# Alliance for Oral Health Across Borders
# Official Response to NCD Alliance.
## RE: Zero draft political declaration of the high-level meeting on UHC 2023

It is important that the Oral Health community respond to this opportunity from the NCD Alliance to share our thoughts:

Both International Association of Dental Research (IADR) and Federation Dentaire International (FDI) are affiliated to and wholeheartedly support the NCD Alliance and are committed to the principle of UHC. Bearing in mind that oral diseases are now added to the list of non-communicable diseases (NCDs), by virtue of the WHA74.5 "landmark resolution" on oral health, we would like to bring our support to the table and will comment on the advocacy and actions we can bring to bear. The Alliance for Oral Health Across Borders intends to focus on this vital component of elevating the voice of civil society.

## I. Invest in prevention and control of NCDs through adequate, predictable and sustained resources for UHC.

- In post-pandemic Dentistry, unfortunately, primary care is under strain and provision of private Dentistry leading to tremendous inequalities in access. While a level of dental care and freedom from pain is a basic human right, Dentistry needs to continue its emphasis on **prevention.** For example, nutritionist Dr. Paula Monyhan, in 2014, spearheaded the global fight against sugars and Sugar-sweetened beverages (SSBs) with her seminal research. This was integrated by the WHO, informing their policies and recommendations on sugar utilization. There will be continued research evidence to advocate and support curbs on the advertising of sugars, banning SSB vending machines in hospitals and schools, supporting initiatives for healthy diet and motivation for behaviour change. Health coaching, integrated health care systems which are already a significant item on the Oral Health agenda will continue to provide data on their topics. We suggest use of the same model for development that addresses the risk factors for Cardiovascular diseases (CVD), diabetes / obesity, cancers and respiratory diseases.

- Along with sugar, the risk factors for dental decay and periodontal disease include tobacco, alcohol, and substance abuse. An example of mitigation of the impact of sugar is the health tax structure implemented in the country of Mexico. Other cities have levied more direct taxes on sugar and SSBs as they have done, with success, on tobacco products.

- Acknowledgement of the need for development of socially responsible public private partnerships that can influence these risk factors such as the example of the development of non-cariogenic sugar substances that has occurred in the past. We strongly recommend at this time all efforts to ensure that big industry is correctly aligned with the world health agenda. Additionally, continued advocacy to influence community agencies in areas of clean water and water fluoridation are essential.

- We advocate 1) continued use of sugar substitutes, 2) expansion of the programs that tax sugar foods and beverages, and 3) reduction of sugar content on a gradient. All these will need cooperation of public and private partnerships and legislative bodies.

- Clinical interventions by the professions should expand utilization of fluoride varnish, and dental sealant treatments. Self care prevention should be expanded with all populations having access to toothbrush and fluoridated toothpaste.

- Continued evaluation with health economic research is encouraged to measure the cost benefit of all the aforementioned risk factors outlined above.

## II. How do we accelerate UHC implementation?

- The UHC care benefit package will look different in every country, due to differences in the economy, infrastructure, workforce, access to, and affordability of care. A good example of a scalable preventive intervention program is the Scottish Government supported ChildSmile model, introduced over a decade ago. This program can be a model as it also addresses holistic care and prevention of other NCDs. Dental professionals worldwide are well positioned to contribute to expansion of this type of program due to their unique access with the biannual dental visit. We recommend emphasising continued integration of oral health with general health outreaches to strengthen the capacity of total health development.

## III. Align development and global health priorities to achieve UHC.

- The recent COVID-19 pandemic was characterised by severe disruption of healthcare, including dental treatment, and furthermore highlighted that those with the greatest social economic challenge suffered most. If the same problems are to be avoided in the future, governments all over the world must consider how to retain a strong and resilient primary health service. The dental workforce should be officially expanded as needed to include community health care workers, nurses, physician's assistants, midwives, and other non-dental participants of a variety of backgrounds, in addition to dentists, dental therapists, and hygienists. These can contribute greatly to NCD surveillance, and population preventive behaviour change.

- In essence, we recommend a much more concerted integration of oral health with colleagues in medicine, pharmacy, optometry and mid-level community health workers in a renewed workforce model. For example, early detection of the deadly disease of NOMA could never be achieved by anyone in the dental workforce as it typically appears in younger children. Early detection and treatment with antibiotics is a simple cure, however, non-diagnosis and lack of medical care in remote areas allows it to continue to become a disfiguring and potentially lethal disease. Recently, the WHO section in Africa has put forward several educational models developed for medical community health workers that include dental information and education regarding diagnosis of early NOMA cases.

- We see another example of a creative preventive initiative in Cambodia, where midwives, who give vaccinations to young children, also check them for dental decay, review oral hygiene and nutritional education with the children and give them fluoride varnish treatments.

## IV. Engage people living with NCDs to keep UHC patient centred.

- Civil society has not had a good track record in either provision of care decisions or conducting patient centred research. The voice of the patient and those with lived experience with their involvement is clearly essential for patient-centred care. The relationship between patients and the dentist has often been characterised by a paternalistic, non-consultative approach that has resulted in profession driven healthcare provision usually without patient input.

- As a result, society is poorly informed by the causes of dental and oral diseases, especially the fact that they are largely preventable and the risk factors for oral diseases are aligned to those of other NCDs. On occasion, when civil society had raised awareness about the consequences of dental neglect and possibilities of primary prevention, there was justifiable outrage. This was seen in the case of a young boy in Maryland USA, Diamonte Driver where a dental infection resulted in systemic infection and death. The subsequent outrage from the public that a preventable disease was allowed to happen as a result of a failed health system resulted in legislative change. First, legislative changes in the state of Maryland and subsequently well beyond.

- Since one of the main reasons for inaction is lack of political will, gaining the confidence and support of civil society to effect political change ought to be a top priority. Strong support of civil society would by definition, result in changes in political will as people elect politicians. This is unlikely to happen organically and needs to be driven from within the profession – via World Health Organization (WHO) oral health, FDI and IADR – and the driving force for this initiative is developing into a primary focus for the Alliance for Oral Health Across Borders (AOHAB).