthcare.

Private Sector

We recommend the inclusion of a statement to address private sector engagement in line with FENSA, in particular, the alcohol, food and beverage and tobacco industries.

## Conclusion

PHAA supports the broad direction of the discussion paper and commends WHO on the work in this area to date. PHAA appreciates the opportunity to make this submission.

Please do not hesitate to contact PHAA should you require additional information or have any queries in relation to this submission.

Yours sincerely,



Terry Slevin  
Chief Executive Officer  
Public Health Association of Australia



Mr Tan Nguyen  
PHAA Co-Convenor  
Oral Health Special Interest Group



Associate Professor Amit Arora  
PHAA Co-Convenor  
Oral Health Special Interest Group

## ***The Platform for Better Oral Health in Europe***

# **Formal response to World Health Organization consultation**

## **on “Draft Global Strategy on Oral Health”**

**The Platform for Better Oral Health in Europe** (“the Platform”) is a joint initiative of the key European organisations involved in oral health, including the Association for Dental Education in Europe (ADEE), the Council of European Chief Dental Officers (CECDO), the European Association of Dental Public Health (EADPH), the Oral Health Foundation and the Pan-European Region of the International Association for Dental Research (PER-IADR) as well as 18 associate Members. Through advocacy at European level, we seek to achieve the improvement of oral health across Europe.

In May 2021, the **Platform** warmly welcomed the World Health Organization (WHO) **Resolution on Oral Health**, adopted at the 74<sup>th</sup> World Health Assembly.

In this context, the Platform is pleased to provide feedback to the **WHO discussion paper on a “Draft Global Strategy on Oral Health”** (hereinafter referred to as the “Global Strategy”).

The Platform strongly welcomes the draft Global Strategy, which **fully aligns with our commitment to integrating oral health as part of general health and promoting cross-sectoral cooperation on good oral health**.

We were very pleased to note that the draft Global Strategy **realizes the importance of public health as a key vehicle** for the improvement of oral health of populations.

We fully support **the emphasis on primary care and a life course approach** to address the excessive burden of oral diseases and conditions and meet population needs.

We commend the Global Strategy for **recognizing the important role of international and civil society partners** in achieving the goal and objectives of the strategy at global, regional, and national levels.

As a general comment, we would **recommend that the strategic focus of the Global Strategy emphasises 'oral health' rather than 'oral disease'**.

We would also **suggest a stronger priority for addressing inequalities in oral health**, applying the broader social determinants framework, and leveraging the momentum of the Resolution WHA74.16 (2021) on Social Determinants of Health.

**The Platform is uniquely positioned and fully prepared to support the implementation of this Global Strategy into action at European level.**

In line with these recommendations, **please find below the Platform's detailed comments on the discussion paper**.

**Georgios Tsakos**

Chair of the Platform for Better Oral Health in Europe  
Professor of Dental Public Health, UCL



Section	Paragraph	Comment
Background	1	No comments
Background	2	<p>While this paragraph includes a very relevant list of documents, it would also benefit from including additional key documents of reference which are not included in this background, notably:</p> <ul style="list-style-type: none"> <li>• additional Sustainable Development Goals in the 2030 Agenda for Sustainable Development, as establishing linkage to the broader sustainability agenda will be crucial for the implementation of this Strategy. Such SDGs include:           <ul style="list-style-type: none"> <li>○ SDG 17: Partnerships for the Goals (essential for implementation)</li> <li>○ SDG 12: Ensure sustainable consumption and production patterns</li> <li>○ SDG 10: Reduce inequality within and among countries (connection with health inequalities and social determinants of oral health)</li> <li>○ SDG 6: Ensure availability and sustainable management of water and sanitation for all (connection to risk factors and self-care)</li> <li>○ SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all (connection to health literacy, self-care and prevention)</li> <li>○ SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture (connection to diet and risk factors)</li> <li>○ SDG 1: End poverty in all its forms everywhere (connection to Universal Health Coverage)</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>• WHA74.16 (2021) on Social Determinants of Health and upcoming strategy on health inequalities, as oral health inequalities are a significant public health issue and reflect a key aspect of health inequalities</li> <li>• the WHO's Global Strategy on Digital Health 2020–2025</li> <li>• the WHO's Global Action Plan on Healthy Lives and Well-being for All</li> </ul>
Global overview of oral health	3	<p>We welcome the focus on the integration of oral health in overall/general health and call for a strategic rethink of the policy focus from disease management to health and quality of life, with an emphasis on prevention and health promotion. We also strongly welcome the holistic and life-course approach taken in this definition of oral health, and its emphasis on oral health being integral to overall health.</p> <p>However, we believe that this paragraph could be improved by including additional key elements of oral health. In particular, "comfortably" does not reflect the aspirations this strategy should aspire to - and we would recommend a change in wording, for example "free from pain and discomfort". Infections are also missing from this definition. In addition, we would also add in the final sentence that "oral health is integral to overall health, <b>physical and cognitive function</b>, well-being and quality of life".</p> <p>Finally, we would recommend the addition that oral diseases are an important part of NCDs, to anchor this strategy and the political discussion around oral health to the chronic disease's framework.</p>

Global overview of oral health	4	<p>As the WHO seeks to give an overview of oral diseases burden, we urge the WHO Secretariat to consider the inclusion of some of the direct and indirect costs of this burden, to emphasize the considerable burden these diseases have for people, health systems and societies at large. For example, oral diseases account for a significantly higher part of health budgets than cardiovascular diseases, but do not benefit from an equal attention from policymakers.</p> <p>In general, we believe that for effective policy to be deployed at national level, policymakers need to have a better grasp of the tremendous burden stemming from oral health diseases – especially in comparison to other NCDs.</p>
Oral disease burden	5	<p>We welcome the emphasis on oral cancer, which echoes the current EU policy focus on cancer as a disease area and will facilitate the integration of oral health in broader preventative strategies.</p> <p>We suggest that, as cancer, noma, and cleft lip and palate have different aetiology, they should be addressed as separate points in this paragraph.</p>

Oral disease burden	NEW	<p>We believe that, as part of the oral disease burden section, it would be relevant to add a paragraph on the trends over time for oral diseases. This paragraph could make the point of the increasing prevalence and impact of oral diseases in the general population and underline the urgency of the context in which this Strategy is being developed.</p> <p>In addition, this background should also refer to the global demographic trends of ageing societies, in combination with the epidemiological oral health trend towards considerably reduced edentulousness rates. This means that current and future cohorts of middle aged and older adults will face much higher dental treatment needs to maintain a good function and enjoying the opportunities in their lives. As they live longer and with the decrease in overall tooth loss, there will be a greater need for restorative treatment.</p> <p>These trends would serve to demonstrate the need to focus on oral health promotion and prevention of diseases throughout the life course, which will be essential to reduce treatment needs that health care systems are struggling to absorb.</p>
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Oral disease burden	NEW	<p>The Platform would urge the WHO Secretariat to emphasise the close links between oral health and general health, in particular the systemic links between major oral conditions and other NCDs, such as cardiovascular diseases, diabetes, frailty and dementia. Indeed, comorbidities considerably increase the total disease burden on people and costs to society, an issue that should be raised in the Strategy.</p>
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<p>Social and economic costs of poor oral health</p>	<p>6</p>	<p>We welcome the emphasis on the consequences of poor oral health for individual and societies, and would suggest the addition of the following points:</p> <ol style="list-style-type: none"> <li>1. The impacts of oral conditions are considerable for the individuals involved (function, well-being and quality of life) but also for their families (with a lot of literature to show the impact of oral conditions on the quality of life not only of children but also affecting the life of the whole family)</li> <li>2. There is considerable evidence that poor oral health negatively affects school attendance and performance of children as well as time off work and productivity loss for parents / adults.</li> <li>3. The economic argument should refer to the proportion of the health (or overall) budget that goes towards oral health, as oral diseases are one of the costliest disease groups for health budgets and societies. This would put the cost into perspective with other NCDs.</li> <li>4. There is a significant burden of costs both to individuals and societies as a result of systemic links to other diseases.</li> <li>5. The cost of dental care is a commonly reported barrier that leaves large parts of populations unable to access treatment to alleviate the burden of poor oral health.</li> <li>6. Lack of oral care (which disproportionately affects the poor) can lead to loss of teeth which in turn can also impact employment.</li> </ol>
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In addition, we would also suggest amending the text to better reflect the reality of people suffering from poor oral health, clarifying notably "physical symptoms" by adding a parenthesis with "pain and infection".

In addition, we believe it would be useful to underline the economic burden of treating malocclusions, which can amount to a significant portion of the overall cost of dental care.

Finally, it would also be useful to clarify what is meant by "indirect costs" to underline the impact poor oral health has on society, for example by adding a clarifying parenthesis including: "loss of productivity, increase in absences from work, increase in absences from education systems, and overall loss to the economy".

<p>Social and economic costs of poor oral health</p>	<p>7</p>	<p>We welcome this paragraph and emphasis on the life course approach, which is essential to build robust policies for the prevention of oral diseases and promotion of good oral health.</p> <p>In addition, we very much welcome the emphasis on inequalities, and would add that the impact of the COVID-19 pandemic on oral health has further exacerbated oral health inequalities, making this an even bigger priority. In that framework, it is essential to consider the way back from the pandemic and the importance of building back fairer (in addition to building back better).</p> <p>Finally, we would suggest changes in the wording of the paragraph. We would recommend replacing "oral diseases and conditions" by "poor oral health (both clinical and self-rated)", in order to put the emphasis on health, rather than disease. Indeed, poor oral health have very serious consequences on a person's life – and this would support the holistic and life-course approach taken by the WHO with this Strategy, which we very much welcome.</p> <p>We would also suggest adding "ethnic minorities and older adults living in institutions".</p>
<p>Commercial determinants and risk factors of oral health</p>	<p>Section title</p>	<p>We suggest amending the section title to "Commercial Determinants and Risk Factors of Poor Oral Health".</p>

Commercial determinants and risk factors of oral health	8	<p>We welcome this paragraph and its emphasis on the commercial determinants of poor oral health, which is especially relevant for public health and the improvement of oral health of populations.</p>
Commercial determinants and risk factors of oral health	NEW	<p>There is a need to also highlight the importance of the broader social determinants framework, which is currently not prominent in the Strategy. We would suggest using the WHO model from the Commission on Social Determinants in its totality and how it has been adapted for oral health by the Lancet Oral Health Series as the latter is a comprehensive framework for the social determinants of oral health.</p> <p>There should also be emphasis on the structural determinants / socioeconomic and political context. The relevance of political factors and the welfare state are essential for oral health both in terms of primary care but also public health. It would be a welcome addition to the WHO strategy to refer to structural determinants and political factors in that respect.</p>

		<p>This could be achieved by the addition of a new paragraph.</p> 
Commercial determinants and risk factors of oral health	9	<p>We welcome this paragraph, which highlights the connection between poor oral health, oral diseases, and other NCDs.</p> <p>We would also recommend the addition of dementia and overall mental health in the list of diseases, as per the WHO's own 5x5 approach to NCDs.</p> <p>We would also add mentions of caries and periodontitis in addition to cleft lip and palate and traumatic dental injuries, as these are two of the main oral conditions and share modifiable risk factors common to the leading NCDs.</p> <p>Finally, we would also suggest amending "harmful alcohol use" to "alcohol use", as the risk for oral cancer is not only associated to harmful alcohol use but alcohol use in general.</p>

Oral health promotion and oral disease prevention	10	<p>We particularly welcome this article and wish to underline its critical importance – as this is very much in line with our own advocacy work at European level. It is essential that the WHO supports a leap from what is currently a mostly curative approach to a preventative one throughout the life course.</p> <p>This will require significant investment and training, as well as policy intervention – but also offer considerable payoffs in the long-term. Such a leap would require a change of mindset for countries and international organisations, which currently focus on treatment and reimbursement, rather than prevention of diseases.</p>
Oral health promotion and oral disease prevention	11	<p>We welcome this paragraph, which is very much in line with our own recommendations on sugar intake. Indeed, initiatives to reduce sugar intake should be taken at national and regional level where relevant (i.e. the EU) for both oral and general health as part of a holistic preventative approach to NCDs – with strong benefits associated with such upstream population interventions.</p> <p>In order to clarify the link between oral and general health with regards to sugar intake and the association with other NCDs, we would recommend to replace “dental public health initiatives” with “public health initiatives” – a more inclusive take on the potential solutions to the challenges posed by sugar intake and its impact on general and oral health. For example, sugar taxes and obesity programs, despite being outside of the “dental public health initiatives”, would have significant positive impact on oral health – demonstrating once again the benefits of a common risk factor approach.</p>

Oral health promotion and oral disease prevention	12	<p>The Platform welcomes this paragraph, which recognizes the value of health promotion and oral disease prevention programme, as well as the benefits of the use of fluorides for the prevention of dental caries, which is the most common NCD.</p> <p>We would suggest clarifications to this paragraph to underline the challenges associated with the use of fluorides:</p> <ol style="list-style-type: none"> <li>1) There is a need to differentiate between promotion and prevention programme with the routine use of fluoride toothpaste, which has reaped major benefits for the oral health of populations and should be underlined as a critical tool for policymakers.</li> <li>2) The lack of availability and affordability of fluoride toothpaste should be highlighted in this paragraph. We would also underline the link to the Universal Health Coverage Declaration, which includes access to oral health. Indeed, universal health coverage does extend beyond a treatment-oriented approach and also encompass access to preventative measures – such as fluoride toothpaste.</li> <li>3) We would also highlight the need to make more extensive use of community-based methods such as water fluoridation and topical fluoride application.</li> </ol>
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Oral health care systems	13	<p>The Platform strongly welcomes this paragraph, which rightly underlines the lack of political commitment and resources dedicated for oral health globally as well as at national and regional level. Indeed, there are currently no dedicated resources for oral health in the WHO Europe regional office, an issue that should be urgently rectified in light of this Strategy and upcoming action plans.</p> <p>A strong political commitment and an increase in overall resources dedicated to oral health will be critical to achieve the vision set out by this Strategy, and we hope that this document will energize all stakeholders in this regard.</p> <p>In addition, we would suggest in this paragraph to make an explicit link to the need for a commitment to prevention as well as care, in line with the holistic and life-course approach of the Strategy.</p> <p>This paragraph should also consider that, as oral health is integral to overall health, there is a need for a stronger integration of oral health care in primary care.</p> <p>Finally, it is worth noting that existing oral healthcare systems will be challenged to implement this Strategy and will require structural changes.</p>
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Oral health care systems	14	<p>We welcome this paragraph, which rightly highlights the need for planning of the oral health workforce distribution on the basis of population oral health needs – something that does not happen in most cases.</p> <p>In light of the Strategy's general approach of closely integrating oral health with general health, we suggest amending the text to read "rather than considering the primary oral health workforce in its totality and taking into account skill mix, i.e. extending beyond the dentists and also including mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists".</p> <p>Other non-dental care providers should also be educated on oral health assessment and promotion when dental professionals are not available (i.e. nursing homes, prisons, etc).</p> <p>In addition, several key frameworks currently being developed by the WHO would significantly benefit from an oral health input, notably the WHO-ASPHER Competency Framework for the Public Health Workforce in the European Region (2020) and the development of a Global Competency Framework for UHC.</p> <p>In addition, we would like to underline that trained dentists are often concentrated in cities and other urban areas, creating care "deserts" for rural or widely dispersed populations.</p> <p>We also want to underline the need for communities to have access to professionals of diverse background who are reflective of the communities they</p>
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		will serve – and call for better access routes to professional training via apprenticeships and training programs, generally supporting the diversity of the oral health workforce.
Oral health care systems	15	<p>In line with our own position paper on the impact of COVID-19 on oral health, we welcome this paragraph, which rightly highlights the challenges that have arisen from the pandemic.</p> <p>In particular, we believe this paragraph should also underline that not only has the pandemic led to a delay in care, but also in detection, screening and prevention, as well as a lapse in good oral hygiene habits and an increase in habits that could be detrimental to good oral health (i.e. snacking and increased alcohol consumption).</p>

		<p>The pandemic has also exacerbated existing oral health inequalities, creating further challenges for global progress on oral health. This has led to an overall deteriorated situation for oral health globally, which will need to be addressed through this Strategy and its follow-up implementation, with a clear focus on building back stronger and fairer in line with the objectives of Universal Healthcare Coverage.</p> <p>The pandemic has led to an increase in antibiotic prescriptions, and we would recommend WHO to consider including oral health in the Global Action Plan on Antimicrobial Resistance or equivalent National Action Plans. The involvement of oral health professionals in these action plans, together with the use of essential prevention measures as outlined in this Strategy could help reduce the need for oral health antibiotic prescriptions.</p> <p>The pandemic, however, has also led to new opportunities, notably by accelerating the understanding, acceptance and use of telemedicine, including teledentistry, in certain aspects of the doctor/patient interface.</p>
Vision	16	<p>We welcome the vision of this strategy, but would argue it should focus on oral health, rather than on access to care and services (“coverage”).</p> <p>In addition, we believe this vision should be firmly anchored in the framework of the SDGs.</p>

Vision	17	<p>We would recommend a broadening vision for this Strategy, expanding beyond just Universal Health Coverage and aspiring to both reducing inequalities while strengthening oral health via a holistic approach that prioritises health promotion and prevention.</p> <p>In addition, we would also suggest an addition to the vision to underline the benefits that it would achieve: “....contributing to them living healthy and productive lives and, over time, lowering the societal and cost burden of chronic diseases”.</p>
Goal	18	<p>We welcome the Strategy’s ambitious goal and stand ready to support all Member States and the broader oral health community to achieve this goal by 2030 as a Platform dedicated to the improvement of oral health in Europe.</p> <p>We would however argue that the development of indicators could be clarified to expand beyond clinical indicators, to also cover function and well-being, and take a holistic approach to health in general. Furthermore, this goal should seek to secure a better integration of oral health with general health and other NCD outcomes – with specific indicators developed to track the relationship between oral health and chronic diseases.</p>
Principle 1: a public health approach to oral health	19	<p>We welcome this paragraph and the strong focus on public health, integration with oral health, and upstream approach, which are in line with the Platform vision.</p>

		<p>We would suggest having a clearer focus on inequalities – changing the title to “A public health approach to improving oral health and reducing oral health inequalities”.</p> <p>This paragraph should also refer to the necessity to focus on upstream interventions to address inequalities, taking into consideration the principle of proportionate universalism.</p>
Principle 2: integration of oral health in primary healthcare	20	<p>We welcome the emphasis in primary care in its totality and the placement of oral health within that context.</p> <p>We would like to see further emphasis on the development and strengthening of information linkage and interaction between the different components of primary care so that the parts of the population that visit health services, but not dental health services are also directed to the latter. This will further facilitate universal oral health coverage.</p> <p>Of note, “basic” and “essential” oral health services seem to be used interchangeably in the document and should be defined to improve the clarity of the document.</p>

Principle 3: a new oral health workforce model to respond to population needs

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The Platform welcomes this principle for a new oral health workforce model and the positive aspirations this sets for the Strategy. Indeed:

- 1) It is essential to align workforce and planning with oral health needs. This also requires population oral health needs to be assessed with a more holistic approach, extending beyond the simple use of clinical measures into a comprehensive assessment that also includes subjective perceptions, consideration of general health factors, behavioural propensity and evidence-based interventions.
- 2) The concept of skill mix and the use of the oral health team makes particular sense in terms of maximizing health gain with the available resources, making for a very cost-effective approach.

We would highlight the need for greater diversity of people entering the oral health workforce to facilitate involvement of more deprived communities.

Principle 4: people-centred oral health care	22	<p>We welcome this principle, which implies a more holistic way to assess needs by also including subjective perceptions about oral health needs and quality of life. This is fundamental as the planning for services and workforce should be based on those needs.</p> <p>We would however prefer this principle to focus on people-centred oral health, rather than oral healthcare. Indeed, this would be in line with a holistic approach that includes and puts the emphasis on oral health promotion and disease prevention, rather than treatment and care.</p> <p>We would suggest three modifications to the text:</p> <ol style="list-style-type: none"> <li>1) "People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by poor oral health."</li> <li>2) "People-centred oral health care actively fosters a more holistic approach to needs assessment, shared decision making, oral health literacy and self-management."</li> <li>3) "Through this process, people receive the opportunity, skills and resources to be articulated, engaged and empowered users and stakeholders of oral health services".</li> </ol>
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Principle 5: tailored oral health across the life-course	23	<p>We welcome this holistic approach to oral health across the lifecourse but would like to raise the attention of the danger of "silo" care arising due to separating age groups and interventions.</p> <p>Indeed, it is important to consider continuity of care and ensuring that access to the system is simplified.</p> <p>In addition, it is critical that this paragraph should make an explicit reference to the need to ensure good oral health-related quality of life to people across the life course.</p> <p>Finally, we would suggest a modification to the text, clarifying the first sentence to "Oral diseases and conditions affect people across the entire life course as does exposure to their risk factors".</p>
Principle 6: optimizing digital technologies for oral health	24	<p>The Platform welcomes this principle on optimizing technologies for oral health, which is essential to ensure that the latest advances in digitalisation and digital technologies can be leveraged to ensure better access to oral health and better oral health for all.</p> <p>Indeed, digital technologies offer many strategic opportunities:</p> <ol style="list-style-type: none"> <li>1) Through digital technologies, such as telemedicine, the reach of qualified practitioners can be extended to access remote areas and "care deserts", ensuring greater access for all</li> <li>2) In general, oral health programmes should be integrated within broader and</li> </ol>

		<p>coordinated public health efforts, and focused on taking advantage of advances in telehealth and digital technologies</p> <p>However, it will be essential to ensure that this bolstering of access is not detrimental to the overall quality of care received to avoid a widening of oral health inequalities.</p>
Strategic Objective 1: oral health governance	25	<p>We strongly welcome Strategic Objective 1 on Oral Health Governance, as it recognises the importance of integrating oral health in all relevant policies and public health programmes.</p> <p>The Platform calls on policymakers to promote joined-up policies and adopt adequate budgets to alleviate the burden of oral health inequalities. This Strategic Objective recognises the importance of this goal and by underlining the need for increased political and resource commitment to oral health, supports our efforts to achieve better oral health.</p>
Strategic Objective 1: oral health governance	26	<p>We welcome this paragraph on the need to establish or strengthen the capacity of a national oral health unit, which should oversee and direct the implementation of a national oral health policy. It is also essential that such a unit be well integrated in health systems.</p>

		<p>In addition, we would also raise the need for additional engagement of national oral health units with research institutions and universities.</p> <p>We understand the term “unit” to refer to “oral health input” at government level, but think that the term may encourage silo thinking, which this Strategy wants to move away from. Integration is the way forward.</p>
Strategic Objective 2: oral health promotion and oral disease prevention	27	<p>The Platform welcomes this strategic objective, especially the emphasis on upstream interventions focusing on oral health promotion. We however believe that this objective could be strengthened and further clarified by giving concrete examples of relevant policies and interventions that would target the social and commercial determinants and risk factors of oral diseases and conditions. Such examples could include:</p> <ol style="list-style-type: none"> <li>1) Fiscal policies, e.g. tax on sugar</li> <li>2) Advertising policies, e.g.. bans on specific types of advertisements, which have demonstrated their effectiveness for the reduction of tobacco consumption</li> <li>3) Policies promoting the availability and affordability of fluoride toothpaste</li> </ol> <p>In addition, WHO should include its core mid-stream policies, such as healthy settings (e.g. healthy schools or healthy cities) to contain oral health input.</p> <p>Finally, and in line with an approach centred around universal health coverage and the reduction of health inequalities, we would suggest that all relevant</p>

		policies (oral but also generally public health policies) should include an health equity impact assessment.
Strategic Objective 2: oral health promotion and oral disease prevention	28	See our comment on paragraph 27. In addition, we suggest making clear references to sugar as a risk factor, rather than "unhealthy foods".
Strategic Objective 3: primary oral health care	29	<p>We welcome Strategic Objective 3 on Primary Oral Health Care. In particular, we are pleased with the inclusion of health promotion and prevention as key components of the basic oral health care package.</p> <p>Of note, the issue of abuse and neglect would be better dealt with as a separate paragraph.</p>

<p>Strategic Objective 3:    primary oral health care</p>	<p>30</p>	<p>We welcome the information provided in this paragraph detailing how Strategic Objective 3 aims to contribute to building workforce capacity.</p> <p>We would recommend clarifying that oral health providers should be members of the primary health care team and work in multidisciplinary teams with other health workers.</p> <p>In addition, we would recommend for non-oral health care providers to be made competent to assess oral health and refer to an oral health professional when appropriate.</p> <p>We would also stress the availability and distribution of fluoride toothpastes as an essential medical consumable which is essential for optimal oral health.</p>
<p>Strategic Objective 4: oral health information systems</p>	<p>31</p>	<p>We welcome Strategic Objective 4 on Oral Health Information Systems.</p> <p>In addition to the objectives outlined in this paragraph, we would highlight the potential benefits of maximising data made available through links with other health or non-health sources. This could contribute to both planning and modelling of services but also to evaluating the provision of services and public health programmes.</p> <p>We would recommend Oral Health Information Systems encompass factors on quality of life as well as economic outcome measures.</p>

		<p>Finally, we would also emphasise the need for standardisation of oral health information, to ensure interoperability of oral health information systems at international level.</p>
Strategic Objective 5: oral health research agenda	32	<p>We fully welcome Strategic Objective 5 and the guiding principles it outlines for an Oral Health Research Agenda. In particular, the focus on public health, primary care interventions and economic analysis is welcomed.</p> <p>In this context, we would also emphasise the need for support of good quality research and adequate education of oral health professionals with adequate budget allocations, as well as the development and implementation of policies to promote efficient workforce models for oral health services.</p> <p>Finally, the Platform stands ready to provide examples of technologies that could contribute to advancing the Oral Health Research Agenda.</p>

Role of Member States, Partners and Secretariat WHO	33	<p>We welcome this paragraph, which outlines the role WHO will provide in terms of leadership, coordination and monitoring of global action on oral health.</p> <p>We call on the WHO to recognise the need for leadership on oral health at the level of the Regional Office for Europe. In order to effectively coordinate the implementation of this Global Strategy and monitor action on oral health within the European region, we would strongly recommend additional WHO support for European countries on oral health.</p> <p>We have three specific recommendations on how to measure the effectiveness of global action on oral health:</p> <ul style="list-style-type: none"> <li>• Incorporate indicators/measures of progress on oral health in general health surveys. At European level, the Platform has identified a range of key health indicators that collectively reflect a range of important and relevant oral health outcomes, and which could be included in future "Health at a Glance: Europe" reports.</li> <li>• Employ indicators/measures that focus on health rather than disease, which would contribute to the measurement of oral health-related quality of life.</li> <li>• Develop indicators/measures that integrate oral health in the 2030 Sustainable Development Goal targets, strategies and monitoring frameworks.</li> </ul>
Role of Member States, Partners and Secretariat WHO	34	<p>We welcome the opportunity to continue to work with WHO on the development and implementation of the Global Strategy on Oral Health.</p>

Role of Member States, Partners and Secretariat WHO	35	<p>We welcome the commitment and timelines this paragraph provides regarding the WHO's upcoming action plan and monitoring framework for tracking progress on the Global Strategy towards 2030.</p> <p>We have three specific recommendations for the development of this action plan and monitoring framework:</p> <ul style="list-style-type: none"> <li>• The proposed monitoring framework for tracking progress on the Global Strategy must account for broad oral health indicators, not just focusing on traditional disease indices (see our comment to paragraph 33).</li> <li>• We call on the WHO to tailor the action plan to the needs of each WHO Region, as there are significant differences in terms of the needs of regional populations and health systems.</li> <li>• The proposed action plan and monitoring framework must also identify and monitor oral health inequalities and policies to address them.</li> </ul>
Role of Member States, Partners and Secretariat WHO	36	<p>In general, we believe that the points this paragraph seeks to make would be better addressed as separate paragraphs.</p> <p>Please see our comment on paragraph 15 – it is essential that the post-pandemic recovery efforts focus on building back stronger and fairer oral health systems, seeking to address both the fallout of COVID-19 (e.g. interruptions of treatment, missed diagnosis, lapse in good oral hygiene habits) but also ensuring that such care will not be interrupted in the context of the next pandemic.</p>

		<p>In addition, and in line with the UN's SDG targets, it is essential that future oral health care systems are built to be sustainable and environment-friendly - a key objective all stakeholders should work towards and that the Platform stands ready to support.</p>
Role of Member States, Partners and Secretariat WHO	37	<p>Please see our comment on paragraph 27 – health equity impact assessments of all innovations pertaining to oral health should be conducted systematically.</p>
Role of Member States, Partners and Secretariat WHO	38	<p>We welcome the information provided in this paragraph regarding the WHO's creation of an oral health data platform. In particular, we are pleased to note the WHO aims to develop new oral health indicators for population health surveys.</p> <p>We also welcome the aim to measure oral health-related quality of life and would recommend including this among the objectives of the oral health data platform.</p>
Member States	39	<p>We fully support the recommendation in this paragraph that to respond to the challenge of oral diseases and conditions, Member States should secure appropriate oral health budgets, also for research purposes.</p> <p>At European level, the European Commission should encourage EU Member States to allocate a certain percentage of their health budget for oral health related interventions and policies. There is a need to allocate funding for the European oral health strategy that closely relates to the objectives of the EU4Health programme, focusing on the prevention of oral diseases, reduction on inequalities, enhancing access to care and supporting EU legislation.</p>

Member States	40	We fully agree with the call in this paragraph for Member States to ensure that oral health is integrated into national health systems.
Member States	41	We suggest incorporating in this paragraph on how Member States can strengthen oral health care system capacities the following recommendations: <ul style="list-style-type: none"> <li>Include social care in the mention of integrating primary oral health care as part of universal health coverage benefit packages.</li> <li>As an example of the recommendation for ensuring the affordability of essential oral medicines and consumables, fluoride toothpaste is an essential health product for oral hygiene.</li> </ul>
Member States	42	We fully support this paragraph's recommendations for how Member States can address the determinants of oral health and risk factors of oral diseases and conditions. In particular, the Platform welcomes the mention that Member States can advocate for health taxes or regulation of the sale and advertisement of unhealthy products, e.g. sugar, tobacco and alcohol.
Member States	43	We agree that the different improved surveillance and data-collecting is critical to improve the effectiveness of policies.
Member States	44	In line with an approach that seeks better integration of oral health with general health, we would suggest amending the text to encompass all future health professionals, not just oral health professionals.
International Partners	45	As a multistakeholder coalition comprising of all key oral health organisations in the European Region, we strongly welcome the role envisaged by this strategy for international partners such as ourselves.

		<p>Alongside with our Members, we look forward to supporting the implementation of the Strategy's vision in the European Region – by supporting the regional WHO Office with tailoring the Strategy and the future Action Plan to Europe's needs.</p> <p>As the voice of the oral health community in Europe we will advocate towards the European Union, Member States, and other key actors for the full implementation of the Strategy at regional and national level.</p>
International Partners	46	<p>The Platform particularly welcomes this paragraph's emphasis on coordination between international partners, in line with SDG 17, which we have sought to achieve at European level since our creation more than a decade ago.</p> <p>Through the coordination of our membership, and by acting as one regional European coalition on oral health, we can effectively and efficiently support countries as well as the WHO in their implementation of the Strategy. Our effectiveness would be further reinforced by the mobilization of dedicated resources for oral health in the WHO Europe Office – and we hope to be able to work closely with our Region's office to best implement this strategy and future action plan.</p>
Civil Society	47	<p>We fully support this paragraph's recognition of the role of civil society to encourage governments to develop ambitious national oral health responses and to contribute to their implementation.</p>

		<p>Civil society should be a key stakeholder in terms also of setting priorities for oral health care services and public health – which should be reflected in this paragraph.</p> <p>The Platform for Better Oral Health in Europe, a joint initiative of key European organisations involved in oral health, including NGO representation, is uniquely positioned to support governments at EU and national level to implement the Global Strategy.</p>
Civil Society	48	<p>We fully support this paragraph's recognition of the role of civil society to mobilise at grass-roots level and advocate for increased focus within the public agenda on oral health promotion and the prevention and control of diseases and conditions.</p> <p>We would also stress that the role of civil society is also to help consumers advocate with governments to <i>"demand that"</i> the food and beverage industry provides healthy products, rather than <i>"request"</i>.</p>
Private Sector	49	<p>We welcome the recommendation regarding the strengthening of the private sector's commitment and contribution to national oral health responses.</p>
Private Sector	50	<p>We would add that the Global Strategy should also recommend a move towards increased transparency and accountability in the private sector.</p> <p>We believe paragraph 50 should be separated into two separate paragraphs – one focusing on products causing oral diseases and conditions, and the other</p>

		on access, affordability and sound research of equipment and products supporting good oral health.
Private Sector	51	We welcome the recognition of the role dental professionals in the private sector can play in support of the implementation of the Global Strategy. We would add that the ethical commitment of the dental profession should also be recognised, to support the oral health of their communities.
Actions by the Executive Board	52	No comments.



Madrid, 14 de septiembre de 2021

## A LA ORGANIZACIÓN MUNDIAL DE LA SALUD

Don Salvador Antón Vidal, en calidad de presidente del **CONSEJO GENERAL DE COLEGIOS DE PROTÉSICOS DENTALES DE ESPAÑA**, con la dirección que consta en el encabezamiento de este escrito, ante la OMS comparece y DICE:

Que en relación al documento de discusión de la OMS (versión de 9 de agosto de 2021), relativo al **PROYECTO DE ESTRATEGIA GLOBAL SOBRE SALUD BUCAL**, hemos de aportar cierta información que podría ayudar a la mejora de la salud bucal, al ser la nuestra una de las profesiones sanitarias de la salud dental reconocidas en España, y por ello tener conocimiento de lo que sucede en nuestro sector.

Partimos de que las prótesis dentales son productos sanitarios sujetos a prescripción facultativa, es decir, no los pueden adquirir los pacientes sin el previo diagnóstico y prescripción del odontólogo, que en principio debería determinar qué prótesis es la más adecuada para cada paciente.

La finalidad de las prótesis dentales es la sustitución de los dientes perdidos, siendo productos que, una vez preparada la boca por el odontólogo, tallando dientes naturales, colocando implantes, etc., se colocan sin intervención quirúrgica.

Las prótesis dentales no tienen finalidad curativa, ya que los pacientes desdentados sufren una secuela de carácter irreversible.

Las prótesis dentales ayudarán a recuperar las funciones perdidas, pero el paciente seguirá siendo desdentado (parcial o total) para toda la vida.

Tratar de solventar los problemas dentales mediante prótesis dentales debiera ser el último recurso, pues habría que procurar una prevención, y si ésta fracasa, una odontología curativa o conservadora para intentar salvar los dientes naturales del paciente.

En gran parte del mundo, de una u otra forma, se ha procurado una regulación que garantice la objetividad que debe presidir toda prescripción médica, para que dicha prescripción no pueda quedar intoxicada por intereses económicos. Es una medida protectora de la salud reconocida e implantada en todos los campos de la salud, **menos en la salud dental**, por los suculentos ingresos económicos generados con su infracción.

El médico prescribe un medicamento y el paciente lo adquiere en la farmacia. El oftalmólogo prescribe unas gafas y el paciente acude a la óptica a comprarlas. El otorrinolaringólogo prescribe un audífono y el paciente va al establecimiento de audioprótesis para su adquisición. El traumatólogo prescribe un producto ortopédico y el paciente se dirige a la ortopedia para su dispensación. **Pero cuando el odontólogo prescribe una prótesis dental, se la proporciona él mismo al paciente, y este comportamiento conlleva una serie de perjuicios sanitarios para los pacientes.**



No hace falta ser muy perspicaz para percibirse de que, si quien prescribe además suministra lo prescrito, en la mayoría de casos optaría por la prótesis que suponga mayor facturación para la clínica dental, aunque no sea la más indicada, desapareciendo la objetividad de la prescripción. Los "sobretratamientos" son práctica demasiado frecuente.

La propia finalidad de las prótesis dentales (sustituir los dientes perdidos), aporta un plus de riesgo para los pacientes cuando no se respeta aquel principio sanitario de "quien prescribe no vende y quien vende no prescribe", pues, desde el mismo momento en el que la facturación de una clínica dental es más elevada proporcionando prótesis a los pacientes que tratando de salvar los dientes naturales, curándolos, el peligro está servido.

El Ministerio de Sanidad de España emitió un informe el 20 de noviembre de 2018, en base a artículo 4.1 del Real Decreto Legislativo 1/2015, sobre el uso racional de los medicamentos y productos sanitarios, diciendo que: *"para salvaguardar las mayores garantías sanitarias del paciente, partiendo del principio de objetividad en la prescripción de cualquier medicamento o producto sanitario, separando los actos clínicos de diagnóstico y prescripción, de las labores técnicas y procedimientos prescritos de la medición y confección de la prótesis adaptada al paciente, a fin de que no se antepongan los intereses económicos de los profesionales sanitarios (dentista y protésico), a la salud y economía de los pacientes, siguiendo una de las máximas en derecho sanitario que es que quien prescribe no puede dispensar y quien dispensa no puede prescribir. La prescripción ha de estar presidida por la objetividad y el interés sanitario del paciente, mientras que en el encargo prima el interés económico."*

Los graves perjuicios económicos para el paciente que ocasiona toda intermediación comercial son evidentes. Téngase en cuenta que, pese a estar las prótesis dentales exentas del IVA para evitar su encarecimiento como producto de primerísima necesidad, lo habitual es que los pacientes las adquieran a un 500% de su valor real.

Esta intermediación, ilegal al menos en España, ocasiona que se vuelva muy costoso para la sanidad pública, y en consecuencia una dificultad de adquisición de estos productos para los grupos de población más desfavorecidos.

Para acabar con la problemática no habría más que implantar sistemas idénticos a los establecidos con todos los medicamentos y productos sanitarios que requieren prescripción, en la línea señalada por el Ministerio de Sanidad en el informe aquí citado.

Es cuanto tenemos que informar, quedando a su entera disposición y esperando les sea de utilidad nuestra información, reciban un cordial saludo.

**D. Salvador Antón Vidal**  
Presidente del Consejo General de Colegios de  
Protésicos Dentales de España

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

**Organisation Name:** Rotary Doctor Bank Finland    **Person(s) Involved in Contribution:** Juhani Brodkin, DDS

**Date:** 14/9/21

**Contact Email:** [juhani.brodkin@gmail.com](mailto:juhani.brodkin@gmail.com)

<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
The vision of this strategy is universal oral health coverage for all people by 2030.	
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	My experience is from Tanzania, Eastern Africa, 2008-2020, as a Rotary Doctor Bank Finland board member. So, my perspective here and below is from a NGO volunteer worker. Africa contains 15% of all global population, every second there lives under poverty-line. The states are poor, experience understaffing, and have few educated personnel. Countries there, and elsewhere with low-income, lack professionals to accomplish these good goals. Even too few tutors to give good education for coming professionals. In many places, a broader response is needed: first to coordinate and then to implement; for example, further education of primary health care workers with tasks in oral health care.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded	To put the mouth back into body - it is important to realize this on all levels of decision makers, in governments, and all organizations in health care.

<p>upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>Especially in underdeveloped countries, there is lack of healthcare workers, and they can be overloaded with work. Generally, it is challenging to introduce new responsibilities into their daily duties. However, as always, importance aspects of healthcare need to be put into practice.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>In Tanzania, dental clinics and healthcare services in general are scarce. In rural villages, people go to grass roots level health workers or to a witch doctor. During pregnancy, however, women visit the maternity clinic. It would be good to add other possible health care services during pregnancy. The MIOH Australia (Midwifery Initiated Oral Health) model is being tailored for a Tanzanian context. This model aims to train midwives to provide oral health promotion for pregnant women.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond</p>	<p>In a Tanzanian context, women can be sources of knowledge in families, and bring knowledge to both men and children.</p>

<p>to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>In developing countries, perhaps public campaigns to raise awareness on oral health related subjects would be helpful as people rarely go to a dental clinic, even when in distress. Dental treatment is avoided partly because these services are limited to towns and rural hospitals. Poverty is also a problem as patients often need to pay for their dental treatment. However, maternity clinics are often free of charge.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>State-level coordination can bring knowledge into already existing digital channels to region level. For example, in Tanzania there is a lightweight mobile platform <a href="https://www.ipath-network.com/ipath/">https://www.ipath-network.com/ipath/</a></p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>There is perhaps the need for a multinational approach when states have a limited workforce. Would WHO Africa be able to coordinate this?</p>

<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>Government agencies, dental and other professional associations need to highlight the importance of oral health.</p>
<p><b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	
<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.</p>	
<p><b>Comment:</b> WHO regional offices actively participate in new and old strategies. Coordinating multinational projects are challenging to implement. There is already a good guide by WHO: Promoting Oral Health in Africa <a href="https://apps.who.int/iris/bitstream/handle/10665/205886/9789290232971.pdf">https://apps.who.int/iris/bitstream/handle/10665/205886/9789290232971.pdf</a> If there are problems in implementing the goals, perhaps then a plan is needed on how then to move forward.</p>	

## Submission to the WHO Global Consultation on Oral Health.

17<sup>th</sup> September 2021

Led by Professor Alex Brown, the Aboriginal Health Equity Theme of the South Australian Medical and Health Research Institute (SAHMRI) aims to establish the nation's leading research unit focused on reducing inequity in health and wellbeing among Australia's First peoples, and the development of the next generation of Indigenous research leaders.

The SAMHRI Aboriginal Health Equity Theme recognises the importance of improved oral health to Indigenous communities in Australia and globally and makes the following submission to the WHO Global Consultation on Oral Health with respect to the WHO Discussion Paper: 'Draft Global Strategy on Oral Health.' (Version dated 9 August 2021).

### *BACKGROUND*

*1. Recognizing the global public health importance of major oral diseases and conditions, the World Health Assembly adopted resolution WHA74.5 (2021) on oral health and requested the Director-General to develop, in consultation with Member States, a draft global strategy on tackling oral diseases.*

The South Australian Medical and Health Research Institute's Aboriginal Health Equity Theme strongly supports WHA resolution 74.5 (2021) recognising that improved oral health and access to oral health care is a key health priority of Indigenous communities.

*7. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes, people living with disability, refugees, prisoners and/or socially marginalized groups.*

We request recognition of Indigenous communities as experiencing inequitably high rates of oral diseases – in particular untreated oral diseases with severe and life threatening consequences.

### *Commercial Determinants and Risk Factors of Oral Health*

We commend the recognition and identification of commercial determinants and risk factors of oral health

10 *However, initiatives that tackle upstream determinants (such as policy and regulation) can be cost-effective and have a high population reach and impact.*

As an example of potential cost saving we note that rural and remote Aboriginal communities have found that Australia's patient assistance transfer schemes at present specifically exclude support of travel to access to general dental care. These schemes support patient transport for community members only after their dental disease has progressed to severe, life-threatening, systemic infection. This leads to costly emergency evacuation, hospitalisation and treatment under general anaesthesia at a financial cost of many thousands of dollars per person. We note that: dental conditions are the third most common cause of potentially preventable hospitalisations in Australia; a change in policy could lead to significant savings to the health system through access to transport to general dentists for simple dental extractions in the chair; and that unless these cost savings are adequately documented there may be limited likelihood of sustainable change in policy.

11 *Nonetheless, dental public health initiatives to reduce sugar consumption are rare.*

We agree with this statement and propose that while many sugar consumption reduction strategies focus on the impact of sugar on chronic diseases such as diabetes which may not manifest for many years; a focus on the more immediate and more concrete impact of sugar consumption on dental caries and the resulting pain and disfigurement of children and adults may have more impact on the reduction of the consumption of sugar.

14. *In many countries, insufficient attention is given to planning the oral health workforce to address the population's oral health needs. Dental training rarely is integrated within general health training systems and focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists.*

AND

*Principle 2: Integration of oral health in primary health care*

20. *Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.*

The WHO discussion paper highlights the weaknesses of developing an oral health workforce dominated by highly specialized dentists and strongly supports the strategy of the development of mid-level providers. We recognise this as a key strategy.

However, in view of the almost complete absence of both dentists and of mid-level dental personnel in rural and remote Indigenous communities, we request consideration of the inclusion of the additional key strategy of the development of appropriate oral health roles of existing primary health care personnel within rural and remote communities.

These key primary health personnel include medical practitioners, nurses and community health workers with Aboriginal and Torres Strait Islander Health Workers and Health practitioners being potentially key to the improved oral health of Indigenous communities. These health personnel are well established within the primary health care system and within Aboriginal Community Controlled Health Services and can be found in our most vulnerable communities who have very little or no access to dental personnel.

Currently these primary health personnel receive little if any training in oral health and undertake few if any primary oral health care activities such as community oral health promotion or screening activities. The development of the oral health role of these personnel is key to the integration of oral health within primary health care and key to the improvement of oral health of our most vulnerable communities globally.

*Principle 3: A new oral health workforce model to respond to population needs*

*21. Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.*

We request consideration of the inclusion of a specific strategy addressed to governments; peak health professional bodies including dental, medical, nursing and community health worker associations; and training institutions. This strategy will call for the joint definition of appropriate oral health roles for primary health care personnel particularly in rural and remote settings; and the joint development of the oral health training and mentoring needed to support the sustainable implementation of these roles. We note the potentially key importance of tele-training. Tele-mentoring and telehealth clinical consultations using the intra-oral camera to support rural and remote primary health care personnel taking up their oral health roles.

*Principle 6: Optimizing digital technologies for oral health*

*24. Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care.*

We request consideration of the inclusion of specific reference to the potentially key role that dental telehealth can play in the support of primary health personnel taking up their primary oral health care role. In particular, we request recognition of improvements in the technology of intra-oral cameras which allow for real time video consultations of rural and remote primary health personnel and their patients with distant dental personnel in major cities and so the shared care of these patients; and the support dental telehealth offers to primary health personnel conducting community oral health promotion and screening programs.

*Strategic Objective 1: Oral Health Governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector*

AND

*Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions*

AND

*Strategic Objective 3: Primary Oral Health Care - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care*

AND

*Strategic Objective 4: Oral Health Information Systems - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making*

AND

*Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health*

We strongly support these strategic objectives. We request inclusion of recognition that the development of the oral health role of primary health care personnel is a significant expansion of the existing dominant model of the delivery of oral health promotion and care solely by dental practitioners and mid-level dental personnel. The development of a model more appropriate to the needs and resources of rural and remote communities will not be achieved without the strong support of national governments through policy development, funding, training and evaluation research.

We note that in this time of the global COVID pandemic there will be limited health resources available for the implementation of these strategic objectives. We note in particular that to achieve the health system changes needed to support the sustainable development of the oral health role of primary health personnel it is essential to undertake the economic evaluation research needed to establish the cost savings this model can bring to the health system.

#### ***ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT WHO WHO***

We request consideration of a commitment of WHO to expand the Oral Health Unit – especially during this period of global oral health strategy development and the associated stakeholder communication and coordination tasks. We request in particular that as WHO is

seeking the development of global strategies, including strategies appropriate to low income countries with severely limited health budgets with ratios of 1 dentist per 150,000 persons, that personnel with experience in low-income countries be co-opted for the period global oral health strategy development. We further request that if WHO is seeking the development of strategies appropriate to the world's Indigenous communities that Indigenous persons be co-opted for this period. We believe that this will support the development of strategies that are achievable in the context of severe poverty and remoteness from dental health services which characterizes a very large portion of the global population.

*ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT WHO  
Member States*

We strongly support the clear and concrete description of the actions needed by Member States and their Governments and Health Departments to bring about improved oral health on a national and global scale.

*ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT WHO  
International Partners*

We strongly support the paper's identification of the importance of international and national professional associations including the World Dental Federation, the World Medical Association and the International Council of Nurses to bring about the workforce change needed to integrate oral health within primary health care. This includes the need for the dental professions to support the development of the primary oral health role of primary health care professions and the willingness of primary health care professions to take up their appropriate primary oral health care role.

Indigenous communities face both a particularly heavy burden of oral disease and severely limited access to dental services with barriers including the cost of services, the distance to services, and cultural and language barriers. We have found reliance on the dominant model of provision of oral health care services solely by dental personnel to perhaps be appropriate to urban communities. We request however that the Oral Health Unit consider strategies appropriate to severe poverty, lack of access to health services and the cultural and language barriers faced by Indigenous communities and that the Oral Health Unit enter into ongoing conversation not only with governments and professional associations but also with Indigenous communities and their health services.

Thank you for your consideration of this submission.



## WHO's DRAFT GLOBAL ORAL HEALTH STRATEGY

**The following are recommendations for revisions to the WHO Strategy on Oral Health.**

**#5:** We recommend updating the incidence of cleft lip and/or palate to 1 in 700, the widely accepted rate. While some risks may be higher for *cleft lip and palate* patients, all phenotypes of cleft (isolated lip, lip and palate, isolated palate) have serious implications on oral health.

**Recommended text:** Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375000 new cases and nearly 180 000 deaths in 2020.<sup>3</sup> Noma is a necrotizing disease that is a marker of extreme poverty; it starts in the mouth and is fatal for as much as 90% of affected children.<sup>4,5</sup> Cleft lip and/or palate, the most common craniofacial birth defect, has a prevalence of approximately 1 in 700 births, with considerable ethnic and geographic variation.<sup>6,7</sup> Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting over one billion people.<sup>8</sup>

**References:**

Dahllöf G, Ussisoo-Joandi R, Ideberg M, Modeer T. Caries, gingivitis, and dental abnormalities in preschool children with cleft lip and/or palate. *Cleft Palate J.* 1989 Jul;26(3):233-7; discussion 237-8. PMID: 2788042.  
Bian Z, Du M, Bedi R, Holt R, Jin H, Fan M. Caries experience and oral health behavior in Chinese children with cleft lip and/or palate. *Pediatr Dent.* 2001 Sep-Oct;23(5):431-4. PMID: 11699170.

**#7:** Families affected by cleft lip and/or palate are part of some of the most vulnerable in communities worldwide. cleft lip and/or palate more often affects socioeconomically disadvantaged individuals and being born with a cleft has been found to exacerbate a child's likelihood of being left out of school, the healthcare system, and the workforce. For this reason, we recommend that orofacial clefts are specifically called out in this section:

**Recommended text:** There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes, born with cleft lip and/or palate, living with disability, refugees, prisoners and/or socially marginalized groups.

**References:**

Socioeconomic Position and Risk of Oral Clefts. *AAP Grand Rounds* Jan 2016, 35 (1) 4; DOI: 10.1542/gr.35-1-4  
Fitzsimons KJ, Deacon SA, Copley LP, Park MH, Medina J, van der Meulen JH. School absence and achievement in children with isolated orofacial clefts. *Arch Dis Child.* 2021 Feb;106(2):154-159. doi: 10.1136/archdischild-2020-319123. Epub 2020 Aug 19. PMID: 32816695.  
Smillie I, Yong K, Harris K, Wynne DM, Russell CJ. Socioeconomic influence on orofacial cleft patient care. *Scott Med J.* 2015 May;60(2):70-4. doi: 10.1177/0036933014564133. Epub 2014 Dec 12. PMID: 25504476.  
Dak-Albab RJ, Dashash MA. The influence of socioeconomic status on oral health-related quality of life among Syrian children with cleft lip, or palate, or both. *Saudi Med J.* 2013 Feb;34(2):181-6. PMID: 23396466.  
Muntz HR, Meier JD. The financial impact of unrepaired cleft lip and palate in the Philippines. *Int J Pediatr Otorhinolaryngol.* 2013 Dec;77(12):1925-8. doi: 10.1016/j.ijporl.2013.08.023. Epub 2013 Sep 20. PMID: 24139590.  
Dvivedi J, Dvivedi S. A clinical and demographic profile of the cleft lip and palate in Sub-Himalayan India: A hospital-based study. *Indian J Plast Surg.* 2012;45(1):115-120. doi:10.4103/0970-0358.96602

**#9:** We recommend detailing modifiable risk factors for conditions referenced, including cleft lip and/palate, to emphasize the shared modifiable risk factors and better inform strategies for prevention.

**Recommended Text:** Oral diseases and conditions share modifiable risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease and diabetes. These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers. The risk factors for noma include malnutrition, coinfections, poor oral hygiene and poor living conditions. Some of these risk factors are also associated with traumatic dental injury. The most common craniofacial malformation, cleft lip and/or palate, is associated with some of these same modifiable risk factors, as well as others such as vitamin deficiencies, maternal metabolic syndromes, and environmental exposures such as cigarette smoke and alcohol.

Additional references:

Nasreddine G, El Hajj J, Ghassibe-Sabbagh M. Orofacial clefts embryology, classification, epidemiology, and genetics. *Mutat Res Rev Mutat Res.* 2021;787:108373. doi:10.1016/j.mrrev.2021.108373

Stothard KJ, Tennant PW, Bell R, Rankin J. Maternal overweight and obesity and the risk of congenital anomalies: a systematic review and meta-analysis. *JAMA.* 2009;301(6):636-650. doi:10.1001/jama.2009.113

Van Dyck J, Begnoni G, Willems G, et al. Dental development in patients with and without unilateral cleft lip and palate (UCLP): a case control study. *Clin Oral Investig.* 2021;25(5):2619-2631. doi:10.1007/s00784-020-03573-1

## **#17: Comment on Vision, Goal, and Guiding Principles:**

We strongly welcome the recognition of oral health as a fundamental human right. The description of the strategy's vision includes the three elements of UHC (quality, accessibility, and affordability) and asks for the oral health response to be needs-based. We welcome reference to the wide range of services that universal oral health coverage should encompass, including prevention and rehabilitation. Rehabilitation should not be forgotten in the context of oral healthcare, as this is an essential service. For example, for people undergoing oral surgery in the context of a cleft or other complications.

**#21:** We welcome the emphasis placed on the education and training of health workers to build capacity for oral health service delivery. This must include education and training across silos to ensure that oral health services align with community needs and are fully integrated within health systems.

**Recommended Text:** Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care acknowledging and understanding some of the most common conditions such as cleft lip and/or palate. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.

**#32:** We align fully with the need to refocus the oral health research agenda as described in Strategic Objective 5. We urge WHO to also emphasize the need for increased funding to support an ambitious and comprehensive oral health research agenda. Oral health research is often given low priority in funding agencies and there is an urgent need for more funding in this area. This is particularly the case for common conditions such as cleft lip and/or palate.

**Recommended Text:** Strategic objective 5 strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and problem description, rather than problem-solving. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions. Financial investment in oral health research, particularly for common conditions such as cleft lip and/or palate, should be prioritized.

### **Suggested additional strategic objective: Oral Health Workforce:**

We urge WHO to consider the addition of a new strategic objective on oral health workforce specifically, in line with the guiding principle: A new oral health workforce model to respond to population needs. This will help address the different challenges affecting the oral health workforce, such as education, retention, geographical distribution, planning, and intra- and inter-professional collaboration. It needs to be specified how oral health workers can help address shared risk factors (e.g., via tobacco cessation support, dietary advice, etc.) and support general health check-ups (e.g., performing screenings for oral cancer and diabetes). Also, non-oral health workers can be trained to deliver brief oral hygiene interventions performing a risk assessment and referring patients to a dentist when relevant.

**#44:** It is imperative to reinforce the point that Member States need to take specific action to see that they are addressing the needs of the most marginalized. Disparities still exist in the access to oral care, mostly affecting the disadvantaged and marginalized populations. To address this, local oral health professionals and the healthcare system should have a focus on reaching those who need it most. This specific point seems to be missing from 41-44; we recommend it is added as such:

**Recommended Text:** Member States should critically review and continuously update their oral health education and training curricula prioritizing a public health approach to oral health and reflective problem-solving and leadership skills among future oral health professionals. They should also review their system's ability to reach marginalized and disadvantaged populations.

#### Additional references:

Ghanbarzadegan A, Bastani P, Luzzi L, Brennan D. Inequalities in utilization and provision of dental services: a scoping review. Syst Rev. 2021;10(1):222. Published 2021 Aug 10. doi:10.1186/s13643-021-01779-2

Ghanbarzadegan A, Balasubramanian M, Luzzi L, Brennan D, Bastani P. Inequality in dental services: a scoping review on the role of access toward achieving universal health coverage in oral health. BMC Oral Health. 2021;21(1):404. Published 2021 Aug 17. doi:10.1186/s12903-021-01765-z

Chang Q, Gao X, Xu M, et al. Socioeconomic-related inequality in dental care utilization among preschool children in China [published online ahead of print, 2021 Jul 20]. Community Dent Oral Epidemiol. 2021;10.1111/cdoe.12681. doi:10.1111/cdoe.12681

Ghanbarzadegan A, Balasubramanian M, Luzzi L, Brennan D, Bastani P. Inequality in dental services: a scoping review on the role of access toward achieving universal health coverage in oral health. BMC Oral Health. 2021;21(1):404. Published 2021 Aug 17. doi:10.1186/s12903-021-01765-z

**#45 – 46:** We align with this section but mention of collaboration of international partners with national actors to ensure implementation at the regional and national level should be added.

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

**Organisation Name:** South Western Sydney Local Health District, Drug Health Services & Oral Health Services      **Person(s) Involved in Contribution:** Prakash Poudel; A/Prof Ravi Srinivas

**Date:** 15 September 2021

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Key Areas of the Draft Global Strategy for Oral Health	Stakeholder Comment
The vision of this strategy is universal oral health coverage for all people by 2030.	As this is a strategy document, consider adding maxillofacial with oral diseases to add conditions such as cleft-lip/palate as well as development disabilities.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	No comment
GUIDING PRINCIPLES – PAGE 4 of Draft Strategy	
Principle 1: <b>A public health approach to oral health</b> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and	Appropriate.

<p>coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>While discussing about the integration, the strategy also needs to discuss the current challenges, requirements and needs to integrate. There are needs to be discussion on measures (resources and workforce planning) to reduce the disruption that may result from integration of oral health at primary care level.</p> <p>The strategy should also focus on the utilisation of the non-dental workforce, particularly nurses. There is currently sufficient evidence to support nurses' role in integration. Additionally, the strategy should involve planning on how the non-dental workforce can be utilised in the integration, such as addressing the current barriers at system, organisational and individual levels.</p> <p>This principle perhaps could be more specific. It lacks detail on how this would allow for translation into outcomes. The impact of dental appointments in providing general prevention interventions must be considered; for example, growth assessments in child dental services. It must clearly articulate that inclusion of oral health services in the universal health coverage will lead to decrease in hospital presentations or perhaps reduce impact on acute care services.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO</p>	<p>Few comments on the suitability of terms:</p> <ul style="list-style-type: none"> <li>• ‘<b>New oral health workforce model</b>’ the approached discussed in the strategy relates more to reforming the existing model - not the development of new model?</li> <li>• Use of the term ‘<b>training of health workers</b>’ is confusing. Does that to refer oral health workforce or also include other health professionals?</li> </ul> <p>Probably incorporate the role of other non-oral health professionals in providing early referral services. Closer alignment with other health professionals is required. Global agreement with expected skills assessment for each professional sub-group is required. Dentists/Dental Specialists must be clearly identified as clinical team leaders.</p>

Global competency framework for universal health coverage.	
<b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.	More emphasis is needed on culturally appropriate care. People-centred care should include patient/consumer values and how this engagement would look like.
<b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.	Principle 5 needs to be better written up in order to convey meaning. Is this a whole of health approach?
<b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce	Agree, however digital technologies can be enablers (such as telehealth etc) or a tool (like diagnostic imaging, 3D printing, CEREC machines etc). This should be clearly articulated.

governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.	
<b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b>	
<i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.	
<i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	
<i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	
<i>Strategic Objective 4: Oral Health Information Systems</i> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	
<i>Strategic Objective 5: Oral Health Research Agenda</i> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b>	

**Comment:**

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

**Organisation Name:** Sydney Local Health District, **Person(s) Involved in Contribution:** Shilpi Ajwani  
**Oral Health Services and Sydney Dental Hospital**

**Date:** 17.9.21

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Key Areas of the Draft Global Strategy for Oral Health	Stakeholder Comment
The vision of this strategy is universal oral health coverage for all people by 2030.	Agree with the vision statement. Universal oral care is an important aspect of integrating oral health into general health.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	Agree with the goal, but it needs to address the financial commitment and support that will be required by the Members and allocation of funding in the budget to achieve this goal, meet the strategic objective (1), and enable the actions that are required. Suggest that “Allocate appropriate resources and funding to achieve it” should be included in the goal.
GUIDING PRINCIPLES – PAGE 4 of Draft Strategy	
Principle 1: <b>A public health approach to oral health</b> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded	Agree. There should also be mention of achieving equitable care. A public health approach to <u>equitable</u> oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.

<p>upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>Another potential benefit of integration of oral health in primary health care is that the common risk factors are addressed as part of preventive health strategies that will improve oral health outcomes.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Although a new and expanded oral health workforce is needed, it is equally important that oral health is included in medical, nursing and allied health training so that the general health workforce does not overlook oral health.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond</p>	<p>Agree. In addition, the focus should be on providing care that matter to people through the most cost-efficient way (i.e. value based oral care).</p>

<p>to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Tailored oral health across the life course <u>and across the cross section of society</u> – this will include the vulnerable groups like CALD (culturally and linguistically diverse) communities, people with disabilities, Indigenous communities and the age groups.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>There should be a mention of using social marketing to enhance community oral health. Social marketing is becoming a very powerful tool in influencing knowledge and behaviours and bringing about change.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>Does resource commitment mentioned here include financial resource commitment? This should be stated clearly. Establishing a national oral health unit is a very good strategy to achieve the objectives but needs to be an action driven unit.</p>

<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>Integrating oral disease prevention strategies with other systemic disease prevention strategies like cardiovascular, diabetes using a common risk factor approach should be added and inclusion in broader policies not just limited to smoking and sugars</p>
<p><b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>This objective should clearly state <u>Basic Universal</u> Oral Health Care. Explanation of what is basic oral care appears out of place as it is not mentioned in the objective. What does agreed quality and patient safety standards mean? Providing basic oral care that is of value to people in a cost-effective way should be part of this objective. The use of telehealth is essential to enable non-dental professionals or wider dental team, especially in rural and remote areas, to communicate with dentists and specialists for universal oral care.</p>
<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>There is the need for easy access to health data for research.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>There is the definite need to embrace newer areas of research that will help evaluate and achieve the goals and above objectives.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.</p>	
<p><b>Comment:</b></p>	



Dr Benoit VARENNE

Dental Officer  
World Health Organization  
Genève - SUISSE

Paris, France le 17 septembre 2021

**Objet :** consultation mondiale sur la stratégie globale sur la santé orale par l'OMS

Cher Confrère, Cher Benoit,

A la lecture de la version de travail soumise à consultation, notre association retrouve pleinement les ambitions portées dans son propre programme associatif.

L'UFSBD souhaite réaffirmer en préambule que personne ne peut se dire en bonne santé, s'il n'a pas une bonne santé bucco-dentaire. Face à des pathologies évitables mais trop largement répandues, il est nécessaire pour tous les états d'en faire une des priorité de santé dans tous leurs politiques.

Il est nécessaire que cette prise de conscience puisse aussi se traduire dans la population, par tous les professionnels de santé y compris les équipes dentaires et leurs représentations nationales.

Au-delà des pathologies bucco-dentaires en elle-même, il est important de montrer aussi leurs interrelations délétères avec des affections chroniques ou aigues générales.

L'UFSBD propose d'ajouter la nécessité de maintenir un lien régulier tout au long de la vie avec une équipe dentaire identifiée. Il serait donc souhaitable pour les systèmes de santé et les couvertures assurantielles de promouvoir la matérialisation du suivi avec un « chirurgien-dentiste traitant » à l'instar de l'état d'esprit du dispositif déjà mis en place en France pour la médecine générale : l'enregistrement obligatoire d'un médecin traitant pour tout assuré.

L'UFSBD ne rentrera pas dans des commentaires de sémantiques sur certains termes, l'état d'esprit du document devant être le plus possible universel pour permettre un cadre suffisamment adaptable aux différents pays membres.

Ci-après l'UFSBD souhaite apporter des remarques et précisions sur le document soumis à consultation. Des repères sont positionnés dans la page de texte original, et nos commentaires sont repris dans la page suivante.

Je te prie d'agréer mes sincères salutations confraternelles.

Dr Benoît PERRIER

Président

DOCUMENT DE RÉFLEXION DE L'OMS  
(version datée du 9 août 2021)

PROJET DE STRATÉGIE MONDIALE POUR LA SANTÉ BUCCO-DENTAIRE

## CONTEXTE

1. Consciente de l'importance des principales maladies et affections bucco-dentaires pour la santé publique mondiale, l'Assemblée mondiale de la Santé a adopté la résolution WHA74.5 (2021) sur la santé bucco-dentaire et prié le Directeur général d'élaborer, en consultation avec les États Membres, un projet de stratégie mondiale de lutte contre les maladies bucco-dentaires.<sup>1</sup> Cette stratégie servira de base à un plan d'action mondial pour la santé bucco-dentaire, y compris un cadre de suivi des progrès assorti d'objectifs clairs et mesurables à atteindre d'ici à 2030.

2. La résolution sur la santé bucco-dentaire et le projet de stratégie mondiale qui en découle sont fondés sur le Programme de développement durable à l'horizon 2030, en particulier l'objectif 3 de développement durable (Permettre à tous de vivre en bonne santé et promouvoir le bien-être de tous à tout âge) et sa cible 3.8, qui consiste à instaurer la couverture sanitaire universelle. Ils concordent avec le treizième programme général de travail de l'OMS (2019) ; la Déclaration politique issue de la réunion de haut niveau sur la couverture sanitaire universelle (2019) ; le cadre opérationnel pour les soins de santé primaires (2020) ; la Stratégie mondiale sur les ressources humaines pour la santé à l'horizon 2030 (2016) ; le Plan d'action mondial pour la lutte contre les maladies non transmissibles 2013-2020 (2013) ; la Convention-cadre de l'OMS pour la lutte antitabac (2003) ; la décision WHA73(12) (2020) sur la Décennie pour le vieillissement en bonne santé 2020-2030 ; et la décision WHA67.11 (2014), intitulée « Conséquences pour la santé publique de l'exposition au mercure et aux composés du mercure : le rôle de l'OMS et des ministères de la santé publique dans la mise en œuvre de la Convention de Minamata ».

## APERCU GÉNÉRAL DE LA SANTÉ BUCCO-DENTAIRE DANS LE MONDE

3. La santé bucco-dentaire est le bien-être de la bouche, qui réunit de nombreuses fonctions essentielles comme celles de respirer, de manger, de parler, de sourire et d'échanger avec les autres. Une bonne santé bucco-dentaire, à la fois source de confort et de confiance, permet à une personne de réaliser tout son potentiel et de participer pleinement à la société. La santé bucco-dentaire fait partie intégrante de la santé globale, du bien-être et de la qualité de vie, depuis la naissance jusqu'à un âge avancé.

### Charge des maladies bucco-dentaires

4. On estime qu'il y a plus de 3,5 milliards de cas de maladies bucco-dentaires et d'autres affections bucco-dentaires dans le monde, dont la plupart peuvent être évitées.<sup>2</sup> Au cours des trente dernières années, la prévalence mondiale cumulée des caries dentaires, des maladies parodontales (gencives) et de la chute de dents est demeurée de 45 %, chiffre qui est plus élevé que la prévalence de n'importe quelle autre maladie non transmissible.<sup>2</sup>

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<sup>1</sup> [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_R5-fr.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R5-fr.pdf).

<sup>2</sup> <http://dx.doi.org/10.1177/0022034520908533>.

5. Les cancers des lèvres et de la cavité buccale se placent au seizième rang des cancers les plus répandus dans le monde, avec plus de 375 000 cas nouveaux et près de 180 000 décès en 2020.<sup>1</sup> Le noma est une maladie nécrosante qui est un marqueur de l'extrême pauvreté ; il commence dans la bouche et est mortel dans une proportion pouvant atteindre 90 % chez les enfants touchés.<sup>2,3</sup> La fente labiale et la fente palatine, anomalies congénitales crâniofaciales les plus courantes, ont une prévalence d'environ 1 pour 1500 naissances.<sup>4,5</sup> On estime que la prévalence mondiale des lésions dentaires d'origine traumatique est de 23 % pour les dents de lait et de 15 % pour les dents définitives, et qu'elles concernent ainsi plus d'un milliard de personnes.<sup>6</sup>

### **Coûts sociaux et économiques des problèmes de santé bucco-dentaire**

6. Si elles ne sont pas traitées, les maladies et affections bucco-dentaires ont des conséquences personnelles graves telles que des symptômes physiques, des limitations fonctionnelles et des effets néfastes sur le bien-être émotionnel et social. Pour les personnes souffrant de maladies et d'affections bucco-dentaires qui se font soigner, les coûts peuvent être élevés et représenter un fardeau économique important. En 2015, à l'échelle mondiale, les maladies et affections bucco-dentaires ont entraîné des coûts directs de 357 milliards de dollars des États-Unis (USD) et des coûts indirects de 188 milliards USD, avec de grandes différences entre les pays à revenu élevé, intermédiaire ou faible.<sup>7</sup>

7. Il y a une corrélation très forte et constante entre le statut socioéconomique (revenu, profession et niveau d'instruction) et la prévalence et la gravité des maladies et affections bucco-dentaires. Tout au long de la vie, ces pathologies touchent davantage les membres pauvres et vulnérables de la société, souvent les personnes qui ont de faibles revenus, les personnes handicapées, les réfugiés, les prisonniers et/ou les groupes socialement marginalisés.

### **Déterminants commerciaux et facteurs de risque des maladies et affections bucco-dentaires**

8. Les maladies et affections bucco-dentaires et les inégalités en matière de santé bucco-dentaire sont directement influencées par des déterminants commerciaux, à savoir les stratégies et les méthodes utilisées par le secteur privé pour promouvoir des produits et des choix qui ont des effets néfastes sur la santé.

9. Les maladies et affections bucco-dentaires dépendent de facteurs de risque modifiables communs aux principales maladies non transmissibles, c'est-à-dire les maladies cardiovasculaires, le cancer, les maladies respiratoires chroniques et le diabète. Ces facteurs de risque comprennent toutes les formes de tabagisme, la consommation de chiques de bétel et de noix d'arec, l'usage nocif de l'alcool, un apport

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<sup>1</sup> <https://geo.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf>.

<sup>2</sup> <https://daccess-ods.un.org/TMP/1058816.4627552.html>.

<sup>3</sup> <http://www.who.int/iris/handle/10665/254579>.

<sup>4</sup> <https://apps.who.int/iris/rest/bitstreams/1320658/retrieve>.

<sup>5</sup> <http://dx.doi.org/10.1016/j.jormas.2021.05.008>.

<sup>6</sup> <http://dx.doi.org/10.1111/edt.12389>.

<sup>7</sup> <http://dx.doi.org/10.1177/0022034517750572>.

élevé de sucres et l'absence d'allaitement maternel, ainsi que le papillomavirus humain pour les cancers de l'oropharynx. Certains de ces facteurs de risque sont également associés à la fente labiale et palatine et à des lésions dentaires traumatisques. Les facteurs de risque du noma comprennent la malnutrition, les co-infections, une mauvaise hygiène bucco-dentaire et de mauvaises conditions de vie.<sup>1</sup>

### **Promotion de la santé bucco-dentaire et prévention des maladies bucco-dentaires**

10. Les initiatives de promotion de la santé bucco-dentaire et de prévention des maladies bucco-dentaires n'ont que rarement visé les déterminants sociaux et commerciaux de la santé bucco-dentaire à l'échelle de la population. Cependant, les initiatives qui s'attaquent aux déterminants en amont (comme les politiques et la réglementation) peuvent être rentables et avoir une portée et un impact importants dans la population. En outre, la promotion de la santé bucco-dentaire et la prévention des maladies bucco-dentaires sont rarement intégrées aux programmes de lutte contre d'autres maladies non transmissibles qui ont les mêmes grands facteurs de risque et déterminants sociaux.<sup>2</sup>

11. En 2015, l'OMS a publié des lignes directrices sur l'apport de sucres chez les adultes et les enfants dans lesquelles elle recommandait vivement de réduire la consommation de sucres libres tout au long de la vie en se fondant sur les preuves scientifiques d'une corrélation positive entre l'apport de sucres libres, d'une part, et d'autre part, le poids corporel et les caries dentaires. Néanmoins, dans le domaine de la santé bucco-dentaire, les initiatives de santé publique visant à réduire la consommation de sucre sont rares.

12. Des millions de personnes ne bénéficient pas de programmes de promotion de la santé bucco-dentaire et de prévention des maladies bucco-dentaires. L'utilisation de fluor pour prévenir les caries dentaires est limitée et, souvent, les méthodes de prévention essentielles, comme les méthodes à assise communautaire, l'application topique de fluor ou l'emploi de dentifrice fluoré, ne sont pas disponibles ou coûtent trop cher pour nombre de personnes.<sup>3</sup>

### **Systèmes de soins bucco-dentaires**

13. L'engagement politique et les ressources consacrées aux systèmes de soins bucco-dentaires sont souvent limités au niveau du ministère de la santé. Ordinairement, le système de soins bucco-dentaires est insuffisamment financé, hautement spécialisé et isolé du système de soins de santé général. Dans la plupart des pays, les prestations prévues par la couverture sanitaire universelle et les interventions contre les maladies non transmissibles n'englobent pas les soins bucco-dentaires essentiels. En règle générale, les établissements de soins primaires ne proposent pas de soins bucco-dentaires, et la couverture des soins bucco-dentaires par les régimes d'assurance privés ou publics varie beaucoup d'un pays à l'autre.

14. Dans de nombreux pays, on n'accorde pas suffisamment d'attention à la planification du personnel de santé bucco-dentaire pour répondre aux besoins de la population. La formation en soins dentaires<sup>4</sup> est rarement intégrée aux systèmes de formation en santé générale et privilégie la formation de dentistes hautement spécialisés plutôt que d'agents de santé communautaires et de prestataires de niveau intermédiaire, tels que les assistants dentaires, les infirmiers dentaires, les thérapeutes dentaires et les hygiénistes dentaires.<sup>5</sup>

15. La pandémie de COVID-19<sup>6</sup> a eu des effets négatifs sur la prestation de services de santé bucco-dentaire essentiels dans la plupart des pays, ce qui a entraîné des retards dans le traitement des

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💬 Nombre : 1 Auteur : drben Sujet : Note Date : 15/09/2021 18:22:37  
La notion d'allaitement maternel ne nous paraît pas adapté, ce n'est pas un élément totalement protecteur. Un allaitement maternel mal maîtrisé impact autant l'apparition de caries précoces du jeune enfant. Face à ce phénomène c'est d'ailleurs ce terme qui est utilisé.

💬 Nombre : 2 Auteur : drben Sujet : Note Date : 15/09/2021 18:34:40  
Pourtant l'intégration de l'aspect bucco-dentaire est un formidable catalyseur dans ces programmes, car elle est une approche universelle concernant tous les publics.

💬 Nombre : 3 Auteur : drben Sujet : Note Date : 15/09/2021 18:48:38  
Il est à noter qu'il est inquiétant de voir se répandre des allégations trompeuses en faveur de dentifrices sans fluor. Il est important pour tous les acteurs de réaffirmer des recommandations et repères clairs en la matière

💬 Nombre : 4 Auteur : drben Sujet : Note Date : 15/09/2021 18:51:08  
Nous préférons parler de formation à la santé bucco-dentaire que formation en soins dentaires. Car la formation doit intégrer un approche globale d'accès à la santé plutôt qu'un accès au soins.

💬 Nombre : 5 Auteur : drben Sujet : Note Date : 15/09/2021 18:55:46  
Il est à noté la nécessité aussi d'intégrer dans la formation initiale et continue de tous les professionnels de santé et paramédicaux d'avoir des modules plus complets sur la santé bucco-dentaire et ses déterminants

💬 Nombre : 6 Auteur : drben Sujet : Note Date : 15/09/2021 19:03:17  
De manière courante, dans la lutte contre l'antibiorésistance, les stratégies permettant d'éviter les pathologies ou de favoriser une approche précoce ne sont pas assez prise en compte pour limiter massivement les prescriptions antibiotiques du secteur dentaire. La pandémie n'a été qu'une révélateur de cette situation

affections bucco-dentaires, une augmentation des prescriptions d'antibiotiques et de plus grandes inégalités en matière de santé bucco-dentaire. La pandémie devrait être considérée comme une occasion de mieux intégrer les soins bucco-dentaires dans les systèmes de soins de santé en général au titre des efforts déployés pour instaurer la couverture sanitaire universelle.

## **FINALITÉ, OBJECTIF ET PRINCIPES DIRECTEURS**

### **Finalité**

16. La finalité de cette stratégie est la couverture universelle en santé bucco-dentaire pour tous d'ici à 2030.

17. La couverture universelle en santé bucco-dentaire signifie que chacun a accès à des services de santé essentiels et de qualité qui répondent à ses besoins et qu'il peut les utiliser sans s'exposer à des difficultés financières. Ces services comprennent des interventions de promotion de la santé bucco-dentaire, de prévention des maladies et affections bucco-dentaires, de traitement et de réadaptation tout au long de la vie. La couverture universelle en santé bucco-dentaire permettra à chacun de jouir du meilleur état de santé bucco-dentaire qu'il est capable d'atteindre, lui donnant ainsi plus de chances de mener une vie saine et productive. La possession du meilleur état de santé bucco-dentaire qu'il est capable d'atteindre constitue l'un des droits fondamentaux de tout être humain.

### **But**

18. La stratégie a pour but d'aider les États Membres à élaborer des programmes nationaux ambitieux pour promouvoir la santé bucco-dentaire, faire reculer les maladies et affections bucco-dentaires et les inégalités en matière de santé bucco-dentaire, progresser sur la voie de la couverture sanitaire universelle dans le domaine bucco-dentaire et envisager de définir des cibles et des indicateurs, en fonction de la situation nationale et d'après les orientations que donnera le plan d'action mondial de l'OMS pour la santé bucco-dentaire, hiérarchiser les actions à mener et évaluer les progrès réalisés d'ici à 2030.

### **Principes directeurs**

#### *Principe 1 : Aborder la santé-bucco-dentaire sous l'angle de la santé publique*

19. Aborder la santé bucco-dentaire sous l'angle de la santé publique, c'est chercher à offrir un avantage maximum en santé bucco-dentaire au plus grand nombre en visant les maladies et affections bucco-dentaires les plus répandues et les plus graves. Pour y parvenir, il faut intégrer les programmes de santé bucco-dentaire dans des initiatives de santé publique d'ordre plus général et coordonnées. Aborder la santé bucco-dentaire sous l'angle de la santé publique suppose de prendre en amont des mesures intensifiées et élargies faisant intervenir un vaste ensemble d'acteurs, par exemple ceux des secteurs de l'action sociale, de l'économie, de l'éducation, de l'environnement et d'autres secteurs concernés.

#### *Principe 2 : Intégrer la santé bucco-dentaire dans les soins de santé primaires*

20. Les soins de santé primaires sont la pièce maîtresse du renforcement des systèmes de santé parce qu'ils améliorent leur performance, progrès qui se traduit par de meilleurs résultats en santé. Le regroupement des services de santé bucco-dentaire de base avec d'autres services de lutte contre les

maladies non transmissibles au niveau des soins de santé primaires est un élément essentiel de la couverture sanitaire universelle. Cette intégration présente de nombreux avantages potentiels, notamment de plus grandes chances de prévenir, détecter rapidement et maîtriser des affections connexes, ainsi qu'un accès plus équitable à des soins de santé complets et de bonne qualité.

*Principe 3 : Un nouveau modèle de dotation en personnel de santé bucco-dentaire pour répondre aux besoins de la population*

21. Les modèles de planification des ressources et de dotation en personnel de santé bucco-dentaire doivent mieux faire concorder la formation théorique et pratique des agents de santé avec les besoins de la population. La couverture universelle en santé bucco-dentaire n'est faisable que si l'on réforme les systèmes de santé, d'éducation et de planification des ressources de telle sorte que les effectifs soient suffisants et le panachage de compétences adéquat pour dispenser les soins bucco-dentaires essentiels. Il faut pour cela réexaminer les rôles et les compétences des prestataires de soins bucco-dentaires de niveau intermédiaire et des agents de santé bucco-dentaire communautaires sur la base du nouveau cadre de compétences mondial de l'OMS pour la couverture sanitaire universelle.

*Principe 4 : Des soins bucco-dentaires centrés sur la personne*

22. Les soins bucco-dentaires centrés sur la personne sont assurés en sollicitant et en prenant en compte le point de vue des individus, des familles et des communautés, surtout des personnes atteintes de maladies et d'affections bucco-dentaires. Cette approche considère les individus comme des participants autant que comme des bénéficiaires d'un système de santé bucco-dentaire fiable qui répond à leurs besoins et tient compte de leurs préférences avec humanité et de façon globale. Les soins bucco-dentaires centrés sur la personne favorisent activement l'amélioration des connaissances de base en santé bucco-dentaire, la prise de décisions en commun et l'autoprise en charge. Grâce à ce processus, les gens ont la possibilité – et aussi les compétences et les ressources nécessaires pour cela – d'être des utilisateurs éclairés, engagés et autonomes des services de santé bucco-dentaire.

*Principe 5 : Une santé bucco-dentaire adaptée tout au long de la vie*

23. Les gens souffrent de maladies et d'affections bucco-dentaires et sont exposés à leurs facteurs de risque tout au long de l'existence. Les effets peuvent varier et s'accumuler au fil du temps et devenir complexes plus tard au cours de l'existence, notamment en ce qui concerne d'autres maladies non transmissibles. Ces évolutions expliquent pourquoi il faut intégrer des stratégies de santé bucco-dentaire adaptées à l'âge dans les programmes de santé prévus à chaque étape de la vie, y compris les programmes prénatals et les programmes de santé du nourrisson, de l'enfant, de l'adolescent, des adultes actifs et des personnes âgées.

*Principe 6 : Optimiser les technologies numériques pour la santé bucco-dentaire*

24. Les technologies numériques peuvent être utilisées de manière stratégique pour la santé bucco-dentaire à différents niveaux, notamment pour améliorer les connaissances de base en santé bucco-dentaire, dispenser des formations en ligne et pratiquer la télésanté entre prestataires, pour faciliter la détection précoce et la surveillance des maladies et affections et assurer l'orientation-recours au niveau des soins primaires. Parallèlement, il est essentiel d'instaurer une gouvernance de la santé numérique ou de la renforcer, et de définir, sur la base des meilleures pratiques et de données scientifiques, des normes et des critères pour mettre les technologies numériques au service de la santé bucco-dentaire.

## OBJECTIFS STRATÉGIQUES

### **Objectif stratégique 1 : Gouvernance de la santé bucco-dentaire – Accroître l'engagement politique et les ressources en faveur de la santé bucco-dentaire, renforcer le leadership et créer des partenariats avantageux pour tous à l'intérieur et à l'extérieur du secteur de la santé**

25. L'objectif stratégique 1 consiste à prendre en compte et à intégrer la santé bucco-dentaire dans toutes les politiques et tous les programmes de santé publique pertinents, dans le cadre de l'action menée au niveau national pour lutter contre les maladies non transmissibles et instaurer la couverture sanitaire universelle. Un engagement politique et des ressources plus importants en faveur de la santé bucco-dentaire sont indispensables aux niveaux national et infranational, tout comme la réforme des systèmes de santé et d'éducation.

26. La création d'un organe national chargé de la santé bucco-dentaire, ou son renforcement, est au cœur de ce processus. Il convient de mettre sur pied un organe spécial qualifié, fonctionnel, responsable et bien doté en ressources, ou de le renforcer, au sein des structures chargées de la lutte contre les maladies non transmissibles et d'autres services de santé publique. Des partenariats durables à l'intérieur et à l'extérieur du secteur de la santé, de même que la collaboration avec les communautés, la société civile et le secteur privé, sont essentiels pour mobiliser des ressources et agir sur les déterminants sociaux et commerciaux de la santé bucco-dentaire.

### **Objectif stratégique 2 : Promotion de la santé bucco-dentaire et prévention des maladies bucco-dentaires – Permettre à tous de jouir de la meilleure santé bucco-dentaire possible, cibler et réduire les déterminants sociaux et commerciaux ainsi que les facteurs de risque des maladies et affections bucco-dentaires**

27. L'objectif stratégique 2 fait appel à la promotion de la santé bucco-dentaire et à des interventions fondées sur des données probantes, d'un bon rapport coût/efficacité et durables pour prévenir les maladies et les affections bucco-dentaires. En aval, la promotion de la santé bucco-dentaire contribue à l'acquisition de compétences personnelles, sociales et politiques qui permettent à chacun de réaliser pleinement son potentiel d'autoprise en charge en matière de santé bucco-dentaire. En amont, la promotion de la santé bucco-dentaire consiste notamment à mettre en place des politiques publiques et à encourager l'action communautaire pour que les gens maîtrisent mieux leur santé bucco-dentaire et pour promouvoir l'équité en matière de santé bucco-dentaire.

28. Les mesures de prévention visent les principaux facteurs de risque et les déterminants sociaux et commerciaux des maladies et affections bucco-dentaires. Ces initiatives devraient être entièrement harmonisées et se renforcer mutuellement avec d'autres stratégies de prévention des maladies non transmissibles et avec la réglementation s'appliquant au tabac, à l'usage nocif de l'alcool et aux produits alimentaires et boissons qui nuisent à la santé, ainsi qu'avec l'utilisation de fluor pour la prévention des caries dentaires.

**Objectif stratégique 3 : Soins bucco-dentaires primaires – Renforcer les capacités du personnel, assurer la protection financière et mettre à disposition les fournitures essentielles dans un système intégré de soins bucco-dentaires primaires**

29. L'objectif stratégique 3 consiste à faire en sorte que l'ensemble de la population puisse accéder à des soins bucco-dentaires primaires à la fois sûrs, efficaces et économiquement abordables dans le cadre des prestations de la couverture sanitaire universelle. Les soins bucco-dentaires de base comprennent la promotion de la santé bucco-dentaire et la prévention des maladies et affections bucco-dentaires, ainsi que les services s'occupant de traiter la douleur, les infections, les traumatismes, les dysfonctionnements, les affections malignes de la sphère orale et d'orienter les patients vers des services spécialisés, selon des normes reconnues de qualité et de sécurité des patients. Les prestataires de soins bucco-dentaires qui soupçonnent une négligence ou des mauvais traitements doivent offrir à leurs patients des conseils et un traitement adéquats ainsi que des moyens concrets de signaler ces cas à l'autorité compétente, selon le contexte national.

30.  <sup>1</sup> prestataires de soins bucco-dentaires doivent être membres de l'équipe de soins de santé primaires et travailler main dans la main avec d'autres agents de santé pour lutter contre les affections bucco-dentaires et d'autres maladies non transmissibles, en cherchant principalement à combattre les facteurs de risque communs et à promouvoir les bilans de santé généraux. La protection financière moyennant l'élargissement de la couverture d'assurance maladie – y compris la couverture des services de santé bucco-dentaire – est l'une des pierres angulaires de la couverture sanitaire universelle. Il est également important de garantir un approvisionnement fiable en produits médicaux essentiels, médicaments génériques et autres fournitures destinées aux soins dentaires ainsi que leur bonne distribution pour la prise en charge des maladies et affections bucco-dentaires au niveau des soins de santé primaires et dans les services spécialisés.

**Objectif stratégique 4 : Systèmes d'information sur la santé bucco-dentaire – Améliorer les systèmes de surveillance de la santé bucco-dentaire et d'information afin de fournir en temps voulu des renseignements utiles aux décideurs pour élaborer des politiques sur la base d'éléments probants**

31. L'objectif stratégique 4 consiste à élaborer des systèmes d'information intégrés plus efficaces et plus efficaces pour la planification, la gestion et l'élaboration de politiques en matière de santé bucco-dentaire. Au niveau national, le renforcement des systèmes d'information sur la santé bucco-dentaire devrait comprendre la collecte systématique de données sur l'état de santé bucco-dentaire, les facteurs de risque et les ressources dépensées, au moyen des systèmes d'information existants sur la gestion de la santé et de technologies numériques prometteuses. Il convient également de mettre en place des systèmes pour suivre la mise en œuvre et mesurer l'impact des politiques et programmes de santé bucco-dentaire existants.

**Objectif stratégique 5 : Programme de recherche en santé bucco-dentaire – Crée et actualiser continuellement un nouveau programme de recherche axé sur l'innovation et les aspects de la santé bucco-dentaire qui relèvent de la santé publique pour avoir une influence plus positive sur la santé bucco-dentaire **

32. L'objectif stratégique 5 traduit la volonté d'aller au-delà du programme de recherche en santé bucco-dentaire traditionnellement centré sur la technologie dentaire et la description des problèmes,

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Il faut en amont que les soins dentaires soient considérés comme faisant partie des soins primaires comme remarqué plus en amont dans le constat

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Dans ce paragraphe nous souhaiterions aussi inclure une orientation à poursuivre l'étude des liens réciproques entre santé bucco-dentaires et pathologies chroniques ou aigues, à travers les liens infectieux ou inflammatoires.

plutôt que sur leur résolution. Le nouveau programme de recherche en santé bucco-dentaire doit être axé sur les programmes de santé publique, les interventions en population, des systèmes de santé en apprentissage constant, des modèles de dotation en personnel, les technologies numériques et les aspects « santé publique » des maladies et affections bucco-dentaires, par exemple les mesures applicables au niveau des soins de santé primaires, les interventions très peu invasives, les matériaux de substitution pour la restauration des dents, les pratiques écologiquement durables et les analyses économiques permettant de distinguer les interventions efficaces par rapport à leur coût.

## **RÔLE DES ÉTATS MEMBRES, DES PARTENAIRES ET DU SECRÉTARIAT**

### **OMS**

33. L'OMS jouera un rôle de chef de file et de coordination en matière de promotion et de suivi de l'action mondiale pour la santé bucco-dentaire, notamment en ce qui concerne les travaux d'autres organismes compétents des Nations Unies, des banques de développement et d'autres organisations régionales et internationales. L'Organisation fixera l'orientation générale et les priorités mondiales en matière de sensibilisation, de partenariats et de réseautage dans le domaine de la santé bucco-dentaire, définira de grandes options stratégiques sur la base de données probantes et fournira un appui technique et stratégique aux États Membres.

34. L'OMS poursuivra ses travaux avec ses partenaires mondiaux en santé publique pour créer des réseaux de renforcement des capacités en matière de soins bucco-dentaires, de recherche et de formation, mobilisera la contribution des organisations non gouvernementales et de la société civile et facilitera la mise en œuvre concertée de la stratégie, en particulier en ce qui concerne les besoins des pays à revenu faible ou intermédiaire.

35. D'ici à 2023, l'OMS déclinera cette stratégie en un plan d'action mondial pour la santé bucco-dentaire, comprenant un cadre de suivi des progrès assorti d'objectifs clairs et mesurables à atteindre d'ici à 2030. D'ici à 2024, l'OMS recommandera des interventions de santé-bucco-dentaire d'un bon rapport coût/efficacité dans le cadre de l'actualisation de l'appendice 3 du Plan d'action mondial de l'OMS pour la lutte contre les maladies non transmissibles et du répertoire OMS des interventions en vue de la couverture sanitaire universelle.

36. L'OMS continuera de mettre à jour les orientations techniques pour assurer des services dentaires sûrs et ininterrompus, y compris pendant et après la pandémie de COVID-19 et d'autres urgences sanitaires. En collaboration avec le Programme des Nations Unies pour l'environnement, l'OMS élaborera des directives techniques pour une odontologie respectueuse de l'environnement et moins invasive. Elle envisagera également de classer le noma dans la feuille de route pour les maladies tropicales négligées 2021-2030.

37. L'OMS aidera à appliquer durablement et plus largement les innovations qui ont un impact sur la santé bucco-dentaire conformément au cadre de l'OMS pour le développement de l'innovation, notamment les innovations sociales, numériques et financières et celles qui concernent la prestation de services, les produits de santé et les modèles d'activité.

38. L'OMS créera une plateforme de données sur la santé bucco-dentaire dans le cadre du recueil de données de l'OMS pour les statistiques sanitaires. Elle renforcera les systèmes intégrés d'information sur la santé bucco-dentaire et les activités de surveillance en élaborant de nouveaux indicateurs de la santé bucco-dentaire pour les enquêtes sur la santé de la population. Elle encouragera et appuiera la recherche dans les domaines prioritaires afin d'améliorer la mise en œuvre, le suivi et l'évaluation des programmes de santé bucco-dentaire.

### **États Membres**

39. C'est aux États membres qu'il revient principalement de relever le défi que représente la lutte contre les maladies et affections bucco-dentaires. Il appartient aux pouvoirs publics de mobiliser tous les secteurs de la société pour mener une action efficace dans le but de prévenir et de maîtriser les maladies et affections bucco-dentaires, de promouvoir la santé bucco-dentaire et de réduire les inégalités dans ce domaine. Ils devraient garantir des budgets suffisants pour la santé bucco-dentaire sur la base du coût des interventions et des argumentaires d'investissement pour instaurer la couverture universelle en santé bucco-dentaire.

40. Les États Membres devraient veiller à ce que la santé bucco-dentaire fasse partie intégrante des politiques nationales de santé et à ce que l'organisme national responsable de la santé la bucco-dentaire ait des capacités et des ressources suffisantes pour diriger les activités avec dynamisme, assurer la coordination et rendre compte de l'action menée en matière de santé bucco-dentaire.

41. Les États Membres peuvent renforcer les capacités du système de soins bucco-dentaires en intégrant les soins bucco-dentaires primaires dans les ensembles de prestations composant la couverture sanitaire universelle ; en garantissant l'accessibilité économique des médicaments et produits essentiels en odontologie, du matériel ou autres fournitures essentiels pour la prise en charge des maladies et affections bucco-dentaires ; et en privilégiant une odontologie respectueuse de l'environnement et moins invasive. Les États Membres devraient également évaluer et repenser la dotation en personnel de santé bucco-dentaire pour répondre aux besoins de la population en favorisant la formation interprofessionnelle et le travail d'équipe entre les prestataires de soins des niveaux intermédiaire et communautaire.

42. Les États Membres peuvent agir sur les déterminants de la santé bucco-dentaire et les facteurs de risque des maladies et affections bucco-dentaires en prônant l'instauration de taxes sanitaires ou d'une réglementation de la vente des produits nocifs pour la santé et de la publicité, et en faisant échec aux intérêts commerciaux sous-jacents qui sont à l'origine des risques ; en renforçant les conditions favorables à la santé dans les lieux les plus importants ; en défendant une législation tendant à rendre le dentifrice fluoré de bonne qualité plus accessible économiquement ; et en plaident pour que celui-ci soit considéré comme un produit de santé essentiel dans la liste nationale des médicaments essentiels. 

43. Les États Membres devraient améliorer la surveillance, la collecte de données et le suivi en matière de santé bucco-dentaire pour rassembler des éléments utiles à la prise de décisions et à l'action de sensibilisation. Il s'agit notamment de renforcer la surveillance intégrée des maladies et affections bucco-dentaires, ainsi que l'analyse des données sur les systèmes et les politiques de santé bucco-dentaire, l'évaluation des programmes et la recherche opérationnelle.

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Il serait logique d'associer dans les produits essentiel à coté d dentifrice fluoré, la brosse à dent

44. Les États Membres devraient revoir de manière critique et mettre à jour en permanence leurs programmes de formation théorique et pratique en santé bucco-dentaire en privilégiant une approche de santé publique, les méthodes de résolution de problèmes et l'aptitude à diriger des futurs professionnels de la santé bucco-dentaire.

### **Partenaires internationaux**

45. Les partenaires internationaux peuvent sensiblement contribuer à la réalisation du but et des objectifs de la stratégie aux niveaux mondial, régional et national, notamment en jouant un rôle plus important dans les activités de plaidoyer, la mobilisation de ressources, l'échange d'informations, la diffusion de bilans d'expérience, le renforcement des capacités et la recherche concertée.

46. Une coordination est nécessaire entre les partenaires internationaux, notamment les organismes du système des Nations Unies, les organes intergouvernementaux, les acteurs non étatiques, les organisations non gouvernementales, les associations professionnelles, les groupes de patients, le milieu universitaire et les instituts de recherche. Œuvrer avec efficience dans le cadre d'une coalition internationale pour la santé bucco-dentaire sera un moyen efficace d'aider les pays à appliquer la stratégie.

### **Société civile**

47. La société civile peut encourager les pouvoirs publics à prendre des initiatives nationales ambitieuses en matière de santé bucco-dentaire et contribuer à leur réalisation. Elle peut former des partenariats et des alliances multipartites pour mettre à profit et partager le savoir, évaluer les progrès accomplis, fournir des services et permettre aux personnes atteintes de maladies et d'affections bucco-dentaires de se faire mieux entendre.

48. La société civile peut diriger la mobilisation et le travail de sensibilisation au niveau local pour faire en sorte que l'action publique accorde plus d'importance à la promotion de la santé bucco-dentaire et à la lutte contre les maladies et affections bucco-dentaires. Elle peut également aider les consommateurs à plaider auprès des pouvoirs publics pour qu'ils demandent à l'industrie alimentaire et aux fabricants de boissons qu'ils fournissent des produits sains ; épauler les pouvoirs publics dans la mise en œuvre des programmes de lutte antitabac ; et former des réseaux et des groupes d'action pour promouvoir la disponibilité d'aliments et de boissons sains et de dentifrice fluoré, y compris par l'octroi de subventions ou l'abaissement des taxes.

### **Secteur privé**

49. Le secteur privé peut adhérer et contribuer plus largement aux interventions nationales en matière de santé bucco-dentaire en appliquant, dans le monde du travail, des mesures favorables à la santé bucco-dentaire, notamment en instaurant une bonne culture d'entreprise, des programmes de bien-être au travail et des régimes d'assurance-maladie.

50. Le secteur privé devrait prendre des mesures concrètes pour éliminer la commercialisation et la vente de produits qui causent des maladies et des affections bucco-dentaires ainsi que la publicité. Il devrait également s'efforcer d'améliorer l'accès à du matériel, des dispositifs et des produits d'hygiène bucco-dentaire sûrs, efficaces et de bonne qualité et leur accessibilité économique. Il devrait également

accélérer la recherche sur l'équipement et les matériaux sûrs, respectueux de l'environnement et économiquement accessibles pour les soins bucco-dentaires.

51. Les professionnels de la santé bucco-dentaire du secteur privé peuvent aider les gouvernements nationaux à mettre en œuvre la stratégie dans le cadre de partenariats public-privé pour la prestation de soins bucco-dentaires essentiels, en aidant à planifier et à appliquer des mesures de prévention à l'échelle de toute la population et en participant à la collecte de données sur la santé bucco-dentaire ainsi qu'à la surveillance des maladies et affections bucco-dentaires.

#### **MESURES À PRENDRE PAR LE CONSEIL EXECUTIF**

52. Le Conseil exécutif est invité à prendre note du rapport et à fournir des orientations sur le projet de stratégie mondiale pour la santé bucco-dentaire.



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## Comments on WHO DISCUSSION PAPER (Version dated 9 August 2021): DRAFT GLOBAL STRATEGY ON ORAL HEALTH

Thank you for the opportunity to review this important document. Delegate members of the World Federation of Public Health Association Oral Health Workgroup have reviewed the document and we would like to share our collective feedback on this WHO draft. If you have questions or need for clarification, please contact Dr. Hyewon Lee ([hylee@jhsph.edu](mailto:hylee@jhsph.edu)), the Chair of the Oral Health Workgroup.

Page	Section/original text	Comments
Throughout the document		<p>We recommend using consistent term for primary oral health. Throughout the document, it was described in different terms: 'basic' oral health, "essential" oral health, and 'primary' oral health. It is critical how WHO defines the primary oral health and primary oral health care as such definition can guide policy and practice significantly. This is an opportunity for WHO to set such definition, what to include in primary oral health care for the universal health coverage.</p> <p>In the document, the 'basic' oral health care was defined as "oral health care includes oral health promotion and prevention of oral diseases and conditions, as well as services which address oral pain, infection, trauma, dysfunction, malignant disease and referral, with agreed quality and patient-safety standards."</p> <p>We propose to include technical definition of primary oral health aligning scope of specific dental services as primary oral health compared to advanced oral health services. This will guide UHC adopt the coverage for primary oral health services. This effort has been done by WHO oral health office with is published as "Basic Package of Oral Care." Will the WHO oral health office keep the same technical definition of primary oral health care?</p>
1	3. "Oral health is integral to overall health, well-being and quality of life, from birth to old age."	We propose to change to "Oral health is integral to overall health, well-being and quality of life across life course."
1	4. "Globally, there are estimated to be more than 3.5 billion cases of oral diseases and other oral conditions, most of which are preventable. <sup>2</sup> For the last three decades, the combined global prevalence of dental caries (tooth decay), periodontal (gum) disease and tooth loss has remained unchanged at 45%, which is higher than the prevalence of any other noncommunicable disease"	<p>We propose to modify this part as "A study of trends in the global burden of oral conditions from 1990 to 2017 (Bernabe et al. 2020) estimated that between 3.2 and 3.7 billion suffered from oral diseases and other oral conditions, most of which are preventable. The available data are often unreliable and standardized methods must be used to collect data in the future. However, globally, the prevalence of dental caries (tooth decay) and tooth loss may have remained unchanged and between 2.1 and 2.5 billion adults had untreated tooth decay. With an aging population and people retaining teeth into old age, the prevalence of periodontitis appears to be increasing."</p> <p>Many of the data collected for this study, from the Global Health Data Exchange (<a href="http://ghdx.healthdata.org">http://ghdx.healthdata.org</a>) were from surveys performed many years ago, using different criteria for</p>

		<p>dental caries and periodontitis, for example from the Ireland National Survey of Adult Oral Health 2000-2002 and the UK Adult Dental Health Survey 2009. These data do not support the statement that the combined global prevalence of periodontal (gum) disease has remained unchanged at 45%. Furthermore, it seems that the statement refers to periodontitis, for which prior to 2008, there were numerous different case definitions (Savage et al. 2009), making reliable inter-country comparisons very unreliable. Dental caries prevalence in many economically developed countries appears to have decreased over the last 30 years but in developing countries appears to have increased.</p> <p>Burden of diseases description might be more impactful if we had disaggregated (including reproductive age-group), LMIC-HIC, indigenous population, and other context specific groups across religions. Some of these variables might act in several combinations and would require an intersectionality framework to measure the burden and make accurate assessments of disease burden.</p> <p>The prevalence of oral diseases shown as 45% is only for diseases in advanced stages, probably those that need a secondary level of prevention.</p> <p>We ask to include dental fluorosis in the list of oral diseases in the areas where natural fluoride level is substantially high as this becomes more prevalent worldwide.</p>
1-2	5. Cleft lip and palate, the most common craniofacial birth defects, have a prevalence of approximately 1 in 1500 births. <sup>67</sup>	Please place a comma between 6 and 7.
2	6. Worldwide, in 2015 oral diseases and conditions accounted for US\$357 billion in direct costs and US\$188 billion in indirect costs, with large differences between high-, middle- and low-income countries. <sup>9</sup>	<p>We propose to change to:</p> <p>“Worldwide, in 2015 oral diseases and conditions were <b>reported to account for</b> US\$357 billion in direct costs and US\$188 billion in indirect costs, with large differences between high-, middle- and low-income countries.”</p> <p>Please explain what the <b>indirect costs</b> are giving some examples.</p>
2	7. There is a very strong and consistent association between socioeconomic status (income, occupation, and educational level) and the prevalence and severity of oral diseases and conditions.	<p>We propose to modify as follows:</p> <p>There is a very strong and consistent association between socioeconomic status (income, occupation, <b>race, sexual orientation</b>, and educational level) and the prevalence and severity of oral diseases and conditions.</p> <p>One might argue that persons belonging to LGBTQ communities might be nested under “socially marginalized groups”. However, I strongly feel that they should be mentioned here. For the purposes of visibility, solidarity, and because the utilization of oral health care is poor</p>

		among this group. Barring the social stigma, they are often generalized to have STDs, which immediately disqualifies them from receiving dental treatment.
2	8. Oral diseases and conditions and oral health inequalities are directly influenced by commercial determinants, which are strategies and approaches used by the private sector to promote products and choices that are detrimental to health.	<p>We believe this language was first noted in the Lancet report. Please put a reference if it does not originate from WHO office.</p> <p>While we understand that this is the direct quote from the Lancet report, we may need to have careful positioning of the private sector as WHO invites private sector as potential partner at the end of the draft. The author who defined the term also discussed that "Previous definitions of commercial determinants of health have stressed the fundamental conflict between imperative shareholder value maximisation and population health—for example, West and Marteau's "factors that influence health which stem from the profit motive." This broad definition does not capture the inherent complexity of commercial determinants, and the profit motive also applies to companies that sell health promoting products such as fruit and vegetables."</p> <p>We recommend modifying to <b>"Oral diseases and conditions and oral health inequalities are directly influenced by commercial determinants of diseases, which are strategies and approaches used by the some private sector to promote products and choices that are detrimental to health."</b></p>
2	9. These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers	We propose to take <b>"lack of breastfeeding"</b> out from the text as the link between oral disease and lack of breastfeeding is not clear. (The pattern of breastfeeding and extensive use of formula feeding may be associated with early childhood caries.
3	12. The use of fluorides for prevention of dental caries is limited, and essential prevention methods, such as community-based methods, topical fluoride applications or the use of fluoridated toothpaste, frequently are notavailable or affordable for people.	<p>We recommend modifying to</p> <p><b>"The use of fluorides for prevention of dental caries is limited, and essential prevention methods, such as topical fluoride, or fluoridated toothpaste, frequently are notavailable or affordable for people. Whereas community-based methods, such as community water or salt fluoridation, ultimately impact the whole community at cost to government or society.</b></p> <p>Where feasible, for the most common dental disease, tooth decay, community water or salt fluoridation are the most cost-effective community-based prevention measure and will ultimate public healthily be the foundation for better oral health for the entire population. There is no cost to the individual. For high risk school populations, school fluoride/sealant programs are also effective for those school children.</p>

		Many may not know what community-based methods are. Talking to 200 children about oral health or telling them to brush doesn't prevent much tooth decay. Whereas evidence-based cost-effective community prevention programs such as community water (CWF) and salt fluoridation benefit most of an entire population. This document needs to explain what community-based prevention is and give examples such as underlined below.
3	14. Dental training rarely is integrated within general health training systems and focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists.	<p>We recommend adding "to improve access and utilization of primary oral health care"</p> <p>"Dental training rarely is integrated within general health training systems and focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists <b>to improve access and utilization of primary oral health care.</b>"</p>
3	15. The pandemic should be seen as an opportunity to strengthen integration of oral healthcare into general health care systems as part of universal health coverage efforts.	<p>We recommend modifying to: "The pandemic should be seen as an opportunity to strengthen integration of oral healthcare into general and <b>primary health care systems as part of universal health coverage efforts across life course, including children, pregnant women, seniors, and other vulnerable populations. Non-invasive caries management and new care modalities should be considered such as mHealth, artificial intelligence, or telehealth.</b></p> <p>Considering COVID 19 situations focus should also be developing newer treatment modalities which are <u>non-aerosol</u> producing like hand scaling, ART etc.</p> <p>Apart from section 23, there is no specific mention of older persons, especially those receiving home care or living in a care home. Insert in section 15 "The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health [and aged] care systems as part of universal health coverage efforts.</p> <p>Oral health should be positioned as an integral part of primary care, especially for children, pregnant women, and seniors</p>
4	21. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.	<p>We propose to add</p> <p><b>"Training of dental and medical professionals in interprofessional manner would be important. Also, retention of dental workforce, especially in rural areas and developing countries, should be considered carefully in planning workforce model and care system so that oral health workforce is adequately distributed, and the most underserved population have access to timely oral health care."</b></p> <p>This would be relevant as many dentists in low-income countries study in their respective countries then travel to high-income countries to work there as the pay and benefits are</p>

		significantly more appealing. With dental tourism, these countries lose their trained dentists and have a shortage.
4	23. Principle 5: Tailored oral health across the life course.	We propose to change to “Oral health tailored across the life course”
4	24. Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care.”	<p>We propose to change to “Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy <b>and digital literacy</b>, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care <b>along with the advancement of smartphone and artificial intelligence.</b>”</p> <p>Artificial Intelligence will play a very important role in health care. Use of AI for improving Oral Health should be exclusively mentioned in the document.</p> <p>Smartphone use and digital literacy are strong predictors of success here. Smartphone is the most used electronic device to access internet services. Digital literacy is also an additional component of digital health reform.</p>
5	26. Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral public health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services.	<p>We propose to change to</p> <p>“Central to this process is establishing or strengthening the capacity of a national oral <b>public</b> health unit <b>with public health trained and experienced dental professionals.</b> A dedicated, qualified, functional, well-resourced, and accountable oral <b>public</b> health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services.”</p> <p>They need to have a public health trained and experienced dentist (ideally board certified in dental public health) with staff working in the Minister of Health's Office. We (World Federation of Public Health Association) performed a global-level survey on dental public health workforce in 73 countries. We found that 62% of participating countries had dental public health integrated in the public health system, while in 25% of countries has not yet been formally integrated it to such system. Over half of participating countries had 0 to 10 trained dental public health professionals, and most countries did not have a dentist trained in public health working for the government in a leadership position (Reference Lomazzi et al. Dental public health capacity worldwide: Results of a global survey. J Public Health Policy. 2016 Dec;37(4):528-542. doi: 10.1057/s41271-016-0029-9. PMID: 28202926.)</p>
5-6	30. Ensuring the reliable availability and distribution of essential medical consumables, generic medicines and other dental supplies is also important for the	We recommend changing from “generic medicines” to “ <b>affordable medicines</b> ”

	management of oral diseases and conditions in primary health care and referral services.	
5	30. Financial protection through expanded health insurance coverage - including coverage of oral health services - is one of the cornerstones of universal health coverage	We propose to change to “Financial protection through expanded health insurance coverage - including coverage of <b>primary</b> oral health services - is one of the cornerstones of universal health coverage,” after defining what the primary oral health is.
6	32. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.	<p>We propose to modify to “The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, <b>oral health inequalities for socially marginalized or excluded populations</b>, and economic analyses to identify cost-effective interventions.”</p> <p>The authors of original article argued that “...people who experience social exclusion face a “triple threat”: they are separated from mainstream society, stigmatized by the dental profession, and severed from wider health and social care systems because of the disconnection between oral health and general health.” (Reference: Muirhead et al. What is intersectionality and why is it important in oral health research? <i>Community Dent Oral Epidemiol.</i> 2020 Dec;48(6):464-470. doi: 10.1111/cdoe.12573.)</p>
6	35. By 2023, WHO will translate this strategy into an action plan for public oral health including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030. By 2024, WHO will recommend cost-effective oral health interventions as part of the updated Appendix 3 of the WHO Global action plan on the prevention and control of noncommunicable diseases and the WHO universal health coverage intervention compendium.	<p>We recommend having core and optional sets of measures so that primary measures can be shared between countries and country-specific measures can also be implemented. We propose to modify to:</p> <p>“By 2023, WHO will translate this strategy into an action plan for public oral health including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030. <b>Those measures should be categorized into fundamental measures and optional measures so that each country can implement according to their country context yet measure standard outcomes.</b> By 2024, WHO will recommend cost-effective oral health interventions as part of the updated Appendix 3 of the WHO Global action plan on the prevention and control of noncommunicable diseases and the WHO universal health coverage intervention compendium.”</p>

Again, thank you for this opportunity to provide feedback.

World Federation of Public Health Association, Oral Health Workgroup (see next page for the full list of workgroup).

Chair: Hyewon Lee  
Past-Chair: Raman Bedi  
Co-Chair: Kenneth Eaton  
Co-Chair: Myron Allukian  
Coordinator: Wendy Barillas

#### AFR

Khabiso Ramphoma (Deputy Chair, Public Oral Health Forum, South Africa)  
Angelina C. Sijaona (Chief Dental Officer, Tanzania)

#### AMR

Sonia Groisman (Professor, University of Rio de Janeiro, Brazil)  
Lynn Ann Bethel (former chair of the American Public Health Association's Executive Board)

#### EUR

Dorjan. Hysi (Previous Chief Dental Officer of Albania)  
Miguel Pavao (President of the Portuguese Dental Association)

#### SEAR

Irene Adyatmaka (Director Global Oral Health Interest Group, Consortium of Universities for Global Health)  
Ramprasad Vastgare Prabhakar (Professor and Head of the Department of Public Health Dentistry, Manipal Academy, India)  
Puneet Gupta (Associate Professor of Public Health Dentistry at Government College, India)  
Sophia Thomas (Public Health Dentist)

#### WPR

Wen-Sheng Rong (Chair, FDI Public Health Standing Committee, China Oral health Foundation)  
Leonie Short (Former director of the Australian Dental Council)  
Rahimah Abdul Kadir (Member of the Alliance of Caries Free Future, Malaysia)

Young professional members: Soleen Ghahraman, Nila Jackson, Jane-Francis Onyunye Esimekara, Aarthi Shanmugavel, Valerie Wordley

## Specific Comments (WHOCC for Translation of Oral Health Science, JPN75)

Section	Sub-section	Paragraph No.	Line No.	Comment
	<b>Oral Disease Burden</b>	Reference:4		<b>The provided link is inaccessible.</b>
Global Overview of Oral Health	<b>Commercial Determinants and Risk Factors of Oral Health</b>	9	3-4	<p>These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers.</p> <p><b>We supposed WHO to include scientific evidence for this share risk factor in both mothers and infants. Although breastfeeding for a certain period is beneficial for both mother and children, lack of breastfeeding is reported to be associated with mentioned general diseases in mothers, but not in infants. Conversely, breastfeeding up to 12 months of age is associated with decreased risk of dental caries, thus lack of breastfeeding is a risk factor for oral diseases in infants, but not in mothers.</b></p>
			4-5	<p>These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers.</p> <p><b>For the clarification of the risk factors, we suggest to use more simple words for better understanding. (For example: instead of 'betel quid and areca nut,' we could use 'chewing tobacco or smokeless tobacco')</b></p>
	<b>Oral Health Promotion and Oral Disease Prevention</b>	11	1	<p>In 2015, the WHO guideline on sugars intake for adults and children made the strong recommendation to reduce intake of free sugars throughout the life course based on the evidence of positive associations between intake of free sugars and body weight and dental caries.</p> <p><b>We propose if we could add more evidence about updated information, it would be better.</b></p>
			12	<p>Millions of people do not have access to oral health promotion and oral disease prevention programmes.</p> <p><b>We would like to urge WHO to describe about the oral health which is highly treatment focusing and mostly based on fee-for-service. Oral health promotion and disease prevention activities such as oral health education, dietary advice, and brief smoking cessation are highly underrated and mostly not incentivized.</b></p>
		2-4		<b>We recommend to made an emphasis for the people in middle and low-income countries for the use of fluorides.</b>

		14 & 15	-	We advise the information in these two paragraphs indicate part of UHC, thus, they might provide same information.
	Oral Health Care Systems	15	3-4	<p>The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health care systems as part of universal health coverage efforts.</p> <p><b>Oral health is a part of health to be integrated into general health care systems even before the occurrence and subsidence of pandemic. There are many oral health diseases and conditions that should be treated with multidisciplinary teams such as cleft, and oro-pharyngeal cancers. Recent evidence shows that better oral health conditions may improve treatment outcomes of some diseases such as DM and vice versa. In term of oral diseases prevention, oral health risks also share several common risk factors with NCDs and cancers. Mentioned above facts should be the main reasons why oral health care should be integrated into general health care systems as part of universal health coverage efforts.</b></p> <p><b>The Covid-19 pandemic intensifies oral health inequality among patients and Silo mentality among dentists.</b></p>
Vision, Goal, and Guiding Principles	Vision	17	1	We suggest WHO to declare what indicates essential, quality health services.
			4-5	<p>Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives.</p> <p><b>We would like to recommend that we should provide keywords regarding especially for healthy ageing population.</b></p>
	Guiding Principles ( <i>Principle 3</i> )	21		The information about how to create and perform a new oral health workforce model should be explained in the action plans.
	Guiding Principles ( <i>Principle 6</i> )	24	1-3	<p>There is evidence that digital technologies like text messaging is effective in encouraging oral health care behaviors (not merely improving oral health literacy). Therefore, the word 'different levels' should be clarified more. Moreover, it is widely implemented in the field of orthodontics, might be worthwhile to include this benefit here.</p>
Strategic objectives	Strategic Objective 1	26	1	We assume dental public health experts and local stakeholders should be engaged to a national oral health unit.
	Strategic objective 2	28	4	These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable

				disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries.  <b>We suppose that these regulatory policies are associated not only for prevention of dental caries, but also for prevention of dental diseases including periodontal diseases and oral cancer.</b>
	<b>Strategic objective 3</b>	29	2-4	Basic oral health care includes oral health promotion and prevention of oral diseases and conditions, as well as services which address oral pain, infection, trauma, dysfunction, malignant disease and referral, with agreed quality and patient-safety standards.  <b>Oral health screening and caries risk assessment should be included in the basic oral health care. Poor populations need access for dental check-ups regardless of their oral health conditions.</b>
		34	3-4	~facilitate collaborative implementation of the strategy, particularly as pertains to the needs of low- and middle-income countries.  <b>WHO should also support low- and middle-income countries in capacity building for their oral health surveillance.</b>
<b>Role of Member States, Partners and Secretariat</b>	<b>WHO</b>	33-38		<b>We would like to urge the paragraphs in this section to reflect and align with the objectives in the above section.</b>
		38	1-2	WHO will create an oral health data platform as part of WHO's data repository for health-related statistics.  <b>Indicate or establish proper methods for oral health surveys with the inclusion of opinions from experts in dental public health</b>
	<b>Private Sector</b>	51	1	<b>Dental professionals in the private sector should seek opportunities to provide oral health promotion and oral disease prevention services, such oral health education, dietary advice, and brief tobacco cessation advice, and participate in dental public health activities when it is possible.</b>  <b>Private dental clinics and hospitals should reform payments to cover health promotion and oral disease prevention services, including counsellings.</b>



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# Comment by World Alliance for Mercury-Free Dentistry on WHO's "Draft Global Strategy on Oral Health"

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The World Alliance for Mercury-Free Dentistry is gravely concerned that WHO's *Discussion Paper: Draft Global Strategy on Oral Health*<sup>1</sup> does not address the most significant problems facing dentistry today: mercury amalgam fillings. As a coalition of more than 50 organizations working around the globe for safer, minimally-invasive, environmentally-sustainable alternatives to amalgam, we urge WHO to adopt the proven strategy to promote oral health: **the transition, during the 2020s, to mercury-free dentistry**

Les gouvernements des Etats-Unis aux Philippines au Vietnam à la Tanzanie au Maurice à l'Union Européenne, de plus beaucoup d'autres, ont dit que l'amalgame doit cesser tout de suite pour les enfants. Tous les pays s'intéressent en la réduction de l'utilisation de l'amalgame pour éviter le mercure en les poissons que les enfants mangent. Si l'OMS s'écoutait à leurs membres, les gouvernements, et si l'OMS s'intéressait en les enfants, elle doit appeler pour la fin de l'amalgame en des enfants (pour leur santé), et donc pour tous (pour protéger l'environnement et donc la source du nourriture). La science est claire. Il est maintenant temps pour l'OMS de dire aux dentistes qui ne sont pas passés à la dentisterie sans mercure de faire le changement.

## 1. WHO should call for the phase out of amalgam use

In light of the known health risks of dental amalgam, WHO should call for the phase out of amalgam use. Scientific studies have confirmed that dental amalgam poses health risks, including:

- *Amalgam damages oral health:* Researchers and governments – as well as many dentists and dental authorities – have agreed that preparation for amalgam placement results in a greater loss of healthy tooth tissue than placement of mercury-free fillings. As a result, amalgam preparation and amalgam placement weaken tooth structure. Conversely, mercury-free fillings preserve tooth structure, which can increase the longevity of the tooth itself – and save the patient the additional costs of more extensive restorative dental treatment in the future.<sup>2,3,4,5,6,7,8,9,10,11,12</sup>

- *Amalgam exposes people to mercury:* Amalgam releases mercury, a neurotoxin, reproductive toxin, and nephrotoxin. As the U.S. Food and Drug Administration explains, “Dental amalgam releases low levels of mercury vapor, with higher amounts released with mastication and gum chewing. Higher levels of exposure to elemental mercury vapor are also associated with placement and removal of dental amalgams.”<sup>13</sup> This mercury, along with mercury from other sources, can bioaccumulate in the human body.
- *Amalgam causes environmental health harms:* Dental amalgam, among the largest intentional uses of mercury, pollutes the environment via many uncontrollable pathways including cremation<sup>14</sup>, dental clinic emissions<sup>15</sup>, and human waste<sup>16</sup>. In the environment, certain microorganisms can change amalgam’s elemental mercury into methylmercury, a form of mercury that builds up in fish, shellfish and animals that eat fish.<sup>17</sup> This mercury can harm people that consume fish, especially children’s developing brains and neurological systems.

In response to these health risks, growing number of countries – including countries with people at high caries risk, lower-income people, and other people with a diverse array of circumstances – have already made significant progress in phasing down and phasing out amalgam use. For example, Czech Republic<sup>18</sup>, Denmark<sup>19</sup>, Finland<sup>20</sup>, Ireland<sup>21</sup>, Italy<sup>22</sup>, Japan<sup>23</sup>, Moldova<sup>24</sup>, Nepal<sup>25</sup>, Netherlands<sup>26</sup>, New Caledonia (independent French territory)<sup>27</sup>, Norway<sup>28</sup>, Philippines<sup>29</sup>, Slovakia<sup>30</sup>, Sweden<sup>31</sup>, and Suriname<sup>32</sup> have phased out amalgam use, announced plans for phasing out amalgam use, or use de minimis amounts of amalgam.

WHO needs to catch up with these countries by joining them in the call to phase out amalgam use.

## 2. WHO should warn against amalgam use in children and other high-risk populations

In light of the known risks of mercury to vulnerable populations, WHO should warn against amalgam use in these high-risk populations. Scientific studies show that amalgam’s mercury poses a greater risk for vulnerable populations, including:

- Pregnant women and their developing babies
- Women who are planning to become pregnant
- Nursing women and their newborns and infants
- Children, especially those younger than six years of age
- People with pre-existing neurological disease

- People with impaired kidney function
- People with known heightened sensitivity (allergy) to mercury or other components of dental amalgam

In response to these risks, countries around the world have taken measures to end amalgam use in children and other vulnerable populations. For example, Australia<sup>33</sup>, Canada<sup>34</sup>, Denmark<sup>35</sup>, the European Union<sup>36</sup>, Germany<sup>37</sup>, Italy<sup>38</sup>, Mauritius<sup>39</sup>, Nepal<sup>40</sup>, New Zealand<sup>41</sup>, Nigeria<sup>42</sup>, Pakistan<sup>43</sup>, Philippines<sup>44</sup>, Tanzania<sup>45</sup>, Sweden<sup>46</sup>, United Kingdom<sup>47</sup>, United States<sup>48</sup>, and Vietnam<sup>49</sup> took action to warn or ban amalgam use in one or more vulnerable population – and some have now ended all amalgam use.

WHO needs to catch up with these countries by joining them in warning against amalgam use in children and other vulnerable populations.

### 3. WHO should urge the use of mercury-free alternatives to amalgam

In light of the many advantages of mercury-free dental fillings, WHO should be actively urging the use of these alternatives to amalgam. Scientific studies show that a variety of mercury-free dental fillings – including composites and glass ionomers – offer many advantages:

- *Mercury-free dental fillings are technically feasible – and superior to dental amalgam:* Recent studies show that composites last as long as – and even longer than – amalgam.<sup>50,51,52,53,54,55,56</sup> They also clearly show that it is easier to repair a composite than an amalgam, which can increase longevity of the filling, increase longevity of the tooth, and reduce costs.<sup>57,58,59</sup>
- *Mercury-free dental fillings are economically feasible – and more accessible in lower-income areas without electricity:* The longevity of composite and their repairability eliminate any cost difference between dental amalgam and composite.<sup>60</sup> Additionally, atraumatic restorative treatment (ART) is a low-cost technique that relies on glass ionomer for the filling material and uses only hand instruments to place the filling. As a Pan American Health Organization report explains, “The costs of employing the PRAT [ART] approach for dental caries treatment, including retreatment, are roughly half the cost of amalgam without retreatment.”<sup>61</sup> Because this technique does not require electricity, it also makes mercury-free fillings more accessible than amalgam. Studies have concluded that after environmental costs are factored in, dental amalgam is more expensive than mercury-free fillings; use of mercury-free alternatives would eliminate the costs of dental mercury pollution.<sup>62,63</sup>
- *Mercury-free dental fillings offer health benefits – even beyond eliminating the many risks of mercury exposure:* Mercury-free fillings preserve tooth structure, which can increase the longevity of the tooth itself – and save the patient the

additional costs of more extensive restorative dental treatment in the future.<sup>64,65,66,67,68,69,70,71,72,73,74</sup> Also studies show glass ionomers release fluoride that can help prevent caries<sup>75,76</sup> and composites placement can incorporate preventive measures like the sealing of adjacent pits and fissures.<sup>77</sup>

In response to these advantages of mercury-free fillings, countries acted to promote mercury-free fillings. For example, the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR) explains, "some recent studies from the Netherlands, Sweden and Denmark showed very good long-term clinical effectiveness for posterior resin composite restorations with equal and better longevity than for amalgam."<sup>78</sup> Another European Commission report concluded, "Given the results of recent studies comparing the longevity of different materials, in the present study it is considered that the longevity of Hg-free fillings is no longer a factor with significant effect on the overall cost difference between dental amalgam and composite or glass ionomer restorations."<sup>79</sup>

WHO needs to catch up with these countries by joining them in urging the use of mercury-free alternatives to amalgam.

**Conclusion:** The World Alliance for Mercury-Free Dentistry urges WHO to incorporate these three strategies into its *Global Strategy on Oral Health*. Dentistry in the 21<sup>st</sup> century is mercury-free dentistry – and it's time for WHO bureaucrats to catch up with practicing dentists in both developing and developed countries worldwide.

Submitted by Charles G. Brown, attorney and president, [charlie@mercury-free.org](mailto:charlie@mercury-free.org)  
Washington  
17 September 2021

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<sup>1</sup> <https://www.who.int/publications/m/item/who-discussion-paper-draft-global-strategy-on-oral-health>

<sup>2</sup> I. A. Mjor and A. Jokstad, *Five-year study of Class II restorations in permanent teeth using amalgam, glass polyalkenoate (ionomer) cermet and resin-based composite materials*, J. Dent. 1993; 21: 338-343, <http://www.jokstad.net/1993%20JDent%205year%20Mjor.pdf>

<sup>3</sup> Walls AW, Murray JJ, McCabe JF. *The management of occlusal caries in permanent molars. A clinical trial comparing a minimal composite restoration with an occlusal amalgam restoration*. Br Dent J 1988; 164: 288–292, <https://www.researchgate.net/publication/20879918> *The management of occlusal caries in permanent molars A 5-year clinical trial comparing a minimal composite with an amalgam restoration/download*, pp.363, 366.

<sup>4</sup> Donovan TE, *Longevity of the tooth/restoration complex: a review*, Journal of the California Dental Association [01 Feb 2006, 34(2):122-128], <https://europepmc.org/abstract/med/16724467>; [https://www.cda.org/Portals/0/journal/journal\\_022006.pdf](https://www.cda.org/Portals/0/journal/journal_022006.pdf)

<sup>5</sup> JJM Roeters, ACC Shortall, and NJM Opdam, *Can a single composite resin serve all purposes?*, BRITISH DENTAL JOURNAL 199, 73 - 79 (2005), <http://www.nature.com/bdj/journal/v199/n2/full/4812520a.html> (emphasis added)

<sup>6</sup> Christopher D. Lynch, Kevin B. Frazier, Robert J. McConnell, Igor R. Blum and Nairn H.F. Wilson, *Minimally invasive management of dental caries: Contemporary teaching of posterior resin-based composite placement in U.S. and Canadian dental schools*, J AM DENTA Assoc 2011; 142; 612-620, <http://jada.ada.org/content/142/6/612.abstract>

<sup>7</sup> Andre V. Ritter, DDS, MS, Clinical Techniques: A Review of Posterior Composites, ADA Professional Product Review (Oct. 2011), p.3

<sup>8</sup> Joseph B. Dennison, DDS, MS & James C. Hamilton, DDS, *Treatment Decisions and Conservation of Tooth Structure*, Dent Clin N Am 49 (2005) 825–845, [https://www.researchgate.net/profile/James\\_Hamilton10/publication/7612380\\_Treatment\\_Decisions\\_and\\_Conversation\\_of\\_Tooth\\_Structure/links/5b3f92ada6fdcc85060366af/Treatment-Decisions-and-Conservation-of-Tooth-Structure.pdf](https://www.researchgate.net/profile/James_Hamilton10/publication/7612380_Treatment_Decisions_and_Conversation_of_Tooth_Structure/links/5b3f92ada6fdcc85060366af/Treatment-Decisions-and-Conservation-of-Tooth-Structure.pdf)

<sup>9</sup> NJM Opdam, R Frankenberger, and P Magne (2016) *From 'Direct Versus Indirect' Toward an Integrated Restorative Concept in the Posterior Dentition*. Operative Dentistry: September 2016, Vol. 41, No. S7, pp. S27-S34, [https://www.researchgate.net/profile/Pascal\\_Magne/publication/296055458\\_From\\_Direct\\_Versus\\_Indirect\\_Toward\\_an\\_Integrated\\_Restorative\\_Concept\\_in\\_the\\_Posterior\\_Dentition/links/572b6f1a08ae057b0a0951fa/From-Direct-Versus-Indirect-Toward-an-Integrated-Restorative-Concept-in-the-Posterior-Dentition.pdf](https://www.researchgate.net/profile/Pascal_Magne/publication/296055458_From_Direct_Versus_Indirect_Toward_an_Integrated_Restorative_Concept_in_the_Posterior_Dentition/links/572b6f1a08ae057b0a0951fa/From-Direct-Versus-Indirect-Toward-an-Integrated-Restorative-Concept-in-the-Posterior-Dentition.pdf)

<sup>10</sup> Norway Directorate for Health and Social Affairs, *A National Clinical Guideline for the Use of Dental Filling Materials: Information for Dental Health Care Personnel*, pp. 6, 8, 15

<sup>11</sup> European Commission Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR), *Final opinion on the safety of dental amalgam and alternative dental restoration materials for patients and users* (29 April 2015), [http://ec.europa.eu/health/scientific\\_committees/emerging/docs/scenihro\\_046.pdf](http://ec.europa.eu/health/scientific_committees/emerging/docs/scenihro_046.pdf), p.69

<sup>12</sup> BIO Intelligence Service (2012), *Study on the potential for reducing mercury pollution from dental amalgam and batteries*, Final report prepared for the European Commission-DG ENV, [http://ec.europa.eu/environment/chemicals/mercury/pdf/Final\\_report\\_11.07.12.pdf](http://ec.europa.eu/environment/chemicals/mercury/pdf/Final_report_11.07.12.pdf), p.77

<sup>13</sup> FDA, *Dental Amalgam Rule* (2009), Federal Register / Vol. 74, No. 148 / Tuesday, August 4, 2009, p. 38687, <http://www.gpo.gov/fdsys/pkg/FR-2009-08-04/pdf/E9-18447.pdf>

<sup>14</sup> OSPAR Commission, *Overview assessment of implementation reports on OSPAR Recommendation 2003/4 on controlling the dispersal of mercury from crematoria* (2011)

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## Principes directeurs

### *Principe 6 : Optimiser les technologies numériques pour la santé bucco-dentaire*

1. Il serait profitable d'améliorer les connaissances en matière de santé bucco-dentaire des **étudiants en médecine** et des professionnels de la santé en général grâce au module de formation orale (m-oral Heath training module).
2. Ces technologies numériques devraient fournir aux étudiants en médecine dentaire et aux "défenseurs de l'équité en matière de santé bucco-dentaire" en Afrique les outils et les compétences nécessaires pour créer et s'engager dans des projets de santé bucco-dentaire ayant un impact en Afrique.

**Objectif stratégique 5 : Programme de recherche en santé bucco-dentaire – Créer et actualiser continuellement un nouveau programme de recherche axé sur l'innovation et les aspects de la santé bucco-dentaire qui relèvent de la santé publique pour avoir une influence plus positive sur la santé bucco-dentaire**

1. Le nouveau programme de recherche en santé bucco-dentaire pourrait inciter les facultés de médecine à s'inscrire dans une dynamique de responsabilité sociale pour améliorer la couverture universelle en santé bucco-dentaire.
2. Il est primordial de doter les étudiants en médecine dentaire *issus des pays à faible revenus*, des compétences, bourses, stages virtuels et de nouvelles possibilités d'apprentissage (formation en ligne plaidoyer, rédaction scientifique, communication, leadership et blogging) pour avoir une influence plus positive sur la santé bucco-dentaire des populations.

## **RÔLE DE L'OMS**

1. Concevoir un cadre stratégique d'engagement de l'OMS-Afrique sur les jeunes et la santé orale permettrait de promouvoir l'inclusion et d'examiner toutes les politiques et programmes en matière de santé bucco-dentaire existants sous l'angle de la jeunesse.
2. L'organisation pourrait mettre en lumière et donner aux héros africains de la santé bucco-dentaire un siège à la table de discussion afin de faciliter les échanges entre eux, les représentants de l'OMS et d'autres parties prenantes clés au niveau mondial.

Eliane MBENDE

Présidente du YTA

**WHO DISCUSSION PAPER**  
(Version dated 9 August 2021)**DRAFT GLOBAL STRATEGY ON ORAL HEALTH****BACKGROUND****Comment by Global Oral Health Interest Group, CUGH**

1. Recognizing the global public health importance of major oral diseases and conditions, the World Health Assembly adopted resolution WHA74.5 (2021) on oral health and requested the Director-General to develop, in consultation with Member States, a draft global strategy on tackling oral diseases.<sup>1</sup> The strategy will inform the development of a global action plan on oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030.
2. The resolution on oral health and the resulting draft global strategy are grounded in the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its target 3.8 to achieve universal health coverage. They are aligned with the WHO's Thirteenth General Programme of Work (2019); the Political Declaration of the High-level Meeting on Universal Health Coverage (2019); the Operational framework for primary health care (2020); the Global strategy on human resources for health: Workforce 2030 (2016); the Global action plan for the prevention and control of noncommunicable diseases 2013–2030 (2013); the WHO Framework Convention on Tobacco Control (2003); WHA73(12) (2020) on the Decade of Healthy Ageing 2020–2030; and WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention.

**GLOBAL OVERVIEW OF ORAL HEALTH**

3. Oral health is the well-being of the mouth, encompassing many essential functions, including breathing, eating, speaking, smiling and socializing. Experiencing good oral health, comfortably and confidently, enables an individual to achieve their full capacity and participation in society. Oral health is integral to overall health, well-being and quality of life, from birth to old age.

**Oral Disease Burden**

4. Globally, there are estimated to be more than 3.5 billion cases of oral diseases and other oral conditions, most of which are preventable.<sup>2</sup> For the last three decades, the combined global prevalence of dental caries (tooth decay), periodontal (gum) disease and tooth loss has remained unchanged at 45%, which is higher than the prevalence of any other noncommunicable disease.<sup>2</sup>

5. Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375 000 new cases and nearly 180 000 deaths in 2020.<sup>3</sup> Noma is a necrotizing disease that is a marker of extreme poverty; it starts in the mouth and is fatal for as much as 90% of affected children.<sup>4,5</sup> Cleft lip and

<sup>1</sup> [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_R5-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R5-en.pdf)

<sup>2</sup> <http://dx.doi.org/10.1177/0022034520908533>

<sup>3</sup> <https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf>

<sup>4</sup> <https://daccess-ods.un.org/TMP/1058816.4627552.html>

<sup>5</sup> <http://www.who.int/iris/handle/10665/254579>

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palate, the most common craniofacial birth defects, have a prevalence of approximately 1 in 1500 births.<sup>67</sup> Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting over one billion people.<sup>8</sup>

### **Social and Economic Costs of Poor Oral Health**

6. The personal consequences of untreated oral diseases and conditions - including physical symptoms, functional limitations, and detrimental impacts on emotional and social well-being - are severe. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burdens. Worldwide, in 2015 oral diseases and conditions accounted for US\$357 billion in direct costs and US\$188 billion in indirect costs, with large differences between high-, middle- and low-income countries.<sup>9</sup>

7. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes, people living with disability, refugees, prisoners and/or socially marginalized groups.

### **Commercial Determinants and Risk Factors of Oral Health**

8. Oral diseases and conditions and oral health inequalities are directly influenced by commercial determinants, which are strategies and approaches used by the private sector to promote products and choices that are detrimental to health.

9. Oral diseases and conditions share modifiable risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease and diabetes. These risk factors include all forms of tobacco use, betel quid and areca nut use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers. Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury. The risk factors for noma include malnutrition, coinfections, poor oral hygiene and poor living conditions.

### **Oral Health Promotion and Oral Disease Prevention**

10. Only rarely have oral health promotion and oral disease prevention efforts targeted the social and commercial determinants of oral health at the population level. However, initiatives that tackle upstream determinants (such as policy and regulation) can be cost-effective and have a high population reach and impact. Moreover, oral health promotion and oral disease prevention typically are not integrated into other noncommunicable disease programmes that share major common risk factors and social determinants.

11. In 2015, the WHO guideline on sugars intake for adults and children made the strong recommendation to reduce intake of free sugars throughout the life course based on the evidence of positive associations between intake of free sugars and body weight and dental caries. Nonetheless, dental public health initiatives to reduce sugar consumption are rare.

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<sup>6</sup> <https://apps.who.int/iris/rest/bitstreams/1320658/retrieve>

<sup>7</sup> <http://dx.doi.org/10.1016/j.jormas.2021.05.008>

<sup>8</sup> <http://dx.doi.org/10.1111/edt.12389>

<sup>9</sup> <http://dx.doi.org/10.1177/0022034517750572>.

12. Millions of people do not have access to oral health promotion and oral disease prevention programmes. The use of fluorides for prevention of dental caries is limited, and essential prevention methods, such as community-based methods, topical fluoride applications or the use of fluoridated toothpaste, frequently are not available or affordable for people.

## Oral Health Care Systems

13. Political commitment and resources for oral health care systems often are limited at the ministry of health level. Typically, the oral health care system is inadequately funded, highly specialized and isolated from the broader health care system. In most countries, universal health coverage benefit packages and noncommunicable disease interventions do not include essential oral health care. Oral health care usually is not covered in primary care facilities, and private and/or public insurance scheme coverage of oral health is highly variable between countries.

14. In many countries, insufficient attention is given to planning the oral health workforce to address the population's oral health needs. Dental training rarely is integrated within general health training systems and focuses on educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists. Primary oral health training can also be integrated into the training of community health workers, public health providers, nurses and primary care physicians. This would expand access to basic, essential oral health care that does not need the specialized skills of dentists particularly in low income and rural communities.

15. The COVID-19 pandemic has had a negative impact on the provision of essential oral health services. ~~Set up oral health care and oral health system as anticipation when pandemic occurs~~ions and greater oral health inequalities. The pandemic should be seen as an opportunity to strengthen integration of oral health care into general health care systems as part of universal health coverage efforts.

## VISION, GOAL, AND GUIDING PRINCIPLES

### Vision

16. The vision of this strategy is universal oral health coverage for all people by 2030.

17. Universal oral health coverage means that every individual has access to essential, quality health services that respond to their needs and which they can use without suffering financial hardship. These include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Universal oral health coverage will enable all people to enjoy the highest attainable state of oral health, contributing to them living healthy and productive lives. Achieving the highest attainable standard of oral health is a fundamental right of every human being.

### Goal

18. The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.

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## Guiding Principles

### *Principle 1: A public health approach to oral health*

19. A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.

**Include legislators and industry as stakeholders**

### *Principle 2: Integration of oral health in primary health care*

20. Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.

**Develop family dentist system as primary health care system**

### *Principle 3: A new oral health workforce model to respond to population needs*

21. Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage. Providing training in basic oral health care for nurses and primary care physicians will expand access to prevention and care.

### *Principle 4: People-centred oral health care*

22. People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.

### *Principle 5: Tailored oral health across the life course*

23. People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, **Health and oral health in senior high school curriculum, not only focus on physical exercise.**

### *Principle 6: Optimizing digital technologies for oral health*

24. Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is

critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.

## STRATEGIC OBJECTIVES

### **Strategic Objective 1: Oral Health Governance - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector**

25. Strategic objective 1 seeks recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national noncommunicable disease and universal health coverage agendas. Increased political and resource commitment to oral health are vital at the national and subnational levels, as is reform of health and education systems.

26. Central to this process is establishing or strengthening the capacity of a national oral health unit. A dedicated, qualified, functional, well-resourced, and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health services. Sustainable partnerships within and outside of the health sector, and engagement with communities, civil society and the private sector, are essential to mobilize resources and address the social and commercial determinants of oral health.

### **Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions**

27. Strategic objective 2 calls for evidence-based, cost-effective and sustainable oral health promotion and interventions to prevent oral diseases and conditions. At the downstream level, oral health promotion supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care. At the upstream level, oral health promotion includes creating public policies and fostering community action to improve people's control over their oral health and to promote oral health equity.

28. Prevention efforts target key risk factors and social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco, harmful alcohol use and unhealthy food and beverage products, as well as the use of fluorides for prevention of dental caries. Expanding access to HPV vaccines for all 11 and 12 year old girls and boys will reduce the incidence of oral cancers.

### **Strategic Objective 3: Primary Oral Health Care and Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care**

29. Strategic objective 3 seeks to increase access by the entire population to safe, effective, and affordable primary oral health care as part of the universal health coverage benefit package. Basic oral health care includes oral health promotion and prevention of oral diseases and conditions, as well as services which address oral pain, infection, trauma, dysfunction, malignant disease and referral, with agreed quality and patient-safety standards. Oral health care providers who suspect abuse or neglect should offer patients appropriate counseling, treatment, and effective means to report such cases to the relevant authority, according to the national context.

30. Oral health providers should be members of the primary health care team and work side-by-side with other health workers in tackling oral health conditions and other non-communicable diseases, with a focus on addressing common risk factors and supporting general health check-ups. Financial protection through

Ensure oral health professionals receive guidance on proper office safety regulations, use of PPE, education on current sterilization and radiographic guidelines, education about safe use and disposal of dental materials and medicaments

generic medicines and other dental supplies is also important for the management of oral diseases and conditions in primary health care and referral services.

**Strategic Objective 4: Oral Health Information Systems - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making**

31. Strategic objective 4 involves developing more efficient and effective integrated information systems for oral health planning, management and policy-making. At the national level, strengthening oral health information systems should include systematic collection of oral health status, risk factors and resource spending data using existing health management information systems and promising digital technologies. Monitoring systems should also be established to track implementation and impact of existing policies and programmes related to oral health.

**Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health**

32. Strategic objective 5 strives to move beyond the historical oral health research agenda that has focused heavily on dental technology and problem description, rather than problem-solving. The new oral health research agenda should be oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.

**ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT**

**WHO**

**WHO's roles with regard to commercial determinants? WHO shall support strategies and steps at every level to counter commercial determinants, such as big-sugar soft drink**

33. WHO will provide a leadership and coordination role in promoting and monitoring global action on oral health, including in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations. The organization will: set the general direction and priorities for global oral health advocacy, partnerships and networking; articulate evidence-based policy options; and provide Member States with technical and strategic support.

34. WHO will continue its work with global public health partners to: establish networks for building capacity in oral health care, research and training; mobilize contributions from nongovernmental organizations and civil society; and facilitate collaborative implementation of the strategy, particularly as pertains to the needs of low- and middle-income countries. Oral health care can be expensive. The WHO can work with the private sector to establish a tiered pricing system to increase the affordability of dental materials for low-income nations. Nations also need to strengthen their supply chains to ensure the reliable delivery of dental materials.

35. By 2023, WHO will translate this strategy into an action plan for public oral health including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030. By 2024, WHO will recommend cost-effective oral health interventions as part of the updated Appendix 3 of the WHO Global action plan on the prevention and control of noncommunicable diseases and the WHO universal health coverage intervention compendium.

36. WHO will continue to update technical guidance to ensure safe and uninterrupted dental care, including during and after the COVID-19 pandemic and other health emergencies. WHO will, in collaboration with the United Nations Environment Programme, develop technical guidance on environmentally-friendly and less-invasive dentistry. WHO will also consider the classification of noma within the road map for neglected tropical diseases 2021–2030.

37. WHO will help scale and sustain innovations for oral health impact in accordance with the WHO innovation scaling framework, including social, service delivery, health product, business model, digital, and financial innovations. The Lancet Commission on Oral Health and other efforts can be reviewed to identify and aggregate cost effect public health measures that can improve oral health. This information should be made widely available on the WHO portal.

38. WHO will create an oral health data platform as part of WHO's data repository for health-related statistics. The institution will strengthen integrated oral health information systems and surveillance activities through the development of new oral health indicators for population health surveys. WHO will promote and support research in priority areas to improve oral health programme implementation, monitoring and evaluation. The WHO Academy can be asked to provide accredited learning modules in oral health for dentists

**Member states putting environmental regulations in place for safe use and disposal of materials/medicaments (amalgam)**

### **Member States**

39. Member States have the primary role in responding to the challenge of oral diseases and conditions. Governments have the responsibility to engage all sectors of society to generate effective responses for the prevention and control of oral diseases and conditions, the promotion of oral health and reduction in oral health inequalities. They should secure appropriate oral health budgets based on intervention costing and investment cases to achieve universal oral health coverage.

**Put in place regulatory body to ensure dental practice regulations are being met** integral part of national health policies and that national oral health units have sufficient capacity and resources to provide strong leadership, coordination and accountability on oral health.

41. Member States can strengthen oral health care system capacities by: integrating primary oral health care as part of universal health coverage benefit packages; ensuring the affordability of essential dental medicines and consumables, and other equipment or supplies for the management of oral diseases and conditions; and prioritizing environmentally-friendly and less-invasive dentistry. Member States should also assess and reorient the oral health workforce as required to meet population needs by enabling interprofessional education and a wider team approach that involves mid-level and community health providers.

42. Member States can address the determinants of oral health and risk factors of oral diseases and conditions by: advocating for health taxes or regulation of the sale and advertisement of unhealthy products, and counteracting the underlying commercial interests that drive risks; strengthening health-promoting conditions in key settings; supporting legislation to increase the affordability of quality, fluoride toothpaste; and advocating for its recognition as an essential health product within the national list of essential medicines. It will be important to share the rate of return on investing in various oral health policies with policymakers.

43. Member States should improve oral health surveillance, data collection and monitoring to inform decision-making and advocacy. This includes strengthening integrated surveillance of oral diseases and conditions, as well as analysis of oral health system and policy data, evaluation of oral health programmes and operational research.

44. Member States should critically review and continuously update their oral health education and training curricula prioritizing a public health approach to oral health and reflective problem-solving and leadership skills among future oral health professionals.

### **International Partners**

45. International partners have a valuable role in achieving the goal and objectives of the strategy at global, regional and national levels, including playing a **Patronage of** part in advocacy, resource mobilization, exchange of

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information, sharing of lessons learned, capacity-building and collaborative research.

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46. Coordination is needed among international partners, including the organizations of the United Nations system, intergovernmental bodies, non-state actors, nongovernmental organizations, professional associations, patients' groups, academia and research institutions. The WHO can facilitate the creation of partnerships between academic institutions in high income and low to low middle-income nations (LLMICS) that will assist in strengthening training capabilities amongst the latter group. This will help to address the worsening human resources deficits in LLMICS. Establishing and working efficiently as an international coalition on oral health will be a more efficient way to support countries in their implementation of the strategy.

### **Civil Society**

47. Civil society has a role to encourage governments to develop ambitious national oral health responses and to contribute to their implementation. Civil society can forge multi-stakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and amplify the voices of people living with and affected by oral diseases and conditions.

48. Civil society can lead grass-roots mobilization and advocacy for increased focus within the public agenda on oral health promotion and the prevention and control of oral diseases and conditions. Civil society can also help consumers advocate with governments to request the food and beverage industry to provide healthy products; support governments in implementing their tobacco control programmes; and form networks and action groups to promote the availability of healthy food and beverages and fluoridated toothpaste, including through subsidization or reduced taxes.

### **Private Sector**

49. The private sector can strengthen its commitment and contribution to national oral health responses by implementing occupational oral health measures, including through good corporate practices, workplace wellness programmes and health insurance plans.

50. The private sector should take concrete steps towards eliminating the marketing, advertising and sale of products which cause oral diseases and conditions. The private sector should also strive to improve access to and affordability of safe, effective and quality dental equipment, devices, and oral hygiene product. It should also accelerate research on affordable, safe and environmentally sound equipment and materials for oral health care. The WHO can convene private sector providers of dental materials to create a tiered system of costs. Increasing production capacity of these materials in low to middle income nations will diversify the supply chain.

51. Dental professionals in the private sector can support national governments in implementation of the strategy through public-private partnerships for the provision of essential oral health care, by helping to plan and implement population-wide prevention measures and by participating in oral health data collection and surveillance.

### **ACTION BY THE EXECUTIVE BOARD**

52. The Executive Board is invited to note the report and to provide guidance on the draft global strategy on oral health.

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# Response to WHO Consultation on the Draft Global Strategy on Oral Health

## ***Opening remarks***

**1.1** The International Centre for Oral Health Inequalities Research and Policy (ICOHIRP) is delighted to have the opportunity to comment on the World Health Organization (WHO) draft *Global Strategy on Oral Health*. The ICOHIRP was established in 2013. Committed to tackling oral health inequalities both within and between countries, academics and policymakers from over 20 countries have formed a global network to act as advocates on oral health inequalities and to inform oral health research and policy around world.

**1.2** Oral diseases are a significant global public health problem and there is a pressing need for radical reform of oral health services and dental policies. Oral diseases disproportionately affect poorer and disadvantaged groups – the unfair, unjust and persistent inequalities in oral health need to be urgently addressed through the implementation of upstream, midstream and downstream evidence-based policies that tackle the underlying social and commercial determinants of oral diseases. Clinical prevention and health education programmes alone will have limited impact on reducing oral health inequalities. A bolder and more integrated public health preventive approach is needed to tackle the root causes of oral health inequalities. Central to this is the need to work in partnership with civil society/community organisations and key stakeholders from relevant agencies and sectors.

**1.3** The ICOHIRP would like to congratulate the WHO for providing renewed global leadership in oral health and in particular wish to acknowledge the excellent work that Dr Benoit Varenne has undertaken to move the global oral health agenda forwards in such an impressive manner. This is a unique window of opportunity for global oral health and it is of paramount importance that international organisations work together collaboratively to support WHO at this time.

**1.4** As a global network of researchers and policy makers working together to tackle oral health inequalities, we are particularly pleased to see in the WHO draft strategy that a strong public health ethos and approach has been adopted. Compared to previous WHO oral health policy documents published in the last 10-20 years, this is a notable and very welcome development. The draft strategy presents a compelling case for

urgent action to tackle the global burden of oral diseases. We particularly applaud the inclusion of the following key public health issues in the draft strategy:

- An updated and holistic definition of oral health
- Recognition of the wider social and economic burden of oral diseases
- The importance of tackling the commercial determinants of oral diseases and the urgent need for action to reduce free sugars consumption globally
- The need for reform of oral health care systems and the importance of Universal Health Coverage
- The importance of utilising a dental team approach rather than solely relying on dentists to provide care
- Recognition of an ambitious set of priorities in the strategic objectives including health promotion and research agendas
- The need to integrate oral health policy and dental services more closely with the broader NCD and other relevant health and development programmes.
- Recognition of the important roles that need to be played by WHO, national governments and international agencies to move the agenda forwards. We are particularly pleased to see recognition placed on the essential role of civil society and community organisations.

### **General comments:**

#### ***Strengthening focus on oral health inequalities***

**2.1** Although we acknowledge that oral health inequalities have been highlighted in various sections of the document, we recommend that inequalities are also mentioned in the *Vision, Guiding Principles and Strategic Objectives*. Ideally a specific point could be presented in both the *Guiding Principles and Strategic Objectives* to ensure that the global strategy has an overriding and core equity perspective enshrined within it.

#### ***Highlighting importance of social determinants***

**2.2** Although we are very pleased to see recognition placed on the commercial determinants and shared common risks with NCDs, we feel that insufficient recognition has been placed on highlighting the importance of the underlying social determinants of oral health. This is particularly important in relation to understanding the underlying causes of oral health inequalities. We therefore recommend that a brief overview of social determinants is inserted into paras 8 and 9. This would link well with the later text in *Strategic Objective 2* (paras 27 and 28).

#### ***Expanding details on policy interventions***

**2.3** Although we understand that a separate *Oral Health Action Plan* will be published by WHO in 2022, we feel more details could be presented in the *Strategic Objectives* on

the range of interventions that could be implemented to promote population oral health and tackle inequalities. In particular more information on upstream sugar, tobacco and alcohol reduction strategies (eg taxation/minimum pricing, advertising controls etc) and midstream policy interventions to create more supportive local environments and settings (eg early years educational settings, workplaces, care homes etc) could be highlighted in *Strategic Objective 2* paras 27 and 28.

#### *Highlighting COVID-19 recovery*

**2.4** The COVID-19 pandemic has had, and continues to have, a significant impact on global health, inequalities and access to health services. As we move towards a recovery phase it is of paramount importance that we do not return to the same 'old ways' of working and instead use this as an opportunity to reform services and policies to better address population oral health needs and inequalities -'*build back fairer and better*'. We therefore suggest that COVID-19 recovery should feature more prominently in the draft *Strategy*. In the *Vision and Guiding Principles* this important issue could be highlighted to inform and guide the proposed actions.

#### ***Specific comments/suggestions:***

**3.1** In para 2 it is important that the recent WHA Resolution on Social Determinants of Health (WHA 74.16) is also mentioned to ensure that the oral health agenda is closely aligned with the emerging plans from WHO on action to address health inequalities.

**3.2** In para 6 the impact of oral diseases on school attendance, educational performance and time off work could also be highlighted as important broader impacts.

**3.3** Although it is impossible to present a complete list of disadvantaged and marginalised groups, we feel that in para 7 mention should be made of housebound and vulnerable older people, minority ethnic groups and people living in remote and rural communities.

**3.4** In para 9 we would specifically mention smokeless tobacco and drug misuse, and would remove 'harmful' from alcohol use as increased risks of oral cancers begin with low levels of alcohol consumption in a linear manner.

**3.5** The role of universities could be highlighted in para 26 as key stakeholders and partners supporting national oral health departments in relation to research, training and developing/evaluating public health policies.

**3.6** In para 31 we recommend that the importance of developing routine administrative data including both diagnostic and treatment data is highlighted as an important component of information systems. We also suggest highlighting the importance of using oral health information systems to monitor patterns and trends in oral health inequalities.

**3.7** We welcome *Strategic Objective 5* and the importance placed on research but suggest adding an additional point that researchers have an important role in supporting the development and evaluation of population oral health policies.

### **Conclusion**

**4.1** Oral diseases remain a significant global public health problem. It is essential that bold and innovative public health measures are adopted to promote oral health and to reduce oral health inequalities. The ICOHIRP very much welcomes the publication of the WHO *Global Strategy on Oral Health* and would happily provide further advice and support to WHO should this be required.

Please contact Professor Richard G Watt ([r.watt@ucl.ac.uk](mailto:r.watt@ucl.ac.uk)) if you require any further information on this ICOHIRP response.

**International Centre for Oral Health Inequalities Research and Policy**  
**16<sup>th</sup> September 2021**

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<b>Organisation Name:</b> <b>Oral Health Nursing Education and Practice (OHNEP), New York University Rory Meyers College of Nursing</b> <b>Date: 15/09/2021</b>	<b>Person(s) Involved in Contribution:</b> <b>Erin Hartnett, DNP, PPCNP-BC, CPNP, FAAN</b> <b>Judith Haber PhD, APRN, FAAN</b> <b>Jessamin Cipollina, MA</b> <b>Contact Email: hartne01@nyu.edu</b>
<b>Key Areas of the Draft Global Strategy for Oral Health</b>  The vision of this strategy is universal oral health coverage for all people by 2030.	<b>Stakeholder Comment</b>
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	Oral Health Nursing Education and Practice (OHNEP) supports the WHO goal to develop ambitious national responses to promote oral health. A national coordinated response is essential.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health	OHNEP supports the WHO public health approach to oral health in order to reach the maximum number of people.

<p>approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: <i>Integration of oral health in primary health care</i></b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>OHNEP supports the WHO goal of integrating oral health into primary health care in order to establish oral health as essential to overall health and detect and prevent further problems. Our choice of significant population health problems that reflect gaps in racial and health equity include: COVID-19, Non-Ventilator Hospital Acquired Pneumonia, HPV/Oncology, Behavioral Health/Disabilities, Pregnant Women and Children, and Chronic Conditions in Older Adults. For each area, oral health is the missing piece in the whole person care framework.</p>
<p><b>Principle 3: <i>A new oral health workforce model to respond to population needs</i></b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>OHNEP supports the WHO goal of a new workforce model for population's oral health needs. A new model of interprofessional collaboration in both education and practice is needed to achieve patient-centered care. Oral health is an essential component of overall health for people across the lifespan. However, health professionals are still predominantly educated in silos. Non-dental educators, students, and clinicians do not immediately "get" the connection between oral health and overall health.</p>
<p><b>Principle 4: <i>People-centred oral health care</i></b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as</p>	<p>OHNEP supports the WHO goal of people-centered oral health care. Having people participate in their own care is more effective and respectful.</p>

<p>beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>OHNEP supports the WHO goal of oral health throughout the lifespan. Oral health needs change throughout the lifespan and is important for healthcare providers to recognize and address these needs. Oral health is now a recognized policy issue for nursing education curriculum development and clinical practice across the lifespan.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>OHNEP supports the WHO goal of optimizing digital technologies for oral health. Digital technologies can be shared with all and updated as needed.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>OHNEP supports the WHO goal of improving government political and resource commitment to oral health. Government support is essential to provide the needed resources.</p>

<p><b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.</p>	<p>OHNEP promotes the WHO goal of prevention of disease through oral health promotion. Many diseases can be recognized and /or prevented by early oral health diagnosis and intervention.</p>
<p><b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.</p>	<p>OHNEP supports the WHO goal of building workforce capacity and ensuring financial protection for oral health in primary care. At this time many primary care providers do not feel that they are financially rewarded for oral health interventions.</p>
<p><b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.</p>	<p>OHNEP supports the WHO goal of enhancing the oral health electronic information system. Very few EHR integrate oral health.</p>
<p><b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.</p>	<p>OHNEP supports the WHO goal of creating and continuously updating new research on public health and oral health. Information on oral health is constantly evolving and research needs to support this.</p>
<p><b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.</p>	
<p><b>Comment:</b> Thank you for the opportunity to work with the WHO on recognizing oral health as a global problem and developing a strategic plan of action.</p>	



## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<b>Organisation Name:</b> Poche Centre for Indigenous Health, The University of Sydney	<b>Person(s) Involved in Contribution:</b> Dr John Skinner, Acting Research Director
<b>Date:</b> 15 September 2021	<b>Contact Email:</b> <a href="mailto:john.skinner@sydney.edu.au">john.skinner@sydney.edu.au</a>
<b>Key Areas of the Draft Global Strategy for Oral Health</b>  The vision of this strategy is universal oral health coverage for all people by 2030.	<b>Stakeholder Comment</b>  Strongly supported.
The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.	Strongly supported.
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded	Strongly supported. To improve oral health in Indigenous communities with a high dental disease and ill-health burden, it is vital we listen to and value Indigenous voices, particularly Elders and young people. We need strategies that engage key stakeholders from a broad base to commit to work together and across professional and political barriers.

<p>upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>Strongly supported</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Strongly supported.</p> <p>While some reassessment of roles and competencies has occurred in some countries/regions, a more even and rapid approach is required. This is particularly true for Indigenous communities with higher disease burden and lower access to services. There are opportunities to link to innovative school-based allied health training programs which can assist with both the delivery of population oral health prevention strategies and provide pathways into formal allied health and oral health/dental careers.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond</p>	<p>Strongly supported. To improve oral health in Indigenous communities with a high dental disease and ill-health burden it is vital we listen to and value Indigenous voices, particularly Elders and young people. Involving more Indigenous people in workforce programs and prevention strategies also helps improve the cultural competency and safety of services.</p>

<p>to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Strongly supported. Listening to and involving young people in this process is vital as many strategies are developed by adults for adults or children with not a lot of thought or involvement of young people.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b></p> <ul style="list-style-type: none"> <li>- Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</li> </ul>	<p>Strongly supported.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><b>Strategic Objective 1: Oral Health Governance</b> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.</p>	<p>Strongly supported. There is a need to engage with strong community, political/government, and academic champions who understand oral health and are committed to the strategy but are not necessarily oral health/dental practitioners/experts. These champions can often bring about broader based change and commitment than the “experts”. They can provide</p>

	broader leadership, advocacy and political influence and take the message into the general health discussions too.
<b>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</b> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	Strongly supported. See earlier comments and suggestions.
<b>Strategic Objective 3: Primary Oral Health Care</b> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	Strongly supported. See earlier comments and suggestions.
<b>Strategic Objective 4: Oral Health Information Systems</b> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	Strongly supported. In considering this objective, there is the need to also consider international Indigenous Data Sovereignty principles.
<b>Strategic Objective 5: Oral Health Research Agenda</b> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	Strongly supported. Greater commitment is required to implementation science and scalability of pilots based on the agreed research agenda. There are many strategies included in national and international strategies with a good evidence base that are never scaled-up nor sustainably funded, then we create another strategy and start the process all over again. This is particularly true for Indigenous communities. We also need to improve community involvement in research and Indigenous research methodologies and knowledge.
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b>	
<b>Comment:</b>	

## Feedback on the Draft Global Strategy on Oral Health

School of Dentistry, University of Birmingham

Dr Vahid Ravaghi, Dr Alexander John Morris

We are academic researchers and teachers in the fields of [Clinical Epidemiology and Dental Public Health](#) within the School of Dentistry at the University of Birmingham. We hereby give feedback on the WHO discussion paper titled ‘Draft Global Strategy on Oral Health’. Specifically, we would like to make recommendations on two topics, which have been addressed in multiple sections of the draft: (1) *Oral health workforce*, and (2) *Fluoride and dental caries*.

### **1. Oral health workforce:**

1.1. It is encouraging that the draft recognised the significance of reforming dental care and developing a new oral health workforce model. The fact that three out of six guiding principles of the draft are exclusively dedicated to reforming dental care and oral health workforce (Articles 20-22) is an indication of the priority given to this important area

1.2. It is promising to see that the draft clearly advocates the involvement of the other health care professionals in dental care through ‘enabling interprofessional education’, and adopting a ‘wider team approach’ to involve ‘mid-level and community health providers’. We also appreciate that the draft recognised the limitation of the current model of dental training which focuses on ‘educating highly specialized dentists rather than community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists’. We agree that there is a strategic imperative to place oral health alongside general health for service delivery and approaches to addressing determinant of disease and risk factors.

1.3. While we applaud the aforementioned suggestions in the draft, we would like to make a number of suggestions to enhance clarity, hence supporting successful implementation of the proposed reforms. We believe it would be beneficial to include the term ‘task-shifting’ in sections of the draft in which the new oral health workforce model has been discussed (Articles 14, 21, 41). This term has been repeatedly used in previous WHO documentations since 2000s and across the literature in health service research. The 2008 WHO documentation<sup>1</sup> describes task-shifting as ‘a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications’. Addition of the term ‘task-shifting’, which to our knowledge, has not been used in dental literature, allows policymakers and dental researchers to link with the wealth of evidence from other areas of health care (e.g. HIV and maternity care)

in which the safety, effectiveness and efficiency of task-shifting has been studied, implemented and established. Therefore, in our opinion, addition of this term (Articles 14, 21 and 41) can help both policy makers to make an informed decision about task-shifting in dental care.

1.4. We feel it would be helpful to emphasise the concept that both traditional “clinical” and “non-clinical” roles might be carried out by a wider range of health workers than allowed for in current regulatory arrangements (e.g. community health workers) in the new models of oral health workforce. The draft currently recommended ‘reassessing the roles and competencies of mid-level oral health care providers and community oral health workers’, furthermore, it mentioned the provision of ‘essential oral health care’. While this seems to be sufficient to justify the involvement of non-dentist providers in providing dental treatment, some stakeholders may use this lack of clarity to restrict the role of new oral health workforce to oral health promotion and oral health education only. The draft can facilitate the successful inclusion of a wider range of health workers (e.g. community health workers) by including the word treatment in relevant sections of the draft where the new oral health workforce models have been described (Articles 14, 21 and 41).

## ***2. Fluoride and dental caries***

2.1. While the WHO has elsewhere recently re-stated support for community water fluoridation (CWF)<sup>2</sup>, it is surprising that it is absent from this document. We agree that this intervention may not be technically feasible for many countries but the effectiveness of CWF, coupled with the increasing cost and impact of dental caries on individuals, society and healthcare systems makes it a viable and important consideration for many to consider.

## **References:**

1- World Health Organization. "Task shifting: Global recommendations and guidelines." Geneva: World Health Organization (2008). Available at:  
[https://www.who.int/workforcealliance/knowledge/resources/taskshifting\\_guidelines/en/](https://www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/)

2- World Health Organisation (2021): Consolidated report by the Director-General. Geneva: WHO. A74/10 Rev.1, 21. Available at: [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_10Rev1-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_10Rev1-en.pdf)

## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<b>Organisation Name:</b> <b>School of Health Medical and Applied Sciences,</b> <b>Central Queensland University</b>	<b>Person(s) Involved in Contribution:</b> <b>Dr. Lal Rawal</b>
<b>Date: 17 Sept 2021</b>	<b>Contact Email:</b> <a href="mailto:l.rawal@cqu.edu.au">l.rawal@cqu.edu.au</a>
<b>Key Areas of the Draft Global Strategy for Oral Health</b>	<b>Stakeholder Comment</b>
<p>The vision of this strategy is universal oral health coverage for all people by 2030.</p> <p>The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.</p>	
<p>Page 2, point 6: The cost of oral health care 2015 is included. It would be good to look at the current one. The large differences between LMICs and HICs is noted, but it would be good to add the costs according to LMICs and HICs too, if available.</p> <p>Page 3, point 12: In many cases, the dental/ oral health problems globally have been highlighted. Given the burden of oral health problems is more concentrated in LMICs, and the people of these countries are more vulnerable to such problems compared to those living in HICs, it would be good to shed light on people in LMICs.</p> <p>Page 3, Goal, 18: While the goal states that the Member States are to develop ambitious national responses, it is also important to note that the national responses are practical and locally contextual. The sense of local context/ and practical responses also to be highlighted.</p>	
<b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b>	
<i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of	

<p>people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Page 4, principle 3, 21:</p> <p>The current health professional education and development systems of LMICs do not prioritize training mid-level health cadres in terms of oral health and care. Therefore, it's important that the guiding principles and action plans emphasize building capacity of mid-level health cadres, or community health workers in terms of pre-service, and in-service training and capacity building of mid-level health cadres. Meanwhile, continuous professional development (CPD) of mid-level health cadres in terms of oral health is also to be highlighted.</p>

<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	
<p><b>Principle 6: Optimizing digital technologies for oral health</b></p> <ul style="list-style-type: none"> <li>- Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and</li> </ul>	

standards for digital oral health based on best practice and scientific evidence.	
<b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b>	
<i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.	
<i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	
<i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	<p>Strategic objective 3, 30, states importance of developing workforce to tackle oral health problems at PHC level.</p> <p>Evidence suggests that most of the LMICs lack an adequate number of oral health professionals, in particular the dental care providers/dentists. Even if there are sufficient numbers, dentists are mostly concentrated in urban areas and major cities.</p> <p>Community health workers (CHWs) and mid-level health cadres, who mostly look after general as well as oral health problems in rural setting/PHC levels, are not yet provided with adequate training or capacity building in oral health. Therefore, it is important that the need to develop the capacity of CHWs and mid-level health cadres working within PHC level/rural settings is clearly stated in this objective.</p>
<i>Strategic Objective 4: Oral Health Information Systems</i> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	
<i>Strategic Objective 5: Oral Health Research Agenda</i> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT – Please see PAGE 6 of Draft Strategy for detail on this section.</b>	

**Comment:**

Page 8, Private sector:

The roles and current contribution of the private sector in oral health care is clearly stated and given due importance in the draft strategy.

Given the private sector is the main service provider to provide general as well as oral health/ dental care services in many LMICs, it is important that the government plays an important role to facilitate the delivery of oral health services more effectively and efficiently.

However, in most countries, the private sector is not yet adequately regulated and the oral health services provided by them is not adequately recorded/ and reported in national HMIS. Therefore, it is also important that the Member state/government plays facilitating roles for regulating the private sector. Further, maintaining the quality of oral health care by the private sector is another important aspect that the member state/government can facilitate.

September 16 2021

Dear Benoit,

**Re: WHO Discussion paper (version dated 9 August 2021) draft global strategy on oral health**

The Oral Health Services Research Centre, University College Cork, Ireland, is a multidisciplinary team of researchers interested in the promotion of oral health and wellbeing both in Ireland and globally. The group represents a wide range of skills and expertise in the following

- The design, co-ordination and analysis of international, national and regional epidemiological studies, oral health services research including a major focus on the use of fluoride in caries prevention and the monitoring of dental fluorosis.
- The design, conduct and analysis of clinical trials of oral health products according to ICH, GCP and ADA, FDA Standards.
- Postgraduate training in epidemiology, health services research and related disciplines. We offer both Masters and PhD Programmes in addition to a taught Masters in Dental Public Health programme.

The Oral Health Services Research Centre congratulates the WHO on the significant achievement producing such comprehensive discussion paper and draft global strategy on oral health, so quickly after the recent WHO oral health resolution (WHA 74.5, 2021).

The document emphasises the key role Member states have in oral health promotion, prevention and protection. Decision makers cannot consider oral health in isolation, critical to success is meaningful, respectful and constructive engagement with all stakeholders (Glick et al, 2021). The Oral Health Services Research Centre is grateful for the opportunity to provide feedback on a document that places oral health on the global health agenda.

Feedback is set out below each of the strategic objectives.

**Strategic Objective 1: Oral Health Governance -**

**Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector**

- The establishment of a national oral health unit is critically important to success. National oral health units underpinned by the WHO Resolution (WHA 74.5, 2021) and UN Sustainable Development Goals with trained interdisciplinary staff must be promoted. The value of an adequately funded and

resourced health unit with multidisciplinary researchers working together and collaborating with external stakeholders must be seen as key to keeping oral health on all agendas. The Oral Health Services Research Centre is such a facility and will actively support the development of a global strategy on oral health.

- The national oral health policy in Ireland (<https://www.gov.ie/en/publication/90687b-smile-agus-slainte-national-oral-health-policy/> DoH, 2019) is aligned with the goals of the WHO strategy. Support for its dissemination and implementation not easy tasks are essential to the embracing the Vision and Goal of the draft WHO global strategy on oral health (Strehlenert et al, 2019).
- Successful implementation at Member state level requires investment that permits action. Bidirectional communication between leads in general health and oral health must occur at the highest level. Success in this area commences with revisiting how health and disease indicators are designed, agreed, data collected, used and findings communicated. Outcomes should include the perspective of the participant (Ni Riordain et al, 2021).
- Succession planning, Leadership and Training must be addressed with clear career structures and ongoing training in public health, leadership and advocacy at all levels for the integration of oral health across the lifecourse considering a whole of society approach.
- Leadership under pinned by a public health ethos is critical to the essential development of research, training and the delivery of oral healthcare.

#### **Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention –**

**Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions**

- Additional funding must be secured for oral health initiatives in health promotion and protection. A much greater focus must be directed towards implementation science and policy implementations (Strehlenert et al, 2019). .
- Additional resources are required for ongoing research in the area of workforce planning and establishing initiatives in oral health promotion and disease prevention.
- Research underpinning Integration of oral health to all spheres will be dependent on the availability of a skilled workforce, capable of integration, communication and appreciation of the social and commercial determinants of health.
- Human capital in research centres and units must be supported to enable change and provide the environment to develop. The vision of primary care as indicated by the WHO must be widely disseminated (WHO and UNICEF, 2020).

#### **Strategic Objective 3: Primary Oral Health Care –**

**Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care**

- Oral health services research, planning and implementation requires additional human, capital and financial resources to address the proposed research agenda, focused on public health aspects of oral health and innovation for better impact on oral health.

#### **Strategic Objective 4: Oral Health Information Systems –**

**Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making**

- Information systems aligned with national oral health units and a dedicated research agenda for oral health and surveillance.
- The Oral Health Services Research Centre can actively contribute to the development and use of information systems. The significant data repository and epidemiological data that is available can contribute to cross country comparisons and drivers for implementation of the global strategy. The Oral Health Services Research Centre has a very strong track record in epidemiology and monitoring population health in dental caries
- and dental fluorosis (James et al, 2021)
- Agreed outcome measures are critical for within and cross-country comparisons. The development of robust systems with an agreed common terminology and which can be easily upgraded must be supported and addressed immediately. Sustainable development and succession planning is critical to retaining skills in this area.

**Strategic Objective 5: Oral Health Research Agenda - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health**

- A national oral health research agenda is critical to development to the WHO resolution on oral health. All research is essential, competing needs and finite resources have perhaps determined what is funded.
- A research agenda oriented towards public health programmes, population-based interventions, learning health systems, workforce models, digital technologies, and the public health aspects of oral diseases and conditions, such as primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions, is the bedrock from which all else can develop.
- Evidence informs us that better health outcomes are derived where institutions are research performing, therefore a supported national oral health research agenda is critical (Boaz et al, 2015).

Two final points:

The discussion paper provided is comprehensive and does demand several readings to comprehend and appreciate all of the critical points within. With ongoing development, I wonder whether the use of infographics or visual content would ensure the discussion paper is widely disseminated and could have contributions from all stakeholders.

Are the five objectives to be considered in a hierarchical order (1 – 5), or pyramidal with 5 at the base, there is so much in Objective 5 that is critical to progress.

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[file:///C:/Users/mharding/Dropbox%20\(Personal\)/My%20PC%20\(oral102\)/Downloads/FDI-vision-2030%20\(1\).pdf](file:///C:/Users/mharding/Dropbox%20(Personal)/My%20PC%20(oral102)/Downloads/FDI-vision-2030%20(1).pdf) [Accessed Sept 16 2021]

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R, Whittaker S, Williams D (2021). Developing a standard set of patient-centred outcomes for adult oral health – an international, cross-disciplinary consensus. *Int Dent J.* <https://doi.org/10.1111/idj.12604>

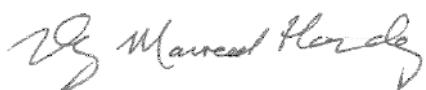
Strehlenert H, Hansson J, Nyström, ME., Hasson H (2019). Implementation of a national policy for improving health and social care: a comparative case study using the Consolidated Framework for Implementation Research. *BMC Health Serv Res* **19**, 730. <https://doi.org/10.1186/s12913-019-4591-2>

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The Oral Health Services Research Centre will engage however possible to enable action on a global oral health strategy that promotes universal access to a sustainable model of better oral health for all.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Máiréad Harding'.

---

Professor Máiréad Harding  
Director Oral Health Services Research Centre

September 17, 2021

Dr Benoit Varenne, DDS, MPH, PhD  
Dental Officer, Oral Health Program  
Division of Non-communicable Diseases  
World Health Organization  
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The area of Dental Public Health of the Graduate Studies Program in Dentistry of the Federal University of Rio Grande do Sul, in Porto Alegre, Brazil, which is a group of faculties and graduate students dedicated to produce and disseminate research to improve Global Oral Health, appreciates the opportunity to contribute with reflections on the Draft Global Strategy on Tackling Oral Diseases published by the World Health Organization (WHO). In addition, we congratulate the Oral Health Program and Member States for approving the Oral Health Resolution during the 74<sup>th</sup> World Health Assembly earlier this year. As a response to the call for comments by the Oral Health Programme, a group of researchers in Dental Public Health at the Federal University of Rio Grande do Sul met over the last weeks. The result of these meetings and discussion is presented below.

Our group praise this relevant document and its defense of public health and public policies in oral health as the response for the burden due to oral diseases, especially the inclusion of oral health into Primary Health Care.

**Suggestion for the item – Global Overview of Oral Health:**

We suggest the use of definition of oral health published by the FDI in 2017: “Oral health is multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex”.

**Suggestion for the item - Oral health promotion and oral disease prevention:**

There is plenty of evidence supporting that water fluoridation is the most cost-effective and democratic preventive measure for dental caries, it is essential that there is an indication by the WHO to guarantee this measure, as well as its surveillance, as part of Universal Health Coverage. Clean water and sanitation are Sustainable Development Goal Number 6 and water fluoridation could represent a key achievement for reducing the burden due to dental caries. In addition, we suggest that toothbrush and fluoridated toothpaste are made available through primary health care for all who otherwise could not access it.

**Suggestion for the item - Oral Health Care Systems:**

The incorporation of oral health care providers into in primary care systems and services must be a goal. If there is a sufficient dental workforce, they should be leveraged and incorporated into primary care. It is also important to support the regulation of dental insurances in countries that opt for such systems, so that patient rights are guaranteed. Finally, as oral health systems are inadequately financed, highly specialized and isolated, novel approaches to oral health care that promote its integration into health systems overall is needed, as well as its evaluation.

Historically, high- and middle-income countries concentrate the global oral health workforce. The WHO Oral Health Programme may play an important role in supporting the education of professionals and tailoring it to the needs of the population. Dental education needs to move from an emphasis on surgical-restorative care and highly specialized dentists, to one that reinforces the importance of generalists and allied dental personnel. The importance of community health workers in providing oral care in areas where there is a severe shortage of dentists, dental technicians must not be neglected. Equity and Comprehensiveness should be complementary to Universal Health Coverage.

#### **Suggestions for Principle 1 - A public health approach to oral health:**

Access to oral health care must be made available to all who need it, but there needs to be an emphasis in the reduction of health inequalities. Providing access alone does not reduce such inequalities. Public policies that promote education, elimination of poverty and security must be in place so that oral health for all is attainable.

Until healthy foods and oral hygiene products are not accessible for all, there will still be an elevated burden due to oral diseases. We suggest that goals be defined to reduce inequalities in oral health, as well as the necessary metrics for its permanent monitoring. Equity needs to be a principle in any public health approach to oral health. Governments must emphasize actions that promote access and make oral health care available for vulnerable populations. Oral health key actors and stakeholders must take part in the formulation and implementation of broader, coordinated oral health efforts, especially those directed to reduce exposure to common risk factors.

#### **Suggestions for Principle 2 - Integration of oral health in primary health care:**

The attributes of Primary Health Care need to be accounted for when developing programs to incorporate oral health care into PHC. Brazil, in particular, has a long experience in integrated dental-medical primary care services and could be used as a benchmark for other countries aiming at improving access to oral health through PHC. The importance of PHC as the first contact of the communities with the health system represents an opportunity for improving access to oral health care. PHC also represents a source of care over the lifecourse and a key component for health systems because. Disease prevention and health promotion should be preferably developed through PHC.

#### **Suggestions for Principle 3 - A new oral health workforce model to respond to population needs:**

Universal oral health coverage can only be achieved through public policy, with a guarantee of sufficient financing and efficient allocation of resources and foreseeing the development of a new model of work process in oral health that meet the needs of the population in each location. The oral health care workforce skill mix should be considered for underserved areas. The development and implementation of protocols for primary oral health care is essential and the education of future cohorts of oral health care professionals needs to incorporate such. Community health workers represent key partners in any effort to improve oral health, and the development of competencies and abilities in oral health should be a goal in their training and continued education.

### **Suggestions for Principle 4 - People-Centered Oral Health Care:**

Oral health care must be made available over the life course. National or State level Electronic Health Records represent an essential tool for monitoring the effectiveness of oral health care provision systems and to track progress.

### **Suggestions for Principle 5 - Tailored Oral Health across the life course:**

People are affected by oral diseases and conditions and their lifelong risk factors. The effects vary and accumulate over time and can have complex consequences in adult life, particularly in relation to other non-communicable diseases. In order to overcome the biomedical model of care for diseases, two forms of transversal insertion of oral health in different comprehensive health programs are proposed: 1) through lines of care; and 2) by living condition. The first provides for the recognition of specificities of age, which can be worked on as child health, adolescent health, adult health and older adults health. The proposal of care by living condition comprises women's health, workers' health, people with special needs, hypertensive, diabetics, among others.

### **Suggestions for Principle 6 - Optimizing Digital Technologies for Oral Health:**

Digital technologies can be used as a complementary strategy for oral health at different levels, including the integration of health information systems, the improvement of digital literacy in oral health, implementation of electronic training in oral health and provider-to-provider telehealth, and increased early detection, surveillance, and referral for oral diseases and conditions in primary care. In parallel, it is critical to establish and/or strengthen governance for e-Health and to define norms and standards for e-Health based on best practices and scientific evidence. Considering all the possibilities of using digital technologies, the importance of developing technologies based on cost-effective artificial intelligence, which are easy to use by any member of primary health care teams, as a surveillance tool in health.

### **Inclusion suggestions - Strategic Objective 1:**

As actions to be developed to encourage the promotion of healthy choices, the adoption of control and inspection measures for consumer goods that harm health is suggested. As examples of these actions, we can mention higher tax collection on ultra-processed foods, lower tax collection on in natura and hygiene products, prohibition of fast food establishments near schools, control of ultra-processed foods advertisements in children's channels, encouragement to agriculture family, limited supply of ultra-processed foods in schools, new labeling standards that make it easier for consumers to read the product, inspection of marketing strategies for ultra-processed products. We emphasize that the focus must be on ultra-processed foods, and not only on sugars (the traditional approach in dentistry). The concept of ultra-processed foods is much more comprehensive and should replace policies that target nutrition based on outdated science about macro and micronutrients.

### **Inclusion suggestions - Strategic objective 2:**

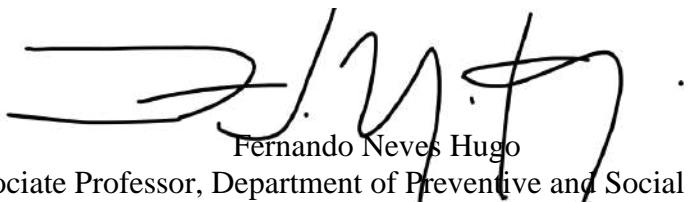
Within the logic of health promotion, actions that aim to combat self-medication, medicalization and excessive dependence on health professionals and/or services are recommended.

**Suggestions - Strategic objective 4:**

In order to strengthen oral health surveillance, it is suggested to include dental data collection in all national health surveys.

**Suggestion - Strategic objective 5:**

The need to reinforce inter and transdisciplinary translational research is highlighted. In addition, the dissemination of research results and the elaboration of protocols are highlighted so that clinical practice is always based on the best available evidence.



Fernando Neves Hugo

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**Harvard School of Dental Medicine comment on WHO Draft Global Strategy on Oral Health**

The Harvard School of Dental Medicine thanks the WHO Oral Health program for their tremendous work on this important initiative and for the opportunity to provide comment on the draft strategy. We collected feedback electronically from global health and expert faculty and have provided a bulleted list of comments offered below for your review.

- Item 3- Change oral health is *essential* to overall health and wellness rather than *integral*.
- Item 4- should acknowledge that global epidemiologic and demographic trends and transitions will have major impact on oral disease burden (e.g. rising NCD rates, aging and growing population, etc.)
- Item 5 - need data on Noma
- Item 6- large disparities and differences exist not only between high, middle and low income countries but also *within* them; intranational disparities are a major challenge for oral health equity and should also be noted along with international disparities; should address urbanization and widening gaps between urban/rural
- Item 7- perhaps stay away from labeling already marginalized groups and rephrase with a focus that they are people first; for example, instead of 'prisoners,' refer to them as 'people housed in correctional facilities'
- Item 9- *The risk factors for noma include malnutrition, coinfections, poor oral hygiene and poor living conditions.*-also malnutrition leads to a compromised immune system increasing the risk to develop this and other diseases. Is not mentioned that mortality and disability, besides that survivors face deformities, disabilities, stigma, isolation.
- Item 12- fluoridated water
- Item 14- dental tourism and highly mobile populations present challenges in workforce and health systems planning; provider shortages, brain drain
- Item 17- *enable all people to enjoy the highest attainable state of oral **and overall** health, contributing to them living healthy and productive lives.*
- Strategic Objective 1- should also note the importance of surveillance programs and health information systems; integrating oral health into national demographic health surveys
- Strategic Objective 2: *Oral Health Promotion and Oral Disease Prevention-Enable all people to achieve the best possible oral health and target and reduce...*perhaps mentioning oral disease prevention might seem too broad, focusing on the most prevalent oral diseases/conditions on another point should be more effective. i.e. Showing some data, so there is area to quantify and track progress by the year of the decade
- Strategic Objective 3- This objective should mirror Objective 5, and discuss strategic shifts in dental training and education/workforce development programs; this shift should be similar to the recommended new oral health research agenda; dental education should grow beyond reactionary



# HARVARD

## School of Dental Medicine

clinical skillset development and also include more robust training in health promotion and prevention, public and population health initiatives, leadership and advocacy, social (+ political, environmental, commercial) determinants of health, and inter professional teamwork; additionally, providers should be trained in aspects directly included in Objective 5- “...primary health care interventions, minimally invasive interventions, alternative dental restorative materials, environmentally sustainable practice, and economic analyses to identify cost-effective interventions.”

- Strategic Objective 5/Item 32- The concept of Environmental health/climate change and oral diseases are not developed enough. Waste management and dental amalgam aren't the only concerns when we talk about environment. Energy use, water use, plastics, and researching climate's impact on oral health should be mentioned. This section should be expanded.
- Item 27- Clean water and sanitation are the most upstream determinant and are not discussed.
- Item 31- Antibiotic overuse/misuse is a concern of WHO - they are hosting a global awareness campaign event in November 2021 to slow antibiotic resistance, and antibiotic misuse is not delineated clearly in this document. Topic could be mentioned in data collection section too.
- Member States- water fluoridation; health professions education reform;
- International Partners- developing guiding frameworks, targets and indicators for streamlined global collaboration, promising/best practices
- Civil Society- develop a culture of responsible internet and information use, combat mis/disinformation on social and digital media platforms (could also apply to Member States)
- Item 43: seems only as a recommendation, but will WHO provide some guidance and tracking on this matter?
- Item 44: suggest that WHO makes available resources for member states to update their oral health education and training curricula rather than each working on their own. Efforts could be distributed and be more uniform across, rather than having people working on the same topics.
- General comment- Does not mention anything about bacterial infections. While we all know, if a policy maker or someone from a different field other than dentistry sees this strategy document, this should address this topic as well.



Philadelphia, PA, USA

September 9, 2021

Dear Dr. Varenne,

We appreciate the opportunity to provide comments on the report entitled *“Draft Global Strategy on Oral Health.”* This is an important document that will be the foundation for *“the development of a global action plan on oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030.”*

Below find our observations and comments that we believe will enhance this excellent and detailed action plan.

#### **Commercial Determinants and Risk Factors of Oral Health**

#8. An approach to risk-based strategies requires developing and implementing prediction modelling that allows patients, clinicians, and policymakers to use baseline risks and their change over time to improve health outcomes. This type of modelling would enhance our understanding of commercial determinants and risk factors of oral health.

#### **Oral Health Care Systems**

#14. This section seems to call for more expanded duties for oral health care professionals other than dentists. This is a horizontal (within the dental profession) integration approach that may not be sufficient to answer the needs of people at risk for and with oral disease. We suggest adding a vertical (outside the dental profession) integration approach that engages non-traditional oral health care professionals, such as nurses, pediatricians and others in an effort to expanding care to vulnerable populations.<sup>1</sup>

#### **Vision**

#17. As written, this vision seems static and could be improved by acknowledging the evolving nature of policy and decision-making.

#### **Guiding Principles**

#19. Any public health approach to oral health should be informed by evidence. Including a suggestion for an evidence-informed public health approach will strengthen a foundation for subsequent evidence-informed policies.

#21. See #14 above. A more vertical integrated workforce might be required to address the need for both prevention and treatment of oral diseases in areas that lack traditional oral health care providers.

1. Balasubramanian M, et al. Planning the Future Oral Health Workforce: A Rapid Review of Supply, Demand and Need Models, Data Sources and Skill Mix Considerations. *Int J Environ Res Public Health.* 2021 Mar 12;18(6):2891. doi: 10.3390/ijerph18062891

#22. Persons' "needs and preferences" are highlighted as part of a people-centered oral health care approach. This seems not to be aligned with other WHO documents and concepts that embrace persons' "values and preferences." Also, any discussion of a people-centered oral health care approach will be enhanced by specifically addressing patient or person-reported outcomes.

#23. Specifically highlighting how social and commercial determinants change and impact oral health across the entire life course will augment existing and emerging oral health strategies.

#24. Optimizing digital technology for oral health should also include analyzing and synthesizing emerging research findings by facilitating access to the research literature and evidence to inform guidelines and policies, especially in low- and middle-income countries. Furthermore, digital technologies should also be utilized to continuously enhance adaption, adoption and analysis of practice guidelines and outcomes of policy implementations.

### **Strategic Objectives**

#30. In medicine, implementation of "general health check-ups" has been shown to create overdiagnosis and overtreatment. Furthermore, it is unclear if such an approach to health prevention result in any net financial or even health benefits. It may be prudent to remove this recommendation until more evidence is available for such an approach.

#31. The suggested strategy seems to focus on surveillance, i.e, monitoring, for evidence-based policymaking. Such an approach seems to conflict with WHO strategies for policy development in medicine that are informed by evidence and value-based care.

Any strategy to develop evidence and value-based care for "more efficient and effective integrated information systems for oral health planning, management and policy-making" must include primary and secondary research. These types of research should be included in both **Strategic Objectives 4 and 5**.

#32. The suggested strategic objective does not address the necessary steps of synthesizing and translating research findings into practice. Including implementation research in the research agenda outlined in **Strategy Objective 5** will address an important and much lacking aspect of oral health research.

### **Role of member states, partners and Secretariat**

#### **WHO**

#33. This strategy includes "articulate evidence-based policy options." This is very important and needs to be addressed and included, to the extent possible, in all **Strategic Objectives**.

#35. "[M]easurable targets" may change and evolve from the time of implementation and 2030. This issue should be addressed.

#38. Will WHO provide any clarification of or guidance on how WHO will "support" research?

#### **Member States**

#41. Adding "prevention" to the stated "management" will reinforce the need for such an intervention.

## **Civil Society**

#47. Adding “at risk for” to “people living with and affected by oral diseases and conditions” (*people at risk for and living with and affected by oral diseases and conditions*) will enhance the message for the need for prevention.

### **Overall comments.**

Emphasizing the “research to practice” loop more prominently throughout this draft report may enhance integration and implementation of the suggested strategies by practicing oral health care providers, as well as support evidence-informed practice and policy strategies.

There is no mention of clinical practice guidelines throughout this report. Including the development and the implementation of regional-specific evidence-informed clinical practice guidelines might be a worthwhile strategy to reduce the burden of oral disease worldwide.

As this document addresses oral health, which includes much more than teeth, it may be pertinent, when appropriate, to change “dental” to “oral health.” Here are some instances in the document where this change may enhance strategies and communication:

#11 “dental public health initiatives”; #14 “Dental training”; #32 “dental technology”; #36 “dental care”; #41 “dental medicines”; and #52 “Dental professionals.”

Respectfully submitted,



Michael Glick  
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University of Pennsylvania  
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USA

**Dental District**

**School of Medicine  
and Health Sciences**



**University of Papua New  
Guinea**

*Premier University of the South Pacific*

# **Gutpla tit blo umi olgeta\***

**\* Pidgin for “Good teeth for all”**

## **Feedback to the World Health Organization on the Draft Global Strategy on Tackling Oral Diseases**

Prof Leonard Crocombe<sup>1, 2, 3</sup>, Dr Mahmood Siddiq<sup>1, 2, 3, 4</sup>, Dr Gilbert Kamae<sup>1, 3</sup>, A/Prof Silvana Bettoli<sup>1, 4</sup>, Prof Geoff Knight<sup>1, 2, 3</sup>, Dr Elizabeth Sari<sup>2, 5</sup>, Prof Michael McCullough<sup>6</sup>, Prof Nakapi Tefuarani<sup>1</sup>

1. University of Papua New Guinea, Port Moresby, Papua New Guinea
2. La Trobe University, Bendigo, Victoria, Australia
3. Papua New Guinea Dental Association, Port Moresby, Papua New Guinea
4. University of Tasmania, Hobart, Australia
5. University of Padjadjaran, Bandung, Indonesia
6. University of Melbourne, Melbourne, Victoria, Australia



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## Executive Summary

This document presents our feedback to the WHO Discussion Paper: Draft Global Strategy on Oral Health, 9 August 2021, Technical document. Our feedback investigates the problem as found in Papua New Guinea (PNG) in tackling oral diseases.

It supports the contentions in resolution WHA74.5 agenda item 13.2 that poor oral health is associated with social determinants, poor access to dental care, fluoride exposure and smoking. Oral health-related behaviours, a subset of which is seeking dental service use, are but one of four steps in the journey towards good or bad oral health.

The limitations with providing dental care in PNG are noted and concludes with the question of, “If developed countries like Australia cannot afford to provide dental care to some social groups, how can developing countries like PNG be able to afford to do so?” The answer is they can’t.

A concerted education and political effort should be undertaken by the PNG Dental Association, the PNG Dental Services and the University of PNG School of Medicine and Health Science so that the PNG National and Provincial Governments integrate oral health within national policies.

The traditional surgical curative approach should only be considered as a last resort. Minimum intervention, with the use of topical sodium fluoride applications by village health workers, the use of silver diamine fluoride to arrest the tooth decay, atraumatic restorative treatment and finally silver-modified atraumatic restorative treatment by dental therapists or dentists should be the initial consideration. Ultimately, the focus needs transfer from problem-based dentistry to regularly preventative check-ups.

A “hub and spokes” model for the provision of dental services is required where the referrals go up and down “the spoke” depending on the necessary intervention. Village health workers should be able to recognise potential oral diseases including potential oral cancers, undertake preventive approaches where possible and refer onto dental therapists and dentists for remedial treatment, who will in turn, refer onto dental specialists if such treatment is required.

A retrospective audit of the PNG Cancer Registry for the years 2012-2021 to ascertain the true incidence of oral cancer in PNG and to determine the five-year survival outcomes for the years 2012-2016 is required.

It is not feasible to do a National Survey of Adult Health or a Child Oral Health Survey along the lines of that done in Australia due to the geographical remoteness of many villages and the limited resources. Final year University of PNG students will be asked to do an oral health survey of children and adults in their hometowns, many of which are in the Provinces outside Port Moresby. Overtime, we will obtain an indication of the oral health situation in PNG.

A fluoride mapping project that will determine the fluoride concentrations in the natural drinking water sources of PNG that has been proposed by Dr Siddiqi and Prof Crocombe with the assistance of undergraduate and postgraduate students of the Dental District, School of Medicine and Health at the University of PNG and members of the PNG Dental Association should be undertaken as a matter of urgency.

Sustainable practice is supported in this feedback document by the suggestions that reduce use of amalgam with preventative measures. the “spoke and hub model” will reduce patient travel time which is approximately 50% of the dental environmental sustainability costs and is the model PNG should adopt. Many issues mentioned in this feedback paper will be pertinent to other developing economies Asia Pacific region. PNG has the opportunity and the incentive to use its own innovative approaches towards improving community oral health. These innovative approaches should align with sustainable health care approaches and the Global Sustainable Development Report (GSD Report)<sup>1</sup> and the latest report from the World Dental Federation<sup>2</sup>.

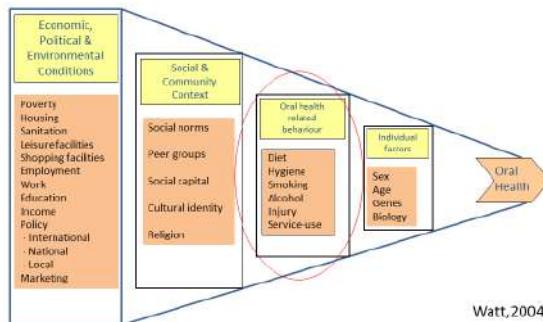
# The Key Risk Factors for Poor Oral Health in PNG

The people of PNG are generally in poor health. Life expectancy at birth is 54 years and one child in 13 will die before the age of five. Preventable and treatable diseases, including malaria, pneumonia, diarrhoea, tuberculosis, HIV, and neonatal sepsis, are the most frequent causes of death. There is an increasing incidence of antibiotic resistant tuberculosis and HIV/ tuberculosis co-infections. The level of violence against women is among the highest in the world. The PNG National Health Plan 2011-2020<sup>2</sup> paints a grim picture for the next two decades of health care due to a rapidly increasing population, a rapid rise in communicable diseases, and low per capita expenditure on health care.

Although no epidemiological oral health surveys have been undertaken in PNG, anecdotal evidence suggests tooth decay is a problem, especially in children, and gum disease continues to be a major cause of tooth loss. There are high levels of trauma, particularly domestic trauma, requiring complex oral surgery and an increasing number of patients with HIV-AIDS presenting with serious oral health issues. Into this mix has been the COVID19 pandemic in PNG resulting in further limiting the supply and access to health care.

When looking at the risk factors for poor oral health in PNG, one needs to go beyond oral health related behaviours and look the economic, political and environmental conditions as well as investigating the social and community context. All of the economic, political and environmental conditions listed in the social determinants and social and community context oral health figure section in the figure on the right are poor in PNG

## Social Determinants and Oral Health



What is not mentioned in the economic, political and environmental conditions section is low fluoride exposure. Water fluoridation is not practical in PNG because most of its people live in remote and difficult to access areas.

The culture of PNG is complex. Most (87%) people live in rural villages and access to health care is often difficult. The adult literacy rate at 58%<sup>2</sup> making dissemination of health information difficult.

Papua New Guinea (PNG) is a country of approximately 7.3 million people located in the Western Pacific and renowned for its environmental, cultural and biological diversity. PNG is categorised as a lower-middle-income country according to the World Bank criteria but throughout its recent history has experienced rapid economic growth as a result of large-scale mineral and gas resource developments<sup>3</sup>. The prevalence of non-communicable diseases (NCDs) and their risk factors in Papua New Guinea is increasing but varied based on ethnicity, lifestyle and the living environment<sup>4</sup>.

A recent example of PNG's low health literacy has been resistance to COVID19 vaccinations. Less than 2% of PNG's population has been fully vaccinated. Prima's CEO, Adrian Chow, said "They think that once you get vaccinated there is electricity through your body ... or that within a few months you might die"<sup>5</sup>. Dr Esorom, the PNG Deputy Pandemic Controller, said PNG's vaccination rate was far too low, and he said hesitancy, rather than a lack of access to the vaccine, was to blame.

Many different cultural groups exist, and over 800 languages are spoken<sup>6</sup>. This fact poses a great challenge in effective communication to people in the districts and wards.

It is important to note that oral health-related behaviours as outlined in red in the figure above are but one step in the road towards good oral health and that the use of dental services is but one part of the oral health-related behaviours step. What is not mentioned in the figure under oral health-related behaviours is betel quid chewing and these two factors are particularly important in the PNG context.

Oral cancer is the most common cancer in Papua New Guinea (PNG)<sup>7</sup> due to smoking and the chewing of betel quid, made of Areca nut, part of the piper betel plant, and slaked lime<sup>8, 9, ,10</sup> or 'buai', as it is known locally, is deeply entrenched daily life practice.

Betel nut was previously only chewed in coastal areas and as part of a cultural practice during important events. Now it has spread to the Highlands of PNG where it is chewed continuously, and increasingly by young children. Oral cancer is now found in people in their teenage years. Hence, we can expect oral cancer to become even a greater problem in PNG.

## **Integration of Oral Health within National Policies**

Oral health is low on the scale of priorities, not even being mentioned in the National Health Plan<sup>7</sup>. This needs to be changed. A limiting factor for such an integration has been the evolving relationships between the national and provincial governments. Provincial governments, particularly in the case of Bougainville, are becoming more financially self-sufficient.

A concerted education and political effort should be undertaken by the PNG Dental Association, the PNG Dental Services and the University of PNG School of Medicine and Health Sciences. Dentistry and dental therapy students, graduated dentists and oral health therapists are located in every Province in PNG where they are respected members of their communities.

The PNG Dental Association is in regular contact with its dentist and dental therapist members and could coordinate a two-pronged approach: One for the national government and another for the provincial governments. The University of PNG School of Medicine and Health Sciences and the PNG Dental Services could provide the necessary background information.

The messages should be the links between oral and general health and the importance of oral health to quality of life. Population oral and general health promotion need to be integrated and include anti-smoking & anti-betel quid chewing, along with newborn and infant oral health messages.

As the dental school was closed for 20 years prior to 2005, there is no middle generation of dentists, and the few senior dental practitioners in PNG are reaching retirement age. This means the younger generation will have to stand up.

## Reorientate the Traditional Curative Approach

The traditional surgical approach to dental treatment is not practical in a developing economy like PNG. Dental treatment has to focus on oral urgent treatment, atraumatic restorative treatments, and finally routine dental care.

Unfortunately, due to the poor oral health and lack of access to dental care in PNG many patients present with a dental problem and such problems have to be managed in the first instance. However, the focus needs to be transferring people from problem-based dental visiting to regularly having a check-up.

To do this, dentistry in PNG must move away from its traditional surgical approach whereby dental caries is removed using drills and restorations placed. Topical sodium fluoride applications could be undertaken not just by dentists and dental therapists, but by village health workers: those closest to the local people. They will be able to ascertain the living conditions of the local people, their local culture and their health literacy. They will require continuing professional development so that the village health workers (See the “hub and spokes” model below) are encouraged to look into people’s mouths and can recognise dental caries. With early dental caries and for all people at risk of dental caries, they could apply topical sodium fluoride and have regular fluoride toothpaste brush ins. Also could be included is dietary advice and the encouragement, where feasible, to regularly brush their teeth with a fluoride-containing toothpaste.

With lesions determined to be unsuitable for arresting with sodium fluoride, the patient should be referred to the closest dental therapist or dentist.

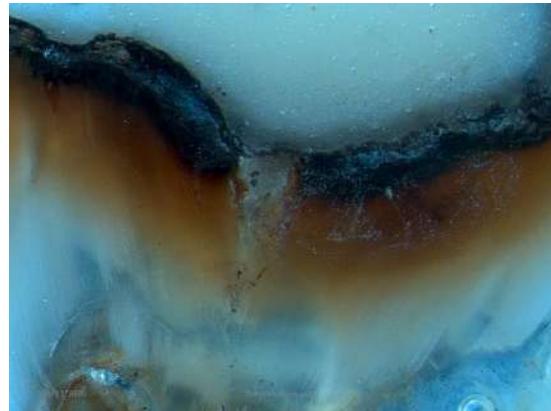
Once the patient sees a dental therapist or dentist, the first option should be the use of silver diamine fluoride to arrest the tooth decay. This option is particularly suitable for young children, the elderly and people with disabilities and the diamine component makes last longer in the hot conditions of PNG. Silver diamine fluoride ( $\text{AgF}(\text{NH}_3)_2$ ) has greater dental caries arrest and prevention abilities than sodium fluoride ( $\text{NaF}$ ) varnish<sup>11-17</sup>. These abilities are thought to derive from the combined effects of silver salt-stimulated sclerotic or calcified dentin formation<sup>18</sup>, silver nitrate’s potent germicidal effect<sup>19</sup>, and fluoride’s ability to reduce dental caries<sup>20, 21</sup>.

Only if the silver fluoride option is not feasible, should the dental therapist or dentist use minimal intervention dentistry that has the philosophy to only cut teeth when necessary and if it is necessary to cut the minimal amount possible. Atraumatic restorative treatment (ART) is a minimally invasive procedure that involves removing markedly softened carious enamel and dentine using only hand instruments and then restoring the resulting cavity with an adhesive restorative material<sup>22</sup>. This has the advantage of not using amalgam which will help satisfy the conditions of the Minamata Convention on Mercury. If fluoride-releasing glass ionomer restorative materials are used it will reduce the risk of further dental caries in the region of the restoration.

The next step would then to look at the use of silver diamine fluoride under glass ionomer cement restorations. Incorporating silver diamine fluoride into the ART protocol before placing a glass ionomer cement, has become known as Silver Modified ART or SMART.

However, silver diamine fluoride causes staining around the margins of the glass ionomer cement restoration limiting its application as an effective aesthetic technique. The use of potassium iodide immediately after the SDF application, and the resultant production of the white silver iodide reaction precipitate, removes the blackness and has a more aesthetic result.

Silver diamine fluoride applied to dental caries beneath a glass ionomer cement restoration<sup>23</sup>. This shows a glass ionomer cement restoration (the white area) covering arrested dental caries (the black area). (The darkened area shows the extent of arrested caries beneath the GIC restoration) Note the depth of penetration of silver diamine fluoride seen as a brown band on the optical image.



Picture courtesy of Dr Joshua Cheetham.  
Description by Dr Geoff Knight.

Only after the options above have been considered should the dental therapist or dentist consider using the traditional surgical approach.

## Promote Efficient Workforce Models

PNG has tended to copy the approach used in developed Western economies when developing its dental workforce. However, this model does not allow access to dental care for people within developed economies. If developed countries like Australia cannot afford to provide dental care to some social groups, how can developing Pacific countries like PNG be able to afford to do so? The answer is they can't and so they should not copy the medical approaches used in Western countries.

The medical approach has seen an increase in dentist numbers but nowhere near enough to provide dental care for PNG's residents. Yet, while the need for dental care is great, the government claims it cannot afford to employ all the graduating dentists. These factors have seen a boom in private practice in the larger cities targeted at people who can afford dental care.

A "hub and spokes" model for the provision of dental services is required. Dental specialist services should be provided at the hub, first at PNG's capital city, Port Moresby. The dentists should continue to be placed in regional hospitals and dental therapists in the field. However, due to the difficulties in visiting many of the remote villages, midwives, general nurses, health promotion teachers and village health workers could be trained in dental and oral cancer screening oral health promotion and fluoride applications including the tooth decay arresting agent silver diamine fluoride<sup>11</sup> and glass ionomer sealants.

Such a system will require further professional development and a referral pathway for further professional dental treatment. For example, in the case of oral cancer, online continuing professional education could be provided to dentists and dental therapists.

It would include:

- How to perform a proper comprehensive oral examination to recognise oral mucosal diseases,
- malignant and non-malignant oral mucosal disease,
- early recognition of squamous cell carcinoma,
- when to biopsy,
- good intra-oral imaging for recording and monitoring, when to follow up
- risk factors, and cessation advise

The correct referral pathway up and down between village health worker to dental therapist to dentist to oral maxillofacial surgeon would have to be established for timely diagnosis and treatment. Village health workers and dental therapists would explain the risk factors and give cessation advise, the dentists would do the biopsies and the Oral and Maxillofacial Surgeons and Ear, Nose and Throat Surgeons undertake the surgical and radiological treatments.

Dr Elizabeth Sari and colleagues found that the ingredients (a higher concentration of polyphenols and arecoline) in unripe betel nut were more likely to cause oral cancer than in ripe betel nut<sup>24,25</sup>. She also found that in Indonesia the least ripe betel nut was in West Papua, on the same island as PNG.



She further found that in West Papua the betel quids mixture was distinctive compared to betel quids used in three other regions of Indonesia. In West Papua, they prefered to include the flower (Stem inflorescent) part of *Piper betle* rather the common leaf of *Piper betle* that wraps the betel quid mixture<sup>25</sup>. This stem inflorescent is consumed in PNG. The stem inflorescent has been reported to cause cell toxicity and proliferation which further could lead to oral submucous fibrosis; a potential malignant disorder<sup>25</sup>.

This suggests that if village health workers cannot get the patient to cease betel nut chewing, they may be able to encourage them to chew ripe as opposed to unripe betel nut which may reduce the incidence of oral cancer. The Indonesian-based project should be extended into PNG.

Also included could be the University of Melbourne's online "Mouth Map" which allows checking from visual references if the lesion is likely to oral cancer and create a visual documentation of the change in the lesion over time.

The "hub and spokes" model for the provision of dental services will be more sustainable because approximately half of the ecological sustainability costs are associated with patient travel.



## **Effective Surveillance and Monitoring Systems**

### **Oral Cancer**

There is no detailed data on the oral cancer and potentially malignant lesions in PNG. Retrospective audit of PNG Cancer Registry (2012-2021) should be done. Currently, the oral cancer details are on paper and hasn't been entered into a computer inventory.



Oral cancer posterior to the upper premolar  
Picture supplied by Prof Michael McCullough

A project has been proposed by Prof Michael McCullough from the University of Melbourne and accepted by the School of Medicine and Health Sciences at the University of PNG, the Port Moresby General Hospital and the PMNG Dental Services to undertake a retrospective audit of the PNG Cancer Registry for the years 2012-2021 to ascertain the true incidence of oral cancer in PNG and to find the five-year survival outcomes for the years 2012-2016.

Data will also be collected from the Port Moresby General Hospital to find if there is a lack of referral due to unawareness of importance of mucosal examinations, if there is late referral of oral cancer leading to late diagnosis and poor outcome, and if inappropriate referral of mucosal disease result in the Oral and Maxillofacial Surgery service at the Port Moresby General Hospital being overwhelmed?

## **National Survey of Oral Health**

It is not feasible to do a National Survey of Adult Health or a Child Oral Health Survey along the lines of that done in Australia due to the geographical remoteness of many villages and the limited resources in PNG.

In Australia, survey participants were selected using a multi-stage probability sampling design that began with the sampling of postcodes within states/territories in Australia. Individuals within selected postcodes were then selected by the Australian Government Department of Human Services from the Medicare database<sup>26</sup>. Following an initial opt-out period, participants were given the option to either complete the questionnaire online, or to complete the questionnaire via a computer assisted telephone interview. Participants were asked a series of questions about their oral health and dental service use. Participants who completed an interview and who reported having one or more of their own natural teeth were invited to undergo a standardised oral examination.

A method similar to this with Australian funding was tried many years ago but it unsuccessful due to resource and security issues. Final year University of PNG students have to undertake a minor research project as part of their degree. As an initial trial, a small number of could be asked to do an oral health survey of children and adults in their hometowns, many of which are in the Provinces outside Port Moresby. To do the survey adequately months of commitment will be required from the WHO, the PNG Defence Force, PNG Dental Services and the Dental Association of PNG.

Another method of obtaining some oral health data is to send de-identified data from mobile devices to a central computer. This has been investigated but requires support.

## **Map and Track the Concentration of Fluoride in Drinking Water**

It is not feasible to fluoridate the water supplies across PNG because the landscape is diverse with many hilly areas and isolated villages. However, we do not know the existing levels of fluoride within the drinking waters in PNG. Though Papua New Guineans should not be encouraged to eat more salt because of its health effects, an alternative to water fluoridation instigated by Government legislation requiring all imported salt to be fluoridated.

However, fluoride mapping is required before policies can be made whether to increase the fluoride exposure whether it be by salt fluoridation, fluoridated toothpastes or topical fluoride applications in villages or dental clinics, in individual communities around PNG. It may be that some areas the water fluoride levels may be too high requiring alternative sources of drinking water.

A fluoride mapping project that will determine the fluoride concentrations in the natural drinking water sources of PNG has been proposed and will be overseen and undertaken by Dr Siddiq and Prof Crocombe. Some of the data will be obtained with the assistance of undergraduate and postgraduate students of the Dental District, School of Medicine and Health Sciences at the University of PNG and members of the PNG Dental Association. This will be used to ascertain the feasibility of the project. Then assistance from the provisional authorities and the WHO will be required.

Larger towns and surrounding water supplies in each of the Provinces of PNG will be selected for sampling of the drinking water sources. The collected drinking water samples will be transported to the Biochemistry Research Laboratory at the School of Medicine and Health Sciences at the University of PNG in Port Moresby where the fluoride concentration will be determined. Where possible local district rivers and streams will be visited.

The results will be published in reports to governments at local, provincial and national level. Where the fluoride levels are not optimal, recommendations made on how to obtain the best population fluoride exposure.

## **Sustainable health care and dental practices**

Worldwide it is recognised that resources are limited and that existing approaches to their use need to change. Apart from climate change, we need to consider the broader impact of sustainability and there are many examples of how insufficient management of environmental issues is having negative effects on the planet and its people.

Health care sectors worldwide are working to include sustainability measures in the evaluation of medical technologies or products via procurement and working with industry partners more closely ie waste management. The idea is to allow service planners, clinicians and patients to choose clinically effective treatments with the best environmental profile. More recently, the exciting news of World Dental Federation (FDI) launching new initiatives, with commitments from four founding industry partners – Colgate, Dentsply-Sirona, GSK Consumer Healthcare, and TePe – to lead the charge on sustainability in dentistry.

Sustainable health care goals<sup>1</sup> is underpinned by the United Nations Agenda 2030, which (in 2015) set 17 sustainability development goals (SDGs) with 169 targets within them. Monitoring reports are provided regularly and an independent review, the Global Sustainable Development Report<sup>2</sup> (GSD Report), is undertaken every four years, the last being in 2019.

In the prologue of the 2019 GSD Report<sup>7</sup>, Ms Gro Harlem Brundtland defined sustainability as follows:

*.... “sustainable development”, a pattern of development that meets the needs of present generations, without compromising the rights of future generations to fulfil their needs.*

This highlights the three pillars of economy, society and environment, in the Agenda 2030 initiative. *Development* refers to managing the economy in a way which is fair to all.

While there is no dedicated SDG for dentistry, SDG 3 is *Good health and well-being* has the overall goal to *ensure healthy lives and promote well-being for all at all ages*. The UN sustainability plan emphasises a holistic approach with the need for interdependence between the goals and the need for underlying policy to assist the change in the way the world looks at its resource use. Other SDGs affect dentistry as a subset of larger problems, such as SDG7 *Affordable and clean energy* and SDG9 *Industry, innovation and infrastructure*.

For all low economic countries this can only be a win/win situation. Sustainability is defined by three core elements, each of which must be carefully considered in relation to the others including environmental protection, social development and economic development.

Sustainable dental practices include procurement but also supporting practitioners. When applied to dentistry, is the practice by which the dental surgery addresses environmental, social and ethical considerations when purchasing goods or services but also how items are disposed.

Sustainable practice is supported in this feedback document by the suggestions that reduce use of amalgam with preventative measures. While amalgam is a valuable product for the treatment of dental caries, due to its cost and durability unfortunately unless disposed correctly can create other health problems in the community.

The rigorous requirements for infection control and for dental procedures overall are not matched with rigorous requirements for waste management in more affluent countries let alone on poorer economies.

We note the difficulties in PNG dental services to

- Disposal of amalgam and X-ray solutions. The latter is being solved by the greater use of digital radiography.
- Disposal of old chairs is difficult in PNG. The equipment disposal problem can be tackled by purchasing the same brand of equipment throughout the Dental Service, training of technicians to be able to repair the equipment and by ensuring any equipment donations are of the same brand as that purchased.

Most dental services rely on patient visits to fixed clinics when in many countries mobile services are more economical and equitable. The use of mobile dental services is difficult due to the difficult terrain. An option is to expand the medical services in boats to include dental services. However, the “spoke and hub model” will reduce patient travel time which is approximately 50% of the dental environmental sustainability costs and is the model PNG should adopt.

The Port Moresby General Hospital Dental Division has developed a plan to establish school dental services in collaboration with the School of Medicine and Health Sciences of the University of PNG and the PNG Dental Association.

Australia has been providing dental, ophthalmology and other limited medical care to the people of PNG through their ship which is covering some coastal provinces of the country. Youth with a Mission (YWAM) has recently acquired a trailer mounted mobile dental clinic which will be useful in providing dental care to the school children in urban areas.

## **Oral Health Worldwide**

Many issues mentioned in this paper will be pertinent to other developing economies in Asia Pacific region. PNG has the opportunity and the incentive to use its own innovative approaches towards improving community oral health. These innovative approaches should align with sustainable health care approaches and the Global Sustainable Development Report (GSD Report)<sup>1</sup> and the latest report from the World Dental Federation<sup>2</sup>.

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## COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

<p><b>Organisation Name:</b>  <b>Improving Palliative, Aged and Chronic Care through Clinical Research and Translation (IMPACCT), Faculty of Health, University of Technology Sydney</b>  <b>Date: 17 Sept 2021</b></p>	<p><b>Person(s) Involved in Contribution:</b>  <b>Dr. Mariana de Souza e Sousa</b></p>
<p><b>Key Areas of the Draft Global Strategy for Oral Health</b></p>	<p><b>Stakeholder Comment</b></p>
<p>The vision of this strategy is universal oral health coverage for all people by 2030.</p>	
<p>The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.</p>	
<p><b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b></p>	
<p><i>Principle 1: A public health approach to oral health</i> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health</p>	

<p>programmes should be integrated within broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>Does Principle 3 also cover a non-dental workforce? It mentions community oral health workers, but it is a bit vague. If not, this is an important aspect to highlight in the document.</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities,</p>	

<p>including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course</b> - People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>In principle 5, it should be tailored across the life course; however, it sort of touches on population needs in Principle 3 and on oral health disease priorities in Principle 1, but the disease groups priorities have not been listed or highlighted. Similarly, tailored approaches to these groups.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	

**STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail**

<i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health, strengthen leadership and create win-win partnerships within and outside of the health sector.	
<i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	
<i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	
<i>Strategic Objective 4: Oral Health Information Systems</i> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	
<i>Strategic Objective 5: Oral Health Research Agenda</i> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.	
<b>Comment:</b>	



COMMENT ON THE WORLD HEALTH ORGANIZATION's DRAFT GLOBAL STRATEGY ON ORAL HEALTH

For consultation details on the WHO website please click [here](#)

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<p><b>Key Areas of the Draft Global Strategy for Oral Health</b></p>	<p><b>Stakeholder Comment</b></p>
<p>The vision of this strategy is universal oral health coverage for all people by 2030.</p>	<p>I agree with this ambitious vision. Implementation is integral to effective reform and part of the vision should include an implementation/action plan for the short, medium and long-term.</p>
<p>The goal of the strategy is to guide Member States to develop ambitious national responses to promote oral health, reduce oral diseases, other oral conditions and oral health inequalities, make progress on the path to universal oral health coverage for their populations, and consider the development of targets and indicators, based on national situations, building on the guidance to be provided by the WHO global action plan on oral health, to prioritize efforts and assess the progress made by 2030.</p>	<p>Again, the goal is ambitious. The global action plan must ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of any reform to be made.</p>
<p><b>GUIDING PRINCIPLES – PAGE 4 of Draft Strategy</b></p>	
<p><b>Principle 1: A public health approach to oral health</b> - A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated within broader and coordinated public health efforts. A public health</p>	<p>I would agree with this. At the moment, private dental care is unaffordable for most people. However, public dental services, which have long waiting lists and seemingly affordable services (eg. emergency dental), can also be unreachable for the most vulnerable in our community. An overhaul of the public dental service, including a concerted effort to build an appropriate oral health workforce for the public sector, is necessary.</p>

<p>approach to oral health requires intensified and expanded upstream actions involving a broad range of stakeholders, including those from social, economic, education, environment and other relevant sectors.</p>	
<p><b>Principle 2: Integration of oral health in primary health care</b> - Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. Integration of basic oral health services with other noncommunicable disease services in primary health care is an essential component of universal health coverage. This integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions, and more equitable access to comprehensive, quality health care.</p>	<p>Successful integration of oral health in PHC will require an increased awareness and understanding of the relationship between oral and general health. Currently the teaching of oral health is minimal (non-existent even) in other health disciplines. A focus on increasing the capacity of non-dental PHC practitioners is critical. Interprofessional collaborative PHC health service research to understand the systematic implementation required is another critical step to build the evidence base for integration.</p>
<p><b>Principle 3: A new oral health workforce model to respond to population needs</b> - Oral health resource and workforce planning models need to better align education and training of health workers with population oral health needs. Universal oral health coverage can only be achieved by reforming the health, education and resource planning systems to ensure the oral health workforce is of adequate size and skills mix to provide essential oral health care. This requires reassessing the roles and competencies of mid-level oral health care providers and community oral health workers based on the new WHO Global competency framework for universal health coverage.</p>	<p>I fully agree with this (see comments from Principle 1).</p>
<p><b>Principle 4: People-centred oral health care</b> - People-centred oral health care consciously seeks and engages the perspectives of individuals, families and communities, including people affected by oral diseases and conditions. In this approach, people are seen as participants as well as</p>	<p>The routine collection, robust analysis and appropriate use of good dental practice data will inform continuous quality improvement and ensure high-quality oral health care and cost-efficiency of the health system. In particular, relevant and feasible patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) will be important for the identification and benchmarking of good patient-centred oral health care.</p>

<p>beneficiaries of trusted oral health systems that respond to their needs and preferences in humane and holistic ways. People-centred oral health care actively fosters oral health literacy, shared decision-making and self-management. Through this process, people receive the opportunity, skills and resources to be articulate, engaged and empowered users of oral health services.</p>	
<p><b>Principle 5: Tailored oral health across the life course -</b> People are affected by oral diseases and conditions and their risk factors across the entire life course. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. These patterns highlight why tailored, age-appropriate oral health strategies need to be integrated within relevant health programmes across the life course, including pre-natal, infant, child, adolescent, working adult and older adult programmes.</p>	<p>Yes, I absolutely agree with this.</p>
<p><b>Principle 6: Optimizing digital technologies for oral health</b> - Digital technologies can be used strategically for oral health at different levels, including improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, and increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.</p>	<p>Efficient and effective shared and integrated digital infrastructure and systems are needed to enable an integrated health record and flexible delivery of services that support continuity of care for patients in an integrated care environment.</p> <p>There also needs to be a strategy to build digital readiness and equip consumers and communities with the information and tools they need to benefit equally from digital health care.</p>
<p><b>STRATEGIC OBJECTIVES – Please see PAGE 5 of Draft Strategy for more detail</b></p>	
<p><i>Strategic Objective 1: Oral Health Governance</i> - Improve political and resource commitment to oral health,</p>	<p>Agree</p>

strengthen leadership and create win-win partnerships within and outside of the health sector.	
<i>Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention</i> - Enable all people to achieve the best possible oral health and target and reduce the social and commercial determinants and risk factors of oral diseases and conditions.	Agree
<i>Strategic Objective 3: Primary Oral Health Care</i> - Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.	Agree
<i>Strategic Objective 4: Oral Health Information Systems</i> - Enhance oral health surveillance and information systems to provide timely and relevant feedback to decision-makers for evidence-based policy-making.	Agree
<i>Strategic Objective 5: Oral Health Research Agenda</i> - Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.	The research agenda should have a strong focus on integration of oral health in primary health care – the design, the capacity building, the implementation and evaluation.
<b>ROLE OF MEMBER STATES, PARTNERS AND SECRETARIAT</b> – Please see PAGE 6 of Draft Strategy for detail on this section.	
<b>Comment:</b>	



Benoit Varenne  
Global Oral Health strategy  
World Health Organisation

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16<sup>th</sup> February 2021

Dear Benoit Varenne,

**Consultation response: World Health Organisation Draft Global Strategy on Oral Health**

I am writing, on behalf of the Association of Dental Groups (ADG) to provide a high-level response to the web based consultation by the World Health Organisation (WHO) on the *“draft Global Strategy on Oral Health”*.

The Association of Dental Groups (ADG) is the trade association for large dental providers in the UK. Our members include 20 of the largest groups of dental practices in the country, representing over 10,000 clinicians delivering NHS and private dentistry to more than 10 million patients every year. ADG members represent corporate, group and community interest companies delivering a wide range of oral healthcare, be this commissioned through General Dental Contract (GDS) services or local authority and community oral healthcare programmes.

We have the following comments in response to the draft strategy.

ADG members welcome the proposal by the WHO to develop a global strategy on tackling oral diseases. We share the belief that oral health is integral to overall health and the concern that the global prevalence of the disease burden of dental caries, most of which are preventable has remained unchanged for the past three decades. The ambition of the WHO Strategy must be for member states to work towards a positive impact on this within the target date proposed of 2030.

The draft strategy has correctly identified that oral health promotion and disease prevention are not well integrated into other programmes. We welcome the announcement this week<sup>1</sup> that the UK has been chosen by the WHO to lead a new Sugar and Calorie Reduction Network in 2022 to take global action on sugar and calorie reduction and believe that this is an opportunity to include and take forward dental health public initiatives on reducing sugar consumption as identified in the draft strategy.

We share the concern in the draft strategy that insufficient attention is given to planning the oral health workforce to address the population’s health needs. In the UK we are currently concerned that the oral health workforce is not of an adequate size and the skills mix is not being fully utilised. The

<sup>1</sup> [UK to spearhead Europe-wide initiative to reduce sugar and calorie intake in food - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/uk-to-spearhead-europe-wide-initiative-to-reduce-sugar-and-calorie-intake-in-food)



lack of workforce planning is leading to gaps in provision, often in rural and coastal areas of the country with higher levels of social deprivation. We believe that member states should be giving further consideration of incentives to address this.

We also share the principle of tailored oral health across the life course. We believe that oral healthcare models of commissioning at a member state level should have a greater amount of local flexible commissioning which responds to particular needs. This aligns with the ambition of the integrated care systems model currently being legislated by the UK Government in England<sup>2</sup>. Previous pilots of flexible commissioning at regional level in England have demonstrated more integrated and preventative work which could be scaled up and delivered within the ICS model (particularly within care home settings) to address specific "*place level*" oral health needs.

The current UK government is also proposing to take powers within the Health and Care Bill currently going through the legislative process for rolling out new water fluoridation programmes. We would urge the WHO to highlight water fluoridation for the prevention of dental caries as an evidence based and cost effective upstream oral health intervention which will require no behaviour change and benefits those in the most deprived areas, as identified in the recent Public Health England report "*Inequalities in Oral Health in England*"<sup>3</sup>. This report underlines several of the other points in this correspondence, including better use of workforce skill mix, and the need for services to be commissioned on local needs.

I also attach consultation response feedback from one of our members, Community Dental Services for your consideration. We would be happy to arrange a meeting with ADG representatives and the WHO team responsible for developing the strategy and subsequent action plan to discuss in further detail if required and next steps in the months ahead.

Yours sincerely

A handwritten signature in black ink that reads "Neil Carmichael".

**Neil Carmichael, Chair, Association of Dental Groups**

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<sup>2</sup> [Health and Care Bill publications - Parliamentary Bills - UK Parliament](#)

<sup>3</sup> [Inequalities in oral health in England - GOV.UK \(www.gov.uk\)](#)

## CONTRIBUTION BY ALIGN TECHNOLOGY TO THE WHO DRAFT GLOBAL STRATEGY ON ORAL HEALTH

As a global medical device company whose innovations are transforming the way dental health professionals deliver orthodontic, restorative, and preventative treatments to millions of people around the world, Align Technology welcomes the adoption of resolution WHA74.5 (2021) on oral health by the World Health Assembly and supports the development and implementation of the global action plan to improve the overall oral health of world populations and tackle oral diseases.

With over 20 years of experience of working closely with orthodontists and dentists, Align appreciates and shares the WHO's view that oral health is integral to overall health, well-being, and quality of life. Poor oral health and untreated periodontal diseases have been linked to other conditions such as diabetes and heart disease, and to inflammatory conditions like strokes, osteoporosis, and cancer. We are encouraged by the calls for heightened political focus and increased resources committed to oral health to ensure that people around the world have equal access to high standards of care and a trained and qualified workforce of licensed dental professionals.

We strongly believe that digital technologies – those underpinning dental diagnosis and treatment itself and those supporting doctor-patient communication, or teledentistry – can facilitate increased and better access to oral health services, and we are encouraged by the WHO's focus in this area. Align understands the opportunities and the risks that come with digital solutions employed in oral health. Technological innovation can improve patient care, enhance treatment outcomes, and expand access, but new tools and methods must be used in ways that continue to prioritize and support the delivery and benefits of doctor-directed care to unserved and underserved populations.

Regarding **Principle 1 on A public health approach to oral health**, we suggest that it be made explicit that a public health approach in oral health should take full advantage of advances in digital technologies and telemedicine that can ensure the continuity of care to patients in times of crisis and amplify the impact of trained healthcare providers to reach underserved populations. The COVID-19 pandemic demonstrated that telemedicine can be effective and practical in many disciplines, including dentistry and dentistry specialties, and can extend the reach of qualified healthcare providers and provide continuity of care to patients in treatment. If technologies like digital intraoral scanners, platforms that connect practitioners with specialists and dental labs, and teledentistry capabilities are not included in the approach it would be a missed opportunity in providing care and ensuring continuity of care.

Furthermore, we support **Principle 6 on Optimizing digital technologies for oral health** and the need to establish and/or reinforce governance for digital health and to define norms and standards for the provision of digital oral healthcare. As we've stated, digital technologies and responsible use of teledentistry can revolutionize patient care – extending the reach of trained licensed practitioners and enhancing both patient outcomes and

convenience. But care must be taken that it is not used to alter dental practice in ways that minimize or deprive patients of the benefits of doctor-directed care.

Align also welcomes **Strategic Objective 5: Oral Health Research Agenda – Create and continuously update a new research agenda focused on public health aspects of oral health and innovation for better impact on oral health.** A focus on technologies that can improve efficiency in preventative and restorative dentistry – by helping practitioners identify problems; assess, monitor, and track the progress of oral health issues over time; and educate patients on the need for and methods of self-care and intervention – would be particularly powerful.

Portable and powerful, digital intraoral scanners enable dentists to create a 3D digital image of a patient's mouth without harmful radiation – an important consideration for potentially vulnerable or fragile populations such as children and pregnant women. With every surface and structure captured in hundreds of thousands of digital data points, scans provide a level of detail that cannot be achieved with physical impressions and radiography alone. Used to support restorative dentistry (crowns, bridges, and implants) and oral appliances, digital scans substantially improve the fabrication accuracy of appliances or restorations. Initial fit is improved and 'remakes' are substantially reduced, which in turn can reduce treatment time and the number of appointments, and lower costs.

Scanners also allow dentists to compare patient records over time and use them to help patients visualize tooth wear and movement, or the gum recession that can signal periodontal disease. Align's newest scanner is also equipped with multiple imaging modalities including Near Infrared Imaging (NIRI) which allows practitioners to visualize the development of interproximal caries between teeth – in the earliest stages, when the problem may be more easily addressed and avoid the need for more extensive (and costly) restorations. We believe that strategically leveraging digital technologies like these to 'leapfrog' analog dental practice tools, address patient needs, and track the impact of treatment and oral health initiatives over time will provide strong evidence of the effectiveness of efforts to improve overall oral health and educate the public on the importance of oral health and its impact on overall health and disease prevention.

Realizing the promise of digital health technologies in oral health requires a licensed oral health workforce that is adequately trained to use these new tools. Align is encouraged by the calls for action in **Principle 4 on A new oral health workforce model to respond to population needs** and **Strategic Objective 3: Primary Oral Health Care – Build workforce capacity and ensure financial protection and essential supplies in integrated primary oral health care.** Workforce training programs should also consider using digital tools to enable primary care healthcare providers to be trained and supported in providing 'specialist' or secondary care treatments. When appropriate, cross-training with digital tool support can improve access. Investment in workforce training, as well as the development of norms and standards, is vital to ensuring the responsible use of new digital health tools.

In line with **Principle 4 on People-centered oral health care** and **Strategic objective 2 on Oral health promotion and oral disease prevention,** Align supports improved oral health literacy. Public oral health education programs are essential to help patients learn how to

maintain their oral health and understand the downstream benefits of good oral health on overall health. Specifically, increased oral health literacy will heighten understanding of the role of orthodontic treatment as an important contributor to achieving and maintaining overall oral health. Straight teeth can improve oral hygiene and aid in prevention of caries and periodontal disease. When teeth are too widely spaced, gums can be injured and become red and inflamed and/or food impacted between teeth leading to decalcification or decay. Conversely, if teeth are crooked or overcrowded, they can be difficult to clean, leading to plaque build-up and gum or periodontal problems. Malocclusions (misalignment of the teeth and jaws) can impact overall health as well, potentially affecting chewing, swallowing, jaw function, and nutrition. Certain malocclusions can also contribute to temporomandibular joint dysfunctions which in turn can cause pain, headaches, and ear problems.

Finally, we welcome the call to action expressed in **point 51** of the Discussion Paper, focused on the development of public-private partnerships to help plan and implement population focused prevention measures and facilitate the collection of oral health data. These are areas in which Align already has experience and insight, which we would be happy to share with the WHO and other partners to strengthen global and national oral health responses. We strive to be an active private sector partner, and a leader in innovation that will continue to help dental professionals improve the care they provide to millions of patients worldwide.

To conclude Align's submission, we would like to thank you for the opportunity to comment and reiterate our support for the development and implementation of the WHO's global action plan to improve the overall oral health of world populations and tackle oral diseases through greater awareness, prevention, diagnosis, and treatment.

Dr. Mitra Derakhshan DDS, MS  
Vice President, Global Clinical  
Align Technology, Inc.

## **GSCF's submission to WHO consultation on the *Draft Global Strategy on Oral Health***

16 September 2021

We welcome the *Draft Global Strategy on Oral Health* and the recognition of oral health as an integral part of overall health, well-being and quality of life, as well as an area where self-management and self-care can play a significant role. As the impact of oral diseases, other oral conditions and oral health inequalities remains significant, with dental caries alone representing the most prevalent condition among Non-communicable Disease (NCD) (of any disease group)<sup>1</sup> we also welcome its integration into the wider Universal Health Coverage (UHC) and NCDs agendas at the World Health Organisation (WHO).

### **Oral health self-care and self-management**

Oral health is an area where self-care and self-care products have long been central to both prevention and maintenance of good health and wellbeing. Fluoride toothpaste with a fluoride concentration between 1,000 and 1,500 ppm, a self-care product, is an “essential prevention method” for preventing, arresting and treating dental caries with a negligible risk of fluorosis. We welcome the *Global Strategy*’s recommendation to increase the availability of fluoride toothpaste with a fluoride concentration between 1,000 and 1,500 ppm through policies including public subsidisation and reduced taxes to reduce oral health inequalities. We also welcome the proposal to include fluoride toothpaste with a fluoride concentration between 1,000 and 1,500 ppm in the WHO Model List of Essential Medicines (EML) & Model List of Essential Medicines for Children (EMLc). This will support increased availability and affordability through policy levers such as efforts to reduce taxation and other approaches (e.g. VAT relief) that foster innovation and robust market competition, resulting in affordable access through self-selection.

Additionally, mouth rinses are low cost, effective means for controlling plaque bacteria and many provide fluoride. Their effectiveness has been established and recognized by oral health practitioners’ associations around the world. The ease and accessibility that a rinse provides people with disabilities and dexterity issues may provide protection beyond brushing and interdental cleaning. Systemic conditions (such as diabetes) may increase the incidence of oral diseases and consideration of the use or addition of a rinse in oral health regimens provides a choice for self-management and prevention of common oral diseases such as gingivitis, gum health and dental caries.

Oral diseases often manifest together with other NCDs such as diabetes, dementia, CVD, and systemic infection, in the form of co-morbidities and shared risk factors.<sup>2</sup> An important

<sup>1</sup> GBD 2019 Diseases and Injuries Collaborators, “Global Burden of 369 Diseases and Injuries in 204 Countries and Territories, 1990–2019: a Systematic Analysis for the Global Burden of Disease Study 2019,” *The Lancet* 396, no. 10258 (October 17, 2020): pp. 1204-1222, [https://doi.org/https://doi.org/10.1016/S0140-6736\(20\)30925-9](https://doi.org/https://doi.org/10.1016/S0140-6736(20)30925-9).

<sup>2</sup> Monsarrat P, Blaizot A, Kémoun P, Ravaud P, Nabet C, Sixou M, Vergnes JN, “Clinical research activity in periodontal medicine: a systematic mapping of trial registers,” *J Clin Periodontol* 43, no. 5 (May 2016): pp. 390-400, doi: 10.1111/jcpe.12534. Epub 2016 Apr 13. PMID: 26881700.

self-care intervention that can reduce risk factors for poor oral health and other NCDs, is quitting smoking and the use of smokeless tobacco. Licensed Nicotine Replacement Therapy (NRT) as first-line therapy in smoking cessation supports the reduced consumption of tobacco products and therefore better oral health through self-care while reducing risk factors for other NCDs. Licensed NRTs, medical and behavioural counselling, and public education to increase awareness of the health risks associated with tobacco use should be available to people as part of their treatment programme to reduce nicotine dependence. In accordance with the World Health Organisation (WHO) policies we believe all countries should take steps to make access to licensed NRTs easier and to help more smokers completely quit cigarettes. Oral healthcare professionals also have an important role to play in engaging and informing smokers of the benefits of quitting as well as signposting available support such as licensed NRT.

### **Oral health promotion, prevention and health literacy**

We also welcome calls to shift the focus from oral health response to prevention through improved and increased investment in Oral Health Promotion, Oral Disease Prevention and Oral Health Literacy, which will increase capacity for individuals to self-manage and make decisions about their oral health. We know that self-care delivers best value to individuals with a high level of self-care literacy and investment in these areas supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care.

For example, while the evidence shows that that systematic, twice-a-day tooth brushing with a fluoride toothpaste maintains oral health and decreases oral disease, only 70-80% percent of adults self-report cleaning their teeth twice a day, 20% are only brushing once a day or less, and the average time spent manually brushing is between 30- 45 secs.<sup>3</sup> Nevertheless, this is a significant increased from around 30-62% (varying by country) in the mid 1990's, in large part due to dental professionals, educators, and the self-care industry global communicating and advertising the clear benefits of good oral hygiene.<sup>4</sup>

It is therefore important to enable the industry to inform consumers of the impact of oral care products on health, on the pack or elsewhere, independent of product classification. National regulatory frameworks and classification systems should enable increasing awareness of the benefits of oral health self-care and enable access, while ensuring quality and safety for products such as fluoride toothpaste and mouth rinses. Currently, in some jurisdictions the regulatory status of oral health products limits industry's ability to communicate to consumers and raise awareness of oral health, including early-stage gum disease and gum health; and, in other jurisdictions the classification of oral health products might limit innovation or access by curtailing availability or product self-selection at point of sale.

### **Integration with wider health systems and policy**

<sup>3</sup> Honkala S, Vereecken C, Niclasen B, Honkala E, "Trends in toothbrushing in 20 countries/regions from 1994 to 2010," *European Journal of Public Health* 25, no. suppl\_2, (April 2015): pp. 20-23, doi: 10.1093/eurpub/ckv013. PMID: 25805781.

<sup>4</sup> Ibid.

The integration of oral health into the wider NCD agenda presents an opportunity to further embed essential oral health self-care prevention methods, such as topical fluoride applications, the use of fluoridated toothpaste and mouth rinses, self-monitoring and self-management into the healthcare continuum as cost-effective interventions. Not only do oral health and many other NCDs share common risk factors, but similar prevention methods (such as smoking cessation supported by licensed NRT) and monitoring/screening also overlap. According to a systematic review of clinical research activity conducted in 2016, periodontitis, the advanced stage of periodontal disease, has been linked to over 57 systemic non-communicable diseases (NCD).<sup>5</sup> There is broad agreement among expert scientific medical bodies linking periodontitis to systemic NCDs, a major cause of global mortality, and that improving and maintaining good oral health is important to improve general health as well as retaining teeth.<sup>6</sup>

Other areas of relevance to oral health, such as antimicrobial resistance (AMR), also present opportunities for further integration. While the *Global Strategy* recognises the impact of increased antibiotic prescriptions for oral health due to COVID-19, oral health is currently not included in the *Global Action Plan on Anti-Microbial Resistance* or equivalent *National Action Plans*. This leads to a lack of engagement of dentists in AMR multisectoral efforts.

Recommending the use of “essential prevention measures” outlined in the *Global Strategy* could help reduce the need for oral health antibiotic prescriptions and including oral health professionals in AMR planning, such as in the *Global Action Plan on Anti-Microbial Resistance*, would also help to fill this gap. As dentists prescribe up to 10% of all antibiotics used worldwide to treat oral infections, their involvement in reducing AMR is essential.<sup>7</sup>

Establishing or strengthening national oral health units to effectively coordinate across national systems would support further integration at a national level, including in primary healthcare. As part of this we would also call for all newly qualified dentists, community oral health workers and mid-level providers, such as dental assistants, dental nurses, dental therapists and dental hygienists as well as other primary healthcare workers to have a clear understanding of oral health self-care and how it can be used in their practice, regularly refreshed through ongoing professional training. This will support the efficient use of resources through increased awareness and utilisation of established oral health self-care practices.

## Surveillance and data

The self-care industry understands the importance of having deep insight of our consumers, their needs and preferences, including using patient reported outcomes. We would encourage the WHO to ensure that these measures are included in the approach of the Oral Health Action Plan to ensure that all aspects of oral health and wellbeing are accounted for in surveillance and data collection. Large amounts of self-care oral health data are already collated by industry and could contribute to global insight into oral health status. This should include measures to encompass the multi-faceted nature of oral health including the ability to

<sup>5</sup> Ibid. 2.

<sup>6</sup> Sanz, M, Marco del Castillo, A, Jepsen, S, et al. “Periodontitis and cardiovascular diseases: Consensus report,” *J Clin Periodontol* 47, (2020): pp. 268– 288, <https://doi.org/10.1111/jcpe.13189>.

<sup>7</sup> “WHO EB144 - FDI Statement on Item 5.8 AMR,” *WHO EB144 - FDI Statement on Item 5.8 AMR*, accessed September 15, 2021, <https://www.fdiworlddental.org/who-eb144-fdi-statement-item-58-amr>.

breath, eat, speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex (head, face, and oral cavity).

It will also be important to ensure consistency in methodology and understanding of these measures. For example, while the *Global Strategy* includes a prevalence of cleft lip and palate (severe birth defects, leading to high rates of infant mortality in rural and poor settings when there is no timely access to quality surgery) at approximately 1 in 1500 births other measures report a higher rate of incidents of orofacial clefts in approximately 1 in 700 live births, accounting for the collective burden of cleft lip, cleft palate, and cleft lip and palate.<sup>8</sup> It will be important to build consensus on the approach to oral health measures, and how they can be effectively integrated into wider UHC and NCD measures, and the Global Health Observatory.

### **Role of the private sector**

The self-care industry continues to play a critical role in helping to deliver better oral health globally by:

- Supporting product innovation through deep consumer insight to deliver improved, clinically proven, safe and effective oral health solutions and self-care products such as NRT, tailored to the needs of individuals throughout their life course.
- Investing considerable global advertising budgets, commercial communications and global reach to build awareness of the importance of oral health and hygiene, leading to increased usage of essential prevention methods such as fluoride toothpaste.
- Partnering with healthcare professionals, non-government organisations (NGO's), and educators to facilitate greater understanding of the importance of oral health on whole body health (and self-care), the prevention of oral disease through effective oral hygiene.
- Contributing between £50- £100 million annually to oral health academic research, both basic scientific knowledge and clinical research, to foster translation of the latest innovation and understanding to society to improve oral health and wellbeing.

The self-care industry looks forward to engaging further on this topic and will continue to support global oral health.

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<sup>8</sup> Mossey PA, Modell B, Cobourne MT (ed), "Cleft Lip and Palate. Epidemiology, Aetiology and Treatment," *Front Oral Biol* 16, (2012): pp. 1-18, <https://doi.org/10.1159/000337464>.