

## Oral health: action plan for promotion and integrated disease prevention

1. Oral disease, such as dental caries, periodontal disease, tooth loss, oral mucosal lesions, oropharyngeal cancers, oral manifestations of HIV/AIDS, necrotizing ulcerative stomatitis (noma), and orodental trauma, is a serious public-health problem. Its impact on individuals and communities in terms of pain and suffering, impairment of function and reduced quality of life, is considerable. Globally, the greatest burden of oral diseases lies on disadvantaged and poor populations. The current pattern of oral disease reflects distinct risk profiles across countries related to living conditions, behavioural and environmental factors, oral health systems and implementation of schemes to prevent oral disease. In several high-income countries with preventive oral-care programmes prevalence of dental caries in children and tooth loss among adults has dropped. Globally, the burden of oral disease is particularly high among older people and has a negative effect on their quality of life. In most low- and middle-income countries, the general population does not benefit from systematic oral health care, nor have preventive programmes been established. In some countries the incidence of dental caries has increased over recent years and may further increase as a result of the growing consumption of sugars and inadequate exposure to fluorides.

2. Tobacco-related oral diseases are currently prevalent in several high-income countries. With the growing consumption of tobacco in many low- and middle-income countries, the risk of periodontal disease, tooth loss and oral-cavity cancer is likely to increase. Moreover, periodontal disease and tooth loss are linked to chronic diseases such as diabetes mellitus; the growing incidence of diabetes in several countries may therefore have a negative impact on oral health. People living with HIV/AIDS suffer from specific oral disease; HIV infection has a negative effect on oral health and quality of life because of, for example, pain, dry mouth and difficulty in chewing, swallowing and tasting food.

3. Noma, a debilitating orofacial gangrene, is an important contributor to the disease burden in many low- and middle-income countries, particularly in Africa and Asia; the key risk factors are poverty, severe malnutrition, unsafe drinking water, deplorable sanitary practices and such infectious diseases as measles, malaria, and HIV/AIDS.

4. Oral disease is the fourth most expensive disease to treat. In high-income countries, the burden of oral disease has been tackled through the establishment of advanced oral-health systems which offer primarily curative services to patients. Most systems are based on demand for care provided by private dental practitioners, although some high-income countries have organized public oral-health systems. In most low- and middle-income countries, investment in oral health care is low and resources are primarily allocated to emergency oral care and pain relief.

5. Most oral diseases and chronic diseases have common risk factors. As is the case for major chronic diseases, oral diseases are linked to unhealthy environments and behaviours, particularly widespread use of tobacco and excessive consumption of alcohol or sugar. In addition to healthy behaviour, promotion of oral health depends on clean water, adequate sanitation, proper oral hygiene and appropriate exposure to fluoride. National health programmes that include health promotion and measures at individual, professional and community levels are cost-effective in preventing oral diseases.

### **Framing policies and strategies for oral health**

6. Promotion of oral health is a cost-effective strategy to reduce the burden of oral disease and maintain oral health and quality of life. It is also an integral part of health promotion in general, as oral health is a determinant of general health and quality of life.

7. One of the main lines of WHO's global strategy for the prevention and control of chronic noncommunicable diseases is to reduce the level of exposure to major risk factors. Prevention of oral disease needs to be integrated with that of chronic diseases on the basis of common risk factors.

8. Some high-income countries have built national capacities in oral-health promotion and oral-disease prevention over the past decades, mostly as isolated components of national health programmes. A number of low- and middle-income countries do not yet have policies on, or financial and human resources for, sustainable, effective oral-health programmes to counter risks and their underlying determinants.

9. To strengthen the formulation or adjustment of policies and strategies for oral health and its integration in national and community health programmes, particular emphasis should be laid on the following elements:

- promotion of a healthy diet, particularly lower consumption of sugars and increased consumption of fruits and vegetables, in accordance with WHO's Global Strategy on Diet, Physical Activity and Health, and reduction of malnutrition;
- prevention of oral and other diseases related to tobacco use (smoking and use of smokeless tobacco), by involving oral-health professionals in tobacco cessation programmes and discouraging children and young people from adopting the tobacco habit;
- provision of access to clean drinking water, general hygiene and better sanitation for proper oral hygiene;
- establishment of national plans for use of fluoride, based on appropriate programmes for automatic administration of fluoride through drinking-water, salt, or milk, or topical use of fluoride such as affordable fluoride toothpaste. Salt fluoridation programmes should be linked to iodization schemes;
- prevention of oral-cavity cancer and oral pre-cancer by involving oral health professionals or specially trained primary health-care workers in screening, early diagnosis and referral for care, and appropriate interventions on the risks of tobacco use and excessive consumption of alcohol;

- strengthening of management of HIV/AIDS through oral-health professional screening for HIV/AIDS-related oral disease, early diagnosis, prevention and treatment, with emphasis on pain relief and improved quality of life and on reduction of the double burden of oral disease and HIV infection in low- and middle-income countries;
- building of capacity in oral-health systems oriented to disease prevention and primary health care, with special emphasis on meeting the needs of disadvantaged and poor populations. Oral-health services should be set up, ranging from prevention, early diagnosis and intervention to provision of treatment and rehabilitation, and the management of oral health problems of the population according to needs and to resources available. In countries with critical shortages of oral-health personnel, essential care may be provided by specially trained primary health-care workers;
- promotion of oral health in schools, aiming at developing healthy lifestyles and self-care practices in children and young people. An integrated approach that combines school health policy, skills-based health education, a health-supportive school environment and school health services can tackle major common risk factors and contribute to effective control of oral disease;
- promotion of oral health among older people, aiming at advancing oral health, general health and well-being into old age through a life-course perspective in health promotion, integrated disease prevention and emphasis on age-friendly primary health care;
- development of oral-health information systems as an integral part of national surveillance of oral health and risk factors, in order to provide evidence for oral health policy and practice, formulation of goals and targets, and measurement of progress in public health. Instruments have been designed in the framework of the WHO Global InfoBase and the WHO STEPwise approach to surveillance (STEPS);
- promotion of research in oral health, aimed at bridging gaps in research between low- and middle-income, and high-income countries, conduct of operational research, and translation of knowledge about oral-health promotion and disease prevention into public-health action programmes.

### **Future action**

10. Working with other international entities involved in oral health, WHO will provide support to Member States in raising awareness of the determinants of oral and general health, and fostering health-promoting environments, healthy behaviour and prevention-oriented oral-health systems. WHO will further strengthen its support for building capacity at national and community levels to plan and implement comprehensive and integrated oral-health programmes, particularly in low- and middle-income countries and for poor and disadvantaged groups.

11. WHO will continue to provide technical support for, and guidance on, the design, implementation and evaluation of evidence-based community demonstration projects worldwide, contribute to sharing of experiences among countries and disseminate lessons learnt through the publication of guidelines. Its expanded evidence base provides a basis for oral-health policies and for investigating the cost and effectiveness of national and community oral health interventions. WHO will also offer technical advice on establishment of integrated oral-health surveillance systems, based on the WHO Global InfoBase and the STEPS methodology. It will also further expand its work with

the WHO collaborating centres on oral health and nongovernmental organizations, including the FDI World Dental Federation and the International Association for Dental Research.

12. In order to respond to the many global changes and trends that directly or indirectly affect oral health and well-being, WHO will further expand its interaction and partnership with other international entities involved in oral health and the private sector within the framework of its overall leadership in health promotion and integrated disease prevention.

**ACTION BY THE EXECUTIVE BOARD**

13. The Executive Board is invited to note the above report.

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