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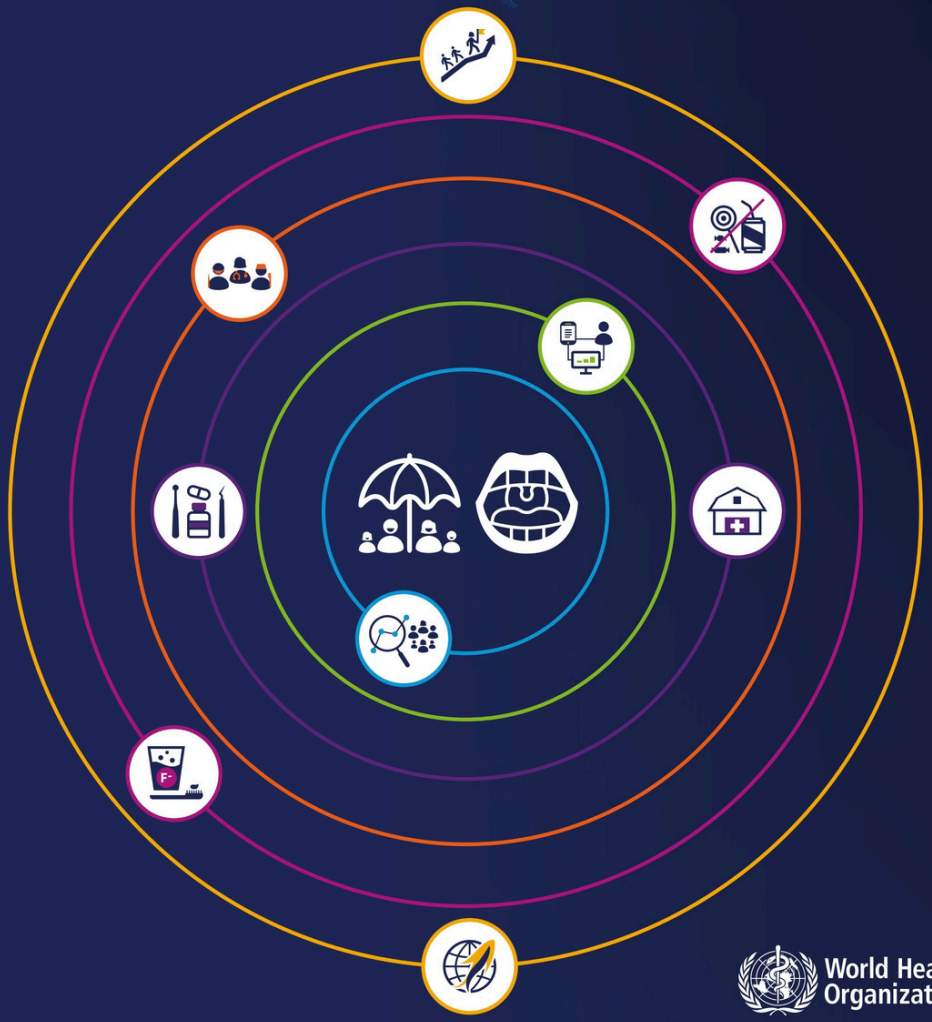
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STUDY GUIDE

COMMITTEE A2

Oral Health

Global strategy and action plan on oral health 2023–2030



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Foreword



Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3.5 billion people. The burden is increasing, particularly in low- and middle-income countries. Good oral health is essential for eating, breathing and speaking, and contributes to overall health. The pain and discomfort associated with oral diseases make concentrating difficult, can cause people to miss school or work, and can lead to social isolation. Left untreated, the health-related impact of oral diseases can be severe.

Unfortunately, access to oral health care is often limited due to an over-reliance on specialised care using high-tech equipment, the cost of which is prohibitive for many families and communities. In fact, many oral diseases are largely preventable and can be treated using simple and non-invasive procedures at the primary health care level. Improving access and affordability to essential oral health care services can be achieved through integrating oral health promotion and care into primary health care and universal health coverage benefit packages.

Member States have demonstrated their commitment to improving oral health in recent years by adopting the landmark Resolution on oral health in 2021 and the *Global strategy on oral health in 2022*. This was followed in 2023 by the development of the Global oral health action plan 2023–2030, which translates the vision, goal and strategic objectives of the global strategy into a series of 100 actions for stronger and more coordinated action on oral health. The action plan also includes a set of 11 global targets to track progress on oral health for all individuals and communities by 2030.

The *Global strategy and action plan on oral health 2023-2030* contains the complete set of policy documents that define WHO's global oral health agenda. Together, these policy documents lay out the path to tackle the challenges faced by communities worldwide, and make the case for integrating oral health into noncommunicable disease and universal health coverage benefit packages. The action plan is a practical tool to support Member States in the adaptation of global oral health policies to national contexts. It outlines a set of priority actions for Member States, the WHO Secretariat, international partners, civil society organisations and the private sector in moving towards our shared commitment to equitable access to oral health for all.

WHO supports Member States in the implementation of these policies, within their own national context. Together, we can reverse the pattern of neglect in oral health, and improve coverage and access around the world, and make sure that everybody gets the care they need for preventable and treatable oral diseases.

There is no health without oral health.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

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Acknowledgements

WHO is grateful for the contributions and collaboration with Member States especially the Member States that supported the *Resolution on oral health* in 2021 (WHA 74.5) led by Sri Lanka, along with other co-sponsoring countries including Bangladesh, Bhutan, Botswana, Eswatini, India, Indonesia, Israel, Japan, Jamaica, Kenya, Myanmar, Peru, Qatar, Thailand and the Member States of the European Union. The resolution provided a mandate to the WHO Secretariat to develop the Global strategy on oral health, adopted in May 2022 (decision WHA75(11)), and the Global oral health action plan 2023–2030 in the report on noncommunicable diseases NCDs, noted by the Seventy-sixth World Health Assembly (WHA 76(9)).

WHO extends sincere gratitude to the many individuals, organizations, and professional bodies who contributed to the development of the *Global strategy on oral health and Global oral health action plan 2023-2030*. These global oral health policy documents are the result of a highly consultative and participatory process involving Member States, international and national non-governmental organizations, related global health networks, partners, stakeholders, and the entire oral health community and beyond. WHO is extremely grateful to all for their valuable feedback and contributions received throughout the development process, including the regional consultations.

Particularly, WHO would like to thank all Members States, UN organizations, and non-State actors that participated in a global web-based consultation. Appreciation also goes to McGill University, Canada, and the International Health Policy Programme, Foundation of the Ministry of Public Health in Thailand. Additionally, WHO appreciates the efforts of the informal expert group and WHO Collaborating Centres on oral health who were part of the development of the global oral health monitoring framework of the *Global oral health action plan 2023-2030*.

Finally, WHO acknowledges the WHO staff and consultants of WHO headquarters and WHO Regional Office for Africa, WHO Regional Office for the Americas, WHO Regional Office for South-East Asia, WHO Regional Office for Europe, WHO Regional Office for the Eastern Mediterranean, and WHO Regional Office for the Western Pacific, who have valuably contributed to producing these global oral health policy documents.

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Purpose

This document incorporates all key policy documents that inform and define the renewed global oral health agenda towards 2030:

- the Resolution on oral health (WHA74.5, 2021)[1]
- the Global strategy on oral health (WHA75 (11), 2022)[2]
- the Global oral health action plan 2023–2030 (WHA76 (9), 2023)[3].

Underlying the global oral health agenda are six guiding principles presented in detail in the Global strategy on oral health. These principles underpin the approach taken to develop the strategy and the Global oral health action plan 2023–2030 and can be applied when implementing the agenda in Member States. They are:

- a public health approach to oral health
- integration of oral health into primary health care
- innovative workforce models to respond to population needs for oral health
- people-centred oral health care
- tailored oral health interventions across the life course
- optimizing digital technologies for oral health.

The action plan provides detailed action-oriented guidance for different stakeholder groups. As such, it is the focus of this document, as it translates how to achieve the ambition set out in the strategy and the mandate of the Resolution on oral health. Combined, these policy documents set the global oral health agenda towards 2030.

The global oral health agenda paves the way towards improved accessibility and affordability of oral health care, in line with UHC, and serves to support cooperation among countries and different sectors. Countries are invited to consider the strategic objectives and actions as a source of ideas and concrete guidance as part of their national oral health policy development. The concepts presented here for implementation have huge potential to reorient oral health care to a patient-centred model as part of a primary health care approach. In doing so, countries will further contribute to their UHC ambition and add value to their efforts in tackling NCDs.

Resolution on oral health: pioneering a new perspective

The World Health Assembly Resolution on oral health (WHA74.5) was a clear milestone in establishing a renewed global oral health policy agenda. It recognized the urgent need for a paradigm shift from the traditional curative approach towards a preventive approach, with improved integration of oral health services within more mainstream health system structures.

[1] Resolution WHA74.5. Oral health. In: Seventy-fourth World Health Assembly, Geneva, 24 May–1 June 2021. Resolutions and decisions, annexes. Geneva: World Health Organization; 2021 (WHA74/2021/ REC/1; https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf#page=1).

[2] A75/10 Add.1. Draft global strategy on oral health. In: Seventy-fifth World Health Assembly, Geneva, 22–28 May 2022. Provisional agenda item 14.1. Geneva: World Health Organization; 2022 (https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add1-en.pdf).

[3] Draft global oral health action plan (2023–2030). Geneva: World Health Organization; 2023 (https://cdn.who.int/media/docs/default-source/ncds/mnd/oral-health/eb152-draft-global-oral-health-action-plan-2023-2030-en.pdf?sfvrsn=2f348123_19&download=true).

By endorsing this resolution, Member States signaled their commitment to prioritize oral health as an integral part of the global health agenda in the context of NCD and UHC agendas, elevating it to the global forefront.

Global strategy on oral health

As a first step to implementing the mandate given to the WHO Secretariat through the resolution, WHO developed the Global strategy on oral health (WHA75(11)). The vision of the global strategy is UHC for oral health for all individuals and communities by 2030, thereby aligning it with the ambition of the Sustainable Development Goals. This vision means that all individuals and communities have access to essential, quality health services that respond to their needs and that they can use without suffering financial hardship. The strategy was developed through an extensive consultation process that included Member States, other United Nations organizations and non-State actors. The strategy outlines six strategic objectives:

1. Oral health governance
2. Oral health promotion and oral disease prevention
3. Health workforce
4. Oral health care
5. Oral health information systems
6. Oral health research agendas.

Additionally, the strategy introduces the respective roles of the WHO Secretariat, Member States and other partners emphasizing a collective responsibility to take action and the importance of collaboration within and outside of the oral health community. Coordination among efforts to bridge gaps, tackle NCDs using a common risk factor approach and progressing the UHC agenda through improved affordability and accessibility to oral health services will enable individuals and communities to enjoy the highest attainable state of oral health, contributing to healthy and productive lives.

Global oral health action plan: translating vision into action

Guided by the Global strategy on oral health, the Global oral health action plan 2023-2030 translates the vision, goal and strategic objectives into action-oriented guidance on interventions for stronger and more coordinated action on oral health. It is the main practical tool for adaptation of the global oral health policy agenda to national contexts. It is structured according to 11 global targets, 6 strategic objectives and 100 actions for Member States, WHO secretariat, international partners, civil society organisation and the private sector. The proposed actions can be adapted and prioritized depending on individual country context, taking into consideration available resources, population needs and social, economic and political factors.

Methods

The Global strategy on oral health was developed through a series of consultative processes, which included a global web-based consultation with Member States, UN organizations, and non-State

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actors from August to September 2021. Furthermore, WHO conducted the Member States information sessions and technical consultation with UN organizations, and non-State actors in official relations with WHO.

Similarly, the development of the Global oral health action plan 2023-2030 involved a series of consultative processes. Specifically, WHO conducted a Delphi process, engaging a global informal expert group that included WHO Collaborating Centres on oral health to inform the global oral health monitoring framework. Subsequently, informal regional consultations took place between May and July 2022. This was followed by a global web-based consultation with Member States, UN organizations, and non-State actors between August and September 2022. Furthermore, WHO organized Member States information session and technical consultation with UN organizations, and non-State actors in official relations with WHO.

As we move forward with this ambitious global oral health agenda towards 2030, this document will serve as the basis for collective action and country support. By embracing the vision, goal and strategic objectives, we all have a role to play in uniting around a shared commitment to equitable access to oral health for all.

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Global oral health action plan (2023-2030)

World health assembly

WHA76(9)

- Background
- Scope, aim and overarching targets of the global oral health action plan (2023–2030)
- Action areas of the global oral health action plan





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Background

Setting the scene

1. In the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (2011), the United Nations General Assembly recognized that oral diseases are major global health burdens and share common risk factors with other noncommunicable diseases (NCDs). In the Political Declaration of the High-Level Meeting on Universal Health Coverage (2019), the General Assembly reaffirmed its strong commitment to the prevention and control of NCDs, including strengthening and scaling up efforts to address oral health as part of universal health coverage (UHC).

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

3. Oral health encompasses a range of diseases and conditions. Those with highest public health relevance include dental caries, severe periodontal (gum) disease, complete tooth loss (edentulism), oral cancer, oro-dental trauma, noma and congenital malformations such as cleft lip and palate, most of which are preventable. The main oral diseases and conditions are estimated to affect close to 3.5 billion people worldwide.[1] These conditions combined have an estimated global prevalence of 45%, which is higher than the prevalence of any other NCD[1].

4. The global burden of oral diseases and conditions is an urgent public health challenge with social, economic and environmental impacts.[2] Oral diseases and conditions disproportionately affect poor, vulnerable and/or marginalized members of societies, often including people who are on low incomes; people living with disability; older people living alone or in care homes; people who are refugees, in prison or living in remote and rural communities; and people from minority and/or other socially marginalized groups. There is a strong and consistent association between socioeconomic status and the prevalence and severity of oral diseases and conditions.[1] Public and private expenditures for oral health care have reached an estimated 387 billion US dollars globally, with very unequal distribution across regions and countries.[1]

5. Oral diseases and conditions share risk factors common to the leading NCDs, including all forms of tobacco use, harmful alcohol use, high intake of free sugars and lack of exclusive breastfeeding. Other risk factors include insufficient oral hygiene for dental caries and severe periodontal diseases; human papillomavirus for oropharyngeal cancers; traffic accidents, interpersonal violence and sports injuries for traumatic dental injuries; and coinfections, malnutrition and poor water, sanitation and hygiene for noma.

6. Oral diseases and conditions are influenced by social determinants of oral health, which comprise the social, economic and political conditions that influence oral diseases, including access to safe

[1] Global oral health status report: towards universal health coverage for oral health by 2030. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[2] Seventy-fifth World Health Assembly, Provisional agenda item 14.1, 27 April 2022, https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add1-en.pdf.

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Definition 02

Oral health means much more than having healthy teeth. WHO includes the ability to eat, breathe and speak and psychosocial dimensions such as self-confidence, well-being and the ability to socialize and work without pain, discomfort or embarrassment.

Interesting Facts 03

WHO's oral-health agenda extends well beyond cavities. It includes dental caries, severe gum disease, complete tooth loss, oral cancer, injuries to the mouth and teeth, noma and congenital conditions such as cleft lip and palate. WHO notes that most of these are preventable.

Did You Know That... 03

The main oral diseases and conditions are estimated to affect close to 3.5 billion people worldwide. Together they have an estimated global prevalence of 45%, which WHO reports is higher than the prevalence of any other NCD.

Something to Think About 04

WHO emphasizes that oral diseases are not distributed equally. Why might populations experiencing greater risks of oral disease also experience greater difficulty obtaining prevention and treatment?

Interesting Facts 04

Worldwide spending on oral-health care has reached an estimated US$387 billion, but WHO emphasizes that this spending is distributed very unequally across countries and regions. This helps show the scale of oral health as an economic as well as a health issue. High global spending does not necessarily mean that everyone has access to care; millions of people still lack access to and financial coverage for essential oral-health services. global strategy on oral health

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Background

Setting the scene

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6. Oral diseases and conditions are influenced by social determinants of oral health, which comprise the social, economic and political conditions that influence oral diseases, including access to safe

[1] Global oral health status report: towards universal health coverage for oral health by 2030. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[2] Seventy-fifth World Health Assembly, Provisional agenda item 14.1, 27 April 2022, https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add1-en.pdf.

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Interesting Facts **04**

Many of the same behaviors that increase the risk of major noncommunicable diseases also increase the risk of oral disease. WHO identifies tobacco use, harmful alcohol use and high intake of free sugars among these shared risk factors. This means that policies intended to prevent conditions such as cardiovascular disease, cancer and diabetes can also contribute to preventing oral disease rather than treating oral health as a completely separate health problem. global strategy on oral health

Definition **06**

WHO describes the social determinants of oral health as the structural, social, economic and political drivers of oral diseases and conditions in society. These determinants help explain why oral diseases and oral-health inequalities are not distributed equally.

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water, sanitation and hygiene. They are also affected by commercial determinants, which are the strategies used by some private-sector actors to promote products and choices that are detrimental to health. This includes marketing, advertising and sale of products that cause oral diseases and conditions, such as tobacco products and food and beverages that are high in free sugars.

7. Essential oral health care covers a defined set of safe, cost-effective interventions at individual and community levels that promote oral health and prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral.

8. Availability and coverage of oral health care are highly variable within and between countries. As a result, millions of people still do not have access to and financial coverage for essential oral health care, leading to high out-of-pocket payments for patients.[3] The COVID-19 pandemic has significantly affected oral health services and worsened inequalities for disadvantaged population groups, highlighting the need for continued essential oral health services in emergency situations.

9. Environmental challenges related to oral health care include the efficient use of natural resources, such as water and energy; the use of safe and environmentally sound oral health supplies and consumables and oral care products; sustainable waste management; reduction of carbon emissions; and the need to accelerate the phase down in use of mercury-containing dental amalgam.

10. Most oral diseases and conditions are preventable and can be effectively addressed through population-based public health measures. Upstream policy interventions, such as those targeting social and commercial determinants, are cost-effective with high population reach and impact. Midstream initiatives include creating more supportive conditions in key settings like households, schools, workplaces, long-term care facilities and community venues. Downstream interventions are also critical, including essential prevention and evidence-based clinical oral health care.

The 2021 resolution on oral health and its mandate

11. Recognizing the global public health importance of major oral diseases and conditions, the World Health Assembly adopted a resolution on oral health (WHA74.5) in May 2021, requesting that oral health be embedded within the NCD and UHC agendas.

12. In the resolution on oral health, Member States also requested the Director-General to develop a draft global strategy on tackling oral diseases, in consultation with Member States, by 2022; to translate this global strategy, by 2023, into an action plan for public oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030; to develop technical guidance on environmentally friendly and less invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury; to continue to update technical guidance to ensure safe and uninterrupted dental services, including under circumstances of health emergencies; to develop "best buy" interventions on oral health by 2024, as part of the updated Appendix 3 of the Global Action Plan of NCDs 2013-2030 and integrated into the WHO UHC Compendium of health interventions; to include noma in the planned WHO 2023 review process to consider the classification of additional diseases within the road map for neglected tropical diseases 2021–2030; and to report back on progress and results until 2031 as part of the consolidated report on NCDs.

[3] Petersen PE, Baez RJ, Ogawa H. Global application of oral disease prevention and health promotion as measured 10 years after the 2007 World Health Assembly statement on oral health. Community Dent Oral Epidemiol. 2020; 48:338–348. doi: 10.1111/cdoe.12538.

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Definition **06**

WHO describes commercial determinants of oral health as strategies used by some private-sector actors to promote products and choices that are detrimental to health. The Action Plan specifically addresses marketing, advertising and sales of products harmful to oral health.

Something to Think About **06**

WHO's strategy goes beyond simply asking individuals to make healthier choices. It also examines commercial practices that influence those choices. What responsibilities should governments, individuals and businesses have for reducing exposure to products that contribute to oral disease?

Definition **07**

WHO describes essential oral health care as a defined set of safe, cost-effective interventions at the individual and community levels that promote oral health and prevent and treat the most prevalent and/or severe oral diseases and conditions.

Something to Think About **08**

WHO identifies inadequate access and financial coverage as major barriers to oral health. If oral health is integral to general health, what oral-health services should governments include in essential health-care coverage?

Interesting Facts **10**

WHO emphasizes that most oral diseases and conditions are preventable and can be addressed through population-wide public-health measures. Its foreword also notes that many oral diseases can be treated using simple and non-invasive procedures at the primary health-care level. This challenges the idea that improving oral health necessarily depends primarily on expanding specialized dental treatment using expensive equipment.

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13. The resolution on oral health is aligned with and builds on other relevant global commitments, including the 2030 Agenda for Sustainable Development, particularly Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its target 3.8 on achieving UHC, as well as Pillars 1 and 3 of WHO's Thirteenth General Programme of Work, 2019–2023.

The global strategy on oral health

14. As a first step in the implementation of the resolution on oral health, Member States adopted the Global Strategy on Oral Health in May 2022 at the Seventy-fifth World Health Assembly (A75/10 Add.1 and WHA75(11)). The strategy is aligned to the Operational Framework for Primary Health Care (2020); the Global Competency and Outcomes Framework for Universal Health Coverage (2022); the Global Strategy on Human Resources for Health: Workforce 2030 (2016); the Global Action Plan for the Prevention and Control of NCDs 2013–2020; the WHO Framework Convention on Tobacco Control adopted in 2003; resolution WHA74.16 (2021) on social determinants of health; decision WHA73(12) (2020) on the United Nations Decade of Healthy Ageing 2021–2030; and resolution 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.

15. The vision of the Global Strategy on Oral Health is UHC for oral health for all individuals and communities by 2030, enabling them to enjoy the highest attainable state of oral health and contributing to healthy and active lives. Universal health coverage means that all individuals and communities have access to essential, quality health services that respond to their needs and that they can use without suffering financial hardship. These services should include oral health promotion and prevention as well as treatment and rehabilitation interventions related to oral diseases and conditions across the life course. Achieving the highest attainable standard of oral health is a fundamental right of every human being.

16. The goal of the Global Strategy on Oral Health is to guide Member States to: (a) develop ambitious national responses to promote oral health; (b) reduce oral diseases, other oral conditions and oral health inequalities; (c) strengthen efforts to address oral diseases and conditions as part of UHC; and (d) consider the development of national and subnational targets and indicators, in order to prioritize efforts and assess progress made by 2030.

17. The six guiding principles of the Global Strategy on Oral Health are:
    - a public health approach to oral health
    - integration of oral health into primary health care
    - innovative workforce models to respond to population needs for oral health
    - people-centred oral health care
    - tailored oral health interventions across the life course
    - optimizing digital technologies for oral health.

18. The six strategic objectives of the Global Strategy on Oral Health are:
    - **Strategic objective 1**: Oral health governance – Improve political and resource commitment to oral health, strengthen leadership and create win–win partnerships within and outside the health sector.
    - **Strategic objective 2**: Oral health promotion and oral disease prevention – Enable all people to achieve the best possible oral health and address the social and commercial determinants and risk factors of oral diseases and conditions.
    - **Strategic objective 3**: Health workforce - Develop innovative workforce models and revise and

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Definition 14

WHO's oral-health strategy calls for essential oral-health care to be incorporated into universal health coverage (UHC) so that people can obtain needed services without financial hardship.

Definition 17

WHO's public-health approach to oral health emphasizes population-wide prevention, integration with other health programmes and action on shared risk factors and the broader determinants of oral disease rather than relying primarily on individual clinical treatment.

Interesting Facts 18

WHO organizes its strategy around six areas: oral-health governance; oral-health promotion and disease prevention; health workforce; oral-health care; oral-health information systems; and oral-health research agendas. The Action Plan translates these objectives into 100 actions.

expand competency-based education to respond to population oral health needs.

- **Strategic objective 4**: Oral health care – Integrate essential oral health care and ensure related financial protection and essential supplies in primary health care.
- **Strategic objective 5**: Oral health information systems – Enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policy-making.
- **Strategic objective 6**: Oral health research agendas – Create and continuously update context- and needs-specific research that is focused on the public health aspects of oral health.

Scope, aim and overarching targets of the global oral health action plan (2023–2030)

19. The Global Oral Health Action Plan (2023–2030) is a critical step in the implementation of both the resolution on oral health and the Global Strategy on Oral Health. It is grounded in the strategy's vision, goal, guiding principles, strategic objectives and the roles it outlines for Member States, the WHO Secretariat, international partners, civil society and the private sector.

20. The aim of the Global Oral Health Action Plan is to translate the six strategic objectives of the Global Strategy on Oral Health into a set of evidence-informed actions that can be adapted to national and sub-national contexts, including proposed actions for Member States, the WHO Secretariat, international partners, civil society organizations and the private sector. The proposed actions for Member States should be adapted and prioritized depending on national circumstances, taking into consideration available resources, population needs and social, economic and political contexts.

21. The monitoring framework of the Global Oral Health Action Plan provides two overarching global targets and nine global targets related to the strategic objectives, including a set of core indicators to assess implementation progress. Information on the core indicators (Appendix 1) will be reported regularly by WHO, using data provided by Member States. A set of complementary indicators (Appendix 2) is also proposed as part of the monitoring framework. Member States are encouraged to use the complementary indicators to monitor other oral health data at the national level for evidence-informed policy development and decision-making.

22. The Global Oral Health Action Plan has two overarching global targets to be achieved by 2030:

A
B

OVERARCHING GLOBAL TARGETS

Overarching global target A: Oral health services are part of UHC



Overarching global target B: Reduced oral disease burden



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Action areas of the global oral health action plan

23. The action areas of the Global Oral Health Action Plan are aligned with the six strategic objectives of the Global Strategy on Oral Health. Generally, a public health and population-level approach should be taken when implementing these actions, including consideration of equity for poor, vulnerable and/or marginalized members of societies.

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Action area for **strategic objective 1: oral health governance**

- Proposed actions for member states
- Actions for the WHO secretariat
- Proposed actions for international partners
- Proposed actions for civil society organizations
- Proposed actions for the private sector





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Action area for strategic objective 1: oral health governance

24. Strategic objective 1 aims to improve political and resource commitments to oral health, strengthen leadership and create win–win partnerships within and outside of the health sector. This objective seeks the recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national NCD and UHC agendas. Increased political and resource commitment to oral health is 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 with professionals trained in public health. A dedicated, qualified, functional, well-resourced and accountable oral health unit should be established or reinforced within NCD structures and other relevant public health and education services.

25. Sustainable partnerships within and outside of the health sector, as well as engagement with communities, civil society and the private sector, are essential to mobilize resources, target the social and commercial determinants of oral health and implement reforms.

1 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 1

Global target 1.1: National leadership for oral health



Global target 1.2: Environmentally sound oral health care



Proposed actions for member states

Action 1. **Develop and implement a national oral health policy, strategy or action plan:** Develop a new national oral health policy or review the existing policy to ensure its alignment with the Global Strategy on Oral Health and its integration with national NCD and UHC policies. Ensure the policy promotes oral health equity and prioritizes public health. Confirm that the policy coordinates oral health efforts and management across relevant national agencies and subnational levels, including safe and uninterrupted oral health services during health emergencies. Prepare national implementation guidance, including a monitoring framework aligned with the monitoring framework of the Global Oral Health Action Plan. A periodic review of the policy should be undertaken within five years of its onset.

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Definition 00

WHO's governance objective focuses on strengthening political commitment and leadership and integrating oral health into wider health and NCD programmes and policies.

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Action 2. **Strengthen national oral health leadership:** Institute or reinforce an oral health unit at the Ministry of Health or another appropriate national governmental health agency to oversee national policy, technical, surveillance, management, coordination and advocacy functions. Appoint an officer to lead the oral health unit. Consider, as appropriate for the national context, active integration and/or coordination mechanisms between the oral health unit and the NCD department or other technical programmes. Support capacities of oral health unit staff by assessing training needs and providing training and coaching opportunities, including management, leadership and public health skills, as appropriate. Empower national regulatory agencies to ensure ethical standards of professional conduct and quality oral health care.

Action 3. **Create and sustain dedicated oral health budgets:** Explore, as appropriate for national context, establishing dedicated oral health budgets at national and subnational levels covering policy, public service staff, programme and supply costs. Examine sustainable domestic sources of financial support, such as taxation policies. Consider directing public health expenditure towards oral health promotion, prevention and care as a distinct budget and a first step towards establishing a guaranteed minimum share of public health expenditure dedicated exclusively to oral health.

Action 4. **Integrate oral health into broader policies:** Advocate for UHC as a means of improving prevention and control of oral diseases and conditions for the whole population. Facilitate and operationalize the inclusion of oral health in all related national policies, strategies and programmes, particularly in the context of NCDs, primary health care, health equity and UHC. Include sectors beyond health, such as education, development, environment, water, sanitation and hygiene, finance, telecommunications or social protection.

Action 5. **Forge strategic partnerships for oral health:** Explore the potential for strategic partnerships to implement policies, mobilize resources, target social and commercial determinants and accelerate required reforms. Engage policy-makers, researchers, oral health professionals and the general public at the earliest stages of policy and research development to ensure they have the greatest positive impact on national oral health and beyond. Develop and enforce policies on engagement with partners to eliminate conflicts of interest and undue influence. Initiate or strengthen ministerial coordination and oversight mechanisms related to partnerships, including public-private partnerships. Collaborate with international and development partners to support implementation of oral health policies in national health plans.

Action 6. **Engage with civil society about oral health:** Ensure participation of civil society organizations and patient support groups and empowerment of the community in planning, implementing and monitoring appropriate programmes. Provide platforms for engagement and actively seek representation from poor, vulnerable and/or marginalized members of societies. Involve national oral health, medical and public health associations and community-based organizations in oral health policy and guideline development as well as implementation and integration of oral health in wider health care and social services.

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Something to Think About **A4**

WHO identifies sectors beyond health as important to oral-health policy. Why might ministries responsible for areas such as education, finance, water and sanitation, social protection or other sectors need to participate in efforts to improve oral health?

Action 7. **Phase down the use of dental amalgam:** Ratify the Minamata Convention on Mercury and support related national assessments and implementation plans. Accelerate implementation of measures to phase down the use of dental amalgam in accordance with existing and future decisions of the Conference of the Parties to the Minamata Convention on Mercury.

Action 8. **Strengthen health emergency preparedness and response:** Include oral health in national emergency preparedness and response plans. Ensure safe and uninterrupted essential oral health services during health emergencies or other humanitarian crises, in accordance with WHO operational guidance on maintaining essential health and oral health services.

Action 9. **Bolster response to noma, where relevant:** In countries affected by noma, develop and implement a national noma action plan that is integrated with existing regional or national programmes, such as those targeting neglected tropical diseases, vaccination and/or nutrition.

Actions for the WHO secretariat

Action 10. **Lead and coordinate the Global Oral Health Agenda:** Drive initiatives to define and update the Global Oral Health Agenda and monitor its implementation. Coordinate the work of other relevant entities of the United Nations system, development banks and regional and international organizations related to oral health. Set the general direction and priorities for global oral health advocacy, partnerships and networking. Advocate for oral health at relevant high-level meetings and platforms, such as the WHO Global NCD Platform, the United Nations High-Level Meeting on Universal Health Coverage and the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs. Accelerate implementation of the action plan by organizing a WHO global oral health summit involving key stakeholders.

Action 11. **Mobilize resources and funding for oral health:** Explore and pursue funding options to strengthen WHO capacities in oral health at global, regional and country levels and enable timely and appropriate technical support to countries. Strive to increase the number of dedicated staff at all levels of the organization, including operational budgets for programmatic work at global, regional and country levels. Advocate to increase resource allocation to oral health within the NCD agenda to ensure adequate staffing and programmatic activities. Include oral health in bi- and multi-lateral conversations with Member States and partners to mobilize resources for WHO oral health activities. Follow WHO's Framework of Engagement with Non-State Actors and engage with nongovernmental organizations and philanthropic foundations to increase resources for implementing the Global Oral Health Action Plan, particularly in low- and middle-income settings.

Action 12. **Support implementation of the Global Oral Health Agenda:** Provide technical assistance upon request of Member States and prioritize support to low- and middle-income settings for developing, implementing and sustaining of their national oral health plans. Create a global technical advisory group on oral health to strengthen international and national action and accelerate implementation

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of the Global Oral Health Agenda. Continue working with global partners, including the United Nations Interagency Task Force on the Prevention and Control of NCDs, WHO collaborating centres and non-State actors in official relation with WHO, to establish networks for building capacity in oral health promotion, care, research and training. Establish or strengthen regional oral health policy, planning and support capacities to address countries' technical support needs for implementation of the Global Oral Health Action Plan, including data collection for its monitoring framework.

Action 13. **Fulfil the mandates given to the WHO Secretariat in the resolution on oral health:** Continue to update technical guidance to ensure safe and uninterrupted dental services, including in health emergencies. By 2024, develop "best buy" interventions on oral health, as part of the updated Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs 2013–2030 and integrated into the WHO UHC Compendium of health interventions. By 2023, include noma in the planned WHO review process to consider the classification of additional diseases within the road map for neglected tropical diseases 2021–2030. By 2025, develop technical guidance on environmentally friendly and less invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury. Report back to the WHO governing bodies on progress and results until 2031 as part of the consolidated report on NCDs.

Proposed actions for international partners

Action 14. **Advocate for the Global Oral Health Action Plan:** Develop technical expertise related to oral health as part of the support mandate of development partners and donor organizations. Promote oral health in alignment with the Global Oral Health Action Plan by including it as a topic in meetings within and outside of the health sector, such as donor, bi- and multi-lateral government meetings, conferences and other forums.

Action 15. **Increase resources for oral health:** Intensify efforts by development partner and donor organizations to address oral health and other NCDs as part of the global NCD and UHC agendas. Expand financial, technical and human resource support. Use innovative financial mechanisms in programming for health, education and social protection.

Action 16. **Support country implementation of the Global Oral Health Action Plan:** Reinforce national capacities and resources for oral health through provision of technical and financial support. Help establish and sustain national technical working groups on oral health involving donors, development partners and the national government. Strengthen capacities of academic institutions and other non-State actors to act and advocate effectively. Prioritize support to low- and middle-income countries for developing, implementing and sustaining their national oral health plans.

Proposed actions for civil society organizations

Action 17. **Promote a whole-of-government approach to oral health:** Advocate for integrating management of oral diseases and other NCDs into primary health care. Engage in multisectoral coordination mechanisms to deliver on oral health and other NCD targets within and beyond the health sector.

Action 18. **Advance oral health as a public good:** Collaborate among civil society organizations, including oral health professional associations, to promote and protect oral health as a public good. Monitor and raise awareness of inappropriate partnerships in which there are conflicts of interest or undue influence. Participate in the development of government guidance on private sector engagement in oral health and NCD programmes. Advocate for governments to phase out subsidies for unhealthy foods and drinks. Support taxation of unhealthy commodities, such as tobacco, alcohol and food and beverages with high free sugars content, in line with the provisions of the Framework Convention on Tobacco Control, the WHO Global Strategy to Reduce the Harmful Use of Alcohol and other WHO guidance documents. Promote a holistic approach to tackling antimicrobial resistance based on the United Nations Sustainable Development Cooperation Framework. Include the oral health workforce in such measures.

Action 19. **Hold governments accountable to global oral health targets:** Participate in regular monitoring of national NCD and UHC work, including development and use of oral health targets and indicators. Strengthen independent accountability efforts related to oral health. Advocate for the operationalization of oral health services as part of UHC.

Action 20. **Include people affected by oral diseases and conditions:** Call for and participate in inclusive oral health governance mechanisms. Ensure that institutionalized oral health decision-making processes engage people living with oral diseases, special care needs or disabilities as well as oral health professionals.

Proposed actions for the private sector

Action 21. **Align activities with global and national public health priorities:** Use the Global Oral Health Action Plan and relevant regional and national policy guidance to incorporate public health principles and priorities in private sector activities to promote oral health.

Action 22. **Support implementation of the Global Oral Health Action Plan:** Identify areas for meaningful and appropriate engagement to support oral health public health priorities at the global, regional or national level. Respect rules of engagement set by public entities and government partners, including voluntary commitments and mandatory measures, such as advertising for children. Ensure environmental and social responsibility and accountability in oral health practices.

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Action area for
strategic objective 2: oral health promotion and oral disease prevention

- **Proposed actions for member states**
- **Actions for the WHO secretariat**
- **Proposed actions for international partners**
- **Proposed actions for civil society organizations**
- **Proposed actions for the private sector**





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Action area for strategic objective 2:
oral health promotion and oral disease prevention

26. Strategic objective 2 aims to address the social and commercial determinants and risk factors of oral diseases and conditions, with the goal of enabling all people to achieve the best possible oral health. This objective calls for evidence-based, cost-effective and sustainable interventions to promote oral health and prevent oral diseases and conditions. 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. At the midstream level, oral health promotion and oral disease prevention interventions can be implemented in key settings, such as educational venues, schools, workplaces and care homes. At the downstream level, oral health education supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care.

27. Prevention efforts target key risk factors and the social and commercial determinants of oral diseases and conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant strategies to prevent NCDs and regulatory policies to reduce or eliminate tobacco use, harmful alcohol use, unhealthy diets and high intake of free sugars. Prevention efforts should also include safe and cost-effective community-based methods to prevent dental caries, such as the use of quality fluoride toothpaste, topical fluoride application and access to systemic fluoride, where appropriate.

2 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 2

Global target 2.1: Policies to reduce free sugars intake



Global target 2.2: Optimal fluoride for population oral health



Proposed actions for member states

Action 23. **Intensify upstream health promotion and prevention approaches:** Ensure that a national oral health policy addresses common risk factors as well as social and commercial determinants of dental caries, severe periodontal disease, tooth loss, oral cancer, oro-dental trauma, cleft lip and palate and noma, where it is prevalent. Support initiatives to coordinate and accelerate the response to oral diseases and conditions and other NCDs, including health promotion and disease prevention focusing on common risk factors, determinants and inequalities across the life course.

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Definition 26

WHO distinguishes among three levels of action. Upstream interventions address broader social, commercial and political determinants; midstream interventions operate in settings such as schools, workplaces and communities; and downstream interventions include health education, self-care and clinical prevention.

Definition 27

WHO defines free sugars as sugars added to foods and beverages by manufacturers, cooks or consumers, as well as sugars naturally present in honey, syrups, fruit juices and fruit-juice concentrates. WHO recommends reducing free-sugar intake to less than 10% of total energy intake and suggests further reduction below 5%.

Supplementary definition verified from WHO nutrition guidance.

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Action 24. **Support policies and regulations to limit intake of free sugars:** Accelerate initiatives to transform the food environment in line with WHO's recommendations. Implement policies to reduce consumption of free sugars. Promote availability of healthy foods and beverages. Consider, when appropriate to national context, implementing health taxes, particularly taxation of food and beverages with high free sugars content. Advocate for earmarking such tax revenue for oral health care and health promotion, depending on country context. Collaborate with other line ministries: to limit package sizes; include more visible, simple and transparent labelling of unhealthy foods and beverages; strengthen regulation of marketing and advertising of such products to children, adolescents and their parents; and avoid sponsorship by related companies for public and sports events. Work with the private sector to reduce portion sizes and reformulate products to decrease levels of free sugars, including medicines for children with high free sugars content.

Action 25. **Support policies and regulations to reduce tobacco consumption and betel-quid and areca-nut chewing:** Accelerate full implementation of the WHO Framework Convention on Tobacco Control. Implement the WHO MPOWER package of policies and interventions, including offering people help to quit tobacco use; warning about the dangers of tobacco; enforcing bans on advertising, promotion and sponsorship; and raising taxes on tobacco products. Integrate brief interventions for tobacco use into oral health programmes in primary care. Regulate electronic cigarettes and all other nicotine-containing products in the same way as tobacco products. Where relevant, develop or strengthen actions for reducing betel-quid and areca-nut chewing, including advocating for legislation to ban their sale.

Action 26. **Support policies and regulations to reduce the harmful use of alcohol:** Implement the WHO SAFER initiative of the five most cost-effective interventions to reduce alcohol-related harm, including strengthening restrictions on alcohol availability; advancing and enforcing drink-driving counter measures; facilitating access to screening, brief interventions and treatment; enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion; and raising prices on alcohol through excise taxes and pricing policies.

Action 27. **Optimize the use of fluorides for oral health:** Develop or update national guidance related to optimal fluorides for population oral health that addresses the universal availability of systemic fluorides (e.g., water, salt, milk) or topical fluorides (e.g., toothpastes, varnishes, gels, rinses). Take into consideration needs and disease burdens across the life course, the fluoride levels present in natural waters, available resources and technical, political and social factors. Depending on the country context and feasibility, consider adjusting water fluoride to safe, optimal levels for protection against dental caries, which may require adding or removing fluoride from drinking water as recommended by national and international guidance.

Action 28. **Advocate for fluoride toothpaste as an essential health product:** Implement measures to improve the affordability and availability of fluoride toothpaste. Reduce or eliminate taxes, tariffs and other fiscal measures. Explore bulk purchasing or manufacturing agreements for use of fluoride toothpaste in community

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Interesting Facts **A24**

WHO's strategy calls for governments to use policies and regulations—not only health education—to reduce people's intake of free sugars. WHO's 2030 target is for 50% of countries to implement policy measures aimed at reducing free-sugar intake. This illustrates how far many countries still have to go in moving from encouraging healthier individual choices to changing the food environment in which those choices are made.

Interesting Facts **A28**

WHO treats affordable, quality fluoride toothpaste as an essential health product and calls for measures to improve its affordability, quality and availability.

settings. Strengthen quality and labelling of fluoride toothpaste in accordance with ISO Standard 11609 by developing national standards and quality controls. Enhance measures to protect consumers from low quality, harmful or counterfeit products. Consider adopting norms that detail available fluoride content, including methods for standardizing laboratory analysis to ensure product efficiency. Advance environmentally sound practices along the fluoride-toothpaste production and supply chain. Promote and incentivize effective self-care and oral hygiene by making affordable, quality fluoride toothpaste universally available.

Action 29. **Review and scale up mid-stream promotion and prevention measures:** Collaborate in community development and action for oral health. Facilitate social mobilization and engage and empower a diverse range of actors, including women as change agents in families and communities. Foster dialogue, catalyse societal change and address oral diseases and conditions and their social, environmental and economic determinants to improve oral health equity. Promote and implement vaccination of girls and boys against human papillomavirus to address cervical and oro-pharyngeal cancers, in accordance with national and international guidance. Encourage early detection of oral cancer in high-risk groups, linked with timely diagnostic work up and comprehensive cancer treatment, in settings with a significant disease burden.

Action 30. **Expand oral health promotion in key settings:** Integrate oral health in health promotion programmes in schools, workplaces, long-term care facilities, hospital and other health care settings, community-based settings and public venues. Partner in these efforts with key stakeholders across sectors, including city and local authorities, professional organizations, community-based organizations and civil society at large. Promote and consider establishing public settings where consumption of free sugars is discouraged and sugar-sweetened beverages are banned.

Action 31. **Achieve comprehensive promotion of oral health in schools:** Create supportive environments for oral health promotion in schools, preschools and other educational settings as part of comprehensive school health programming. Improve access to clean water, sanitation and hygiene services; increase availability of healthy food options; eliminate foods high in salt, free sugars and trans fats; and ban sugar-sweetened beverages, tobacco use and alcohol use on and around the premises. Collaborate in joint health and education ministry oversight of school health and feeding programmes, including creating an environment that supports healthy choices in schools and educational settings. Strive for integrated monitoring of education, school health, and water, sanitation and hygiene based on national, regional or international guidance and initiatives, including the WHO health-promoting schools' initiative and the WHO and UNESCO Guidelines on School Health Services. Improve school linkages with the formal health care system. Establish rules and regulations for ethical commercial support and sponsorship in schools.

Action 32. **Fortify and improve downstream promotion and prevention measures:** Develop and implement evidence-based, cost-effective, sustainable, and age-appropriate interventions to prevent oral diseases and promote oral health. Include

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Interesting Facts **A29**

WHO's Oral Health Action Plan calls for vaccination of girls and boys against human papillomavirus (HPV) to address cervical and oropharyngeal cancers, in accordance with national and international guidance.

Something to Think About **A31**

WHO's school approach includes clean water, sanitation and hygiene; healthier food options; restrictions on products harmful to health; and links between schools and health services. Why might changing the school environment have a greater effect than relying only on oral-health education?

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oral health in broader health communication, health education and literacy campaigns to raise awareness and empower people for prevention through self-care, oral hygiene and early detection of oral diseases. Draw on the WHO Mobile Technologies for Oral Health implementation guide to promote oral health literacy among individuals, communities, policy makers, the media and civil society using digital health technologies. Tailor interventions to address oral health along the life course, such as programmes targeting children, adolescents, pregnant women, parents and older adults, with special consideration for poor, vulnerable and/or marginalized members of the society. Ensure quality monitoring and evaluation of health promotion and prevention programmes.

Action 33. **Strengthen personal, social and political oral health skills:** Support all people to achieve their full potential for oral health self-care and oral health care of others. Promote twice-daily tooth brushing with fluoride toothpaste and other forms of oral health self-care and care for others. Employ skills-based oral hygiene education in communities, schools and primary care settings. Include oral health in population health education campaigns and relevant digital and social media platforms. Advocate for supportive policies to strengthen the availability and affordability of fluoride toothpaste.

Actions for the WHO secretariat

Action 34. **Integrate oral health promotion in relevant WHO guidance:** Consider establishing a WHO internal coordination mechanism to facilitate systematic integration of oral health in related policies, strategies and technical documents. Integrate oral health in technical guidance on health taxes. Encourage research with WHO collaborating centres and other research entities on interventions to effectively address the social and commercial determinants of oral health.

Action 35. **Provide technical guidance for oral health promotion and oral disease prevention:** Recommend cost-effective, evidence-based interventions for oral health promotion and disease prevention by 2024 as part of the updated Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs 2013–2030 and the WHO UHC Compendium of health interventions.

Action 36. **Hold to account economic operators in the production and trade of products harmful to oral health:** Strengthen technical support and guidance on nutrition, labelling and fiscal measures to promote healthy food options. Encourage private-sector transparency and alignment with mandatory regulations and voluntary codes of practice to reduce the marketing, advertising and sale of products harmful to oral health, such as tobacco products and food and beverages that are high in free sugars.

Proposed actions for international partners

Action 37. **Target risk factors and determinants of oral health:** Integrate oral health into new or existing programmes that address NCDs more broadly, including common risk factors and determinants of health. Support and conduct research to

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strengthen the evidence for interventions that effectively target the determinants of oral health, including those that reduce oral health inequalities.

Action 38. **Consider oral health in policy impact assessments:** Ensure that oral health is considered when conducting health, inequality or environmental impact assessments in trade, food, environment, finance and other sectors, so that unintended health impacts can be avoided and mitigation measures are put in place.

Proposed actions for civil society organizations

Action 39. **Mobilize support for oral health promotion:** Facilitate community action for health promotion among diverse groups, such as nongovernmental organizations, academia, media, human rights agencies, faith-based organizations, labour and trade unions and organizations working with poor, vulnerable and/or marginalized people. Support the development of personal, social and advocacy skills to enable all people to achieve their full potential for effective self-care and comprehensive oral hygiene, including persons with impaired motor skills, such as children, people with disabilities and older individuals.

Action 40. **Advocate for policies and regulations for oral disease prevention:** Support policies aimed at creating healthy environments and settings, such as healthy school meals, tobacco-free environments and related sales restrictions for minors. Advocate for the implementation of health taxes, including those for foods and beverages high in free sugars. Promote national action on the commercial determinants of health, such as mandatory legislation and regulation to limit the influence of food and drink corporations. Call for transparent conflict-of-interest policies between commercial corporations and oral health policy-makers, dental schools and oral health researchers to limit undue influences and safeguard public health interests.

Action 41. **Ensure civil society inclusion in policy development:** Advocate for including professional, provider and patient organizations and diverse other civil society organizations in the development and implementation of policies related to oral health promotion, common risk factors and the determinants of oral diseases and other NCDs. Strengthen transparency and commitment by holding all stakeholders accountable to the Global Oral Health Action Plan's actions on oral health promotion and oral disease prevention.

Proposed actions for the private sector

Action 42. **Reduce marketing, advertising and sale of harmful products:** Prioritize monitoring, transparency and compliance with voluntary and legally binding policies and regulations related to healthy settings, protection of vulnerable population groups, marketing, advertising and sponsorship, depending on country context. Consider reformulation of products to reduce intake of free sugars.

Action 43. **Improve affordability and quality of fluoride products for oral health:** Cooperate with governments to improve the affordability and quality of fluoride-containing products for oral health. Ensure that tax reductions or subsidies applied

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to such products are entirely reflected in lower consumer prices.

Action 44. **Implement occupational oral health measures:** Strengthen the commitment and contribution to oral health by implementing measures at the workplace, including through good corporate practices, workplace health and wellness programmes and health insurance coverage for employees, according to country context.

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Action area for **strategic objective 3: health workforce**

- Proposed actions for member states
- Actions for the WHO secretariat
- Proposed actions for international partners
- Proposed actions for civil society organizations
- Proposed actions for the private sector



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Action area for strategic objective 3: health workforce

28. Strategic objective 3 aims to develop innovative workforce models and to revise and expand competency-based education to support new skill mixes. Progress towards oral health services as part of UHC requires health workers who are educated and empowered to provide the oral health services that populations need. Central to this objective is the availability of skilled health workers in adequate numbers to ensure the delivery of an essential package of oral health care. Planning and prioritization of oral health services must be included in all national health workforce policies, plans or strategies and investment plans.

29. More effective, innovative workforce models will probably include health professionals who traditionally may not have been involved in oral health care working together with oral health professionals to provide an essential package of oral health services. Developing and expanding the role of oral health care providers working autonomously at the mid-level is particularly important. Reform of intra- and inter-professional education and collaborative practice will be key to fully integrating oral health services at the primary care level and into broader health systems. Professional oral health education must go beyond developing a fundamental clinical skill set to incorporate community health, public health, leadership and research competencies.

3 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 3

Global target 3: Innovative workforce model for oral health



Proposed actions for member states

Action 45. **Foster innovative oral health workforce models:** Develop and implement workforce models that enable sufficient numbers of adequately trained, motivated and well-distributed health workers to provide oral health services as members of collaborative and interprofessional primary health care teams at all levels of care. Review and update national legislative and regulatory policies for licensing, accreditation and scopes of practice to support flexible workforce models and competency-based education and practice. Explore task shifting and increase the number and availability of oral health providers working autonomously at the mid-level. Facilitate career-transition pathways between professional tracks to increase flexibility and deployment of oral health providers in underserved areas. Include basic oral health promotion and preventive oral health care as a core competency for key health care professionals, such as doctors, nurses and pharmacists.

Action 46. **Increase capacity to deliver oral health services as part of UHC:** Expand coverage of essential oral health care by planning for the availability, accessibility,

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Something to Think About **29**

WHO proposes greater involvement of health professionals who have not traditionally provided oral-health care. Could expanding the range of appropriately trained health workers providing basic oral-health services improve access in underserved areas? What measures would be needed to ensure quality?

Interesting Facts **29**

WHO argues that professional oral-health education should extend beyond clinical skills to include areas such as public health, prevention, leadership, research, evidence-informed decision-making and people-centred care.

Definition **A45**

WHO calls on countries to explore task shifting, increase the availability of mid-level oral-health providers, and include basic oral-health promotion and preventive care among the core competencies of health professionals such as doctors, nurses and pharmacists.

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acceptability and quality of skilled health workers able to deliver an essential package of oral health care for all, including for poor, vulnerable and/or marginalized populations. Ensure that investment in human resources for oral health is efficient, sustainable and aligned with the current and future needs of the population. Include oral health workforce planning within national health workforce plans, policies and strategies. Develop comprehensive investment plans to scale up the oral health workforce. Consider designing a standardized national competency-based training curriculum for oral health aligned with the WHO Global Competency and Outcomes Framework for Universal Health Coverage, which guides the standards of education and practice for health workers in primary care.

Action 47. **Strengthen collaborative, cross-sectoral workforce governance:** Establish and enable professional councils and associations at the national level to develop, regularly review and adapt accreditation mechanisms and regulations. Promote portability of licensure across countries to support innovative oral health workforce models. Include standards of practice and professional behaviour, under the oversight of the Ministry of Health and fully integrated with national health workforce planning. Leverage existing collaborations among the ministries of health, labour, economy, finance and education and engage with related professional councils and associations, to ensure occupational health and safety, health worker rights, reduced biases in the workforce and appropriate remuneration. Foster interprofessional collaboration, including interdisciplinary teamwork in oral health care and scale-up of surveillance capacities for communicable and noncommunicable conditions.

Action 48. **Reform intra- and inter-professional oral health education:** Prepare students for collaborative practice and integrating oral health into primary health care. Promote and safeguard equitable access to oral health professional education to increase socio-economic, gender, disability, ethnic and geographic diversity and cultural competency of the oral health workforce.

Action 49. **Improve oral health workforce curricula and training:** Reform education to prioritize competencies in public health, health promotion, disease prevention, evidence-informed decision-making, digital oral health, service planning and the social and commercial determinants of health. Ensure the curriculum provides oral health workers with clinical and public health competencies to prevent and treat the most common oral diseases with essential oral health care and rehabilitation measures in a primary care context. Encourage and consider making it mandatory for professional organizations and dental schools to educate and train oral health professionals and students on the use of evidence-based, mercury-free alternatives for dental restoration and on best practices for waste management in oral health care facilities. Support training on rational antimicrobial prescribing and infection control to prevent the spread of antimicrobial resistance.

Action 50. **Strengthen oral health professional accreditation:** In accordance with country regulations, create or improve accreditation mechanisms for public and private oral health education and training institutions. Support effective oversight

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bodies to ensure minimum quality standards of oral health education. Establish standards for social accountability and social and commercial determinants of health. Work with professional associations to define oral health specializations and their training and accreditation requirements, recognizing the priority of essential oral health care and public health specialists while balancing the demand for advanced and specialist oral health care. Strengthen awareness of nonclinical career pathways among students in public health, epidemiology, research and other areas. Make life-long professional continuing education mandatory to retain accreditation and license to practise.

Actions for the WHO secretariat

Action 51. **Explore innovative workforce models for oral health:** Initiate regional and national workforce assessments to inform the development of innovative workforce models for oral health service delivery, based on the WHO Competency Framework for Universal Health Coverage and the objectives of the Global Strategy on Human Resources for Health: Workforce 2030. Consider developing capacity building programmes as part of institutional and educational workforce reform, with the support of the WHO Academy.

Action 52. **Provide normative guidance and technical support for oral health workforce reform:** In collaboration with partners, disseminate best practices on assessment of health system needs, reform of education policies, analysis of health labour markets, and costing of national policies, plans and strategies on human resources for health, taking into account the organization of the national oral health team. Review and strengthen tools, guidelines and databases related to human resources for NCDs, including oral diseases and conditions, in collaboration with the WHO health workforce department.

Action 53. **Strengthen country-level reporting on human resources for oral health:** Gather, analyse and report public and private oral health workforce data as part of the monitoring framework of the Global Oral Health Action Plan. Track progress on implementation of workforce-related actions. Support country-level data collection on the oral health workforce, including leveraging the national health workforce accounts reporting system.

Proposed actions for international partners

Action 54. **Champion the workforce reform agenda:** Engage international professional, research and dental education associations to align with the workforce reform agenda and support regional and national member associations. Support innovative oral health workforce models by focusing international and regional support on countries with the most critical workforce shortages. Consider financial and grant support for assessing, strengthening and diversifying the oral health workforce.

Action 55. **Advance data, information and accountability:** Reinforce integrated health and oral health workforce planning. Provide technical support for collecting,

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analysing and using data on the national oral health workforce for improved planning and accountability. Align these efforts with the health labour market framework and the national health workforce accounts reporting system.

Action 56. **Improve oral health training and accreditation:** Under the oversight of the Ministry of Health and in collaboration with professional associations, integrate basic competencies for oral health in health worker training programmes on prevention and management of major NCDs. Promote mutual recognition of professional diplomas and qualifications by regional and national accreditation entities to enable free movement, license portability and practice between countries and geographic areas of need for oral health professional, in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Proposed actions for civil society organizations

Action 57. **Collaborate to accelerate oral health workforce reform:** For dental councils and oral health professional associations, develop appropriate task-sharing and interprofessional collaboration models and strengthen effective accreditation and regulation processes for improved workforce competency, quality and efficiency, under government leadership and through collaboration with community and patient organizations, where appropriate. For academic training and research institutions, train the workforce to minimize the environmental impact of oral health services and prioritize oral health worker competencies in line with the WHO Competency Framework for Universal Health Coverage and the Global Strategy on Human Resources for Health: Workforce 2030.

Action 58. **Strengthen oral health in primary health care:** For dental councils and oral health professional associations, foster ongoing self-reflection of the dental profession on the goal of improving access to and quality of oral health care in primary health care and patient safety as a societal responsibility within and beyond dentistry.

Action 59. **Improve quality of oral health care through continuing education:** For dental councils and oral health professional associations, support continuing education of the oral health workforce. Develop or review codes of practice and similar frameworks to enhance management of potential conflicts of interest and undue influences, including when dental and pharmaceutical companies and other private-sector entities sponsor professional education and conferences.

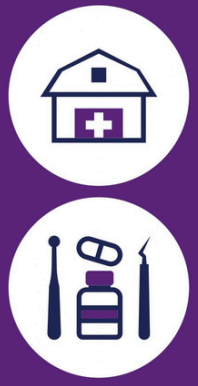
Proposed actions for the private sector

Action 60. **Align private and public oral health workforce training:** Ensure involvement and alignment of public and private oral health workforce training institutions in meeting the requirements of national health workforce policies, plans or strategies aimed at addressing current and future population health needs. Adapt concepts and programmes of private oral health education to include competency-based training. Strengthen oral health education in the public interest.

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Action area for **strategic objective 4: oral health care**

- Proposed actions for member states
- Actions for the WHO secretariat
- Proposed actions for international partners
- Proposed actions for civil society organizations
- Proposed actions for the private sector



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Action area for strategic objective 4:
oral health care

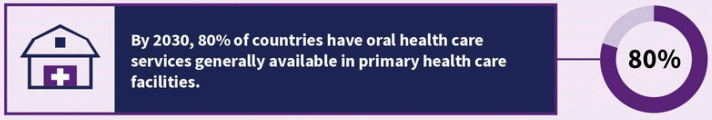
30. Strategic objective 4 aims to integrate essential oral health care into primary health care and ensure related financial protection and essential supplies. This objective seeks to increase access by the entire population to safe, effective and affordable essential oral health care as part of national UHC benefits packages. These promote oral health and prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral. Health workers who provide oral health services should be active members of the primary health care team.

31. Financial protection through expanded pre-payment financing arrangements supported by adequate levels of public spending, is one of the cornerstones of UHC. Ensuring the reliable availability, affordability 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. It is particularly important to explore ways to make oral health products more affordable in low- and middle-income settings, where resources are limited and the burden of oral diseases is increasing.

32. Digital health technologies should be examined for their potential role in delivering of accessible, effective oral health promotion and essential oral health care. This may include developing policy, legislation and infrastructure to expand the use of digital health technologies. Digital health technologies may also improve remote access and consultation for early detection and referral to services for the management of oral diseases and conditions. The benefits of digital health technologies need to be balanced against potentially negative effects, including those related to digital exclusion and the challenges of data protection.

4 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 4

Global target 4.1: Integration of oral health in primary care



Global target 4.2: Availability of essential dental medicines



Proposed actions for member states

Action 61. **Establish an essential oral health care package:** Coordinate a national stakeholder-engagement process to review evidence, assess current service capacity

Definition 31

For oral health, WHO links financial protection to expanded pre-payment financing arrangements supported by adequate public spending. The goal is to enable people, including poor, vulnerable and marginalized populations, to obtain essential oral-health care without financial hardship.

Interesting Facts 32

WHO says digital technologies such as mobile phones and intra-oral cameras may support remote access and consultation for the early detection and referral of oral diseases and conditions.

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for oral health care and agree on cost-effective oral health interventions as part of the national UHC benefits package. Ensure that the package includes emergency care, prevention and treatment of common oral diseases and conditions and essential rehabilitation. Prioritize the prevention and treatment of dental caries with minimal intervention. Advocate that national UHC includes safe, affordable essential oral health care based on the WHO UHC Compendium of health interventions and oral health-related interventions in Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs 2013–2030. Using the available evidence, support introducing remuneration systems that incentivize prevention over treatment and models of good practice.

Action 62. **Integrate oral health care into primary health care:** Develop and review all aspects of primary health care services and plan to integrate oral health care at all service levels, including required staffing, skill mix and competencies. Implement workforce models that produce sufficient numbers of adequately trained health workers to provide oral health services within primary health care teams at all levels of care. Establish referral pathways and support mechanisms that streamline coordination of care with other areas of the health system. Consider including private oral health providers through appropriate contracting and/or reimbursement schemes. Explore how to optimize private oral health care providers' engagement in such schemes, particularly in countries where they make up a sizeable proportion of providers.

Action 63. **Work towards integrated oral health services as part of UHC:** Expand coverage through on-demand care in primary care facilities using an essential oral health care package. Assess, strengthen and rehabilitate infrastructure for oral health services to support the quality and scope of needed oral health care. Ensure that oral health care is of sufficient quality to be effective and safeguards patient safety. Establish an oral health quality monitoring and management system for both the private and public sectors, including periodic quality-improvement measures.

Action 64. **Guarantee financial protection for essential oral health care:** Establish appropriate financial protection for patients through expanded payment financing arrangements supported by adequate levels of public spending, in accordance with national UHC strategies. Promote and safeguard access of poor, vulnerable and/or marginalized population groups to essential oral health care packages without financial hardship. For such groups, consider appropriate co-payment regulations supported by adequate levels of public spending.

Action 65. **Ensure essential oral health supplies:** Prioritize the availability and distribution of essential oral health care supplies and consumables as part of public procurement mechanisms for primary health care. Establish or update national lists of essential medicines that include supplies and medicines required for oral health services, aligned with the WHO Model Lists of Essential Medicines, which encompass the medications considered to be effective and safe to meet the most important needs in a health system.

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Interesting Facts **A62**

According to WHO, 58% of countries—113 of 194—reported that procedures for detecting, managing and treating oral diseases were available in public primary-care facilities. WHO's 2030 target is for 80% of countries to have oral-health services generally available in primary health-care facilities. For this target, WHO looks for basic services such as oral-health screening, emergency treatment and pain relief, and basic treatment of dental decay. Making these services available through primary health care would allow more people to receive preventive care, detect problems earlier and obtain basic treatment without having to rely on specialized dental services.

Interesting Facts **A65**

WHO's Model List of Essential Medicines does not include only medicines used to treat diseases such as infections, cancer or heart disease. It also includes products used to prevent and treat tooth decay, including fluoride toothpaste, glass ionomer cement and silver diamine fluoride. Glass ionomer cement is a material used to seal or repair decayed teeth that also releases fluoride. Silver diamine fluoride is a liquid that can be painted onto a decayed tooth to stop the decay from getting worse—without drilling or placing a conventional filling. WHO added these dental products to its Essential Medicines Lists in 2021 because they provide relatively simple and affordable ways of preventing and treating tooth decay, including in settings without specialized dental equipment.

Action 66. **Strengthen action against antimicrobial resistance:** Promote stewardship and engagement in initiatives to prevent and control the spread of antimicrobial resistance. Develop guidance on rational antibiotic use for oral health professionals. Strengthen standard procedures for infection prevention and control in line with WHO and other international and national guidance. Include oral health professionals in initiatives to prevent and control the spread of antimicrobial resistance.

Action 67. **Promote safe, environmentally sound, mercury-free products and minimal intervention:** Advocate for the prevention and treatment of dental caries with minimal intervention. Restrict the use of dental amalgam to its encapsulated form. Exclude or do not allow the use of mercury in bulk form by dental practitioners. Exclude or do not allow or recommend against the use of dental amalgam for the dental treatment of deciduous teeth, patients under 15 years of age and pregnant and breastfeeding women, except when considered necessary by the dental practitioner based on the needs of the patient. Promote the use of mercury-free alternatives for dental restoration. Discourage insurance policies and programmes that favour use of dental amalgam over mercury-free dental restoration.

Action 68. **Reinforce best environmental practices:** In collaboration with the Ministry of Environment, ensure that measures are in place to reduce the environmental impact of oral health services. Minimize carbon emissions and the use and production of waste from single-use plastic and nonbiodegradable materials. Use natural resources, such as water and energy sources, in sustainable ways. Follow best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land. When expanding essential oral health care services, explore ways to minimize their impact on the environment, such as through promotion of oral health self-care and preventive lifestyle and behavioural changes, as well as careful treatment planning and efficient use of digital technologies.

Action 69. **Optimize digital technologies for oral health care:** Support digital access and consultation for oral disease early detection, management and referral. Monitor and evaluate the effectiveness and impact of such interventions. Integrate digital access and consultation into interprofessional platforms to facilitate access for patients. Draw on the WHO Mobile Technologies for Oral Health implementation guide to improve oral health literacy, health worker training, early detection of oral diseases and oral health surveillance within national health systems. Develop and strengthen data protection and privacy policies to safeguard confidentiality, patient access to personal data and appropriate consent to data use. Strengthen access and capacity for using digital technologies to ensure that digital health approaches do not increase inequalities and that services remain accessible to all, aligned with the WHO–ITU Global Standard for Accessibility of Telehealth Services.

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Interesting Facts — A 66

WHO includes oral-health professionals in efforts to address antimicrobial resistance (AMR) and calls for rational prescribing of antibiotics and stronger infection-prevention and control practices.

Definition — A 67

WHO's Action Plan calls for prevention and treatment of dental caries with minimal intervention and promotes mercury-free alternatives for dental restoration. WHO's separate guidance on minimal intervention emphasizes approaches intended to preserve tooth tissue and minimize unnecessary invasive treatment.

Supplementary explanation verified from WHO guidance on mercury-free products and minimal intervention.

Definition — A 67

Dental amalgam is a dental-restoration material containing mercury. WHO's technical information reports that dental amalgam contains approximately 50% elemental mercury by weight. The Action Plan promotes mercury-free alternatives and implementation of relevant provisions of the Minamata Convention.

The composition information is supplementary and verified from WHO technical guidance.

Interesting Facts — A 68

Dental amalgam, which has traditionally been used to fill cavities, contains about 50% mercury. The environmental concern is that mercury from dental amalgam can be released when fillings are placed or removed and when dental waste is disposed of. If it is not properly collected, mercury can enter wastewater and eventually contaminate the environment. This is one reason WHO supports reducing the use of dental amalgam and safely managing amalgam waste.
But amalgam is not the only environmental concern. Dental treatment also generates waste from disposable plastics, protective equipment, packaging and materials used to repair teeth. WHO therefore encourages countries to consider the environmental impact of dental products throughout their life cycle—from how they are manufactured and packaged to how they are used and eventually disposed of.
Possible solutions include safely collecting and disposing of mercury and other dental waste, reducing unnecessary single-use products and packaging, using alternatives to amalgam, and preventing oral disease so that fewer fillings and other treatments are needed.

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Actions for the WHO secretariat

Action 70. **Provide guidance on essential oral health care and cost-effective oral health interventions:** By 2024, recommend interventions as part of the updated Appendix 3 of the Global Action Plan for the Prevention and Control of NCDs 2013–2030 and the WHO UHC Compendium of health interventions. Update interventions periodically to consider the emergence of new evidence of cost–effectiveness. Support Member States to develop specific definitions of essential oral health care for their contexts and implement cost-effective interventions for oral health as part of other NCD initiatives. Facilitate learning and sharing of best practices related to UHC and oral health care in primary care.

Action 71. **Advocate for digital oral health:** Drawing on the Global Strategy on Digital Health 2020–2025 and the WHO Mobile Technologies for Oral Health implementation guide, provide technical guidance and support for digital oral health. Encourage countries to share lessons learned and best practices related to digital oral health technology.

Action 72. **Accelerate implementation of the Minamata Convention on Mercury:** In collaboration with the Secretariat of the Minamata Convention on Mercury and the United Nations Environment Programme, support countries with implementing the provisions of the Convention, particularly those related to the phase down in use of dental amalgam in Environment Facility 7 (GEF-7) project "Accelerate implementation of dental amalgam provisions and strengthen country capacities in the environmentally sound management of associated wastes under the Minamata Convention" and relevant future GEF projects. Develop technical guidance on environmentally sound and less invasive dentistry.

Proposed actions for international partners

Action 73. **Strengthen oral health services as part of UHC:** Consider including oral health services in programmatic and budget planning for UHC. Support the development and implementation of a package of essential oral health services, particularly in low- and middle-income settings. Provide platforms to share lessons learned and key success factors to integrate oral health services into UHC schemes.

Proposed actions for civil society organizations

Action 74. **Mobilize stakeholders for oral health care:** Consider establishing multistakeholder advisory committees for NCDs, including oral diseases and conditions, at national and local levels of government. Ensure representation of civil society organizations to strengthen participation and ownership. Encourage new and support existing civil society organizations to serve as advocates and catalysts to increase access to essential oral health care and promote its inclusion in UHC.

Action 75. **Help mitigate environmental impacts of oral health care:** Advocate for environmentally sound practices and sustainable use of natural resources in the con-

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Did You Know That... **A 72**

WHO's 2030 target is for 90% of countries to have implemented measures to phase down the use of dental amalgam as required by the Minamata Convention or to have phased it out altogether.

text of oral health services, including accelerating the phase down in use of dental amalgam and minimizing the use of single-use plastic and non-biodegradable materials.

Proposed actions for the private sector

Action 76. **Invest in digital oral health for all:** Amplify research on and development of digital oral health care devices and technologies that are low-cost and simple to use, in support of population-based interventions.

Action 77. **Commit to environmentally responsible manufacturing:** Develop, produce and market oral health care products and supplies that are cost-effective, environmentally responsible and sustainable. Engage with governments to improve availability and affordability of such products through bulk purchasing and other cost-saving approaches to public procurement. Accelerate research on and development of new mercury-free, safe and effective dental filling materials.

Action 78. **Establish sustainable public-–private partnerships:** Engage manufacturers and suppliers of oral care products in ethical, transparent and long-term partnership agreements with key national actors, in line with public health principles and the Global Oral Health Action Plan. Prioritize dental caries prevention and health promotion, thereby minimizing the need for dental restoration. Improve access to essential oral health care and supplies, particularly in low- and middle-income settings, including supporting governmental initiatives to make these products more affordable. Encourage insurance policies and programmes that favour the use of quality alternatives to dental amalgam for dental restoration.

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Action area for **strategic objective 5: oral health information systems**

- Proposed actions for member states
- Actions for the WHO secretariat
- Proposed actions for international partners
- Proposed actions for civil society organizations
- Proposed actions for the private sector



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Action area for strategic objective 5: oral health information systems

33. Strategic objective 5 aims to enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers. This objective involves developing more efficient and effective integrated health information systems that include oral health to inform planning, management and policy-making. At the national and subnational levels, strengthening information systems should include the systematic collection of data on oral health status, social and commercial determinants, risk factors, workforce, oral health services readiness and resource spending. These efforts should ensure that appropriate measures gather information on the oral health needs of populations to inform service reforms. Development and implementation of oral health information systems should be guided and supported by the monitoring framework of the Global Oral Health Action Plan, as relevant to country context.

34. New oral health research methods, including high-resolution video, multispectral imaging and mobile technologies, can be explored to improve the quality of population-based oral health data while reducing costs and complexity. The improved systems should protect patient data, monitor patterns and trends in oral health inequalities and track the implementation and impact of existing policies and programmes related to oral health.

5 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 5

Global target 5: Monitoring implementation of the national oral health policy



Proposed actions for member states

Action 79. **Strengthen oral health information systems:** Support the development and improvement of oral health information and surveillance systems. Depending on country context, integrate oral health indicators into existing national health information systems, such as facility-based service reporting. Integrate surveillance of population health by incorporating oral health indicators into national NCD and UHC monitoring frameworks. Monitor risk factors and the social and commercial determinants of oral health inequalities. Improve oral health system and policy data, evaluation of oral health programmes and information on the oral health workforce in national health workforce accounts. Consider conducting population-based oral health surveys or other appropriate surveillance specific to oral diseases, including self-reported data collection and integration with existing NCD surveillance systems.

Action 80. **Integrate electronic patient records and protect personal health data:** Encourage integration of electronic oral health patient records into medical and

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Definition 33

WHO calls for oral-health information systems that systematically collect data on oral-health status, social and commercial determinants, risk factors, the workforce, service readiness and resource spending. These systems should provide timely information for planning, management and policy-making.

Interesting Facts 34

WHO identifies high-resolution video, multispectral imaging and mobile technologies as innovations that may support oral-health surveillance and data collection.

Something to Think About 34

National averages can hide important differences between population groups. Why is information about oral-health inequalities necessary if the goal is to improve equity rather than simply improve a country's overall average?

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pharmacological records and sharing data among public and private providers, to facilitate continuity of people-centred care as well as population-level health monitoring. Establish data protection and confidentiality regulations that protect patient-related information while allowing anonymized data analysis and reporting, in accordance with national context. Ensure that patients have access to all information recorded and stored about them.

Action 81. **Use innovative methods for oral health data collection:** Participate in periodic global WHO surveys that collect health system, NCD and other health information. Develop and standardize innovative methods for collecting and analysing oral health and epidemiological data using digital technologies. Explore applications supported by artificial intelligence in mobile devices, opportunities provided by more complex and larger data sets from new sources, and novel approaches to generating comprehensive disease estimates.

Action 82. **Increase transparency and accessibility of oral health information:** Make anonymized information and appropriately disaggregated data on population oral health publicly available to inform research, analysis, planning, management, policy decision-making and advocacy. Consider creating centralized repositories of data to promote standardization of data and reduce fragmentation across databases. Ensure alignment of the national oral health monitoring framework with the monitoring framework of the Global Oral Health Action Plan. Regularly report national data to WHO as proposed in the framework.

Actions for the WHO secretariat

Action 83. **Track implementation and impact of the Global Oral Health Action Plan:** Gather and analyse country data for the monitoring framework of the Global Oral Health Action Plan. Share findings as required within broader NCD reporting. Create an oral health data portal as part of WHO's data repository for health-related statistics. Compile health systems information from multiple data sources to routinely update information on implementation of the Global Oral Health Action Plan. Adapt and update existing global WHO surveys and tools to enable tracking of progress implementing the Global Oral Health Action Plan.

Action 84. **Support integration of oral health in national health information systems:** Develop guidance documents for effective strengthening of oral health information systems at global, regional, national and subnational levels. Engage with WHO collaborating centres and international partners, such as the Institute for Health Metrics and Evaluation's Global Burden of Disease group, to improve indicators, data collection and inclusion, analysis methodology and interpretation of oral-health-related estimates. Build the trust of health professionals and the public in the capacity and value of integrated oral health monitoring and information systems.

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Proposed actions for international partners

Action 85. **Support the monitoring framework of the Global Oral Health Action Plan:** Improve capacities of effective oral health information systems, surveillance, research and data analysis by providing appropriate tools and training opportunities for all stakeholders as part of broader health system strengthening.

Action 86. **Advance oral health metrics:** Promote the use of oral health indicators aligned with global health metrics used to assess the burden of disease, such as prevalence and disability-adjusted life years, to strengthen usability of information in the context of the Sustainable Development Goals and other key global health agendas.

Proposed actions for civil society organizations

Action 87. **Promote oral health data protection and confidentiality:** In accordance with country regulations, seek protection of patient and provider-related information while allowing anonymized data analysis and reporting for planning, evaluation and research.

Proposed actions for the private sector

Action 88. **Provide access to insurance data for research and service planning:** Enable access to private oral health insurance data on coverage, health outcomes and economic information, in full compliance with national data protection policies.

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Action area for
strategic objective 6:
ORAL HEALTH research agendas

- Proposed actions for member states
- Actions for the WHO secretariat
- Proposed actions for international partners
- Proposed actions for civil society organizations
- Proposed actions for the private sector



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Action area for strategic objective 6:
oral health research agendas

35. Strategic objective 6 aims to create and periodically update context- and needs-specific research that is focused on the public health aspects of oral health. This objective strives to create and implement new oral health research agendas that are oriented towards public health programmes and population-based interventions. Translation of research findings into practice is equally important and should include the development of country-specific, evidence-informed clinical practice guidelines. Researchers play an important role in supporting the development and evaluation of population oral health policies and evaluating and applying the evidence generated by public health interventions.

6 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 6

Global target 6: Research in the public interest



Proposed actions for member states

Action 89. **Reorient the oral health research agenda:** Define national oral health research priorities to focus on public health and population-based interventions, taking into account the wider NCD, primary health care, UHC and health system context. Review and establish adequate public funding mechanisms for oral health research aligned with national priorities. Facilitate the dissemination of and alignment with the national oral health research agenda among all national research institutions, academia and other stakeholders. Foster collaboration within and across countries, including multidisciplinary research, based on the principles of research ethics and equity in health research partnerships.

Action 90. **Prioritize oral health research of public health interest:** Support research areas of high public health interest in addition to basic health research, such as research on rare oral diseases. Strengthen implementation and operational research. Close gaps in evidence and translation of research into practice for: upstream interventions; evaluation of essential oral health care and integration into primary health care, including workforce models and learning health systems; barriers to access to oral health care; oral health inequalities; oral health promotion in key settings, such as schools; digital technologies and their application in oral health; environmentally-sound practices and mercury-free dental materials for dental restoration; and economic analyses to identify cost-effective interventions. In countries where oral cancer and oro-facial clefts are prevalent, support population-based epidemiological studies and statistical modelling tools to strengthen the evidence for estimating, preventing and controlling these

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Something to Think About **35**

WHO wants oral-health research to include public-health programmes and population-based interventions rather than concentrating only on clinical treatment. How might research on prevention, health systems and population interventions influence what governments choose to fund?

Definition **35**

In this strategy, translation of research findings into practice includes using research in evidence-informed clinical-practice guidelines and in developing and evaluating population oral-health policies.

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diseases and conditions globally and nationally. Consider research on noma's aetiology, prevention, therapy and rehabilitation, to contribute to more effective care and support the review process for including noma in WHO's list of neglected tropical diseases.

Action 91. **Translate oral health research findings into practice:** Ensure that dedicated funding is available for implementation and translation research. Evaluate population oral health policies. Apply evidence generated from innovative public health approaches, such as digital health technologies. Strengthen evidence-informed decision-making with the full participation of target populations. Develop country-specific, evidence-based clinical practice guidelines.

Actions for the WHO secretariat

Action 92. **Guide Member States in oral health research:** Provide Member States with guidance on research priority setting and partnerships. Promote implementation research focused on an integrative, life-course and public health approach to improve oral health, in coordination with the WHO Technical Advisory Group on NCD-related Research and Innovation.

Action 93. **Contribute to noma research:** Set up a platform for knowledge-sharing about noma. Initiate a research agenda on noma, in collaboration with WHO collaborating centres and academia. Support or conduct research to develop guidance for noma treatment, including a list of essential therapeutic agents and rehabilitation best practices.

Proposed actions for international partners

Action 94. **Promote equity in all aspects of global oral health research:** Support shared agenda setting for global oral health research, programme planning, implementation and evaluation. Foster equitable partnerships in priority-setting, methodological choices, research funding, project management, analysing and reporting results and authorship in scientific publication. Ensure equitable access to data, research results and publications, including reducing or eliminating fees to access information.

Action 95. **Facilitate reorientation of the oral health research agenda:** Support the prioritization of research on public health and population-based oral health interventions. Promote capacity building and training that meet the needs of new priorities for oral health research. Strengthen evidence on the prevalence and incidence of diseases and conditions of public health interest that may be under-researched, such as oro-facial clefts and noma.

Proposed actions for civil society organizations

Action 96. **Consider establishing a national oral health research alliance or task force:** Engage academia, research institutions, professional associations, the government, community representatives, patients and other stakeholders in such an

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initiative. Support alignment with and prioritization of the national oral health research agenda. Advocate for transparent reporting of research findings.

Action 97. **Ensure research alignment with national oral health priorities:** For academic and other relevant civil society organizations, review the research and science training curricula of academic and research institutions to assess whether they address public health, implementation research and national priorities. Promote oral health research priorities in relevant conferences and research forums.

Action 98. **Conduct participatory research to identify oral health needs and interventions:** When considering interventions for inclusion in essential oral health care packages and UHC, enlist the participation of diverse community members, including patients, people living with oral diseases and marginalized people. Establish patient public panels for prioritizing studies, design and management of research, data collection, analysis, reporting and dissemination of findings. Evaluate different approaches to social participation and community engagement to improve oral health, such as citizen forums.

Proposed actions for the private sector

Action 99. **Develop public–private partnerships for oral health research:** Strive to avoid or reduce real or perceived conflicts of interest and researcher bias in public–private research partnerships. Foster the public's interest in reforming oral health research agendas. Collaborate with the public sector and other stakeholders in research on digital oral health technologies. Disseminate essential public health research and results in open access platforms so that they are accessible to the public. Ensure low publication fees for low- and middle-income countries.

Action 100. **Invest in research for safe, environmentally sound, mercury-free dental filling materials:** Accelerate research and development of new mercury-free, safe and effective dental filling materials. Strengthen the production and trade of environmentally friendly and sustainable products and supplies.

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Monitoring implementation progress of the global oral health action plan

36. The monitoring framework will track the implementation of the Global Oral Health Action Plan by monitoring and reporting on progress towards the two overarching global targets and nine global targets related to the strategic objectives. The monitoring framework has 11 core indicators that will be used for global monitoring and reporting towards the 11 global targets (Appendix 1). The monitoring framework also has 29 complementary indicators that, according to their relevance, usefulness for decision-making and resources available, can be selected and used by countries to monitor specific actions at the national level (Appendix 2). Together, these 40 indicators can be used to prioritize efforts, monitor trends and assess progress on oral health within broader NCD and UHC agendas, based on global, regional, national and subnational contexts.

37. The monitoring framework of the Global Oral Health Action Plan is based on a results chain approach that visualizes the logical relations from inputs and processes to desired outputs, outcomes and impact, supported by evidence-informed policies. Its conceptual model draws on the results-chain framework in the WHO Primary Health Care Measurement Framework and Indicators as well as the monitoring approach of the WHO's Thirteenth General Programme of Work 2019–2023 to measure progress made towards programmatic milestones and the triple billion targets.

38. WHO will provide technical guidance to support countries with collecting and reporting data for the monitoring framework indicators. This guidance will detail the indicator specifications, including indicator definitions, detailed methods of calculation, disaggregation, data sources, data limitations and links for further information.

39. Annually, WHO will report back to the World Health Assembly on progress and results of the Global Oral Health Action Plan as part of the consolidated report on NCDs, in accordance with paragraph 3(e) of decision WHA72(11). Every three years (starting in 2024), WHO will submit a comprehensive report on progress on implementing the Global Oral Health Action Plan, including collation of data on the core indicators and progress achieved towards the global targets.

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Interesting Facts **36**

The Action Plan contains 11 global targets and 11 core indicators for monitoring progress. Countries can also select from 29 complementary indicators according to their circumstances and monitoring needs.

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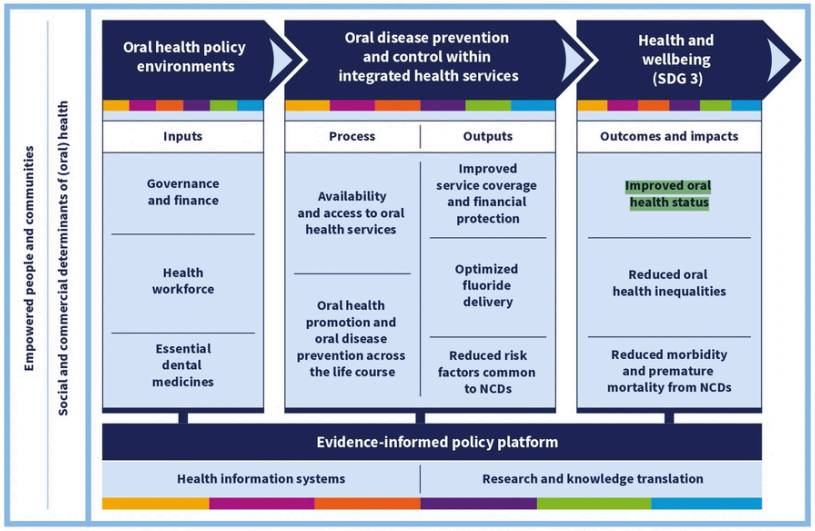
Appendix 1
Monitoring framework of the global oral health action plan

Appendix 1

Monitoring framework of the global oral health action plan

The monitoring framework of the Global Oral Health Action Plan will track implementation by monitoring and reporting on progress towards the two overarching global targets and nine global targets related to the strategic objectives. Tracking progress of oral health services as part of UHC by 2030 supports mobilization of political and resource commitment for stronger and more coordinated global action on oral health. A key to understanding how the indicators and strategic objectives align with the monitoring framework can be found in Fig. 1 and in Appendix 2.

Fig. 1 Monitoring framework of the Global Oral Health Action Plan



The monitoring framework of the Global Oral Health Action Plan outlines how inputs within the oral health policy environment contribute to the processes and outputs of oral disease prevention and control in integrated health services, which in turn lead to outcomes and impacts related to health and well-being. Key inputs of the monitoring framework are government and finance, the health workforce and essential dental medicines. Key processes are oral health promotion and oral disease prevention across the life course and availability and access to oral health services. Key outputs are improved service coverage and financial protection, optimized fluoride delivery and reduced risk factors common to NCDs. Key outcomes and impacts are improved oral health status, reduced oral health inequalities and reduced morbidity and premature mortality from NCDs.

The monitoring framework includes an evidence-informed policy platform that incorporates health information systems and research and knowledge translation to facilitate evidence-informed decision-making. This evidence-informed policy platform informs and is informed by the oral health policy environment, oral disease prevention and control within integrated health services, and health and well-being outcomes and impacts. The entire framework is grounded in empowered people and communities and the social and commercial determinants of oral health.

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Overview of indicators

The global monitoring framework identifies 11 core and 29 complementary indicators to track and monitor progress of implementation of the Global Oral Health Action Plan. As a priority, data on the **core indicators** (Table 1) should be collected in all countries using existing and/or new systems and resources. In addition, countries may use the **complementary indicators** (Appendix 2) to monitor other oral health data at the national level, as relevant to their specific contexts. Where possible, the monitoring framework indicators align with existing global, regional and national monitoring activities to minimize the reporting burden and avoid duplication of work.

During planning and implementation of oral health data collection, effort should be made to collect sociodemographic data across multiple dimensions (e.g., sex, age, socio-economic status, place of residence). This should allow for data disaggregation during analysis, assessment of oral health inequalities and dissemination of such findings to decision-makers to help them develop more equity-oriented oral health policies.

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Table 1. Overview of Global Oral Health Action Plan strategic objectives, global targets and core indicators

A-B	OVERARCHING GLOBAL TARGETS	
	Global target definition	**Core indicator**
Overarching global target A: Oral health services are part of UHC	**A.1.** By 2030, 80% of the global population is entitled to essential oral health care services.	**A.1.** Percentage of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes.
Overarching global target B: Reduced oral disease burden	**B.1.** By 2030, the combined global prevalence of the main oral diseases and conditions over the life course shows a relative reduction of 10%.	**B.1.** Prevalence of the main oral diseases and conditions.
1	**STRATEGIC OBJECTIVE 1: ORAL HEALTH GOVERNANCE**	
	Global target definition	**Core indicator**
Global target 1.1: National leadership for oral health	**1.1.** By 2030, 80% of countries have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agency.	**1.1.** Percentage of countries that have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agencies.
Global target 1.2: Environmentally sound oral health care	**1.2.** By 2030, 90% of countries have implemented measures to phase down the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out.	**1.2.** Percentage of countries that have implemented measures to phase down the use of dental amalgam as stipulated in the Minamata Convention on Mercury or that have phased it out.
2	**STRATEGIC OBJECTIVE 2: ORAL HEALTH PROMOTION AND ORAL DISEASE PREVENTION**	
	Global target definition	**Core indicator**
Global target 2.1: Policies to reduce free sugars intake	**2.1.** By 2030, 50% of countries implement policy measures aiming to reduce free sugars intake.	**2.1.** Percentage of countries that implement policy measures aiming to reduce free sugars intake.
Global target 2.2: Optimal fluoride for population oral health	**2.2.** By 2030, 50% of countries have national guidance on optimal fluoride delivery for oral health of the population.	**2.2.** Percentage of countries that have national guidance on optimal fluoride delivery for oral health of the population.

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3	STRATEGIC OBJECTIVE 3: HEALTH WORKFORCE	
	Global target definition	Core indicator
Global target 3: Innovative workforce model for oral health	**3.1.** By 2030, 50% of countries have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs.	**3.1.** Percentage of countries that have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs.

4	STRATEGIC OBJECTIVE 4: ORAL HEALTH CARE	
	Global target definition	Core indicator
Global target 4.1: Integration of oral health in primary care	**4.1.** By 2030, 80% of countries have oral health care services generally available in primary health care facilities.	**4.1.** Percentage of countries that have oral health care services generally available in primary health care facilities.
Global target 4.2: Availability of essential dental medicines	**4.2.** By 2030, 50% of countries include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list.	**4.2.** Percentage of countries that include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list (or equivalent guidance).

5	STRATEGIC OBJECTIVE 5: ORAL HEALTH INFORMATION SYSTEMS	
	Global target definition	Core indicator
Global target 5: Monitoring implementation of national oral health policy	**5.1.** By 2030, 80% of countries have a monitoring framework for the national oral health policy, strategy or action plan.	**5.1.** Percentage of countries that have a monitoring framework for the national oral health policy, strategy or action plan.

6	STRATEGIC OBJECTIVE 6: ORAL HEALTH RESEARCH AGENDAS	
	Global target definition	Core indicator
Global target 6: Research in the public interest	**6.1.** By 2030, 50% of countries have a national oral health research agenda focused on public health and population-based interventions.	**6.1.** Percentage of countries that have a national oral health research agenda focused on public health and population-based interventions.

Core indicators



OVERARCHING GLOBAL TARGET A: ORAL HEALTH SERVICES ARE PART OF UHC

By 2030, 80% of the global population is entitled to essential oral health care services.

Core indicator

A.1. Percentage of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes.

Monitoring framework output

Improved service coverage and financial protection.

Indicator definition

Percentage of population entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes. The term "largest" is defined as having the highest total population eligible to receive services. The term "government" is defined as including any public-sector scheme for health service provision, including coverage for groups such as the general population, public sector employees and/or the military.

Essential oral health interventions include, but are not limited to:

- routine and preventive oral health care (including oral health examination, counselling on oral hygiene with fluoride toothpaste, fluoride varnish application, glass ionomer cement as a sealant and early detection of oral cancer in high-risk groups, linked with timely diagnostic work-up and comprehensive cancer treatment, in settings with a significant disease burden)
- essential curative oral health care (including topical silver diamine fluoride, atraumatic restorative treatment, glass ionomer cement restoration and urgent treatment for emergency oral care and pain relief, such as non-surgical extractions and drainage of abscesses).

Numerator: number of people entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes.

Denominator: total global population listed in World Population Prospects by the United Nations Department of Economic and Social Affairs (UN DESA).

Data type

Percentage.

Preferred data source

WHO Health Technology Assessment/Health Benefit Package (HTA/HBP) Survey.

Baseline

The percentage of the global population entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes is 23%.

Data sources: HTA/HBP 2020–21 survey and the World Population Prospects by UN DESA 2020.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator were collected by WHO in 2020/21 using the global HTA/HBP Survey. The questionnaire was completed by officially nominated survey focal points in WHO Member States and areas. It is anticipated that minor adjustments to the existing collection tool will be required for reporting on this indicator.

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OVERARCHING GLOBAL TARGET B: REDUCED ORAL DISEASE BURDEN

By 2030, the combined global prevalence of the main oral diseases and conditions over the life course shows a relative reduction of 10%.

Core indicator

B.1. Prevalence of the main oral diseases and conditions.

Monitoring framework outcome and impact

Improved oral health status.

Indicator definition

Estimated prevalence of the main oral diseases and conditions as defined by the Global Burden of Disease (GBD) study. The main oral diseases and conditions include:

- untreated dental caries of deciduous teeth
- untreated dental caries of permanent teeth
- edentulism
- severe periodontal disease
- other oral disorders (excluding lip and oral cavity cancer and orofacial clefts).

Data type

Percentage.

Preferred data source

The Institute for Health Metrics and Evaluation (IHME) GBD database.

Baseline

The prevalence of the major oral diseases combined is 45%.
Data source: IHME GBD 2019 database.

Years for data collection

2023, 2026, 2029/2030.

Comments

Estimates for this indicator are provided in the IHME GBD database. The GBD 2019 estimates are based on multiple relevant data sources, such as national oral health surveys. To improve the quality of GBD estimations and for national planning, countries are encouraged to conduct population-based oral health surveys or other appropriate surveillance specific to oral diseases, integrated with existing NCD surveillance systems. The WHO Global Oral Health Status Report uses the latest data available from GBD 2019.

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STRATEGIC OBJECTIVE 1: ORAL HEALTH GOVERNANCE



GLOBAL TARGET 1.1: NATIONAL LEADERSHIP FOR ORAL HEALTH

By 2030, 80% of countries have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agency.

Core indicator

1.1. Percentage of countries that have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agencies.

Monitoring framework input

Governance and finance.

Indicator definition

Percentage of countries that have an operational national policy, strategy or action plan for oral health available and technical/professional staff in the unit/branch/department working on NCDs at the Ministry of Health (or other national governmental health agencies) dedicating a significant portion of their time to oral health, such as a Chief Dental Officer.

Achievement criteria for indicator:

1. Fully achieved: The country reports it has both:
   - an operational policy, strategy or action plan for oral health – if the policy, strategy or action plan expiration date has been reached or is not clearly stated (e.g., ongoing), it would only be considered a "positive response" if it has been updated within the last five years; and
   - technical/professional staff in the NCD unit/branch/department dedicating a significant proportion of their time to oral health.
2. Partially achieved: The country reports it has one of the two criteria.
3. Not achieved: The country reports it has neither of the two criteria.
4. No information: Data are not reported by the country.

Data type

Percentage.

Preferred data source

WHO NCD Country Capacity Survey (CCS).

Baseline

The percentage of countries that have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health is 31% (61 out of 194).

Data source: NCD CCS 2021 survey results.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator have been periodically collected and regularly reported by WHO through the WHO NCD CCS. The questionnaire is completed by national NCD focal points or designated officers within the Ministry of Health or national institute/agency. It is anticipated that minor adjustments to the existing data collection tool will be required for reporting on this indicator.

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GLOBAL TARGET 1.2: ENVIRONMENTALLY SOUND ORAL HEALTH CARE

By 2030, 90% of countries have implemented measures to phase down the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out.

Core indicator

1.2. Percentage of countries that have implemented measures to phase down the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out.

Monitoring framework input

Governance and finance.

Indicator definition

Percentage of countries that have implemented measures to phase down the use of dental amalgam in accordance with the provisions of the Minamata Convention on Mercury and decisions made by the Conference of the Parties or have phased it out.

Achievement criteria for indicator:

1. Fully achieved: The country reports implementation of option (a) or option (b) as follows:
   Option (a) The country is still using dental amalgam and has implemented all three of the following requirements to phase down the use of dental amalgam:*
   - excluded or not allowed, by taking measures as appropriate, the use of mercury in bulk form by dental practitioners; and
   - excluded or not allowed, by taking measures as appropriate, or recommended against the use of dental amalgam for the dental treatment of deciduous teeth, of patients under 15 years and of pregnant and breastfeeding women, except when considered necessary by the dental practitioner based on the needs of the patient; and
   - Implemented two or more of the measures from the following list (taking into account the country's domestic circumstances and relevant international guidance):
     i. Setting national objectives aiming at dental caries prevention and health promotion, thereby minimizing the need for dental restoration;
     ii. Setting national objectives aiming at minimizing its use;
     iii. Promoting the use of cost-effective and clinically effective mercury-free alternatives for dental restoration;
     iv. Promoting research and development of quality mercury-free materials for dental restoration;
     v. Encouraging representative professional organizations and dental schools to educate and train dental professionals and students on the use of mercury-free dental restoration alternatives and on promoting best management practices;
     vi. Discouraging insurance policies and programmes that favour dental amalgam use over mercury-free dental restoration;
     vii. Encouraging insurance policies and programmes that favour the use of quality alternatives to dental amalgam for dental restoration;
     viii. Restricting the use of dental amalgam to its encapsulated form;
     ix. Promoting the use of best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land.

   Option b) Phased out dental amalgam: Country does not use dental amalgam and does not allow its manufacture, import or export.
2. Partially achieved: The country reports using dental amalgam but has implemented only one or two of the requirements to phase down its use.
3. Not achieved: The country reports using dental amalgam but has not implemented any of the requirements to phase down its use.
4. No information: Data are not reported by the country.

**As of 2022, this is aligned with the dental amalgam provisions of the Minamata Convention on Mercury.*

Data type

Percentage.

Preferred data source

Reports submitted by Parties to the Secretariat of the Minamata Convention on Mercury; data obtained from non-Parties to the Convention through WHO consultation in preparation for the Conference of the Parties of the Convention.

Baseline

Baseline partially available:
The percentage of countries that have implemented two or more of the recommended measures to phase down dental amalgam in line with the Minamata Convention on Mercury or have phased it out is 43% (83 out of 194).

Data source: 2021 Full National Reports submitted to the Minamata Convention on Mercury.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator were collected by reviewing reports submitted in 2021 to the Secretariat of the Minamata Convention on Mercury. The indicator has been defined so that it is relevant for all countries, including Parties and non-Parties to the Minamata Convention on Mercury. It is anticipated that adjustments to the existing data collection tool will be required for reporting on this indicator.

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STRATEGIC OBJECTIVE 2: ORAL HEALTH PROMOTION AND ORAL DISEASE PREVENTION



GLOBAL TARGET 2.1: POLICIES TO REDUCE FREE SUGARS INTAKE

By 2030, 50% of countries implement policy measures aiming to reduce free sugars intake.

Core indicator

2.1. Percentage of countries that implement policy measures aiming to reduce free sugars intake.

Monitoring framework process

Oral health promotion and oral disease prevention across the life course.

Indicator definition

Percentage of countries that implement policy measures* aiming to reduce free sugars intake. Measures include:

- nutrition labelling: front-of-pack or other interpretative labelling to inform about sugars content, including mandatory declaration of sugars content on pre-packaged food
- reformulation limits or targets to reduce sugars content in foods and beverages
- public food procurement and service policies to reduce offering food high in sugars
- policies to protect children from the harmful impact of food marketing, including for foods and beverages high in sugars
- taxes on sugar-sweetened beverages (SSBs) and on sugars or foods high in sugars.

Achievement criteria for indicator

1. Fully achieved: The country reports it has implemented mandatory policy measures to reduce free sugars intake (as captured by scores 3 or 4 on the WHO Sugars Country Score Card).
2. Partially achieved: When the country reports it has:
   - implemented voluntary policy measures to reduce free sugars intake (as captured by score 2 on the WHO Sugars Country Score Card); and/or
   - implemented national-level SSB taxes.
3. Not achieved: The country reports it has not implemented any policy measures (listed in the achievement criteria) to reduce free sugars intake.
4. No information: Data are not reported by the country.

**Policy measures are stated in the WHO Sugars Country Score Card and the summary of SSB taxation of the Global database on the Implementation of Nutrition Action (GINA) and the updated Appendix 3 of the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2030.*

Data type

Percentage.

Preferred data source

GINA; forthcoming WHO data on the price and tax of SSBs.

Baseline

The percentage of countries that have implemented mandatory policy measures aiming to reduce free sugars intake (as captured by scores 3 or 4 on the WHO Sugars Country Score Card) is 20%.

Data source: GINA, accessed 11 October 2022.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator will be periodically collected and regularly reported by WHO through GINA.

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GLOBAL TARGET 2.2: OPTIMAL FLUORIDE FOR POPULATION ORAL HEALTH

By 2030, 50% of countries have national guidance on optimal fluoride delivery for oral health of the population.

Core indicator

2.2. Percentage of countries that have national guidance on optimal fluoride delivery for oral health of the population.

Monitoring framework output

Optimized fluoride delivery.

Indicator definition

Percentage of countries that have national guidance related to fluorides for oral health of the population that addresses the universal availability of systemic or topical fluorides. Depending on the country context, this includes consideration of addition or removal of fluoride from drinking water to provide safe and optimal levels for prevention of dental caries.

Fluoride delivery methods may include, but are not limited to:

- topical fluorides: self-applied (e.g., fluoride toothpaste) and professionally applied (e.g. fluoride gels or foams, fluoride varnish, silver diamine fluoride)
- systemic fluorides (e.g., water fluoridation)
- defluoridation methods in fluorosis-endemic areas.

The national guidance should include the optimum levels of fluoride concentration for the delivery method(s).

Data type

Percentage.

Preferred data source

Government representative at the Ministry of Health; government databases.

Baseline

To be established through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator have not been collected or reported in the past by WHO. Oral health policies are available in the WHO NCD document repository, with some policies containing guidance on optimal fluoride delivery. Data will be collected through an updated version of the existing WHO NCD CCS.

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STRATEGIC OBJECTIVE 3. HEALTH WORKFORCE



GLOBAL TARGET 3: INNOVATIVE WORKFORCE MODEL FOR ORAL HEALTH

By 2030, 50% of countries have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs.

Core indicator

3.1. Percentage of countries that have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs.

Monitoring framework input

Health workforce.

Indicator definition

Percentage of countries that have an operational national health workforce policy, plan or strategy and whether a workforce trained to respond to population oral health needs is included in the strategy.

Workforce trained and legally permitted to respond to the oral health needs of all population groups may include:

- oral health professionals (e.g. dentists, dental assistants, dental therapists, dental hygienists, dental nurses and dental prosthetic technicians)
- other primary health care workers, including community health workers.

Data type

Percentage.

Preferred data source

Government/Ministry of Health; government databases.

Baseline

To be established through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator have not been collected or reported in the past by WHO. Data will be collected through an updated version of the WHO NCD CCS, informed by the Global Strategy on Human Resources for Health: Workforce 2030 and the National Health Workforce Accounts Module 9 on governance and health workforce policies.

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STRATEGIC OBJECTIVE 4. ORAL HEALTH CARE

GLOBAL TARGET 4.1: INTEGRATION OF ORAL HEALTH IN PRIMARY CARE

By 2030, 80% of countries have oral health care services generally available in primary health care facilities.

Core indicator

4.1. Percentage of countries that have oral health care services generally available in primary health care facilities.

Monitoring framework process

Availability and access to oral health services.

Indicator definition

Percentage of countries with procedures for detecting, managing and treating oral diseases that are generally available in primary health care facilities (public and/or other sectors).
"Generally available" refers to reaching 50% or more of patients in need whereas "generally not available" refers to reaching less than 50% of patients in need.

Achievement criteria for indicator:

1. Fully achieved: The country reports that all of the following oral health care services are generally available in primary health care facilities (public and/or other sectors):
   - oral health screening for early detection of oral diseases
   - urgent treatment for emergency oral care and pain relief
   - basic restorative dental procedures to treat existing dental decay.
2. Partially achieved: The country reports that one or two of the oral health care services above are generally available in primary health care facilities.
3. Not achieved: The country reports that no oral health care services are generally available in primary health care facilities.
4. No information: Data are not reported by the country.

Data type

Percentage.

Preferred data source

WHO NCD CCS.

Baseline

Baseline partially available:
The percentage of countries that have procedures for detecting, managing and treating oral diseases in primary care facilities of the public health sector is 58% (113 out of 194).

Data source: WHO NCD CCS 2021 survey results.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator were collected by WHO in 2021 through the existing global survey WHO NCD CCS. The questionnaire is completed by national NCD focal points or designated officers within the Ministry of Health or another national institute/agency. It is anticipated that minor adjustments to the existing data collection tool will be required for reporting on this indicator.

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GLOBAL TARGET 4.2: AVAILABILITY OF ESSENTIAL DENTAL MEDICINES

By 2030, 50% of countries include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list.

Core indicator

4.2. Percentage of countries that include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list (or equivalent guidance).

Monitoring framework input

Essential dental medicines.

Indicator definition

Percentage of countries that include dental preparations in the WHO Model Lists of Essential Medicines (Essential Medicines List and Essential Medicines List for Children) in their national essential medicines list (or equivalent guidance).

Achievement criteria for indicator:

1. Fully achieved: The country reports that all of the following dental preparations are included in the national essential medicines list or equivalent guidance:
   - paste, cream or gel containing between 1000 and 1500 ppm fluoride (any type)
   - glass ionomer cement
   - silver diamine fluoride.
2. Partially achieved: The country reports that one or two of these dental preparations are included in the national essential medicines list or equivalent guidance.
3. Not achieved: The country reports that none of these dental preparations are included in the national essential medicines list or equivalent guidance.
4. No information: Data are not reported by the country.

Data type

Percentage.

Preferred data source

Government/Ministry of Health (oral health officer/essential medicines unit).

Baseline

Baseline partially available:
The percentage of countries that include fluoride in their national essential medicines list is 21% (40 out of 194).

Data source: Global Essential Medicines Database 2017.

Baseline is subject to change to incorporate additional data that will be shared by Member States through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator will be collected through an updated version of the WHO NCD CCS in collaboration with the WHO department of health products, policies and standards. Dental preparations were added to the WHO Model Lists of Essential Medicines in 2021.

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STRATEGIC OBJECTIVE 5. ORAL HEALTH INFORMATION SYSTEMS



GLOBAL TARGET 5: MONITORING IMPLEMENTATION OF NATIONAL ORAL HEALTH POLICY

By 2030, 80% of countries have a monitoring framework for the national oral health policy, strategy or action plan.

Core indicator

5.1. Percentage of countries that have a monitoring framework to track progress on implementation of the national oral health policy, strategy or action plan.

Monitoring framework policy platform

Health information systems.

Indicator definition

Percentage of countries that have a monitoring framework to track progress on implementation of the national oral health policy, strategy or action plan.

Achievement criteria for indicator:

1. Fully achieved: The country reports it has a national monitoring framework for the national oral health policy, strategy or action plan that meets the following criteria:
   - includes a set of indicators with baselines and targets based on the national oral health policy, strategy or action plan
   - specifies data collection methods and reporting of key indicators using existing and/or new health information systems
   - aligns with the monitoring framework of the Global Oral Health Action Plan by being able to report on the core indicators.
2. Partially achieved: The country reports it has a national monitoring framework for the national oral health policy, strategy or action plan, but it does not fully meet the achievement criteria.
3. Not achieved: The country reports it does not have a national monitoring framework for the national oral health policy, strategy or action plan.
4. No information: Data are not reported by the country.

Data type

Percentage.

Preferred data source

Routine health information system; government representative at the Ministry of Health (oral health officer/oral health unit).

Baseline

To be established through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator have not been collected or reported in the past by WHO. Oral health policies available in the WHO NCD Document Repository could be explored to inform this indicator. Data will be collected through an updated version of the existing WHO NCD CCS.

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STRATEGIC OBJECTIVE 6. ORAL HEALTH RESEARCH AGENDAS



GLOBAL TARGET 6: RESEARCH IN THE PUBLIC INTEREST

By 2030, 50% of countries have a national oral health research agenda focused on public health and population-based interventions.

Core indicator

6.1. Percentage of countries that have a national oral health research agenda focused on public health and population-based interventions.

Monitoring framework policy platform

Research and knowledge translation.

Indicator definition

Percentage of countries that have a national oral health research agenda that focuses on public health programmes and population-based interventions.

Examples of a national oral health research agenda include:

- a list of oral health research priorities in the country
- guidance on research focus
- a specific research component in the national oral health policy
- a specific oral health research component in the national research agenda.

Data type

Percentage.

Preferred data source

Ministry of Health; national and sub-national government health research agencies.

Baseline

To be established through the first data collection process.

Years for data collection

2023, 2026, 2029/2030.

Comments

Data for this indicator have not been collected or reported in the past by WHO. Oral health policies available in the WHO NCD Document Repository could be explored to inform this indicator. Data will be collected through an updated version of the WHO NCD CCS.

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Appendix 2
Complementary indicators

Appendix 2

Complementary indicators

A	OVERARCHING GLOBAL TARGET A: ORAL HEALTH SERVICES ARE PART OF UHC
Complementary indicator	**A.2.** Prevalence of unmet oral health needs and reason for unmet needs.
Monitoring framework output	Improved service coverage and financial protection.
Indicator definition	Percentage of the population unable to obtain oral health care when they perceive the need. Reasons for unmet oral health care needs include financial (too expensive), transportation/geographic (too far to travel) and timeliness (long waiting lists). *This indicator must be tracked at the same time as indicators A.3 and A.4.* Data type: Percentage, by reason (financial, transportation/geographic and timeliness).
Complementary indicator	**A.3.** Out-of-pocket payment for oral health care services, US$ per capita.
Monitoring framework output	Improved service coverage and financial protection.
Indicator definition	Out-of-pocket payments for oral health care services are any direct payments made by a household at the point of using any oral health care service provided by any type of provider. Out-of-pocket payments include formal co-payments (user charges or user fees) for covered goods and services, formal payments for the private purchase of goods and services and informal payments for covered or privately purchased goods and services. They exclude pre-payment (e.g., taxes, contributions or premiums) and reimbursement of the household by a third party, such as the government, a health insurance fund or a private insurance company. *This indicator must be tracked at the same time as indicators A.2 and A.4.* Data type: Money.
Complementary indicator	**A.4.** Percentage of catastrophic health spending due to outpatient oral health care services.
Monitoring framework output	Improved service coverage and financial protection.
Indicator definition	Percentage of out-of-pocket payments dedicated to oral health care among people incurring catastrophic health spending. *This indicator must be tracked at the same time as indicators A.2 and A.3.* Data type: Percentage.

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B	OVERARCHING GLOBAL TARGET B: REDUCED ORAL DISEASE BURDEN
Complementary indicator	**B.2.** Mean number of decayed, missing due to caries and filled teeth (DMFT) in the permanent teeth in the population.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	At the individual level, DMFT is the sum of the number of decayed, missing due to caries and filled teeth in the permanent teeth. The mean number of DMFT is the sum of individual DMFT values divided by the sum of the population. Data type: Count.
Complementary indicator	**B.3.** Pulp, ulceration, fistula and abscess (PUFA) index.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	The PUFA index qualifies and quantifies the systemic consequences of severe dental caries in deciduous and permanent teeth. The index can be used as a stand-alone indicator for the severity of dental caries or in addition to other indices, such as DMFT. Data type: Count.
Complementary indicator	**B.4.** Prevalence of untreated caries of deciduous teeth in children.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated prevalence of untreated caries of deciduous teeth in children: the percentage of children who have untreated caries in one or more deciduous teeth. “Untreated caries” is defined as a lesion in a pit or fissure or on a smooth tooth surface, that has an unmistakable cavity, undermined enamel or a detectably softened floor or wall (coronal caries) or feels soft or leathery to probing (root caries). Data type: Percentage.
Complementary indicator	**B.5.** Prevalence of untreated caries of permanent teeth.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated prevalence of untreated caries of permanent teeth in people: the percentage of persons with one more carious permanent teeth. “Untreated caries” is defined as a lesion in a pit or fissure or on a smooth tooth surface, that has an unmistakable cavity, undermined enamel or a detectably softened floor or wall (coronal caries) or feels soft or leathery to probing (root caries). Data type: Percentage.

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Complementary indicator	**B.6.** Prevalence of severe periodontal disease.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated prevalence of severe periodontal disease in people: The percentage of persons affected by severe periodontal disease, a chronic inflammation of the soft and hard tissues that support and anchor the teeth. Severe periodontal disease is defined as a gingival pocket depth equal to or more than 6 mm or a Community Periodontal Index of Treatment Needs (CPITN); also referred to as Community Periodontal Index (CPI) score of 4 or a clinical attachment loss (CAL) of more than 6 mm. Data type: Percentage.
Complementary indicator	**B.7.** Prevalence of edentulism.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated prevalence of edentulism in people: the percentage of persons with complete loss of natural teeth. Data type: Percentage.
Complementary indicator	**B.8.** Incidence rate of oral cancer (lip and oral cavity cancer).
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated incidence rate of lip and oral cavity cancer per 100 000 population: age-standardized incidence rates of lip and oral cavity cancer as defined by ICD-10 C00-C06 or ICD-11 2B60-2B66, in females, males and the total population (all ages) per 100 000 population. Data type: Rate.
Complementary indicator	**B.9.** Prevalence of orofacial clefts.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Estimated prevalence of orofacial clefts in people. Percentage of any livebirths with isolated cleft lip, isolated cleft palate or combined cleft lip and cleft palate resulting from the tissues of the face not joining properly during foetal development. Data type: Percentage.

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Complementary indicator	**B.10.** Self-reported oral health status.
Monitoring framework outcome and impact	Improved oral health status.
Indicator definition	Percentage of population who reported a problem, including functional limitation, because of the state of their teeth, gums or mouth. Problems include but are not limited to: • difficulty in chewing foods • difficulty in swallowing water • difficulty with speech or trouble pronouncing words • mouth feeling dry • avoiding smiling • days not at work or school because of teeth or mouth. Data type: Percentage.

1	STRATEGIC OBJECTIVE 1. ORAL HEALTH GOVERNANCE
Complementary indicator	**1.3.** Per capita government expenditure on oral health care.
Monitoring framework input	Governance and finance.
Indicator definition	Domestic general government expenditure per capita on oral health care. Data type: Money.
Complementary indicator	**1.4.** Per capita total expenditure on oral health care.
Monitoring framework input	Governance and finance.
Indicator definition	Estimate of the annual national per capita total expenditure on oral health care. Oral health care expenditure is calculated as dental outpatient curative care, such as visits for regular control and other oral treatment (based on data from a System of Health Accounts 2011 [SHA2011:4]). Data type: Money, by source of funding (domestic general government health expenditure ([GGHE-D], private or external).
Complementary indicator	**1.5.** Oral health integration into community-based programmes.
Monitoring framework input	Governance and finance.
Indicator definition	Oral health integration into community-based programmes that serve targeted populations, such as programmes set in schools, workplaces, aged care facilities and outreach programmes. Data type: Categorical (Yes/No, by programme) or percentage (by programme).
Complementary indicator	**1.6.** Noma recognized as a national public health problem.
Monitoring framework input	Governance and finance.
Indicator definition	Noma (cancrum oris) is a noncommunicable necrotizing disease that starts as a lesion of the gums inside the mouth and destroys the soft and hard tissues of the mouth and face. Countries in the WHO African Region are part of the Regional Noma Control Programme and recognize noma as a national public health problem. Data type: Categorical (Yes/No).

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2	STRATEGIC OBJECTIVE 2: ORAL HEALTH PROMOTION AND ORAL DISEASE PREVENTION
Complementary indicator	**2.3.** Percentage of population using fluoride toothpaste on a daily basis.
Monitoring framework output	Optimized fluoride delivery.
Indicator definition	Percentage of the population cleaning or brushing daily with fluoride toothpaste. The recommended fluoride concentration of toothpaste is between 1000 and 1500 ppm for all age groups. Current recommendations for young children are a "smear/rice-sized" amount for children younger than 3 years and a "pea-sized" amount for children older than 3 years. Data type: Percentage.
Complementary indicator	**2.4.** Per capita availability of sugar (grams/day).
Monitoring framework output	Reduced risk factors common to NCDs.
Indicator definition	Per capita availability of sugar (grams/day): The availability of sugar is based on sugar (raw equivalent), including: (a) raw cane or beet sugar; (b) cane sugar, centrifugal; (c) beet sugar; (d) refined sugar; and (e) sugar confectionery for national consumption and then computed as grams available per person and day. Data type: Count.
Complementary indicator	**2.5.** Prevalence of current tobacco use among persons aged 15 years and older.
Monitoring framework output	Reduced risk factors common to NCDs.
Indicator definition	Percentage of the population aged 15 years and older who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis (age-standardized rate). Data type: Percentage.
Complementary indicator	**2.6.** Per capita alcohol consumption among persons aged 15 years and older (litres of pure alcohol per year).
Monitoring framework output	Reduced risk factors common to NCDs.
Indicator definition	Per capita total alcohol consumption among persons aged 15 years and older (litres of pure alcohol per year). The total alcohol per capita consumption comprises both the recorded and the unrecorded alcohol per capita consumption. Data type: Rate.

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Complementary indicator	**2.7.** Prevalence of current betel-quid and areca-nut use among persons aged 15 years and older.
Monitoring framework output	Reduced risk factors common to NCDs.
Indicator definition	Percentage of the population aged 15 years and older who currently chew betel quid at least three days per week. Data type: Percentage.
Complementary indicator	**2.8.** National policy or legislation to restrict all forms of tobacco consumption.
Monitoring framework output	Oral health promotion and oral disease prevention across the life course.
Indicator definition	State Parties to the WHO Framework Convention on Tobacco Control with complete policies on MPOWER measures. These are defined in the WHO Report of the Global Tobacco Epidemic 2021 (page 23) as follows: • smoke-free environments: all public places completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation) • cessation programmes: national quit line and both nicotine replacement therapy and some cessation services (cost-covered). • pack warnings: large warnings with all appropriate characteristics. • mass media: national campaign conducted with at least seven appropriate characteristics, including airing on television and/or radio. • advertising bans: ban on all forms of direct and indirect advertising (or at least 90% of the population covered by subnational legislation completely banning tobacco advertising, promotion and sponsorship). • taxation: 75% or more of the retail price is tax. Data type: Categorical (Yes/No, by measure).

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3	STRATEGIC OBJECTIVE 3. HEALTH WORKFORCE
Complementary indicator	**3.2.** Density of active oral health personnel per 10,000 population.
Monitoring framework input	Health workforce.
Indicator definition	Total active oral health personnel density per 10 000 population: (a) dentists; (b) dental assistants and therapists, dental hygienists and dental nurses; and (c) dental prosthetic technicians. An "active" oral health worker is defined as one who provides services to patients and communities ("practising health worker") or whose oral health education is a prerequisite for the execution of the job (e.g., education, research, public administration), even if the oral health worker is not directly providing services ("professionally active health worker"). If data are not available for practicing or professionally active health workers, data with the closest definition can be used, such as "health worker licensed to practise". Data type: Rate (density).
Complementary indicator	**3.3.** Trained primary health care workers (including community health care workers) can perform essential oral health interventions.
Monitoring framework input	Health workforce.
Indicator definition	"Yes" response to the question "Can trained primary health care workers (other than oral health personnel) perform essential oral health interventions in your country?" Primary health care workers include community health care workers. Training can include both preservice education (prior to and as a prerequisite for employment in a service setting, such as during undergraduate training) and in-service education (for persons already employed in a service setting, such as part of continuing professional development). Data type: Categorical (Yes/No).

4	STRATEGIC OBJECTIVE 4. ORAL HEALTH CARE
Complementary indicator	**4.3.** Percentage of population that visits an oral health care professional.
Monitoring framework process	Availability and access to oral health services.
Indicator definition	Percentage of the population that visited an oral health care professional within a certain period of time. Data type: Percentage.
Complementary indicator	**4.4.** Technical guidance on the prescription of antibiotics for use in oral health care.
Monitoring framework input	Essential dental medicines.
Indicator definition	Technical guidance on the prescription of antibiotics for use in oral health care. Data type: Categorical (Yes/No.)

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5	STRATEGIC OBJECTIVE 5. ORAL HEALTH INFORMATION SYSTEMS
Complementary indicator	**5.2.** Oral health data collected using WHO survey tools or through a national oral health survey, across the life course.
Monitoring framework policy platform	Health information systems.
Indicator definition	Country has collected oral health data across the life course in the last five years using any of the following survey tools: • WHO survey tool (e.g., the Oral Health Module of the WHO STEPwise approach to NCD risk factor surveillance, or STEPS) • national oral health survey (using or not using digital technology). Data type: Categorical (Yes/No, by survey tool).
Complementary indicator	**5.3.** Integration of oral health indicators into routine health information systems.
Monitoring framework policy platform	Health information systems.
Indicator definition	Country has integrated oral health and oral health care indicators into routine health information systems to periodically monitor health service performance. Routine health information systems regularly collect and report data from health facilities on routine health service activities and health conditions. These data are reported on a regular basis from health facilities and should be aggregated and utilized at the district, provincial and national levels to support evidence-informed decision-making. Data type: Categorical (Yes/No).

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6	STRATEGIC OBJECTIVE 6. ORAL HEALTH RESEARCH AGENDAS
Complementary indicator	**6.2.** Percentage of government funds for oral health research.
Monitoring framework policy platform	Research and knowledge translation.
Indicator definition	Percentage of public funds for health research that are allocated for oral-health-related research. Data type: Percentage.

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Annex 1
Global strategy on oral health
WHA75(11)

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World health assembly

Global Strategy on Oral Health WHA75(11)

Background

1. Recognizing the global public health importance of major oral diseases and conditions, in May 2021 the World Health Assembly adopted resolution WHA74.5 on oral health and requested the Director-General to develop, in consultation with Member States, a draft global strategy on tackling oral diseases. 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, in particular SDG Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and SDG target 3.8 on achieving UHC. They are aligned with the WHO's Thirteenth General Programme of Work, 2019–2023; the political declaration of high-level meeting on universal health coverage adopted by the United Nations General Assembly in 2019; the Operational Framework for Primary Health Care of 2020; the Global Strategy on Human Resources for Health: Workforce 2030 of 2016; the NCD-GAP; the WHO Framework Convention on Tobacco Control adopted in 2003; resolution WHA74.16 (2021) on social determinants of health; decision WHA73(12) (2020) on the Decade of Healthy Ageing 2020–2030; and resolution 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 state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential.

Oral disease burden

4. Globally, there were estimated to be more than 3.5 billion cases of oral diseases and other oral conditions in 2017, most of which are preventable.[1] 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.

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.[2] Noma is a noncommunicable necrotizing disease that typically occurs in young children living in extreme poverty. Noma starts as a lesion of the gums inside the mouth and destroys the soft and hard tissues of the mouth and face;

[1] Bernabe GE, Marcenes W, Hernandez CR, Bailey J, Abreu LG, Alipour V, et al. Global, Regional, and National Levels and Trends in Burden of Oral Conditions from 1990 to 2017: A Systematic Analysis for the Global Burden of Disease 2017 Study J Dent Res. 2020;99(4):362-373. doi: 10.1177/0022034520908533.

[2] Lip, oral cavity. International Agency for Research on Cancer fact sheet. Geneva: World Health Organization (https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf, accessed 1 December 2021).

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it is fatal for as many as 90% of affected children.[3] Orofacial clefts, the most common craniofacial birth defect, have a global prevalence of approximately 1 in 1000–1500 births with wide variation in different studies and populations.[4,5] Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting more than 1 billion people.[6]

6. Oral diseases often have comorbidity with other noncommunicable diseases. Evidence has shown an association between oral diseases, particularly periodontal disease, and a range of other noncommunicable diseases, such as diabetes and cardiovascular disease.

Social, economic and environmental costs of poor oral health

7. The personal consequences of untreated oral diseases and conditions – including physical symptoms, functional limitations, stigmatization and detrimental impacts on emotional, economic and social well-being – are severe and can affect families, communities and the wider health care system. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burdens.

8. High out-of-pocket payments and catastrophic health expenditure associated with oral health care often lead people not to seek care when needed. Worldwide, in 2015 oral diseases and conditions accounted for an estimated US$ 357 billion in direct costs (such as treatment expenditures) and US$ 188 billion in indirect costs (such as productivity losses due to absence from work or school), with large differences between high-, middle- and low-income countries.[7]

9. There is a strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions.[8,9] 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; older people living alone or in care homes; people who are refugees, in prison or living in remote and rural communities; and people from minority and/or other socially marginalized groups.

10. The environmental impact of the oral health care system is a great concern, as shown in the Minamata Convention on Mercury, a global treaty that obliges parties to implement measures to phase down the use of dental amalgam, which contains 50% mercury. Other environmental challenges related to oral health care include the use of natural resources, such as energy and water; the use of safe and environmentally sound dental material and oral care products; and sustainable waste management.

[3] Information brochure for early detection and management of noma. World Health Organization. Regional Office for Africa. 2017.

[4] Birth defects surveillance. A manual for programme managers. Geneva: World Health Organization; 2020.

[5] Salari N, Darvishi N, Heydari M, Bokaee S, Darvishi F, Mohammadi M. Global prevalence of cleft palate, cleft lip and cleft palate and lip: A comprehensive systematic review and meta-analysis. J Stomatol Oral Maxillofac Surg. 2021;S2468-7855(21)00118X. doi:10.1016/j.jormas.2021.05.008.

[6] Petti, S, Glendor U, Andersson L. World traumatic dental injury prevalence and incidence, a meta-analysis – One billion living people have had traumatic dental injuries. Dent Traumatol. 2018 Apr;34(2):71-86. doi: 10.1111/edt.12389.

[7] Righolt AJ, Jevdjevic M, Marcenes W, Listl S. Global-, Regional-, and Country-Level Economic Impacts of Dental Diseases in 2015. J Dent Res. 2018;97(5):501-507. doi: 10.1177/0022034517750572.

[8] Peres MA, Macpherson LMD, Weyant RJ, Daly D, Venturelli R, Mathur MR, et al. Oral diseases: a global public health challenge. Lancet. 2019;394(10194):249-260. doi: 10.1016/S0140-6736(19)31146-8.

[9] Matsuyama Y, Jürges H, Listl S. The Causal Effect of Education on Tooth Loss: Evidence From United Kingdom Schooling Reforms. Am J Epidemiol. 2019;188(1):87-95. doi: 10.1093/aje/kwy205.

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Social and commercial determinants and risk factors of oral health

11. Oral diseases and conditions and oral health inequalities are directly influenced by social and commercial determinants. The social determinants of oral health are the structural, social, economic and political drivers of oral diseases and conditions in society. The commercial determinants of oral health are the strategies used by some actors in the private sector to promote products and choices that are detrimental to health.

12. Oral diseases and conditions share risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease, diabetes and mental health conditions. These risk factors include both smoking and smokeless tobacco, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papillomavirus for oropharyngeal cancers.

13. Modifiable risk factors for cleft lip and palate include maternal active or passive tobacco smoking, while those for traumatic dental injury include alcohol use, traffic accidents and sports injuries. The aetiology of noma is unknown but its risk factors include malnutrition; coinfections; vaccine-preventable diseases; poor oral hygiene; and poor living conditions, such as deficiencies in water, sanitation and hygiene.

Oral health promotion and oral disease prevention

14. Only rarely have oral health promotion and oral disease prevention efforts targeted the social and commercial determinants of oral health at the population level. Moreover, oral health promotion and oral disease prevention are not typically integrated in other noncommunicable disease programmes that share major common risk factors and social determinants. In 2015, the WHO guideline on sugars intake for adults and children made the strong recommendation to reduce the intake of free sugars throughout the life course based on the evidence of direct associations between the intake of free sugars and body weight and dental caries. Nonetheless, public health initiatives to reduce sugar consumption are rare.

15. Initiatives that address upstream determinants can be cost-effective and have a high population reach and impact. Upstream strategies to reduce the intake of free sugars and the use of tobacco and alcohol include policies, taxes and/or regulation of the price, sale and advertisement of unhealthy products. Midstream policy interventions include creating more supportive conditions in key settings, such as educational settings, schools, workplaces and care homes.

16. Millions of people do not have access to oral health promotion and oral disease prevention programmes.[10] The use of fluorides for the prevention of dental caries is limited. Frequently, essential prevention methods, such as fluoridation of the water supply and other community-based methods, topical fluoride applications or the use of quality, fluoride toothpaste, are not available or affordable.

[10] Petersen PE, Baez RJ, Ogawa H. Global application of oral disease prevention and health promotion as measured 10 years after the 2007 World Health Assembly statement on oral health. Community Dent Oral Epidemiol. 2020;48:338–348. doi: https://doi.org/10.1111/cdoe.12538.

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Oral health care systems

17. 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, delivered by independent private providers, 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.

18. Essential oral health care covers a defined set of safe, cost-effective interventions at the individual and community levels to promote oral health, as well as to prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral. Oral health care is not usually covered in primary care facilities and the private and/or public insurance scheme coverage of oral health is highly variable within and between countries.

19. In many countries, insufficient attention is given to planning the health workforce to address the population's oral health needs. Oral health training is rarely integrated in general health education systems. Typically, training focuses on educating highly specialized dentists rather than mid-level and community oral health workers or optimizing the roles of the wider health team.

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

Global overview of oral health

Vision

21. The vision of this strategy is universal health coverage for oral health for all individuals and communities by 2030, enabling them to enjoy the highest attainable state of oral health and contributing to healthy and productive lives.

22. Universal health coverage means that all individuals and communities have access to essential, quality health services that respond to their needs and that they can use without suffering financial hardship. These services include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. In addition, upstream interventions are needed to strengthen the prevention of oral diseases and reduce oral health inequalities. Achieving the highest attainable standard of oral health is a fundamental right of every human being.

Goal

23. The goal of the strategy is to guide Member States to: (a) develop ambitious national responses to promote oral health; (b) reduce oral diseases, other oral conditions and oral health inequalities; (c) strengthen efforts to address oral diseases and conditions as part of universal health coverage; and (d) consider the development of targets and indicators, based on national and subnational contexts, building on the guidance to be provided by WHO's global action plan on oral health, in order to prioritize efforts and assess the progress made by 2030.

Guiding principles

Principle 1: A public health approach to oral health

24. 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 in broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions on the social and commercial determinants of oral health, involving a broad range of stakeholders from social, economic, education, environment and other relevant sectors.

Principle 2: Integration of oral health in primary health care

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

Principle 3: Innovative workforce models to respond to population needs for oral health

26. Resource and workforce planning models need to better align the education and training of health workers with public health goals and population oral health needs, particularly for underserved populations. Universal health coverage can only be achieved by reforming health, education and resource planning systems to ensure the health workforce has the needed competencies to provide essential oral health care services across the continuum of care. This may require reassessing the roles and responsibilities of mid-level and community-based health workers and other relevant health professionals that include the oral health sector. The new WHO Global Competency Framework for Universal Health Coverage should guide the development of health workforce models for oral health.

Principle 4: People-centred oral health care

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

Principle 5: Tailored oral health interventions across the life course

28. People are affected by oral diseases and conditions – and their risk factors and social and commercial determinants – from early life to old age. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases.

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Tailored, age-appropriate oral health strategies that include essential oral health care need to be integrated in relevant health programmes across the life course, including prenatal, infant, child, adolescent, working adult and older adult programmes. These may include age-appropriate, evidence-based interventions that are focused on promoting healthier eating, tobacco cessation, alcohol reduction and self-care.

Principle 6: Optimizing digital technologies for oral health

29. Artificial intelligence, mobile devices and other digital technologies can be used strategically for oral health at different levels, including for improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, as well as for 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 the health sector

30. Strategic objective 1 seeks the 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 the reform of health and education systems. Ideally, this would include a guaranteed minimum share of public health expenditure that is directed exclusively to national oral health programmes.

31. Central to this process is establishing or strengthening the capacity of a national oral health unit with professionals trained in public health. 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.

32. Sustainable partnerships within and outside the health sector, as well as engagement with communities, civil society and the private sector, are essential to mobilize resources, target the social and commercial determinants of oral health and implement reforms. For example, collaboration between the ministry of health and the ministry of environment is critical to address environmental sustainability within oral health care, such as the implementation of the Minamata Convention on Mercury and challenges related to the management of chemicals and waste (including mercury).

Strategic objective 2: Oral health promotion and oral disease prevention – Enable all people to achieve the best possible oral health and address the social and commercial determinants and risk factors of oral diseases and conditions

33. Strategic objective 2 calls for evidence-based, cost-effective and sustainable interventions to promote oral health and prevent oral diseases and conditions. At the downstream level, oral health education 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

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includes creating public policies and fostering community action to improve people's control over their oral health and to promote oral health equity.

34. Prevention efforts target key risk factors and the 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 use, harmful alcohol use and limiting free sugars intake to less than 10% of total energy and ideally to less than 5%. Prevention efforts should also include safe and cost-effective community-based methods to prevent dental caries, such as fluoridation of the water supply where appropriate, topical fluoride application and the use of quality, fluoride toothpaste.

Strategic objective 3: Health workforce – Develop innovative workforce models and revise and expand competency-based education to respond to population oral health needs

35. Strategic objective 3 aims to ensure that there is an adequate number, availability and distribution of skilled health workers to deliver an essential package of oral health services to meet population needs. This requires that the planning and prioritization of oral health services be explicitly included in all costed health workforce strategies and investment plans.

36. More effective workforce models will likely involve a new mix of dentists, mid-level oral health care providers (such as dental assistants, dental nurses, dental prosthetists, dental therapists and dental hygienists), community-based health workers and other relevant health professionals who have not traditionally been involved in oral health care, such as primary care physicians and nurses. Implementing such models may require reassessing and updating national legislative and regulatory policies for the licensing and accreditation of the health workforce. Health educators will be key stakeholders in establishing competency and professionalism standards for oral health to guide and assess the education, training and practice of an innovative health workforce.

37. Curricula and training programmes need to adequately prepare health workers to manage and respond to the public health aspects of oral health and address the environmental impact of oral health services on planetary health. Professional oral health education must go beyond development of a clinical skill set to include robust training in health promotion and disease prevention and key competencies, such as evidence-informed decision-making, reflective learning about the quality of oral health care, inter-professional communication and the provision of people-centred health care. Intra- and inter-professional education and collaborative practice will also be important to allow the full integration of oral health services in health systems and at the primary care level.

Strategic objective 4: Oral health care – Integrate essential oral health care and ensure related financial protection and essential supplies in primary health care

38. Strategic objective 4 seeks to increase access by the entire population to safe, effective and affordable essential oral health care as part of the universal health coverage benefit package. Health workers who provide oral health services should be active members of the primary health care team and work collaboratively, including across other levels of care, to tackle oral diseases and conditions as well as other noncommunicable diseases, with a focus on addressing common risk factors and supporting general health consultations.

39. Financial protection through expanded private and public insurance policies and programmes, including coverage of oral health services, is one of the cornerstones of universal health coverage.

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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.

40. Digital health technology should be examined for its potential role in the delivery of accessible and effective essential oral health care. This might include the development of policy, legislation and infrastructure to expand the use of digital health technologies, such as mobile phones, intra-oral cameras and other digital technologies, to support remote access and consultation for early detection and referral to services for the management of oral diseases and conditions.

Strategic objective 5: Oral health information systems – Enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policy-making

41. Strategic objective 5 involves developing more efficient, effective and inclusive integrated health information systems that include oral health to inform planning, management and policy-making. At the national and subnational levels, strengthening information systems should include the systematic collection of data on oral health status, social and commercial determinants, risk factors, workforce, oral health services readiness and resource spending.

42. These improved systems can use routine health information systems, demographic and health surveys and promising digital technologies and should ensure protection of patient data. They should also be established to monitor patterns and trends in oral health inequalities and track the implementation and impact of existing policies and programmes related to oral health.

43. New oral health epidemiological methods, including high-resolution video, multispectral imaging and mobile technologies, have the potential to improve the quality of population-based oral health data while reducing costs and complexity. WHO's new mobile technologies for oral health implementation guide, for example, provides guidance on using mobile technologies for population-based and health service delivery surveillance.

Strategic objective 6: Oral health research agendas – Create and continuously update context and needs-specific research that is focused on the public health aspects of oral health

44. Strategic objective 6 strives to create and implement new oral health research agendas that are oriented towards public health programmes and population-based interventions. These should include research on learning health systems, implementation sciences, workforce models, digital technologies and the public health aspects of oral diseases and conditions.

45. Other research priorities include upstream interventions; primary health care interventions; mercury-free dental restorative materials; barriers to access to oral health care; oral health inequalities; oral health promotion in key settings such as schools; environmentally sustainable practices; and economic analyses to identify cost-effective interventions.

46. The translation of research findings into practice is equally important and should include the development of regionally specific, evidence-informed clinical practice guidelines. Researchers have an important role in supporting the development and evaluation of population oral health policies and evaluating and applying the evidence generated by new public health interventions.

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Role of WHO, member states and partners

WHO

47. 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. It 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.

48. WHO will continue its work with global public health partners, including WHO collaborating centres, to establish networks for building capacity in oral health care, research and training; mobilize contributions from nongovernmental organizations and civil society; and facilitate the collaborative implementation of the strategy, particularly with respect to the needs of low- and middle-income countries. WHO will also collaborate with Member States to ensure that there is uptake and accountability for the strategy at the national level, particularly in national health policies and strategic plans.

49. 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 to the NCD-GAP and the WHO UHC Compendium.

50. 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. In collaboration with the United Nations Environment Programme (UNEP), WHO will develop technical guidance on environmentally sustainable oral health care, including mercury-free products and less invasive procedures. WHO will also consider the classification of noma within the road map for neglected tropical diseases 2021–2030.

51. WHO will help scale up 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.

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

Member States

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

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

55. Member States can strengthen oral health care system capacities by integrating oral health in primary health care as a part of universal health coverage benefit packages; ensuring the affordability of essential oral health medicines and consumables, as well as other equipment or supplies for the prevention and management of oral diseases and conditions; and prioritizing environmentally sustainable and less invasive oral health care.

56. Member States should also assess and reorient the health workforce as required to meet population oral health needs by reorienting the outcomes of the education programmes to the oral health services to be provided. This requires enabling inter-professional education and collaborative practice that involves mid-level and community-based health workers. They should critically review and continuously update their oral health education content across health worker training programmes and training curricula, prioritizing a public health approach to oral health that enables health workers to develop essential competencies such as reflective problem-solving and leadership skills.

57. Member States can address the determinants of oral health and the risk factors of oral diseases and conditions by advocating for evidence-based regulatory measures that address the underlying determinants that increase or reduce risks and working with commercial entities to encourage them to reformulate products to reduce sugar levels, reduce portion sizes or shift consumer purchasing towards products with lower sugar content. Member States can also target determinants by strengthening health-promoting conditions in key settings; implementing community-based methods to prevent dental caries; 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.

58. 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, integrating electronic dental and medical records and strengthening the integrated surveillance of oral diseases and conditions. It also includes the analysis of oral health system and policy data, operational research and the evaluation of oral health interventions and programmes.

International partners

59. UNICEF, UNEP, the International Telecommunication Union and other United Nations agencies, as well as development banks and other international partners, have valuable roles to play in achieving the goals and objectives of the strategy at global, regional and national levels. This includes taking initiative in advocacy, resource mobilization, exchange of information, sharing of lessons learned, capacity-building, research and developing targets and indicators for streamlined global collaboration.

60. Coordination is needed among international partners, including the organizations of the United Nations system, intergovernmental bodies, non-State actors, nongovernmental organizations, professional associations, youth and student organizations, patients' groups, academia and research institutions. Establishing and working efficiently as an international coalition on oral health will better support countries in their implementation of the strategy.

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Civil society

61. Civil society is a key stakeholder in setting priorities for oral health care services and public health. It has a role to play in encouraging governments to develop ambitious national and subnational oral health responses and contributing to their implementation. Civil society can forge multistakeholder 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. Actively engaging in meaningful partnership with civil and community organizations, as well as co-designing/co-producing innovative approaches to oral health care, provide an opportunity to develop more responsive and sustainable models of care.

62. Civil society can support consumers and lead grass-roots mobilization and advocacy for increased focus in the public agenda on oral health promotion and the prevention and control of oral diseases and conditions. Civil society and consumers can advocate with governments and industries to demand that the food and beverage industry provide healthy products; support governments in implementing their tobacco control programmes; and form networks and action groups to promote the availability of food and beverages that are low in free sugars and of quality, fluoride toothpaste, including through subsidization or reduced taxes.

63. National dental associations and other oral health professionals organizations have a responsibility to support the oral health of their communities. They can collaborate with and support national and subnational governments in implementing the strategy through the provision of essential oral health care, including by helping to plan and implement population-wide prevention measures and by participating in oral health data collection and surveillance.

Private sector

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

65. The private sector should take concrete steps towards reducing the marketing, advertising and sale of products that cause oral diseases and conditions, such as tobacco products and food and beverages that are high in free sugars. Increased private sector transparency and accountability is a key component of such actions.

66. The private sector should strive to improve the access to and affordability of safe, effective and quality dental equipment and devices and oral hygiene products. It should accelerate research on affordable, safe and environmentally sound equipment and materials for oral health care.

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Annex 2
Resolution on oral health
WHA74.5

World health assembly
Resolution on oral health WHA74.5

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;[1]

Recalling resolutions WHA60.17 (2007) on oral health: action plan for promotion and integrated disease prevention, WHA69.3 (2016) on the global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life, WHA72.2 (2019) on primary health care; and decisions WHA72(11) (2019) on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and WHA73(12) (2020) on the Decade of Healthy Ageing 2020–2030;

Mindful of 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 recognizing the important intersections between oral health and other Sustainable Development Goals, including Goal 1 (End poverty in all its forms and everywhere), Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) and Goal 12 (Ensure sustainable consumption and production patterns);

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011), recognizing that oral diseases pose a major challenge and could benefit from common responses to noncommunicable diseases;

Recalling also the political declaration of the high-level meeting on universal health coverage (2019), including the commitment therein to strengthen efforts to address oral health as part of universal health coverage;

Mindful of the Minamata Convention on Mercury (2013), a global treaty to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds, calling for phase down of the use of dental amalgam taking into account domestic circumstances and relevant international guidance; and recognizing that a viable replacement material should be developed through focused research;

Recognizing that oral diseases are highly prevalent, with more than 3.5 billion people affected by them, and that oral diseases are closely linked to noncommunicable diseases, leading to a considerable health, social and economic burden,[2] and that while there have been notable improvements in some countries, the burden of poor oral health remains, especially among the most vulnerable in society;

Noting that untreated dental caries (tooth decay) in permanent teeth occurs in 2.3 billion people, more than 530 million children have untreated dental caries of primary teeth (milk teeth) and 796 million people are affected by periodontal diseases;[3] noting also that early rates of childhood caries are

[1] Document A74/10 Rev.1.

[2] GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet. 2018;392(10159):1789-1858. doi: 10.1016/S0140-6736(18)32279-7.

[3] GBD 2017 Oral Disorders Collaborators, Bernabe E, Marcenes W, Hernandez CR, Bailey J, Abreu LG, et al. Global, regional, and national levels and trends in burden of oral conditions from 1990 to 2017: A systematic analysis for the Global Burden of Disease 2017 study. J Dent Res. 2020;99(4):362-373. doi: 10.1177/0022034520908533.

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highest among those in vulnerable situations; and aware that these conditions are largely preventable;

Noting also that oral cancers are among the most prevalent cancers worldwide with 180 000 deaths each year,[4] and that in some countries they account for the most cancer-related deaths among men;

Noting further the economic burden due to poor oral health and that oral diseases worldwide account for US$ 545 billion in direct and indirect costs,[5] ranking poor oral health among the most costly health domains, such as diabetes and cardiovascular diseases;

Also taking into account that poor oral health – apart from pain, discomfort and lack of well-being and quality of life – leads to school and workplace absenteeism,[6] leading to shortfalls in learning and productivity losses;

Concerned about the effect of poor oral health on quality of life and healthy ageing both physically and mentally; and noting that poor oral health is a regular cause of pneumonia for elderly people, particularly those living in care facilities, and for persons with disabilities;

Aware that poor oral health is a major contributor to general health conditions, and noting that it has particular associations with cardiovascular diseases, diabetes, cancers, pneumonia and premature birth;[7]

Noting that noma, a necrotizing disease starting in the mouth, is fatal for 90% of affected children in poor communities, mostly in some regions in Africa, and leads to lifelong disability and often social exclusion;

Concerned that the burden of poor oral health reflects significant inequalities, between and within countries, disproportionally affecting low- and middle-income countries, mostly affecting people from lower socioeconomic backgrounds and other risk groups, such as persons who cannot maintain their oral hygiene on their own due to their age or disability;

Acknowledging the many risk factors that oral diseases share with noncommunicable diseases, such as tobacco use, harmful use of alcohol, a high intake of free sugars and poor hygiene, and therefore the necessity to integrate strategies on oral health promotion, prevention and treatment into overall noncommunicable disease policies;

Recognizing that adequate intake of fluoride plays an important role in the development of healthy teeth and in the prevention of dental caries; and recognizing the need to mitigate the adverse effects of excessive fluoride in water sources on the development of teeth;[8]

Concerned about the potential environmental impact caused by the use and disposal of mercury-containing dental amalgam, and the use of toxic chemicals for developing X-ray photographs;

[4] International Agency for Research on Cancer, Global Cancer Observatory. Lip, oral cavity. December 2020. Lyon: Global Cancer Observatory, International Agency for Research on Cancer; December 2020 (https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf, accessed 5 May 2021).

[5] Righolt AJ, Jevdjevic M, Marcenes W, Listl S. Global-, regional-, and country-level economic impacts of dental diseases in 2015. J Dent Res. 2018;97(5):501-507. doi: 10.1177/0022034517750572.

[6] Peres MA, Macpherson LMD, Weyant RJ, Daly B, Venturelli R, Mathur MR et al. Oral diseases: a global public health challenge. Lancet. 2019;394(10194):249-260. doi: 10.1016/S0140-6736(19)31146-8.

[7] Seitz MW, Listl S, Bartols A, Schubert I, Blaschke K, Haux C et al. Current knowledge on correlations between highly prevalent dental conditions and chronic diseases: an umbrella review. Prev Chronic Dis. 2019;16:E132180641. doi: 10.5888/pcd16.180641.

[8] Petersen PE, Lennon MA. Effective use of fluorides for the prevention of dental caries in the 21st century: the WHO approach. Community Dent Oral Epidemiol. 2004;32(5):319-21. doi: 10.1111/j.1600-0528.2004.00175.x.

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Concerned also that oral health services are among the most affected essential health services because of the coronavirus disease (COVID-19) pandemic, with 77% of countries reporting partial or complete disruption;

Highlighting the importance of oral health and interventions with a life course approach;

Noting that a number of oral and dental conditions can act as indicators of neglect and abuse, especially among children, and that oral health professionals can contribute to the detection of child abuse and neglect,

1. **URGES Member States, taking into account their national circumstances:**

   (1) to understand and address the key risk factors for poor oral health and associated burden of disease;

   (2) to foster the integration of oral health within their national policies, including through the promotion of articulated interministerial and intersectoral work;

   (3) to reorient the traditional curative approach, which is basically pathogenic, and move towards a preventive promotional approach with risk identification for timely, comprehensive and inclusive care, taking into account all stakeholders in contributing to the improvement of the oral health of the population with a positive impact on overall health;

   (4) to promote the development and implementation of policies to promote efficient workforce models for oral health services;

   (5) to facilitate the development and implementation of effective surveillance and monitoring systems;

   (6) to map and track the concentration of fluoride in drinking water;

   (7) to strengthen the delivery of oral health services as part of the essential health services package that deliver universal health coverage;

   (8) to improve oral health worldwide by creating an oral health-friendly environment, reducing risk factors, strengthening a quality-assured oral health care system and raising public awareness of the needs and benefits of good dentition and a healthy mouth;

2. **CALLS ON Member States:**

   (1) to frame oral health policies, plans and projects for the management of oral health care according to the vision and political agendas in health projected for 2030, in which oral health is considered an integral part of general health, responding to the needs and demands of the public for good oral health;

   (2) to strengthen cross-sectoral collaboration across key settings, such as schools, communities and workplaces, to promote good habits and healthy lifestyles, integrating teachers and families;

   (3) to enhance oral health professionals' capacities to detect potential cases of neglect and abuse, and provide them with the appropriate and effective means to report such cases to the relevant authority according to the national context;

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3. REQUESTS the Director-General:

(1) to develop, by 2022, a draft global strategy, in consultation with Member States, on tackling oral diseases, aligned with the global action plan for the prevention and control of noncommunicable diseases 2013–2030 and pillars 1 and 3 of WHO's Thirteenth General Programme of Work, 2019–2023 for consideration by the governing bodies in 2022;

(2) to translate this global strategy, by 2023, into an action plan for public oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030, encompassing control of tobacco use, betel quid and areca nut chewing, and alcohol use – and community dentistry, health promotion and education, prevention and basic curative care – providing a basis for a healthy mouth, where no one is left behind; this action plan should also contain the use of provisions that modern digital technology provides in the field of telemedicine and teledentistry;

(3) to develop technical guidance on environmentally friendly and less-invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury, including supporting preventive programmes;

(4) to continue to update technical guidance to ensure safe and uninterrupted dental services, including during health emergencies;

(5) to develop best buy interventions on oral health, as part of an updated Appendix 3 to the global action plan on the prevention and control of noncommunicable diseases and integrated into the Universal Health Coverage Compendium;

(6) to include noma in the planned WHO 2023 review process to consider the classification of additional diseases within the road map for neglected tropical diseases 2021–2030;

(7) to report on progress and results until 2031 as part of the consolidated report on noncommunicable diseases, in accordance with paragraph 3(e) of decision WHA72(11) (2019).

(Seventh plenary meeting, 31 May 2021 – Committee A, first report)

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