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EDITORIAL

Progress in policy issues to improve oral health in Africa

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Introduction

In the African region there is a disproportionate amount of oral disease which has grave and often fatal consequences, some of which seems to be growing in prevalence as a result of the massive social disruption on the continent. Although oral conditions are not always life-threatening, they are important public health problems because of their high prevalence, their severity, or public demand due to their impact on individuals and society. The combined effect of the resulting pain, discomfort, social and functional limitations, financial burden and handicap these have on the quality of life, has been largely ignored. It has also become evident that a substantial number of colonial and other unsustainable oral health strategies exported to Africa have failed so far to improve oral health in the region. Where viable interventions have existed, their accessibility for most communities has been limited or entirely excluded by the constraints of class, demography or political status (Hobdell *et al*, 1997).

In June 2002, the Group of Eight meeting in Canada placed new emphasis on the plight of the African continent and attempted to address how financial assistance might best be structured to facilitate socio-economic development. This journal has previously drawn attention to the particular challenges facing oral health in Africa, and to the need to change oral health priorities (Hobdell *et al*, 1997). We have also recently produced data to show how oral diseases around the world are closely interwoven with Socio-Economic Status and internationally accepted measures of poverty and so-called 'development' (Hobdell *et al*, 2003a). Nevertheless, in spite of continuing famine in many areas, wars and civil unrest, not all is 'gloom and doom' in the 'dark continent'. The present Editorial summarizes real progress in developing appropriate oral health policies in recent years, though it is still too early to demonstrate concrete outcomes in terms of improvements in normative measures of personal and public health.

Encouraging developments were triggered when African Ministers of Health attending the 48th session of the World Health Organisation (WHO) Regional Committee in Harare, Zimbabwe, in September 1998, adopted a new oral health strategy for the African Region for the 10-year period 1999–2008 (WHO, 1998a). That strategy, prepared by an Expert Group sitting in Dakar, Senegal, in 1998 (WHO, 1998b) is reproduced in full in this issue of Oral Diseases because, although it is now 6 years old, it represents a fundamental shift in thinking about the determinants of oral diseases, their management and their inter-relationship with general and community health (Myburgh *et al*, 2004). That paradigm shift is gaining wider acceptance, as summarized below.

The conceptual core of this strategy

The strategy (WHO, 1998a) recognizes that oral health is fundamentally influenced by the same environmental factors that influence general health, and that an effective oral health policy or programme must address both the generic and specific influences on oral health. The notion of oral health as an integral part of community health is central to the construction of the strategy. It offers an alternative way of interpreting the oral health information available, one that contextualizes the professional and community perspective on oral health needs in Africa. This introduces a fundamental re-orientation of the way in which conditions are identified as priority oral health problems and whether they are considered to be public health concerns requiring a public health response.

A systematic approach to the selection of interventions capable of addressing these needs on the basis of scientifically proven efficacy is presented. The critical role of evidence-based-dentistry research in the oral health policy and planning process is specifically

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highlighted. It demands a pragmatic assessment of what interventions are actually viable in the poorly resourced environments found in Africa.

An important conceptual difference between this approach and its predecessors, is its emphasis upon flexibility and customization to match local circumstances. In this respect it directly challenged the then prevailing WHO approach centred on a generic set of global disease goals, normative indicators and a focus, until recently, on caries and periodontal disease (WHO, 1992, 1997).

The strategy document provides a conceptual framework for countries, regions or even district level health planners to construct oral health policy or plans that can actually work. It aims to ensure that the oral health needs of a given community are meaningfully identified and prioritized, that locally relevant determinants of oral health are matched with proven intervention options effective locally, and that oral health activities are integrated with other elements of public health that can be effectively adapted to enhance oral health.

The strategy concludes by proposing a set of guidelines for the construction of a national oral health policy and a timetable of activities to support the process in the African Region.

The implications of this strategy

New priorities must include conditions such as oral cancer, noma (cancrum oris) and the significant burden of disease and disability caused by the oral manifestations of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome. We need better to understand the oral manifestations of those tropical and infectious diseases endemic in Africa (Prabhu *et al*, 1994). Although varying in severity and extent, dental caries (Manji *et al*, 1991) and periodontal diseases (Baelum *et al*, 1991, 1996; Baelum and Scheutz, 2002; Baelum and Lopez, 2003) remain ubiquitous and their sequelae impact considerably on quality of life and the productivity of society: nevertheless they need to be put into perspective with the other more serious oral diseases. An increased attention to oral mucosal conditions is long overdue, but it may be difficult for professionals who have dedicated their lives to fixing hard tissue lesions to accept this!

Treatment need assessments and the intervention options selected will change dramatically, and procedures such as scaling, topical fluoride gel application, fluoride rinsing and a number of other procedures may well be abandoned because of lack of efficacy in the very real circumstances of the mass of the African population. The targeting of oral disease determinants becomes the task of public health teams rather than more narrowly focused oral health workers. Alternatively, the job description of existing oral health workers will have to merge with such teams.

The strategy supports the enhancement of research into, and promotion of, effective traditional methods of oral health promotion, another area that has been largely ignored. This could benefit immediately from existing WHO initiatives elsewhere in the health sector.

Implementation of the strategy

Whether the strategy can and will be implemented is a more difficult question to answer. The WHO has no shortage of Resolutions and expressions of good intent, but the real test will the ability of this initiative to stimulate country level activity. At a continental and global level the strategy has now gained wide acceptance.

The April 1999 Harare meeting set out to assist participants in implementing the Regional Oral Health Strategy. It prepared a framework with which to address priority areas of prevention and other interventions at country level, outlined key elements to be included in the African Regional Plan of Action for the early years of the new millenium, and established a Network of Partnerships.

Final recommendations from the Harare meeting

These recommendations were unanimously adopted by the participants and strongly supported by the then Regional Director of WHO for the period 2000–02. Given the very different levels of development in oral health strategic planning and service delivery in the region, the recommendations were regarded as essential to support individual countries in their efforts to develop their own national oral health strategies. The recommendations encompass the desirability of redefining oral health as par of general health; promoting the use of traditional (indigenous) interventions with proven oral health benefits; building partnerships and thus capacity with other health agencies, both WHO and NGO's, across the region.

Research and information are an essential platform. This should include research into the efficacy and cost effectiveness of existing traditional (indigenous) oral health practices and a regional system of oral health information collection and analysis. A more efficient system of communication in the region using fax, e-mail, list-serve and the internet is now possible.

Special action on noma, HIV and other serious conditions

The WHO established a global campaign against noma in 1994, and there is a strong collaboration with the international oral health programme of the National Institute for Dental and Craniofacial Research of the USA. That campaign has created the noma network, with an established strategy of prevention, treatment and research. For noma, trauma, cancer, HIV-related oral lesions, congenital abnormalities and other serious and life-threatening conditions WHO leadership and coordination is essential to ensure cost-effective use of charitable and other donated funds.

Subsequent milestones

These include:

- The WHO Consultative Meeting: *New Approaches in Oral Health Training and Education in Africa*, Cape Town, South Africa, 2002.

The WHO Collaborating Centre for Oral Health at the University of the Western Cape, hosted the first ever WHO consultative meeting of the heads of dental training institutions from across the continent of Africa in April 2002. Every institution, Anglophone, Francophone and Portuguese-speaking was represented. Many of the participants were meeting for the first time and thus began a process of networking that is promising to be the beginning of long-standing and fruitful partnerships between all academics involved in training oral health personnel in and for Africa.

It was agreed: (i) To establish a database of training institutions including: Entry and exit levels; type and numbers of personnel trained; learning methods used; exit competencies. (ii) To establish an African database of research resources and infrastructure, disease profiles and current research efforts; identify collaborative interdisciplinary research teams; identify publication opportunities for research from the region including strengthening of existing regional journals. There should be a sharing of knowledge on potential funders for joint research initiatives. (iii) To establish an electronic listserve to improve communication between all institutions in the region; strengthen collaborative postgraduate and undergraduate education, joint research initiatives, student and staff exchange and sharing of curricular components. Establish shared courses in research skills training for teachers, educational method for teachers, leadership, management and IT training.

An *African Oral Health Education Association* was formed with a steering committee comprising persons covering geographic, linguistic and gender diversity. This will become part of the International Federation of Dental Education Associations. The full proceedings of this meeting are available as a pdf file from nmyburgh@uwc.ac.za

- Preparation and publication of a new set of *Global Goals for Oral Health* by a joint working group of the FDI World Dental Federation, WHO and the International Association for Dental Research (IADR) (Hobdell *et al*, 2003b). This is highly significant for at least two reasons: First it discards the old concept of normative goals for the whole world, replacing them with a short set of strategic goals and objectives: what were formerly called goals are now targets. Targets are expressed in terms of proportional improvements in national and local situations and focus on morbidity and quality of life, and the development of appropriate systems to deliver and to monitor progress towards these targets. The philosophy is firmly based on recognition of common risk factors for oral and general and community ill health. Secondly, this document represents a joint initiative of arguably the three most important and influential bodies in world dentistry and oral health – WHO representing the voice of governments; the FDI representing the practicing dental profession worldwide; the IADR representing the academic/research community which provides the knowledge base upon which the oral health sciences progress.
- Appointment of a new WHO Regional Director of Oral Health for the Afro region, in 2003. Following the retirement of Dr Sam Thorpe, who had lead many initiatives throughout the continent with wisdom and energy for many years, his successor, Dr Charlotte Ndyai, is formulating implementation plans (See http://www.afro.who.int/)
- Formulation and publication of a new global strategy for oral health by the new Responsible Officer at WHO Headquarters, which firmly espouses the above philosophy (Petersen, 2004). See also http://www.who.int/oral_health/publications/report03/en/
- Preparation of an Oral Health Policy Manual for Africa, espousing the foregoing principles. A prepublication version of this is available as a pdf file from nmyburgh@uwc.ac.za

As we write there is about to be a gathering of health ministers and oral health leaders from across the continent, organized jointly by the FDI World Dental Federation and WHO, in Nairobi, Kenya (14–16 April 2004; see http://www.fdiworldental.org). We pray this will add real teeth to the foregoing aspirations. A report of this important meeting will be published in a subsequent issue of Oral Diseases.

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