World Health Organization

WHO DISCUSSION PAPER
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DRAFT GLOBAL ORAL HEALTH ACTION PLAN (2023-2030)

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 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 that include dental caries, periodontal (gum) disease, tooth loss, oral cancer, oro-dental trauma, noma, birth defects such as cleft lip and palate, and many others, most of which are preventable. The main oral diseases and conditions are estimated to affect close to 3.5 billion people worldwide.[1] These combined conditions have an estimated global prevalence of 45%, which is higher than the prevalence of any other NCD.[2]

4. The global burden of oral diseases and conditions is an urgent public health challenge with social, economic and environmental impacts.[3] Oral diseases and conditions disproportionately affect poor, vulnerable and disadvantaged members of societies. There is a strong and consistent association between socioeconomic status and the prevalence and severity of oral diseases and conditions.[4] Public and private expenditures for oral health care have reached an estimated US$ 387 billion globally, with very unequal distribution across regions and countries.[5]

5. Oral diseases and conditions share risk factors common to the leading NCDs, including all forms of tobacco use, harmful alcohol use, high sugars intake and lack of exclusive breastfeeding. Other risk factors include human papillomavirus for oropharyngeal cancers; traffic accidents and sports injuries for traumatic dental injuries; and co-infections, poor hygiene and living conditions and malnutrition for noma.

[1] WHO global oral health status report [in press]
[2] WHO global oral health status report [in press]
[3] https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add1-en.pdf.
[4] WHO global oral health status report [in press]
[5] WHO global oral health status report [in press]

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

7. In most countries, oral health care systems are not funded adequately. Essential oral health care is not integrated in primary care and is not part of universal health coverage benefit packages. As a result, millions of people still do not have access to and financial coverage for essential oral health care, leading to a high proportion of patient out-of-pocket payments.[6] The COVID-19 pandemic has demonstrated again that oral health services are too often isolated from the broader health care system.

8. 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 supplies, consumables and oral care products; sustainable waste management and reduction of carbon emissions, and the need to accelerate the phase-down in use of mercury-containing dental amalgam.

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

The 2021 Resolution on Oral Health and its mandate

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

11. In the resolution, 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, as part of an updated Appendix 3 of the Global Action Plan on the Prevention and Control of Noncommunicable Diseases 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.

12. The resolution on oral health is aligned and build on other relevant global commitments, including the 2030 Agenda, in particular Sustainable Development Goal 3 (Ensure healthy lives and

[6] 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.

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

13. 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 of 2020; the Global Competency and Outcomes Framework for Universal Health Coverage of 2022; the Global Strategy on Human Resources for Health: Workforce 2030 of 2016; the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 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 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.

14. 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 productive 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, 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.

15. 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 prioritise efforts and assess progress made by 2030.

16. The six guiding principles of the global strategy on oral health are: a public health approach to oral health, integration of oral health in primary health care, innovative workforce models to respond to population needs for oral health, people-centred oral health care and tailored oral health interventions across the life course and optimizing digital technologies for oral health.

17. The six strategic objectives of the global strategy on oral health relate to oral health governance, oral health promotion and oral disease prevention, the health workforce, oral health care, oral health information systems, and oral health research agendas. Specifically:

- **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 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, GOAL AND OVERARCHING TARGETS OF THE GLOBAL ORAL HEALTH ACTION PLAN (2023-2030)

18. 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, WHO, international partners, civil society and the private sector.

19. The goal of the global oral health action plan is to translate the global strategy on oral health into a set of evidence-informed actions that can be adapted to national and sub-national contexts, including a monitoring framework for tracking implementation progress with measurable targets to be achieved by 2030.

20. The global oral health action plan and its monitoring framework provide two overarching global targets and, for each strategic objective, identify respective global targets with proposed actions for Member States, the WHO Secretariat, international partners, civil society organizations and the private sector. The proposed actions should be adapted and prioritised by Member States depending on national circumstances, taking into consideration social, economic and political contexts and available resources.

21. The global oral health action plan has two overarching global targets to be achieved by 2030:

Overarching global targets

Overarching global target I: UHC for oral health

By 2030, 75% of the global population will be covered by essential oral health care services to ensure progress towards UHC for oral health

Overarching global target II: Reduce oral disease burden

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

KEY AREAS FOR GLOBAL ACTION

22. The key areas of the global oral health action plan are aligned with the six strategic objectives of the global strategy on oral health. Actions for Member States, the WHO Secretariat, international partners, civil society organizations and the private sector are proposed for each of the strategic objectives.

ACTION AREA FOR STRATEGIC OBJECTIVE 1: ORAL HEALTH GOVERNANCE

23. 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 are vital at the national and subnational levels, as is reform of health and education systems. Central to this process is establishing or strengthening the capacity of a national oral health unit 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.

24. 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.

Global target 1

Global target 1.1: National leadership for oral health

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

Global target 1.2: Environmentally-sound practices

By 2030, 90% of countries will have implemented two or more of the recommended measures to phase down dental amalgam in line with the Minamata Convention on Mercury or will have phased it out.

Proposed actions for Member States

Action 1. **Develop and implement a national oral health policy, strategy or action plan:** Develop a new or review the existing national oral health policy and ensure alignment with the global strategy for oral health and national NCD and UHC policies. Prepare implementation guidance, including a monitoring framework aligned with the monitoring framework of the global oral health action plan.

Action 2. **Strengthen national oral health leadership:** Institute or strengthen an oral health unit at the ministry of health 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 coordination mechanisms between the oral health unit and the NCD department or other technical programmes. Strengthen capacities of oral health unit staff by assessing training needs, providing training and coaching opportunities, including management, leadership, and public health skills as appropriate.

Action 3. **Create and sustain dedicated oral health budgets:** Consider, as appropriate for national context, establishing dedicated oral health budgets at national and subnational levels covering policy, public service staff, programme and supply costs.

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

Action 5. **Forge strategic partnerships for oral health:** Identify potential for strategic partnerships to implement policies, mobilize resources, target social and commercial determinants and accelerate required reforms. Develop policies setting rules for engagement with partners, including policies to avoid conflicts of interest and undue influence. Initiate or strengthen existing 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 the broader context of health systems strengthening.

Action 6. **Engage with civil society:** Ensure participation of civil society organizations and empowerment of the community in planning, implementation and monitoring of appropriate programmes by providing platforms for engagement. Involve national oral health, medical and public health associations and community-based organizations in policy and guideline development and implementation.

Action 7. **Phase down the use of dental amalgam**: Ratify the Minamata Convention on Mercury, or, for those Member States that have already done so, accelerate implementation of recommended measures to phase down the use of dental amalgam in accordance with existing and future decisions of the Minamata Convention Conference of Parties.

Action 8. **Strengthen health emergency preparedness and response:** Include oral health in national emergency preparedness and response plans to 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 services.

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

Actions for the WHO Secretariat

Action 10. **Lead and coordinate the global oral health agenda:** Monitor the global oral health agenda and coordinate the work of other relevant United Nations agencies, 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 on NCDs. Accelerate implementation of the action plan by organising 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 level and enable timely and appropriate technical support to countries. 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 mobilise resources for WHO oral health activities. Extend engagement with nongovernmental organizations and philanthropic foundations to increase resources for implementing the global oral health action plan.

Action 12. **Support implementation of the global action plan:** Establish a technical advisory group on oral health to strengthen international and national action and accelerate implementation of the global oral health action plan. Continue working with global partners, including WHO collaborating centres and non-state actors in official relation with WHO, to establish networks for building capacity in oral health promotion and care, research and training. Set-up dedicated oral health teams at the regional level to address countries' technical support needs for implementation of the global oral health action plan, including data collection for the monitoring framework of the global oral health action plan. Provide technical support upon request of Member States.

Action 13. **Fulfil the mandates given to the WHO secretariat in the resolution on oral health**: Develop technical guidance on environmentally-friendly and less-invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury. Continue to update technical guidance to ensure safe and uninterrupted dental services, including under circumstances of health emergencies. Develop "best buy" interventions on oral health, as part of an updated Appendix 3 of the global action plan on the prevention and control of noncommunicable diseases and integrated into the WHO UHC Compendium of health interventions. 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. Report back 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, including in donor, bi- and multi-lateral government meetings, conferences and other fora.

Action 15. **Support implementation of the global oral health action plan in countries**: Strengthen national capacities and resources for oral health through technical and financial assistance. Help establish and sustain national technical working groups on oral health involving donors, development partners and the national government.

Proposed actions for civil society organizations

Action 16. **Advocate for a whole-of-government approach to oral health**: Advocate for integrating management of oral diseases and other NCDs in primary health care. Engage in multisectoral coordination mechanisms to deliver on oral health and other NCD targets within and beyond the health sector.

Action 17. **Promote oral health as a public good:** Promote and protect oral health as a public good by monitoring and raising awareness of incompatible partnerships. Advocate for governments to phase out subsidies and implement taxation of unhealthy commodities, such as sugar, tobacco and alcohol. Support governments in developing guidance on private sector engagement in oral health and NCD programmes.

Action 18. **Hold governments accountable to global oral health targets:** Participate in the regular monitoring of national NCD work, including development and use of oral health targets and indicators. Strengthen independent accountability efforts related to oral health.

Action 19. **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 20. **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 regulations, such as advertising for children.

ACTION AREA FOR STRATEGIC OBJECTIVE 2: ORAL HEALTH PROMOTION AND ORAL DISEASE PREVENTION

25. Strategic objective 2 aims to 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. 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.

26. 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 NCD prevention strategies and regulatory policies to reduce or eliminate tobacco use, harmful alcohol use and free sugars intake. 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.

Global targets for strategic objective 2

Global target 2.1: Reduction of sugar consumption

By 2030, 70% of countries will have implemented a tax on sugar-sweetened beverages.

Global target 2.2: Optimal fluoride for population oral health

By 2030, at least 50% of countries will have national guidance to ensure optimal fluoride delivery for the population.

Proposed actions for Member States

Action 21. **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 oral diseases and conditions. Support initiatives to coordinate and accelerate the response to NCDs, including oral diseases and conditions, in the context of broader health promotion and disease prevention focusing on key common risk factors, determinants and inequalities.

Action 22. **Support policies and regulations to limit free sugars intake**: Support initiatives to transform the food environment by implementing policies to reduce free sugar consumption and promote availability of healthy foods and beverages in line with WHO's recommendations. Initiate or support implementation of health taxes, particularly taxation of food and beverages with high sugar content; and advocate for earmarking such tax revenue for oral health and health promotion, depending on country context. Advocate and collaborate with other line ministries to limit package sizes and include transparent labelling of unhealthy foods and beverages; strengthen regulation of marketing and advertising of such products to children and adolescents; and reduce sponsorship by related companies for public and sports events. Work with the private sector to encourage them to reduce portion sizes and reformulate products to lower sugar levels, in order to shift consumer purchasing towards healthier products.

Action 23. **Support policies and regulations to reduce all forms of 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 tobacco interventions into oral health programmes in primary care. Where relevant, develop or strengthen actions for the reduction of betel-quid chewing, including advocating for legislation to ban areca-nut sales.

Action 24. **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 drunk-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 25. **Optimize the use of fluorides for oral health:** Develop or update national guidance related to fluorides for oral health, addressing the universal availability of systemic or topical fluorides, taking into consideration needs and disease burden across the life-course, available resources, and technical, political and social factors. Depending on the country context, consider adding or removing fluoride from drinking water to provide safe, optimal levels for protection against dental caries, as recommended by national and international guidance.

Action 26 **Promote fluoride toothpaste as an essential health product**: Implement measures to improve the affordability and availability of fluoride toothpaste, including reducing or eliminating taxes and tariffs and other fiscal measures, as well as bulk purchasing or manufacturing agreements for use of fluoride toothpaste in community settings. Strengthen quality and labelling of fluoride toothpaste in accordance with ISO Standard 11609 for fluoride toothpaste by developing national standards and quality controls. Enhance environmental sustainability along the fluoride toothpaste production and supply chain. Promote effective self-care and oral hygiene through twice-daily tooth brushing with fluoride toothpaste and making affordable, quality toothpaste universally available. Enhance measures to protect consumers from counterfeit products.

Action 27. **Review and improve mid-stream promotion and prevention measures:** Create supportive environments for oral health promotion in key settings, such as schools, pre-schools, workplaces and long-term care facilities. Establish rules and regulations for commercial support and sponsorship in schools, workplaces and other key settings, including mechanisms for monitoring and evaluation. Collaborate in joint health and education ministry oversight of school health programming. Facilitate social mobilisation and engage and empower a broad range of actors, including women as change-agents in families and communities, to promote dialogue, catalyse societal change and address oral diseases and conditions, their social, environmental and economic determinants and oral health equity. Promote and implement vaccination of girls and boys against human papilloma virus (HPV) to address cervical and oro-pharyngeal cancers, in accordance with national and international guidance.

Action 28. **Strengthen and scale-up downstream promotion and prevention measures:** Develop and implement evidence-based, cost-effective, sustainable, age-appropriate interventions to prevent oral diseases and promote oral health. Include oral health in broader health communication, health education and literacy campaigns to raise awareness and empower people for prevention through self-care and oral hygiene, as well as early detection of oral disease. 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, mothers, and older adults, with special consideration for people living in vulnerable or disadvantaged situations, including indigenous people, migrant populations and people with disabilities.

Actions for the WHO Secretariat

Action 29. **Ensure integration of 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 30. **Provide technical guidance for oral health promotion and oral disease prevention:** Recommend cost-effective, evidence-based oral health promotion and disease prevention interventions by 2023 as part of the updated Appendix 3 of the NCD-GAP and the WHO UHC Compendium of health interventions.

Action 31. **Hold to account economic operators in the production and trade of harmful products:** Encourage private sector transparency and alignment with 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 32. **Target risk factors and determinants of oral health**: Include oral health in new or existing programmes addressing NCDs, common risk factors and determinants of health. Support and conduct research to strengthen the evidence for interventions that effectively target the determinants of oral health, including those that reduce oral health inequalities.

Action 33. **Consider oral health in policy impact assessments**: When conceptualising, negotiating, or implementing programmes in related sectors, such as trade, food, environment and finance, ensure that oral health is considered when conducting health and environmental impact assessments so that unintended health impacts can be avoided and mitigation measures be put in place.

Proposed actions for civil society organizations

Action 34. **Mobilise support for oral health promotion:** Facilitate community action with diverse groups, such as nongovernmental organizations, academia, media, human rights organizations, faith-based organizations, labour and trade unions, and organizations focused on poor, disadvantaged and vulnerable members of societies, 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 other socially marginalised groups, as well as organizations of patients and people affected by oral diseases and conditions. Support the development of personal, social and advocacy skills to enable all people to achieve their full potential for effective self-care and oral hygiene.

Action 35. **Advocate for policies and regulations for oral disease prevention:** Support policies aiming at 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 with high sugar content.

Action 36. **Ensure civil society inclusion in policy development:** Advocate for inclusion of professional organization and other civil society organizations in the development and implementation of policies related to oral health promotion, common risk factors and the determinants of oral health. 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 37. **Implement occupational oral health measures:** Strengthen commitment and contribution to health and oral health by implementing measures at the workplace, including through good corporate practices, workplace health and wellness programmes and by providing health insurance coverage to employees according to country context.

Action 38. **Improve affordability of fluoride products for oral health**: Cooperate with governments to improve affordability and quality of fluoride-containing products for oral health and ensure that tax reductions or subsidies applied to such products are entirely reflected in lower consumer prices.

Action 39. **Reduce marketing, advertising and sale of harmful products:** Prioritise 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. Consider reformulation of products to reduce sugar intake.

ACTION AREA FOR STRATEGIC OBJECTIVE 3: HEALTH WORKFORCE

27. Strategic objective 3 aims to develop innovative workforce models and revise and expand competency-based education. Progress towards UHC for oral health requires health workers who are educated and empowered to provide the oral health services that populations need. This objective seeks to ensure that there is an adequate number, availability and distribution of skilled health workers to deliver an essential package of oral health services. This requires that the planning and prioritization of oral health services be included in all health workforce strategies and investment plans.

28. More effective workforce models will likely involve a new mix of oral health professionals and other relevant health professionals who have not traditionally been involved in oral health care. Implementing such models may require reassessing and updating national legislative and regulatory policies for the licensing and accreditation of the health workforce. Curricula and training programmes need to adequately prepare health workers to manage and respond to population oral health needs and public health aspects of oral health, as well as 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 incorporate community health and research competencies. Intra- and inter-professional education and collaborative practice will also be important to allow the full integration of oral health services in at the primary care level and in broader health systems.

Global targets for strategic objective 3

Global target 3: Innovative workforce model for oral health

By 2030, at least 50% of countries will have an operational national health workforce strategy that includes workforce trained to respond to population oral health needs.

Proposed actions for Member States

Action 40. **Foster innovative oral health workforce models**: Develop and implement workforce models which enable sufficient numbers of adequately trained health workers to provide oral health services as members of collaborative primary health care teams at all levels of care. Review and update national legislative and regulatory policies for licensing and accreditation to support flexible workforce models and competency-based education and practice. Increase availability of mid-level oral health providers. Ensure career transition pathways between professional tracks to increase flexibility and deployment of oral health providers in underserved areas.

Action 41. **Increase capacity for universal health coverage for oral health:** Expand coverage of essential oral health care by planning for and providing an adequate number, availability, accessibility and geographical distribution of skilled health workers able to deliver an essential package of oral health care. Ensure that investment in human resources for oral health is efficient, sustainable and aligned with current and future needs of the population. Include oral health workforce planning in national health workforce strategies. Develop comprehensive investment plans to scale up the oral health workforce. Consider development of a standardised 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, so they are fully aligned with efforts to achieve UHC.

Action 42. **Strengthen collaborative, cross-sectoral workforce governance:** Establish and enable professional councils and associations to develop, regularly review and adapt accreditation mechanisms and regulation, including standards of practice and professional behaviour, under the oversight of the ministry of health and in full alignment with national health workforce planning. Collaborate 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 and appropriate remuneration.

Action 43. **Reform oral health workforce training programmes:** Reform education to prioritise 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 competencies to prevent and treat the most common oral diseases with essential oral health care and rehabilitation measures in a primary care context. Strengthen collaborative intra- and inter-professional education and practice towards integration in primary health care. Ensure equitable access to oral health professional education to increase socio-economic, gender, ethnic and geographic diversity and the cultural competency of the oral health workforce. Encourage professional organizations and dental schools to educate and train oral health professionals and students on the use of mercury-free dental restoration alternatives and on promoting best waste management practices of materials used in oral healthcare facilities.

Action 44. **Strengthen professional accreditation**: In accordance with country regulations, create or improve accreditation mechanisms for oral health education and training institutions, including effective oversight institutions as well as standards for social accountability and social determinants of health. Work with professional associations to define oral health specialisations and their training and accreditation requirements, recognizing the priority of primary oral health care and public health specialists while balancing the demand for advanced and specialist oral health care. Make continuous life-long professional education mandatory to retain accreditation and license to practice.

Actions for the WHO Secretariat

Action 45. **Explore innovative workforce models for oral health:** Initiate regional and national workforce assessments to inform the development of innovative workforce models for oral health, based on the WHO Competency Framework for Universal Health Coverage approach and the objectives of the Global Strategy on Human Resources for Health "Workforce 2030". Consider capacity building programmes to support workforce reform, in collaboration with the WHO Academy.

Action 46. **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, health labour market analyses, and costing of national strategies on human resources for health. Review and strengthen tools, guidelines and databases relating to human resources for NCDs, including oral health, in collaboration with the WHO health workforce department.

Action 47. **Strengthen country-level reporting on human resources for oral health:** Gather, analyse and report oral health workforce data as part of the monitoring framework of the global oral health action plan to track progress in implementation of workforce-related actions. Support country-level data collection on the oral health workforce in the context of national health workforce accounts.

Proposed actions for international partners

Action 48. **Support 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. Strengthen innovative oral health workforce models by focusing international and regional support to countries on countries with the most critical workforce shortages.

Action 49. **Provide technical support for health system strengthening:** Strengthen integrated health and oral health workforce planning, including technical support for national oral health workforce data collection, analysis and use for improved planning and accountability, in alignment with the national health workforce accounts framework.

Action 50. **Improve oral health training and accreditation:** Under the oversight of the ministry of health and in collaboration with professional associations, integrate basic oral health 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 and practice of oral health professionals between countries and geographic areas of need, in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Proposed actions for civil society organizations

Action 51. **Collaborate to accelerate oral health workforce reform:** Develop appropriate task-sharing and inter-professional collaboration models for the provision of oral health care. Strengthen effective accreditation and regulation processes for improved workforce competency, quality and efficiency, under the oversight of the government and through collaboration with professional councils and associations, and, where appropriate, community and patient organizations. For academic training and research institutions, support implementation of the global oral health action plan by prioritising oral health worker competencies in line with the WHO Competency Framework for Universal Health Coverage and the Global Strategy on Human Resources for

Health and by fostering abilities to minimize the environmental impact of oral health services.

Action 52. **Strengthen oral health in primary care:** Foster continuous self-reflection of the dental profession with a goal to improve access to and quality of primary oral healthcare as a societal responsibility within and beyond dentistry.

Action 53. **Improve quality of care through continued education:** Continuously improve quality of care through oral health workforce education. 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 54. **Align private and public oral health workforce training:** Ensure alignment of all oral health workforce training institutions with national health workforce planning to address population health needs. Adapt concepts and programmes of private oral health education to include competency-based training and strengthen education in the public interest.

ACTION AREA FOR STRATEGIC OBJECTIVE 4: ORAL HEALTH CARE

29. Strategic objective 4 aims to integrate essential oral health care and ensure related financial protection and essential supplies in primary health care. This objective seeks to increase access by the entire population to safe, effective and affordable essential oral health care as part of the national UHC benefit package. Essential oral health care covers a defined set of safe, cost-effective interventions at individual and community levels. 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. Financial protection through expanded private and public insurance policies and programmes, including coverage of oral health services, is one of the cornerstones of UHC. 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.

30. 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 as well as remote access and consultation for early detection and referral to services for the management of oral diseases and conditions.

Global targets for strategic objective 4

Global target 4.1: Oral health in primary care

By 2030, 80% of countries will have oral health care services available in primary care facilities of the public health sector.

Global target 4.2: Essential dental medicines

By 2030, at least 50% of countries will have included the WHO essential dental medicines in the national essential medicines list.

Proposed actions for Member States

Action 55. **Establish an essential oral health care package**: Facilitate a national stakeholder engagement process to review evidence, assess current oral healthcare service capacity and agree on cost-effective oral health interventions as part of national UHC benefit packages. Ensure that the packages include emergency care, prevention and treatment of common oral diseases and conditions as well as essential rehabilitation. 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 comprised in Annex 3 of the WHO global action plan for the prevention and control of noncommunicable diseases. Support the introduction of remuneration systems that incentivize prevention over treatment.

Action 56. **Integrate oral health care into primary care:** Develop and review all aspects of primary health care services and plan for integration of oral healthcare at all service levels, including required staffing, skill mix and competencies. Implement workforce models that ensure sufficient numbers of adequately trained health workers provide oral health services as members of collaborative primary health care teams at all levels of care. Ensure that referral pathways and support mechanisms are in place to streamline coordination of care with other areas of the health system. Consider inclusion of private oral health providers through appropriate contracting and/or reimbursement schemes.

Action 57. **Work towards achieving universal health coverage for oral health**: Expand coverage through on-demand care in primary care facilities, using an essential oral health care package. Assess, strengthen and rehabilitate essential clinical infrastructure for oral health services as part of primary care, including the provision of essential oral health supplies and consumables to ensure the quality and scope of needed oral health services.

Action 58. **Provide financial protection for oral health care:** Establish appropriate financial protection for patients through expanded public and private insurance policies and programmes, in accordance with national UHC strategies. Ensure that vulnerable and disadvantaged population groups have access to an essential oral health care package without financial hardship.

Action 59. **Ensure essential oral health supplies:** Prioritise 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 Essential Medicines List. Develop guidance on rational antibiotic use for oral health professionals and promote engagement in initiatives addressing antimicrobial resistance. Strengthen standard procedures for infection prevention and control in line with WHO and other national and international guidance.

Action 60. **Promote 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. Promote the use of mercury-free alternatives for dental restoration. Discourage insurance policies and programmes that favour dental amalgam use over mercury-free dental restoration.

Action 61. **Reinforce best environmental practices:** In collaboration with the ministry of environment, ensure that measures to reduce the environmental impact of oral health services are put in place, including minimising waste, carbon emissions and use of resources. Use best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land.

Action 62. **Optimise digital technologies for oral health care:** Support digital access and consultation for early detection, management of oral diseases and referral, and continue the evaluation of effectiveness and impact of such interventions. Integrate digital access and consultation in interprofessional platforms to facilitate access for patients. Draw on the WHO Mobile Technologies for Oral Health implementation guide for guidance on digital technologies related to improving 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 ensure full confidentiality, patient access to personal data and appropriate consent to data use in a digital health context.

Actions for the WHO Secretariat

Action 63. **Provide guidance on cost-effective oral health interventions:** Recommend interventions as part of the updated Appendix 3 to the WHO global action plan for the prevention and control of noncommunicable diseases and the WHO UHC Compendium of health interventions by 2023 and update them routinely. Support Member States to implement cost-effective interventions on oral health as part of other NCDs initiatives. Facilitate learning and sharing of best practices related to primary oral care and UHC.

Action 64. **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 on digital oral health. Encourage cross-country learning and promote sharing of best practices related to digital oral health technology.

Action 65. **Accelerate implementation of the Minamata Convention on mercury:** In collaboration with the UN Environment Programme, support countries in implementing the provisions of the Minamata Convention on Mercury, particularly those related to the phase down in use of dental amalgam in the framework of the WHO GEF7 project on "Accelerate implementation of dental amalgam provisions and strengthen country capacities in the environmental sound management of associated wastes under the Minamata Convention". Develop technical guidance on environmentally-friendly and less-invasive dentistry.

Proposed actions for international partners

Action 66. **Strengthen universal health coverage for oral health:** Consider inclusion of oral health services in the context of programmatic and budget planning for UHC. Support the development and implementation of a package of essential oral health services. Provide platforms to share lessons learned and key success factors to transition UHC schemes to incorporate oral health services.

Proposed actions for civil society organizations

Action 67. **Mobilise stakeholders for oral health care:** Consider establishing multistakeholder advisory committees for NCDs, including oral health, at national and local levels of government, with representation from civil society organizations to strengthen participation and ownership. Encourage new and strengthen existing civil society organizations to serve as advocates and catalysts to increase access to essential oral healthcare and inclusion in UHC.

Action 68. **Empowerment for self-care:** Strengthen the development of personal, social and political skills of all people to enable them achieving their full potential for oral health self-care. Promote oral health self-care through skills-based oral hygiene education in communities and schools, as well as through inclusion of oral health in population health education campaigns and digital and social media platforms. Advocate for supportive policies to strengthen the availability and affordability of fluoride toothpaste.

Action 69. **Address the environmental impact of oral health care:** Advocate for sustainability, environmental protection and preservation of resources in the context of oral health services, including accelerating the phase down in use of dental amalgam.

Proposed actions for the private sector

Action 70. **Invest in digital oral health for all:** Amplify research 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 71. **Commit to sustainable manufacturing**: Develop, produce and market oral health care products and supplies that are cost-effective, environment-friendly and sustainable. Engage with governments to improve availability and affordability of such products through bulk purchasing and other cost-saving public procurement approaches. Accelerate research and development of new mercury-free, safe and effective dental filling materials.

Action 72. **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 to improve access to essential oral health care and supplies, in line with public health principles and the global oral health action plan. Encourage insurance policies and programmes that

favour the use of quality alternatives to dental amalgam for dental restoration in the context of implementation of the Minamata Convention.

ACTION AREA FOR STRATEGIC OBJECTIVE 5: ORAL HEALTH INFORMATION SYSTEMS

31. Strategic objective 5 aims to enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policy-making. This objective 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. These improved systems should ensure protection of patient data. They should monitor patterns and trends in oral health inequalities and track the implementation and impact of existing policies and programmes related to oral health. 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 the country context.

32. New oral health research 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.

Global targets for strategic objective 5

Global target 5: Integrated oral health indicators

By 2030, 75% of countries will have included oral health indicators in their national health information systems in line with the monitoring framework of the global oral health action plan.

Proposed actions for Member States

Action 73. **Strengthen oral health information systems**: Improve oral health information and surveillance systems, and, depending on country context, integrate into existing national health information systems, such as facility-based service reporting. Strengthen integrated surveillance of population health by incorporating oral health indicators into national NCD and UHC monitoring frameworks. Monitor risk factors as well as the social and commercial determinants of oral health inequalities. Improve information on the oral health workforce in national health workforce accounts. Consider conducting population-based oral health surveys or other appropriate oral disease-specific surveillance, integrated with existing NCD surveillance systems.

Action 74. **Integrate electronic patient records and protect personal health data:** Encourage integration of electronic dental patient records with medical and pharmacological records, as well as public and private providers, to facilitate continuity of patient-centred care as well as population-level health

monitoring. Ensure data protection and confidentiality regulations protect patient-related information while allowing anonymized data analysis and reporting in accordance with national regulations. Ensure that patients have access to all information recorded and stored about them.

Action 75. **Use innovative methods for oral health data collection:** Participate in periodic global WHO surveys that collect NCD, health system and other health information. Develop and standardize innovative methods for gathering oral health and epidemiological data by using digital technologies for data collection and analysis, including artificial intelligence-supported applications in mobile devices; opportunities provided by more complex and big data sets from new data sources; and novel approaches to generating comprehensive disease estimates.

Action 76. **Increase transparent use of oral health information:** Make de-identified information and appropriately disaggregated data on population oral health publicly available to inform research and analysis, planning, management, policy decision-making and advocacy. Ensure alignment of the national oral health monitoring framework with the monitoring framework of the global oral health action plan and regularly report national data, including to WHO as proposed.

Actions for the WHO Secretariat

Action 77. **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 and provide 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 progress on the implementation of the global oral health action plan.

Action 78. **Build capacity for integrated oral health information systems and surveillance:** Develop guidance documents for effective oral health information system strengthening at global, regional, national and subnational levels. Engage with WHO collaborating centres, international partners such as Institute of Health Metrics and Evaluation's Global Burden of Disease group and others, to improve indicators, data inclusion, analysis methodology and interpretation of oral health-related estimates.

Proposed actions for international partners

Action 79. **Advance oral health metrics aligned with global health metrics**: Promote the use of oral health indicators aligned with standard global health metrics used to assess 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.

Action 80. **Support the monitoring framework of the global oral health action plan** Improve capacities for effective oral health information systems and surveillance, research and data analysis by providing appropriate tools and training opportunities at all levels and for all stakeholders in the context of health system strengthening.

Proposed actions for civil society organizations

Action 81. **Advocate for data protection and confidentiality regulations:** In accordance with country regulations, advocate for protection of patient-related information while allowing anonymized data analysis and reporting for planning, evaluation and research.

Proposed actions for the private sector

Action 82. **Provide access to insurance data for research and service planning:** Enable transparent access to private insurance data on coverage, health outcomes and economic information, in full compliance with national data protection policies.

ACTION AREA FOR STRATEGIC OBJECTIVE 6: ORAL HEALTH RESEARCH AGENDAS

33. Strategic objective 6 aims to create and continuously 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. The translation of research findings into practice is equally important and should include the development of country-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 public health interventions.

Global targets for strategic objective 6

Global target 6: Research in the public interest

By 2030, at least 20% of countries will have a national oral health research agenda focused on public health and population-based interventions.

Proposed actions for Member States

Action 83. **Reorient the oral health research agenda:** Define national oral health research priorities to focus on public health and population-based interventions. 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 partnerships within and across countries including multi-disciplinary

research, based on the principles of research ethics and equity in health research partnerships.

Action 84. **Prioritise oral health research of public health interest:** Support research areas of high public health interest while maintaining a balance with basic health research. Close evidence-gaps for: upstream interventions; implementation and operational research; evaluation of primary oral 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 sustainable practices and mercury-free dental restorative materials; and economic analyses to identify cost-effective interventions. In countries where oral cancer and oro-facial clefts are prevalent, support large-scale population-based epidemiological studies to strengthen the evidence for prevention and control of these diseases and conditions. Consider research on noma's aetiology, prevention, therapy and rehabilitation, to contribute to more effective care and support the review process for integration of noma in the WHO list of neglected tropical diseases. Promote research and development of quality mercury-free materials for dental restoration.

Action 85. **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. Develop country-specific, evidence-based clinical practice guidelines.

Actions for the WHO Secretariat

Action 86. **Guide Member States in oral health research:** Provide guidance on research priority-setting and research partnerships to support Member States. Promote implementation research focusing 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 87. **Contribute to noma research:** Set up a platform for knowledge-sharing and initiate a research agenda on noma, in collaboration with WHO collaborating centres and academia.

Proposed actions for international partners

Action 88. **Promote equity in all aspects of global health research:** Support shared agenda-setting for global oral health research, programme planning, implementation and evaluation. Ensure equitable partnerships in priority setting, methodological choices, research funding, project management, analysis and reporting of results and scientific publication authorship.

Action 89. **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 meets the needs of new oral health research priorities. Strengthen evidence of 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 90. **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. Ensure alignment and prioritization of the national oral health research agenda and transparent reporting of progress and results.

Action 91. **Ensure research alignment with national oral health priorities:** Review research and science training curricula of academic and research institutions to assess whether they address public health, implementation research, and national priorities. Enhance representation of oral health research priorities in relevant conferences and research forums.

Action 92. **Conduct participatory research to identify oral health needs and interventions:** When considering interventions for inclusion in essential oral healthcare packages and universal health coverage, enlist the participation of diverse community members, including patients, people living with oral diseases, and people who are poor, vulnerable or disadvantaged. Establish and evaluate patient-public panels for prioritisation of studies, design and management of research, data collection, analysis, reporting and dissemination of findings. Evaluate different social participation and community engagement approaches to improve oral health, such as citizen forums.

Proposed actions for the private sector

Action 93. **Develop modalities of public-private partnerships for oral health research:** Strive to reduce or avoid real or perceived conflict of interest and researcher bias in public-private research partnerships. Foster the public's interest in reforming oral health research agendas.

Action 94. **Invest in research for mercury-free dental filling materials**: Accelerate research and development of new mercury-free, safe dental filling materials. Strengthen the production and trade of environment-friendly and sustainable products and supplies.

MONITORING IMPLEMENTATION PROGRESS OF THE GLOBAL ORAL HEALTH ACTION PLAN

34. A monitoring framework will track the implementation of the global oral health action plan through monitoring and reporting on progress towards the two overarching global targets and nine strategic objective global targets (see Appendix 1). The global monitoring framework is composed of 11 core and 30 complementary indicators, which based on regional, national, and subnational contexts, can be used to prioritize efforts, monitor trends and assess progress on oral health within broader NCD and UHC agendas. The core indicators relate to assessing the global targets and will be used by WHO to populate the monitoring framework of the global oral health action plan. The complementary indicators can be used by countries to monitor specific actions at national level (see Appendix 2).

35. The monitoring framework of the global oral health action plan is based on a results chain approach that visualises the logical relations from inputs and processes to desired outputs, outcomes and impact, supported by evidence-informed policies. The conceptual model of the monitoring framework draws on the results chain framework in the WHO Primary Health Care Measurement Framework and Indicators, and 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.

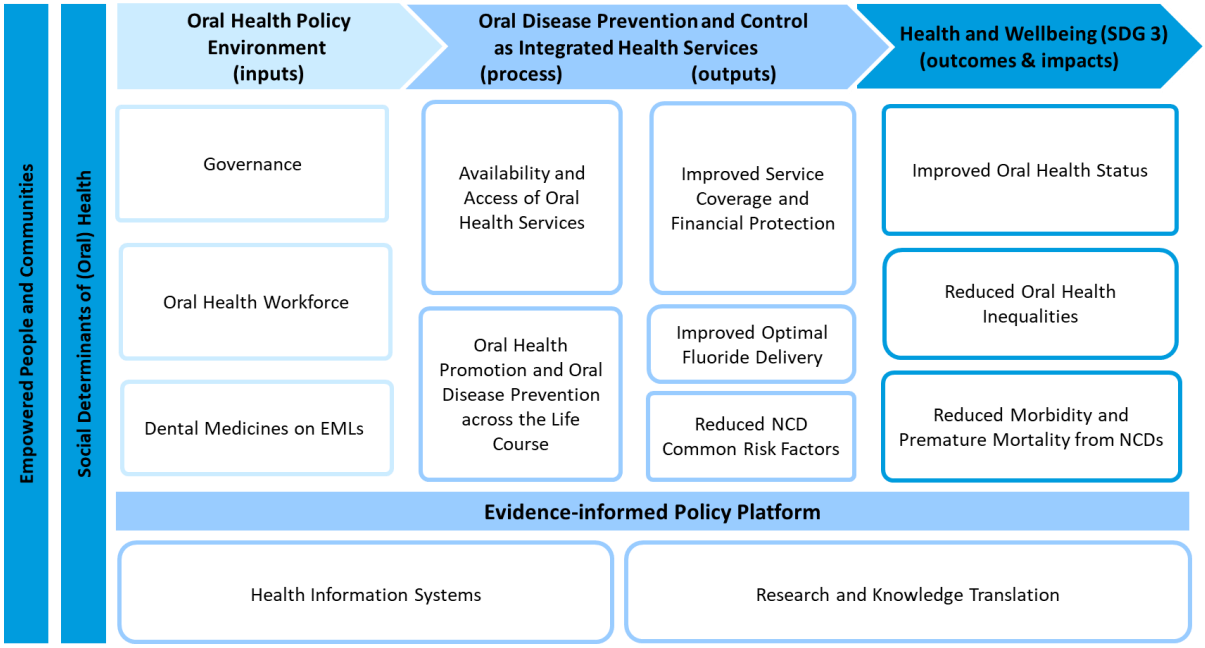
APPENDIX 1

MONITORING FRAMEWORK OF THE GLOBAL ORAL HEALTH ACTION PLAN

MONITORING FRAMEWORK GOALS

The monitoring framework will track implementation of the global oral health action plan by monitoring and reporting on progress towards the two overarching global targets and nine strategic objective global targets. Tracking progress towards UHC for oral health by 2030 supports mobilization of political and resource commitment for stronger and more coordinated global action on oral health.

UHC FOR ORAL HEALTH MONITORING FRAMEWORK



OVERVIEW OF INDICATORS

The global monitoring framework is composed of 11 core and 30 complementary indicators to track and monitor progress on the implementation of the global oral health action plan. As a priority, data on the **core indicators** should be collected in all countries using existing systems and resources. Countries may complement the core indicators by using **complementary indicators** as relevant according to their specific national or regional 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.

CORE INDICATORS

Overarching global target I: UHC for oral health

By 2030, 75% of the global population will be covered by essential oral health care services to ensure progress towards UHC for oral health

Core Indicator	I.1. Proportion of population covered by essential oral health interventions under a public health benefit package
Indicator definition	Proportion of population covered by essential oral health interventions under a health benefit package of the largest government health financing scheme. The term "largest" is defined as having the highest total population eligible to receive services, while 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, oral cancer screening for high-risk individuals) • Essential curative oral health care (including topical silver diamine fluoride, atraumatic restorative treatment, glass ionomer cement restoration, urgent treatment for providing emergency oral care and pain relief such as non-surgical extractions and drainage of abscesses) **Numerator**: number of people covered by essential oral health interventions under the health benefit package of the largest government health financing scheme **Denominator**: total country population listed in World Population Prospects by the United Nations Department of Economic and Social Affairs
Data type	Percent
Data source	WHO Health Technology Assessment/Health Benefit Package Survey
Years for data collection	2023 2025 2029/2030
Comments	Data for indicator I.1 was collected by WHO in 2020/21 using the global Health Technology Assessment and Health Benefit Package Survey. The questionnaire was completed by officially nominated survey focal points in WHO Member States and areas. It is anticipated that minor adjustments will be required to the existing collection tool for reporting on this indicator.

Overarching global target II: Reduce oral disease burden

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

Core Indicator	II.1. Prevalence of the main oral diseases and conditions
Indicator definition	Estimated prevalence of the main oral diseases and conditions. Main oral diseases and conditions include: • untreated dental caries of deciduous teeth • untreated dental caries of permanent teeth • edentulism • severe periodontal diseases • other oral disorders (excluding lip and oral cavity cancer and orofacial clefts). **Refer to GBD source for further definitions.*
Data type	Percent
Data source	IHME Global Burden of Disease database
Years for data collection	2023 2025 2029/2030
Comments	Estimates for indicator II.1 are provided in the IHME Global Burden of Disease (GBD) 2019 database. The GBD 2019 estimates are based on multiple relevant data sources, such as National Oral Health Surveys. Countries are encouraged to conduct population-based oral health surveys or other appropriate oral disease-specific surveillance, integrated with existing NCD surveillance systems. The WHO Global Oral Health Status Report (in press) uses the latest available from GBD 2019.

Strategic Objective 1. Oral health governance

Global target 1.1: National leadership for oral health

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

Core Indicators	1.1.1 Existence of operational national oral health policy, strategy or action plan 1.1.2. Presence of dedicated staff for oral diseases in the NCD Department or other Department of the Ministry of Health
Indicator definition	1.1.1 Existence of an operational policy, strategy, or action plan for oral health available in respective country. Operational is defined as a policy, strategy or plan of action which is being used and implemented in the country and has resources and funding available to implement it. 1.1.2 Presence of technical/professional staff in the unit/branch/department working on NCDs at Ministry of Health dedicating a significant portion of their time to oral diseases, such as a Chief Dental Officer
Data type	Categorical (Yes/No)
Data source	Ministry of Health (Responding to WHO NCD Country Capacity Survey which is conducted periodically by WHO and completed by NCD focal point at the Ministry of Health)
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicators 1.1.1 and 1.1.2 have been periodically collected and regularly reported by WHO through the WHO NCD Country Capacity Survey. 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 will be required to the existing data collection tool for reporting on these indicators. A country would need to respond "Yes" to both indicators (1.1 and 1.2) in order to count towards the target.

Global target 1.2: Environmentally-sound practices

By 2030, 90% of countries will have implemented two or more of the recommended measures to phase down dental amalgam in line with the Minamata Convention on Mercury or will have phased it out.

Core Indicator	1.2. Implemented measures to phase down the use of dental amalgam
Indicator definition	The extent to which measures have been implemented by a country to phase down the use of dental amalgam, taking into account national circumstances and relevant international guidance, in accordance with the provisions of the Minamata Convention on Mercury and decisions made by the Conference of the Parties. *"Measures to be taken by a Party to phase down the use of dental amalgam shall take into account the Party's domestic circumstances and relevant international guidance and shall include two or more of the measures from the following list:* *(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.* *In addition, Parties shall:* *(i) Exclude or not allow, by taking measures as appropriate, the use of mercury in bulk form by dental practitioners;* *(ii) Exclude or not allow, by taking measures as appropriate, or recommend 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."* Phase out dental amalgam: Country no longer using dental amalgam and not allowing the manufacture, import or export of the material.
Data type	Categorical (Yes/No, by measure)

Data source	WHO consultation in preparation to Conference of the Parties of the Minamata Convention on Mercury, in collaboration with the Secretariat of the Convention
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 1.3 was collected and reported by WHO in 2019 and 2021 through an informal consultation. The indicator has been defined so that it is relevant for all countries (including Parties and non-Parties of the Minamata Convention on Mercury) and assesses progress to phase down the use of dental amalgam at the global level.

Strategic Objective 2. Oral health promotion and oral disease prevention

Global target 2.1: Reduction of sugar consumption

By 2030, 70% of countries will have implemented a tax on sugar-sweetened beverages

Core Indicator	2.1. Implemented tax on sugar-sweetened beverages (SSBs)
Indicator definition	Country has implemented a tax on sugar-sweetened beverages. "Yes" responses refer to the application of excise taxes and/or special VAT/sales tax rates.
Data type	Categorical (Yes/No)
Data source	WHO NCD Country Capacity Survey
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 2.1 has been periodically collected and regularly reported by WHO. Data is collected through the WHO NCD Country Capacity Survey. The questionnaire is completed by national NCD focal points or designated officers within the Ministry of Health or national institute/agency.

Global target 2.2: Optimal fluoride for population oral health

By 2030, at least 50% of countries will have national guidance to ensure optimal fluoride delivery for the population

Core Indicator	2.2. National guidance on optimal fluoride delivery for oral health
Indicator definition	Availability of national guidance related to fluorides for oral health, addressing the universal availability of systemic or topical fluorides. Depending on the country context, consider adding or removing 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
Data type	Categorical (Yes/No, by fluoride delivery methods included in guidance)
Data source	Government representative at Ministry of Health; Government databases
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 2.2 has not been collected or reported in the past by WHO. Data will be collected through an updated version of the existing WHO NCD Country Capacity Survey.

Strategic Objective 3. Health workforce

Global target 3: Innovative workforce model for oral health

By 2030, at least 50% of countries have an operational national health workforce strategy that includes workforce trained to respond to population oral health needs

Core Indicator	3.1. Existence of an operational national health workforce strategy that includes workforce trained to respond to population oral health needs
Indicator definition	Existence of an operational national health workforce strategy, and whether a workforce trained to respond to population oral health needs are included in the strategy Workforce trained to respond to population oral health needs may include: • Oral health professionals (dentists, dental assistants, dental therapists, dental hygienists, dental nurses, dental prosthetic technicians) • Primary health care workers (including community health workers)
Data type	Categorical (Yes/No)
Data source	Government/Ministry of Health; government databases
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 3.1 has not been collected or reported in the past by WHO. Data will be collected through an updated version of the WHO NCD Country Capacity Survey, in line with the WHO Global strategy on human resources for health: Workforce 2030 and the WHO Global competency framework for UHC

Strategic Objective 4. Oral health care

Global target 4.1: Oral health in primary care

By 2030, 80% of countries will have oral health care services available in primary care facilities of the public health sector

Core Indicator	4.1. Availability of oral health care services in primary care facilities of the public health sector
Indicator definition	Availability of procedures for detecting, managing and treating oral diseases in primary care facilities of the public health sector: Generally available refers to reaching 50% or more patients in need whereas generally not available refers to reaching less than 50% of patients in need. The indicator requires that all of the following oral health care services are generally available in the country: • availability of oral health screening for early detection of oral diseases • availability of urgent treatment for providing emergency oral care and pain relief • availability of basic restorative dental procedures to treat existing dental decay
Data type	Categorical (available/unavailable, by oral health care service as defined in the WHO NCD Country Capacity Survey)
Data source	WHO NCD Country Capacity Survey
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 4.1 has been periodically collected and regularly reported by WHO. Data is collected through the existing global survey titled WHO NCD Country Capacity Survey. The questionnaire is completed by national NCD focal points or designated officers within the Ministry of Health or national institute/agency.

Global target 4.2: Essential dental medicines

By 2030, at least 50% of countries will have included the WHO essential dental medicines in the national essential medicines list

Core Indicator	4.2. WHO EMLs dental preparations are listed in the national essential medicines list (or equivalent guidance)
Indicator definition	The extent to which dental preparations on the WHO Essential Medicines List and WHO Essential Medicines List for children are listed in the national Essential Medicines List (or equivalent guidance). Responses can be disaggregated by dental preparations (fluoride, glass ionomer cement and silver diamine fluoride) and/or amount of dental preparations (1,2 or all).
Data type	Categorical (Yes/No, by dental preparation)
Data source	Government/Ministry of Health (Oral health officer/essential medicines unit)
Years for data collection	2023 2025 2027 2029/2030
Comments	Additional dental preparations were added to the WHO EML in 2021, data for this indicator has not been previously collected. Data will be collected through an updated version of the WHO NCD Country Capacity Survey in collaboration with the WHO Department of health products, policies and standards.

Strategic Objective 5. Oral health information systems

Global target 5: Integrated oral health indicators

By 2030, 75% of countries will have included oral health indicators in their national health information systems in line with the monitoring framework of the global oral health action plan

Core Indicator	5.1. Oral health indicators in routine health information systems
Indicator definition	The extent to which indicators are integrated into the existing national routine health information system (e.g., Health Management Information System (HMIS), The District Health Information Software (DHIS2), Integrated Disease Surveillance and Responses (IDSR)) in line with the monitoring framework of the global oral health action plan.
Data type	Categorical (Yes/No, by indicator)
Data source	Routine health information system; Government representative at Ministry of Health (oral health officer/oral health unit)
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 5.1 has not been collected or reported in the past by WHO. Data will be collected through an updated version of the existing WHO NCD Country Capacity Survey.

Strategic Objective 6. Oral health research agendas

Global target 6: Research in the public interest

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

Core Indicator	6.1. Setting national oral health research agendas focused on public health and population-based interventions
Indicator definition	Existence of a national oral health research agenda (e.g. priority list, research focus guidance, specific research component in the national oral health policy, specific oral health research component in the national research agenda) that focusses on public health programmes and population-based interventions.
Data type	Categorical (Yes/No)
Data source	National and sub-national government health research agencies
Years for data collection	2023 2025 2027 2029/2030
Comments	Data for indicator 6.1 has not been collected or reported in the past by WHO. Data will be collected in collaboration with international research partners.

APPENDIX 2

COMPLEMENTARY INDICATORS

UHC FOR ORAL HEALTH COMPLEMENTARY INDICATORS

Complementary Indicator	I.2. Prevalence of unmet oral health needs (and reason for unmet needs) [it includes unmet oral health needs due to financial reason]
Indicator definition	Proportion of the population unable to obtain oral health care when they perceive the need (e.g. question „during the past year, have you had need for oral health care but not been able to obtain it? “). Reasons for unmet oral health care needs would include financial (too expensive), transportation/geographic (too far to travel), or timeliness (long waiting lists) reasons. **Numerator:** Number of people unable to obtain oral health care when they perceive the need **Denominator**: Total number of people surveyed. Data type: Percent, by reason (financial, transportation/geographic, and timeliness)
Complementary Indicator	I.3. Out-of-pocket payment for oral health care services, US$ per capita
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. **Data type:** Money

REDUCE ORAL DISEASE BURDEN COMPLEMENTARY INDICATORS

Complementary Indicator	II.2. DMFT
Indicator definition	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	II.3. PUFA index
Indicator definition	The Pulp, Ulceration, Fistula, Abscess (PUFA) Index qualifies and quantifies the systemic consequences of severe dental caries in deciduous (pufa) and permanent teeth (PUFA). 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	II.4. Prevalence of untreated caries of deciduous teeth in children
Indicator definition	Estimated prevalence of untreated caries of deciduous teeth in children: Rate of children who have caries in one or more deciduous teeth. Untreated caries is defined as a lesion in a pit or fissure, on a smooth tooth surface, has an unmistakable cavity, undermined enamel, or a detectably softened or floor or wall (coronal caries), or feel soft or leathery to probing (root caries). **Data type:** Percent
Complementary Indicator	II.5. Prevalence of untreated caries of permanent teeth
Indicator definition	Estimated prevalence of untreated caries of permanent teeth in people: Rate of persons with one more carious permanent teeth. Untreated caries is defined as a lesion in a pit or fissure, on a smooth tooth surface, has an unmistakable cavity, undermined enamel, or a detectably softened floor or wall (coronal caries), or feel soft or leathery to probing (root caries). **Data type:** Percent
Complementary Indicator	II.6. Prevalence of severe periodontal disease
Indicator definition	Estimated prevalence of severe periodontal disease in people: Rate 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 or more than 6 mm, or Community Periodontal Index of Treatment Needs (CPITN) also referred as Community Periodontal Index (CPI) score of 4, or a clinical attachment loss (CAL) more than 6 mm. **Data type:** Percent

Complementary Indicator	II.7. Missing teeth
Indicator definition	Missing teeth status refers in the number of the missing teeth. Normally measured in in permanent teeth and adult populations and is related to a fully dentate status of 28 teeth (excluding third molars). A person suffers from severe tooth loss when less than nine teeth are remaining in the mouth, including complete toothlessness.
Complementary Indicator	II.8. Incidence rate of oral cancer (lip and oral cavity cancer)
Indicator definition	Estimated incidence rate of lip and oral cavity cancer (age-standardized per 100,000 population): Incidence rates of lip and oral cavity cancer in female, male and total, among all ages as age-standardized per 100,000 population. **Data type:** Rate
Complementary Indicator	II.9. Prevalence of orofacial clefts
Indicator definition	Estimated prevalence of orofacial clefts in people. Any livebirth with isolated cleft lip, isolated cleft palate, and combined cleft lip and cleft palate resulting from the tissues of the face not joining properly during foetal development. **Data type:** Percent
Complementary Indicator	II.10. Self-reported oral health status
Indicator definition	Self-reported oral health status, including pain or discomfort, dry mouth, difficulty in chewing food and swallowing water, days not at work because of teeth or mouth (e.g. question: "During the past 12 months, did your teeth or mouth cause any pain or discomfort?) **Data type:** Categorical (Yes/No) or Ordinal (Likert scale)

STRATEGIC OBJECTIVE 1. ORAL HEALTH GOVERNANCE COMPLEMENTARY INDICATORS

Complementary Indicator	1.3. Government per capita expenditure on oral health care
Indicator definition	Domestic general government expenditure per capita on oral healthcare. **Data type:** Money
Complementary Indicator	1.4. Per capita expenditure on oral health care
Indicator definition	Estimate of the annual national per capita expenditure on oral healthcare for outpatient oral health care (public and private). **Data type:** Money
Complementary Indicator	1.5. National policies, strategies or action plans with a specific policy goal or action towards reducing sugars intake (exc. SSBs taxation)
Indicator definition	Existence of a national policy, strategy or action plan with a specific goal or action towards reducing sugars intake. Specific goal or action could refer to measures such as: -Taxes: Taxes on sugars or on foods high in sugars (excluding sugar-sweetened beverages (SSBs) taxes that are captured by another indicator) -Nutrition labelling: Front-of-pack or other interpretative labelling/claim to indicate healthier food choices related to sugars -Reformulation limits or targets to reduce sugars content in foods and beverages -Public food procurement and service policies to reduce the offer of food high in sugars -Restriction of marketing of food and non-alcoholic beverages high in sugars to children **Data type:** Categorical (Yes/No, by measure)
Complementary Indicator	1.6. National policy or legislation to restrict all forms of tobacco consumption

Indicator definition	State Parties to WHO Framework Convention on Tobacco Control (FCTC) with complete policies on MPOWER measures (as defined in the WHO Report of the Global Tobacco Epidemic, page 23): - 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 (NRT) 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% of retail price is tax **Data type:** Categorical (Yes/No, by measure)
Complementary Indicator	1.7. Oral health integration in community-based programs
Indicator definition	Oral health integration in community-based programs that serve specific targeted populations, for example, programs set in schools, workplaces, aged care facilities, outreach programs, and other settings. **Data type:** Categorical (Yes/No, by program) or Percent, by program
Complementary Indicator	1.8. Noma recognized as a national public health problem
Indicator definition	Noma (cancrum oris) is a non-communicable 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 are part of the Regional Noma Control Programme in the WHO African Region and recognize noma as a national public health problem. **Data type:** Categorical (Yes/No)

STRATEGIC OBJECTIVE 2. ORAL HEALTH PROMOTION AND ORAL DISEASE PREVENTION COMPLEMENTARY INDICATORS

Complementary Indicator	2.3. Population using fluoride toothpaste on a daily basis
Indicator definition	Proportion of the population cleaning or brushing daily with fluoride toothpaste. The recommended concentration in toothpaste is between 1000 and 1500 ppm for all age groups. Current recommendations for young children suggest a "smear/rice sized" (for children below 3 years) and "pea sized" amount for young children. **Data type:** Percent
Complementary Indicator	2.4. Per capita availability of sugar (grams/day)
Indicator definition	Per capita availability of sugar (g/day) (2019): The availability of sugar (raw equivalent) including i) raw cane or beet sugar, ii) cane sugar, centrifugal, iii) beet sugar, iv) refined sugar and v) 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, 15+ years (%, age-standardized rate)
Indicator definition	The percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis. Tobacco products include cigarettes, pipes, cigars, cigarillos, waterpipes (hookah, shisha), bidis, kretek, heated tobacco products, and all forms of smokeless (oral and nasal) tobacco. Tobacco products exclude e-cigarettes (which do not contain tobacco), "e-cigars", "e-hookahs", JUUL and "e-pipes". **Data type:** Percent
Complementary Indicator	2.6. Per capita total alcohol consumption, 15+ years (litres of pure alcohol per year)
Indicator definition	Per capita total alcohol consumption, 15+ (litres of pure alcohol): The total alcohol per capita consumption comprises both, the recorded and the unrecorded alcohol per capita consumption. **Data type:** Rate
Complementary Indicator	2.7. Prevalence of current betel quid use among persons aged 15 years and older
Indicator definition	Prevalence of current betel quid use among persons aged 15 years and older (%): The percentage of the population aged 15 years and over who currently chew BQ at least 3 days a week. **Data type:** Percent

STRATEGIC OBJECTIVE 3. HEALTH WORKFORCE COMPLEMENTARY INDICATORS

Complementary Indicator	3.2. Active oral health personnel (per 10,000 population)
Indicator definition	Total active oral health personnel density, per 10,000 population: 1) dentists; 2) dental assistants and therapists, dental hygienists, and dental nurses; and 3) dental prosthetic technicians. "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 practising or professionally active health workers, data with the closest definition can be used, such as "*health worker licensed to practice"*. **Data type:** Rate (density)
Complementary Indicator	3.3. Trained primary healthcare workers (inc. community healthcare workers) can perform cost-effective interventions on oral health
Indicator definition	"Yes" responses to the question "Can trained primary healthcare workers (inc. community healthcare workers) perform cost-effective interventions on oral health in your country?" Primary healthcare workers exclude oral health care personnel (dentists, dental assistants and therapists, dental hygienists, and dental nurses, dental prosthetic technicians). Cost-effective interventions on oral health (Best buys) are currently under development. Training can include both pre-service education (prior to and as a prerequisite for employment in a service setting; e.g. during undergraduate training) or in-service education (for persons already employed in a service setting; e.g. as part of continuing professional development) **Data type:** Categorical (Yes/No)

STRATEGIC OBJECTIVE 4. ORAL HEALTH CARE COMPLEMENTARY INDICATORS

Complementary Indicator	4.3. Proportion of the population who visited an oral health care professional
Indicator definition	Proportion of the population who visited an oral health care professional within a certain period of time (e.g. question: "Did you consult with an oral health professional during the past year?") Numerator: Number of people who visited an oral health care professional within a certain period of time Denominator: Total number of people surveyed. **Data type:** Percent
Complementary Indicator	4.4. Existence of technical guidance on the prescription of antibiotics for use in oral health care
Indicator definition	Existence of technical guidance on the prescription of antibiotics for use in oral health care Categorical (Yes/No)

STRATEGIC OBJECTIVE 5. ORAL HEALTH INFORMATION SYSTEMS COMPLEMENTARY INDICATORS

Complementary Indicator	5.2. Collection of oral health data using WHO NCD survey tools or national oral health survey, across the life course
Indicator definition	Collection of oral health data using WHO NCD survey tools (STEPS, NCD Country Capacity Surveys, Global School-based Student Health Survey, etc.) or national oral health survey (using or not digital technology), across the life course. **Data type**: Categorical (Yes/No, by indicator)
Complementary Indicator	5.3. Full set of oral health information received by WHO HQ
Indicator definition	Countries reporting data for all core indicators in line with the monitoring framework of the global oral health action plan
Complementary Indicator	5.4. National Monitoring Framework to track national oral health policy
Indicator definition	Existence of a National Monitoring Framework to track the progress of implementation of the national oral health policy/strategy/plan (Y/N) (Among those countries that have an oral health policy, strategy, or action plan). **Data type**: Categorical (Yes/No)

STRATEGIC OBJECTIVE 6. ORAL HEALTH RESEARCH AGENDAS COMPLEMENTARY INDICATOR

Complementary Indicator	6.2. Percentage of government funds for oral health research
Indicator definition	Percentage of public funds for health research that is allocated for oral health-related projects. **Numerator**: Amount of public funds devoted to oral health-related research projects **Denominator:** Total amount of public funds for health research **Data type**: Percent

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