Tracking progress on the implementation of the Global oral health action plan 2023–2030

Baseline report

World Health Organization

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The data to inform this report was sourced from the WHO Noncommunicable Disease Country Capacity Survey, the WHO Health Technology Assessment and Health Benefit Package Survey, Institute for Health Metrics and Evaluation's Global Burden of Disease study, the WHO Global Database on the Implementation of Food and Nutrition Action and surveys managed by the WHO and the Secretariat of the Minamata Convention on Mercury, United Nations Environment Programme

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Abbreviations

COP4	Fourth Meeting of the Conference of the Parties to the Minamata Convention on Mercury
EML	WHO Model Lists of Essential Medicines
GBD	Global Burden of Disease
GIFNA	Global Database on the Implementation of Food and Nutrition Action
GOHAP	Global Oral Health Action Plan 2023–2030
GPW14	WHO fourtheenth General Program of Work
HTA/HBP	Health Technology Assessment and Health Benefit Package
IHME	Institute for Health Metrics and Evaluation
NCD	Noncommunicable Disease
NCD CCS	Noncommunicable Disease Country Capacity Survey
PHC	Primary Health Care
UHC	Universal Health Coverage
WHA	World Health Assembly
WHO	World Health Organization

Executive summary

The World Health Organization (WHO) defines oral health as 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 *(1)*. Oral diseases are a major public health problem for countries and populations worldwide. Although they are largely preventable and treatable at an early stage, oral diseases contribute to a substantial economic burden globally, particularly affecting underserved and vulnerable populations with limited access to essential oral health care services *(2)*. Improving access to and the affordability of essential oral health care services can be achieved by integrating these services into primary health care (PHC) and universal health coverage (UHC) benefit packages.

In 2021, the WHO Member States adopted the landmark Resolution on oral health (WHA74.5) recognizing that oral health should be embedded within the noncommunicable disease (NCD) and UHC agendas. The resolution was followed by the development of the Global strategy on oral health (decision WHA75(11)) and translated into the Global oral health action plan 2023–2030 (GOHAP) (decision WHA 76(9)) *(1)*. The GOHAP is an important step towards the implementation of the strategy and resolution and is structured according to six strategic objectives, with eleven global oral health targets to be achieved by 2030.

This report describes the status of the global oral health targets as at late 2024, constituting a baseline assessment, using data provided by Member States and other relevant sources. From this foundation, the WHO secretariat will report on progress every three years until 2031, in accordance with the mandate outlined by the Resolution on oral health (WHA74.5).

WHO has been able to collect data on 10 of the 11 core indicators that inform the global targets of the GOHAP to prepare this comprehensive baseline report. Most targets report a substantial gap between the current situation and the ambition of the global target for 2030. Currently, only one target—the integration of oral health into primary care—has been implemented by more than three-quarters of Member States (80.9%, n=157), suggesting that in principle, that target has been met. However, when considering only facilities in the public sector, this percentage drops to 66.5% (n=129), highlighting that this indicator does not consider dimensions such as population coverage. In parallel, only 23.3% of the global population is entitled to essential oral health care as part of the health benefit packages of the largest government health financing scheme. A summary of the current baseline results compared to the global targets can be found in Table 1.

Table 1: Summary of the baseline results, by global targets as defined by the Global oral health action plan 2023–2030

Global targets	Baseline	Target
Overarching Global Targets		
Overarching global target A: Oral health services are part of UHC (2020/21)	23.3%	80%
Overarching global target B: Reduced oral disease burden (2021)	46.8% (42.5%-51.2%)	- 10%
Strategic Objective 1: Oral Health Governance		
Global target 1.1: National leadership for oral health (2023)	27.8%	80%
Global target 1.2: Environmentally sound oral health care (2023/2021)	31.4%	90%
Strategic Objective 2: Oral Health Promotion and Oral Disease Prevention		
Global target 2.1: Policies to reduce free sugars intake (2023)	21.1%	50%
Global target 2.2: Optimal fluoride for population oral health (2023)	28.9%	50%
Strategic Objective 3: Health Workforce		
Global target 3: Innovative workforce model for oral health	Data not available	50%
Strategic Objective 4: Oral Health Care		
Global target 4.1: Integration of oral health in primary care (2023)	80.9%	80%
Global target 4.2: Availability of essential dental medicines (2023)	0.5%	50%
Strategic Objective 5: Oral Health Information Systems		
Global target 5.1: Monitoring implementation of national oral health policy (2023)	6.2%	80%
Strategic Objective 6: Oral Health Research Agenda		
Global target 6.1: Research in the public interest (2023)	18%	50%

This comprehensive baseline report establishes the reference point for monitoring the implementation of the GOHAP globally and highlights areas that require immediate attention globally or regionally. It is intended for policymakers and stakeholders at global, regional and national levels to understand where to target their respective efforts in progressing the global oral health agenda. As countries implement tangible actions that align with the GOHAP, it is anticipated that WHO can monitor this progress through periodic reporting on the global oral health targets. WHO relies on data collected from countries that is shared with WHO through existing mechanisms to fulfil its mandate to report on progress and results until 2031 as part of the consolidated report on noncommunicable diseases, in accordance with paragraph 3(e) of decision WHA72(11) (2019).

Introduction

Oral diseases, though largely preventable, currently affect 3.7 billion people globally, affecting 47% of the world's population (2021). This burden is unevenly distributed, with disadvantaged and marginalized groups being disproportionately affected. The economic toll is substantial—treatment costs in 2019 surpassed US$ 380 billion, representing 4.8% of global health care expenditure *(2)*.

In May 2021, the WHO Member States adopted a landmark Resolution on oral health (WHA74.5). Following this, WHO led the development of the Global strategy on oral health (WHA75(11)) adopted in 2022 and then the Global oral health action plan 2023–2030 (WHA76(9)) in 2023 *(1)*. The resolution and following policy documents affirm that oral health should be embedded within the NCD agenda and that oral health care services should be included in national UHC benefit packages. Combined these policy documents set the global oral health agenda and are ready for adaptation and implementation in countries.

The vision of the Global strategy on oral health is:

"Universal health coverage for oral health for all individuals and communities by 2030, enabling them to enjoy the highest attainable state of oral health and contributing to healthy and productive lives." (1) p. 77

To achieve this vision, the ambition is framed around six strategic objectives *(1)*:

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

The GOHAP translates the six strategic objectives into a set of 100 actions, organized according to key stakeholder groups: Member States, WHO secretariat, international partners, civil society organizations and the private sector. The GOHAP also outlines a monitoring framework with core indicators that inform the 11 global oral health targets. Additionally, there are 29 complementary indicators to support national and regional monitoring *(1)*.

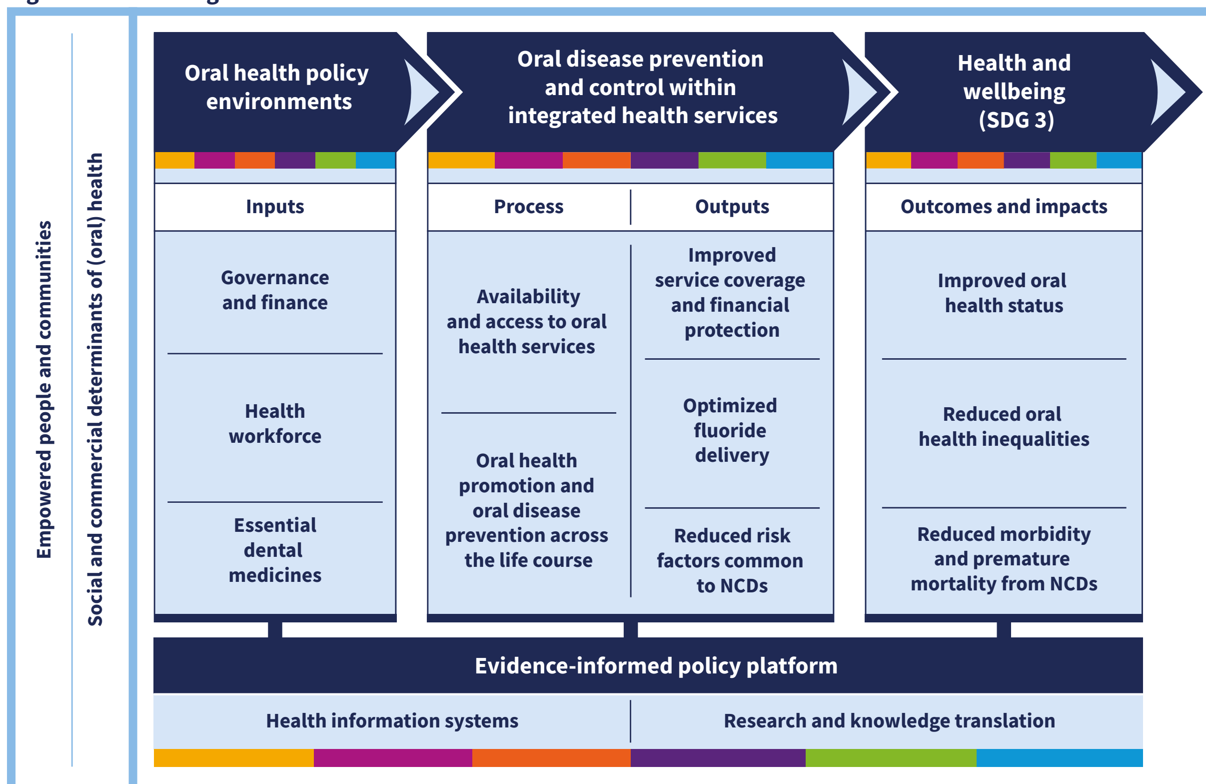
The aim of this report is to provide a comprehensive baseline assessment on the global oral health targets to track implementation progress of the GOHAP. The report offers an overview of the current situation and serves as a reference for future reports. From this foundation, progress can be tracked every three years until 2031 and reported back to Member States through the mandate outlined in the 2021 Resolution on oral health (WHA74.5).

Methods

Monitoring Framework of the Global oral health action plan 2023–2030

The monitoring framework of the GOHAP outlines how inputs within the oral health policy environment contribute to the processes and outputs of oral disease prevention and control in integrated health services, which in turn lead to outcomes and impacts related to health and well-being (Figure 1).

Figure 1: Monitoring framework of the Global Oral Health Action Plan 2023–2030



Implementation of the GOHAP will be monitored by tracking progress against the 11 global targets, informed by the defined core indicators *(1)*. There are two overarching global targets: oral health services are part of UHC and reduced oral disease burden; and nine global targets related to each of the strategic objectives, aligned with the monitoring framework components (Table 2). Data on the core indicators were collected and reported in this report.

Table 2: Summary of global oral health targets, core indicators, and relevant monitoring framework component

Global target	Core indicator	Monitoring framework component
Overarching global target A: Oral health services are part of UHC	A.1. Percentage of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes	Output: Improved service coverage and financial protection
Overarching global target B: Reduced oral disease burden	B.1. Prevalence of the main oral diseases and conditions	Outcome and Impact: Improved oral health status
Global target 1.1: National leadership for oral health	Percentage of countries that have an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agencies	Input: Governance and finance
Global target 1.2: Environmentally sound oral health care	Percentage of countries that have implemented measures to phase down the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out	Input: Governance and finance
Global target 2.1: Policies to reduce free sugars intake	2.1. Percentage of countries that implement policy measures aiming to reduce free sugars intake	Process: Oral health promotion and oral disease prevention across the life course
Global target 2.2: Optimal fluoride for population oral health	2.2. Percentage of countries that have national guidance on optimal fluoride delivery for oral health of the population	Output: Optimized fluoride delivery
Global target 3: Innovative workforce model for oral health	3.1. Percentage of countries that have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs	Input: Health Workforce
Global target 4.1: Integration of oral health in primary care	4.1. Percentage of countries that have oral health care services generally available in primary health care facilities	Process: Availability and access to oral health services
Global target 4.2: Availability of essential dental medicines	4.2. Percentage of countries that include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list (or equivalent guidance)	Input: Essential dental medicines
Global target 5: Monitoring implementation of national oral health policy	5.1. Percentage of countries that have a monitoring framework to track progress on implementation of the national oral health policy, strategy, or action plan	Evidence-informed policy platform: Health information systems
Global target 6: Research in the public interest	6.1. Percentage of countries that have a national oral health research agenda focused on public health and population-based interventions	Evidence-informed policy platform: Research and knowledge translation

Data sources and analysis

The majority of the global oral health targets were informed by data collected through the WHO Noncommunicable Disease Country Capacity Survey (NCD CCS) *(3)*. Other data sources used included the WHO Health Technology Assessment and Health Benefit Package Survey (HTA/HBP Survey) *(4)*, Institute for Health Metrics and Evaluation's (IHME) Global Burden of Disease study (GBD) data *(5)*, the Global Database on the Implementation of Food and Nutrition Action (GIFNA) *(6)*, the WHO and Minamata Convention Secretariat Survey *(7)*, Full national reports submitted to the Minamata Convention Secretariat *(8)*, Fourth Conference of the Parties (COP4) submissions to the Minamata Convention on Mercury *(9)*, and the informal global WHO consultation with policymakers in dental public health *(10)*.

All country responses were reviewed and validated against submitted supporting documents or internal sources when necessary. For example, data on policies to reduce free sugars intake from GIFNA were cross-checked with the relevant data from the NCD CCS. Based on the country's response ('Yes,' 'No,' or 'I don't know') and the criteria for achieving each target (where applicable), each country was classified as having 'fully achieved,' 'partially achieved,' or 'not achieved'. For countries that did not respond or did not submit the necessary documents when validation or further data extraction was needed, 'No information provided' was recorded. Responses from countries stating 'Don't know' were retained as submitted. Statistical analyses were conducted using Microsoft Excel to generate global and regional estimates. Subgroup analyses were performed by WHO region for all 194 WHO Member States and World Bank income groups for 191 Member States, that have income group classifications (Venezuela, Cook Islands and Niue were excluded, using the FY2023 classification) *(11)*. However, for 2021 data where the relevant FY2021 World Bank Income group classification was applied, subgroup analyses by World Bank income groups was possible for 192 Member States (Cook Islands and Niue were excluded) *(11)*. All data extraction, cleaning, and analyses were carried out by WHO. Table 2 contains details on the 11 global oral health targets, respective core indicators, and monitoring framework component. Full details on each global target, including the definition of the related indicators, criteria for achieving the target, method of computation, data sources, and technical notes, can be found in Annex 1.

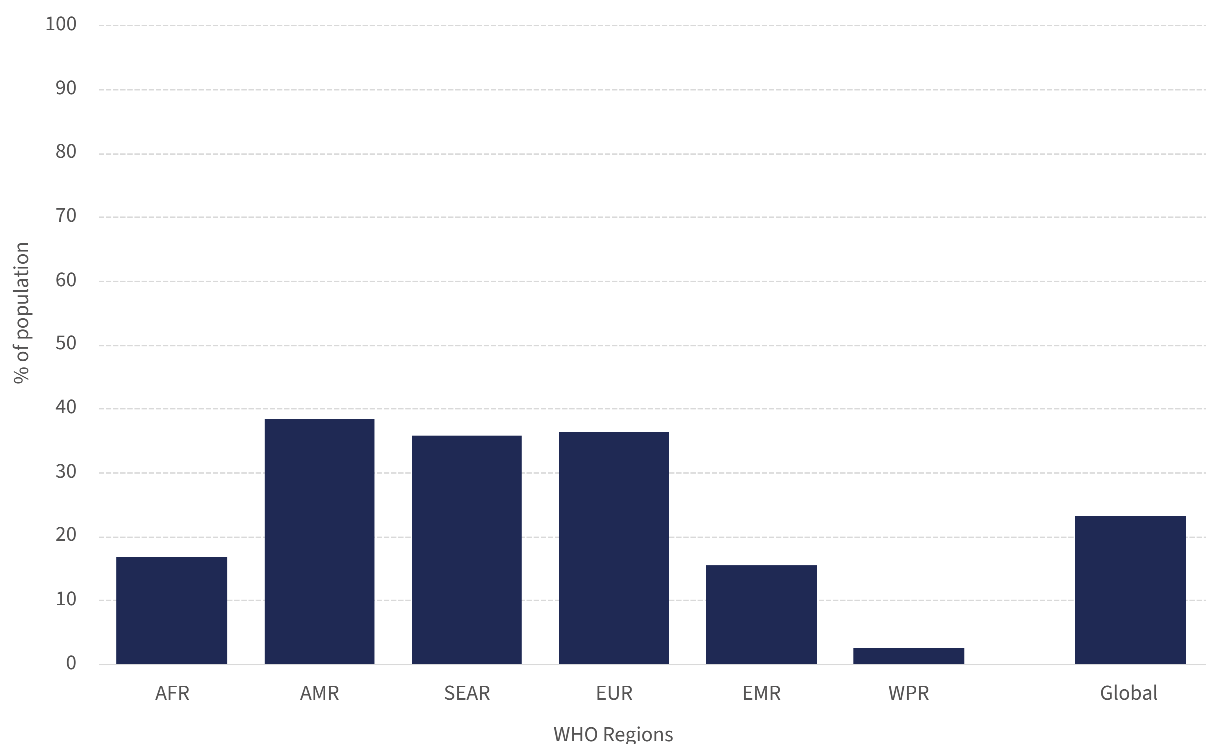
Results

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

In 2020-2021,

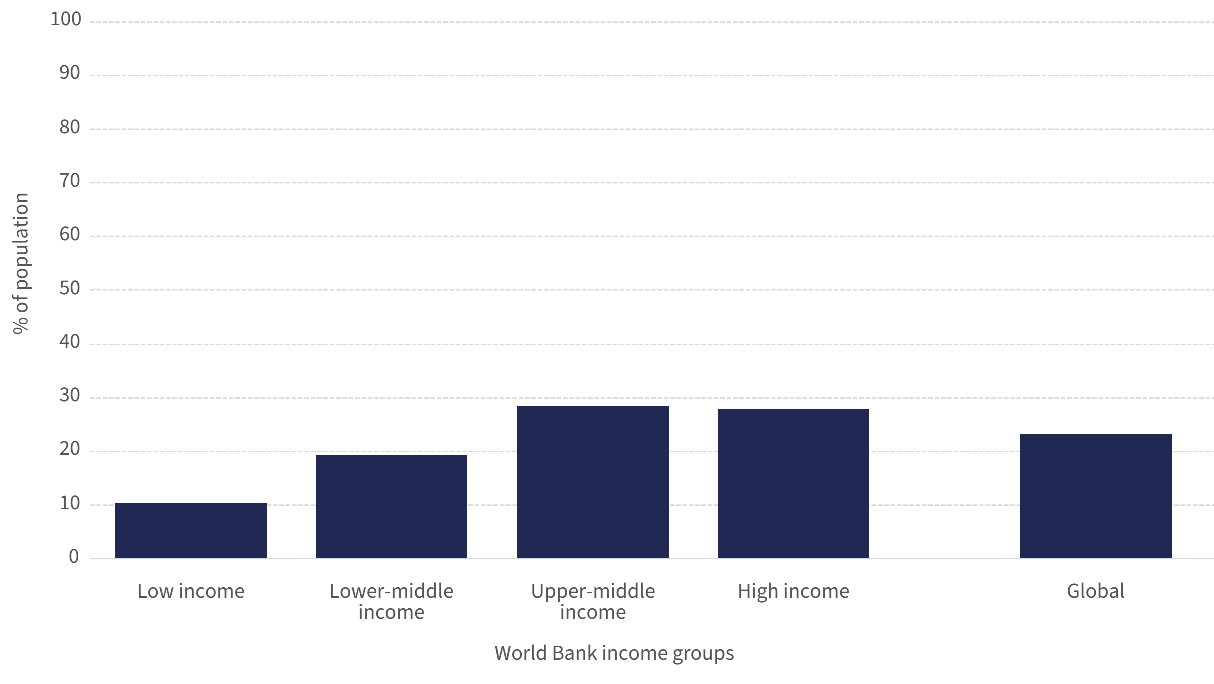
- Only, 23.3% of the global population are entitled to essential oral health care services, as part of health benefit packages of the largest government health financing schemes (Figures 2 and 3).
- The WHO Regions with the highest proportion of the population entitled to essential oral health care services are the WHO Region of the Americas (38.4%), the WHO Region for Europe (36.5%), and the WHO Region for South-East Asia (35.9%) (Figure 2).
- Nearly all World Bank income groups had around one quarter of their populations entitled to essential oral health care services. However, in countries within the low-income World Bank income group, only 10.3% of the population are entitled to these services (Figure 3).

Figure 2: Percentage of population entitled to essential oral health health care services, by WHO Regions, 2020–2021



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 3: Percentage of population entitled to essential oral health health care services, by World Bank income groups, 2020–2021



Discussion

The purpose of this target is to understand the coverage dimension of UHC in the context of essential oral health care services and integration into national UHC benefit packages. While there are some case examples from countries that have enabled an entitlement to essential oral health care services through integration of these services with national UHC benefit packages, globally there is still a large gap to close by 2030 in most of the WHO regions. As an overarching target to achieving the ambition of the GOHAP, it has also been set as one of the outcome indicators for the WHO fourtheenth General Program of Work, which guides WHO's work in support of Member States and partners for the 4-year period 2025-2028 (GPW14).

The data to inform this target is sourced from the WHO HTA/HBP survey, 2020–2021. Due to the complexities and variation of national UHC benefit package design, the survey asks specifically for information based on the largest government health financing scheme only. However, it is worth noting that inclusion of essential oral health care interventions could also be provided under other government health financing schemes outside the largest one but are not captured in this indicator. It is anticipated that this survey will be updated and conducted again from 2025.

Overarching global target B: Reduced oral disease burden

In the context of the GOHAP, the term "main oral diseases and conditions" aligns with the IHME GBD definition representing oral diseases and conditions with the highest burden including untreated dental caries (in both primary and permanent teeth), severe periodontal disease, edentulism (complete tooth loss), and other oral disorders. This term excludes a number of oral diseases such as lip and oral cavity cancer, congenital malformations, and trauma.

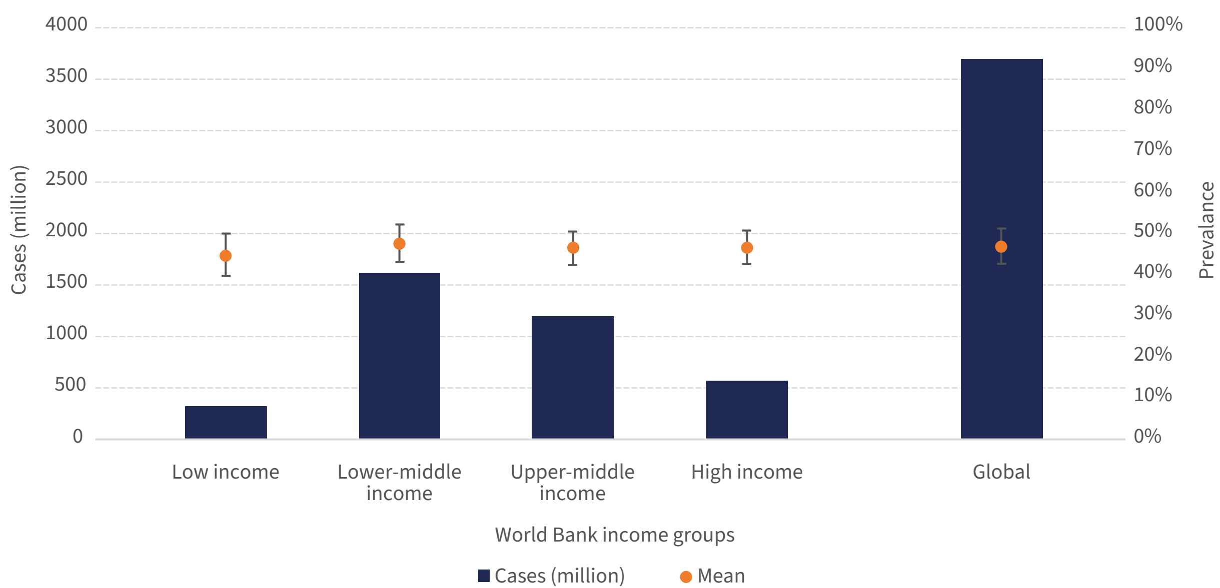
In 2021

- Approximately 3.7 billion people (46.8% of the world's population, with a 95% confidence interval of 42.5%–51.2%) are affected by oral diseases. Among these, around 1.9 billion are residing in low or lower-middle income countries (Figures 4 and 5).
- The prevalence of oral diseases is similar across WHO regions and World Bank income groups, with the WHO Region for Europe having the highest prevalence at 53.6%, followed by the WHO Region for South-East Asia (49.8%). The largest number of cases is present in WHO Regions for South-East Asia and the Western Pacific due to their large population sizes (Figures 4 and 5).

Figure 4: Estimated case numbers and prevalence of the main oral diseases and conditions for both sexes and all ages combined, including confidence intervals, by WHO region, 2021

AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 5: Estimated case numbers and prevalence of the main oral diseases and conditions for both sexes and all ages combined, including confidence intervals, by World Bank income groups, 2021



Discussion

The purpose of this target is to track progress of the impact of policy implementation in countries on the actual disease burden experienced by populations. With concerted action globally, it is anticipated that prevalence rates of oral diseases can not only be halted, but potentially even see a reduction in prevalence of oral diseases by 2030. However, comparison of figures between the 2019 *(2)* and the current 2021 GBD estimates suggests an upward trend in the main oral diseases and conditions prevalence and number of cases.

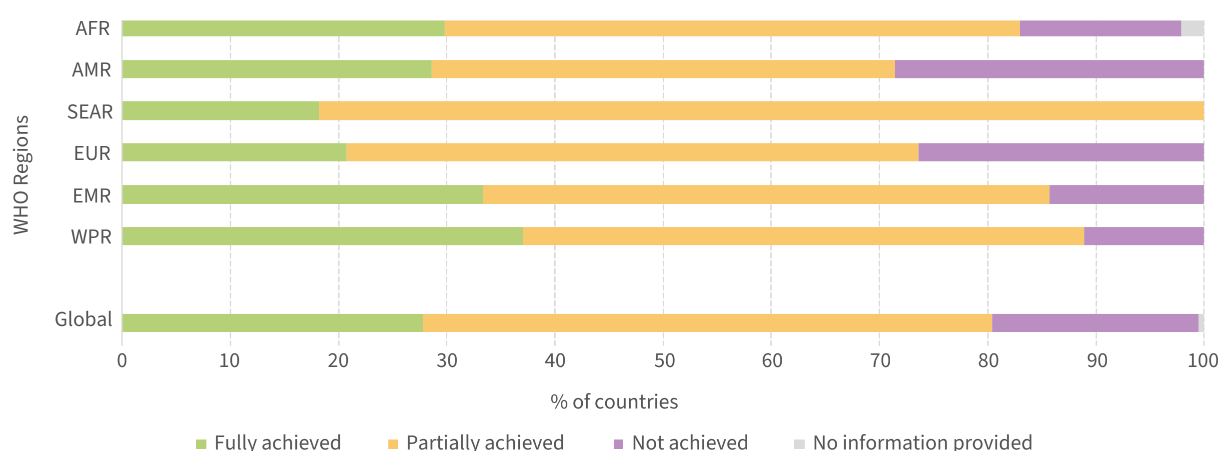
Each of the diseases that contribute to this burden represent a significant public health problem on a global, regional and national level. With their unparalleled burden, stark inequalities and risk factors shared with other NCDs, oral diseases have a major impact on health, well-being, healthcare systems and economies, adding to the increasing burden of NCDs. Traditional oral health measurements, such as the Decayed, Missing, and Filled Teeth index or the Community Periodontal Index, for specific age groups, have been typically used to monitor oral disease burden. In the absence of comprehensive, comparable data with global coverage, this target uses the IHME estimates informed by the GBD study.

Strategic objective 1: Oral health governance
Global target 1.1 National leadership for oral health

In 2023:

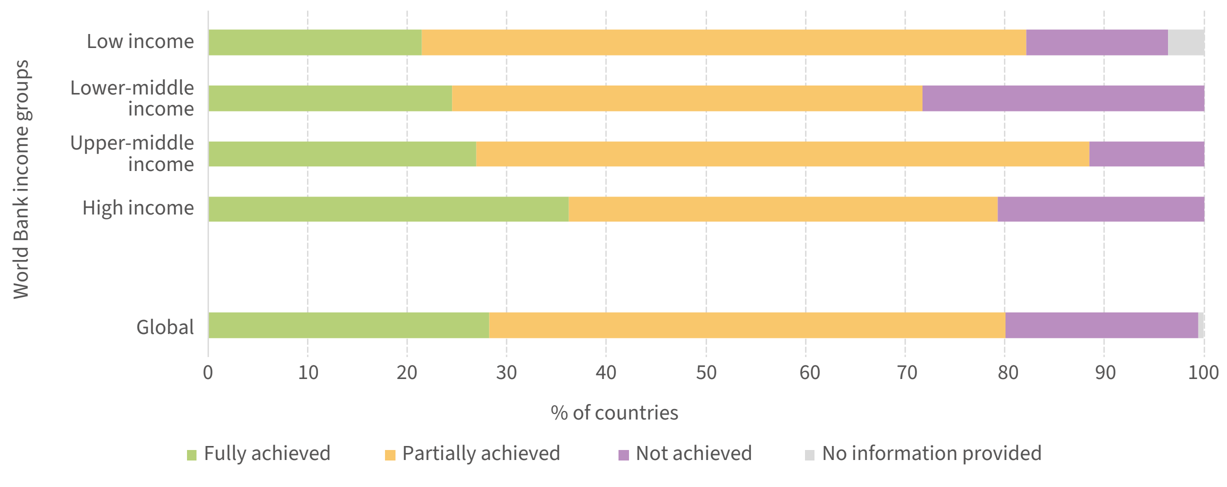
- More than one quarter (27.8%, n=54) of Member States reported having an operational national oral health policy, strategy, or action plan, and dedicated staff for oral health, thereby fully achieving this target (Figure 6).
- Of the countries that met the criteria for fully achieved, most were based in the WHO Region for the Western Pacific (37.0%, n=10) or in high-income countries (36.2%, n=21) (Figures 6 and 7).
- More than half of Member States (52.6%, n= 102) have either an operational national oral health policy, strategy, or action plan, or a dedicated staff for oral health, thus partially achieving the target (Figure 6).
- Over three-quarters of the Member States in the WHO Region for South-East Asia (81.8%, n=9) have partially achieved this target, followed by the WHO Regions for Africa (53.2%, n=25), Europe (52.8%, n=28), Eastern Mediterranean (52.4%, n=11) and Western Pacific (n=14, 51.9%) (Figure 6).

Figure 6: Percentage of countries with an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agency, by WHO region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 7: Percentage of countries with an operational national oral health policy, strategy or action plan and dedicated staff for oral health at the Ministry of Health or other national governmental health agency, by World Bank income groups, 2023



Discussion

The purpose of this indicator is to understand the readiness and political commitment within countries to drive forward progress on oral health. A national strategy, oral health policy, strategy or action plan is important to ensure planned and coordinated efforts in countries. This needs to be supported by staff dedicated to its implementation to realize the goals it sets out. While having a national policy does not guarantee the availability of resources, it typically serves as a prerequisite for engaging stakeholders and for scaling up action.

The data indicates that many countries have made efforts on oral health governance, even though not all have fully met the achievement criteria for the target. Specifically, many countries (52.6%, n=102) have plans that are either expired, lack a specified expiry date, have not been updated in the last five years, or do not have dedicated staff for oral health within their ministries.

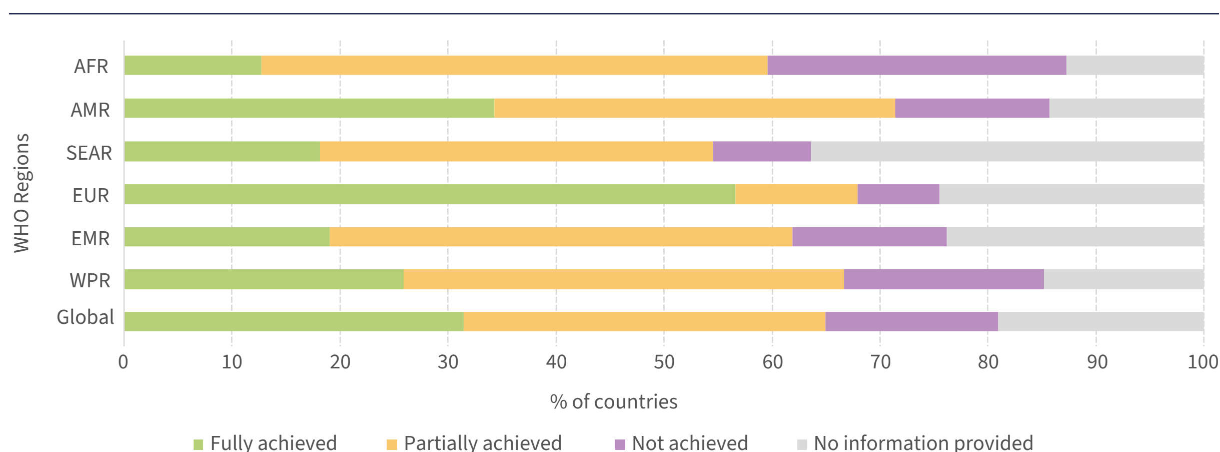
Global target 1.2: Environmentally sound oral health care

Global target 1.2: Environmentally sound oral health care

In 2023:

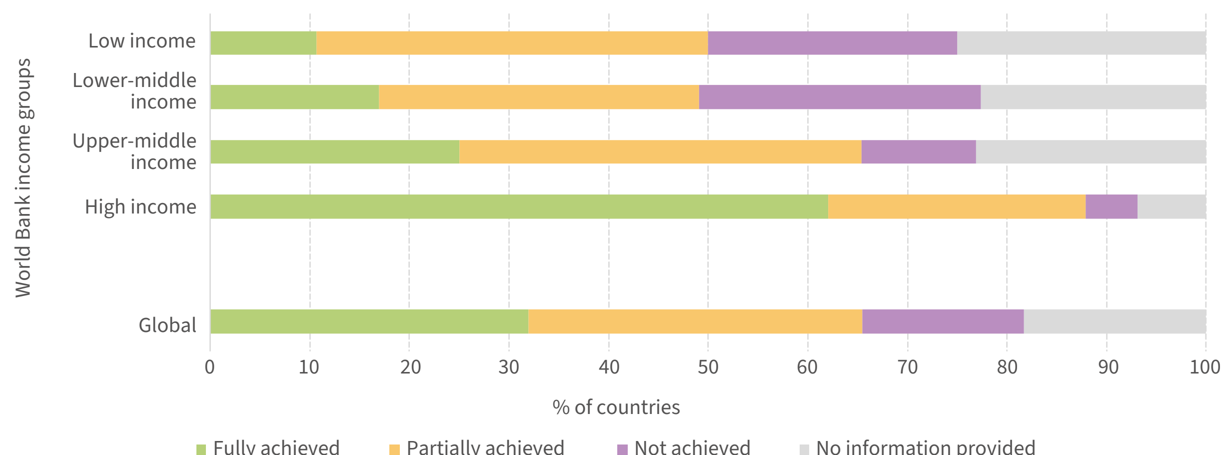
- Around one third of countries (31.4%, n= 61) have implemented two or more of the original nine measures and both COP4 mandatory measures to phase down the use of dental amalgam, in accordance with the provisions of the Minamata Convention on Mercury. Some of these countries have phased out its use completely, thus fully achieving the target (Figures 8 and 9).
- Of countries that have fully achieved this target, most were based in the WHO Region for Europe (56.6%, n=30) or in high-income countries (62.1%, n=36) (Figures 8 and 9).
- Forty seven percent of Member States in the WHO Region for Africa (n=22), followed by 42.9% (n=9) in the WHO Region for the Eastern Mediterranean and 40.7% (n=11) in the WHO Region for the Western Pacific reported using dental amalgam but have implemented one or two of the requirements to phase down its use as stipulated by the Minamata convention on Mercury. Thus, partially achieving the target (Figure 8).
- Thirty-one countries (16.0%) are still using dental amalgam and have not implemented any measures to phase down its use (Figures 8 and 9).

Figure 8: Percentage of countries that have implemented measures to phasedown the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out, by WHO Region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 9: Percentage of countries that have implemented measures to phasedown the use of dental amalgam as stipulated in the Minamata Convention on Mercury or have phased it out, by World Bank income groups, 2023



Discussion

The purpose of this indicator is to monitor the progress of WHO Member States in phasing down the use of dental amalgam, or even phasing it out. While not all WHO Member States are Parties to the Minamata Convention on Mercury, WHO is actively engaged in supporting all countries to implement the dental amalgam provisions stipulated within the Convention as at 2022, or to phase it out when appropriate.

The original text of Annex A Part II of the Minamata Convention on Mercury listed nine measures from which Parties are to implement two or more. The COP4 in 2022 amended the Annex, with the addition of two mandatory measures which entered into force on 28 September 2023.

High income countries and those in the WHO European Region are leading in putting in place regulatory restrictions to support the phase down or phase out of dental amalgam use. For example, the European Union will be enforcing a prohibition from 1 January 2025, on the use of dental amalgam, except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient. In contrast, the majority of low- and middle-income countries have only partially achieved the global target, underscoring the importance of continued international cooperation and the need for targeted support and capacity-building initiatives in these countries.

In collaboration with the United Nations Environment Programme (UNEP) and funded by the Global Environment Facility (GEF), WHO launched a 3-year project to accelerate implementation of dental amalgam provisions and strengthen country capacities in the environmental sound management of associated wastes under the Minamata Convention. The project supports the implementation Convention in both global and national contexts, with several activities being implemented in three countries: Senegal, Thailand and Uruguay. The results from this project will be especially useful for those WHO Member States that have not achieved or have partially achieved the target and looking for ideas to scale up their efforts.

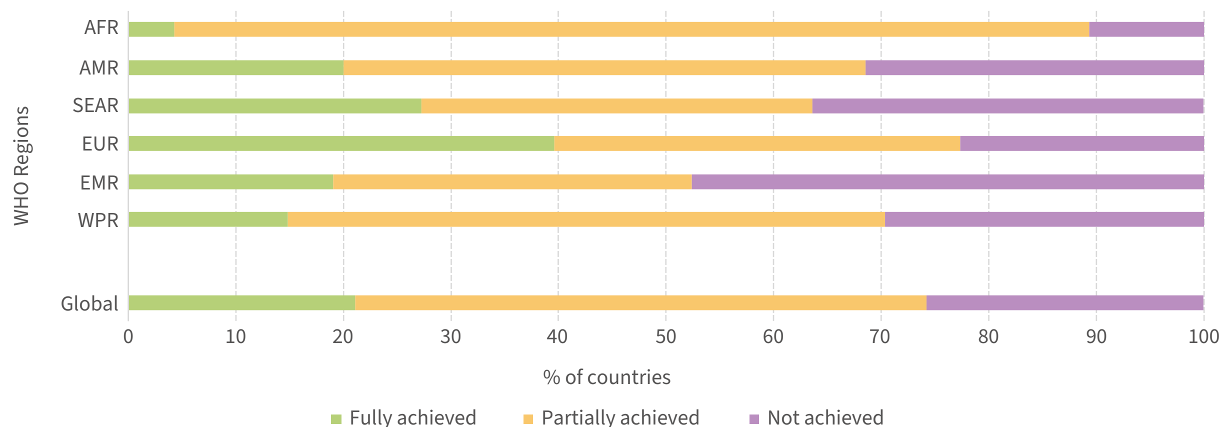
Strategic objective 2: Oral health promotion and oral disease prevention

Global target 2.1: Policies to reduce free sugars intake

In 2023:

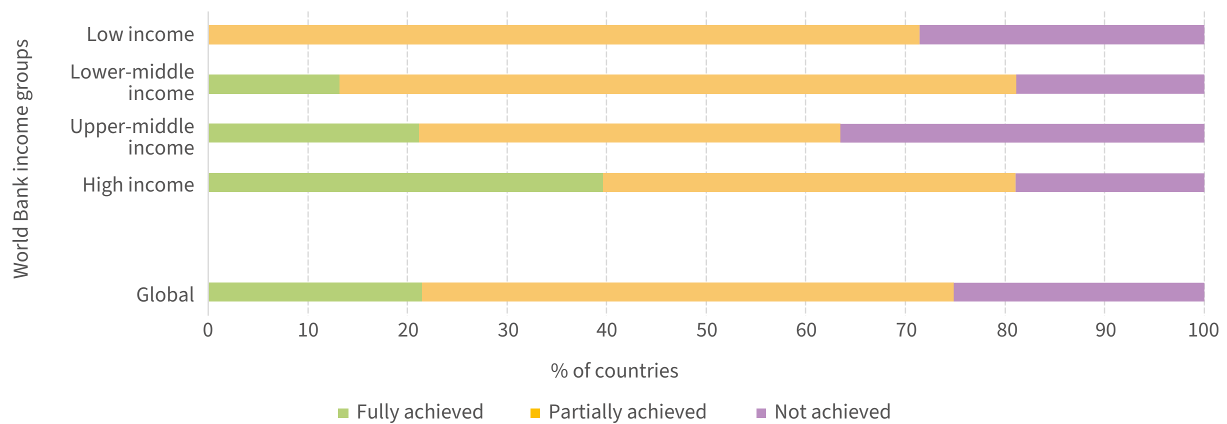
- Globally, 21.1% (n=41) of Member States have implemented mandatory policy measures to reduce free sugars intake, fully achieving the target (Figures 10 and 11).
- No low-income country reported implementing any mandatory measures to reduce free sugars intake, to fully achieve the criteria for the target, compared to 39.7% (n=23) of high-income countries and 21.2% (n=11) of upper-middle income countries (Figure 11).
- In the WHO Region for Africa, 85.1% (n=40) of Member States implemented voluntary policy measures to reduce free sugars intake, partially achieving the target, followed by 55.6% (n=15) of Member States in the WHO Region for the Western Pacific and 48.6% (n=17) of Member States in the WHO Region of the Americas (Figure 10).
- Almost half (47.6%, n=10) of the countries in the WHO Region for Eastern Mediterranean region have not implemented any policy measures to reduce free sugars intake (Figure 10).

Figure 10: Percentage of countries implementing measures to reduce free sugars intake, by WHO region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 11: Percentage of countries implementing measures to reduce free sugars intake, by World Bank income groups, 2023



Discussion

The purpose of this target is to track progress on policy measures to manage one of the key risk factors for dental caries and other NCDs: free sugars. At baseline, globally countries are already close to half-way to meeting the target. However, the mandatory measures required to fully achieve the criteria for the target require timely policy instruments for implementation.

Public health solutions for prevention of dental caries and other oral diseases are most effective when integrated with the prevention of other NCDs, based on the principles of addressing common risks and the wider shared determinants of health. The common risk factor approach recognizes that NCDs share a set of key modifiable risk factors *(12)*. The common risk factor approach is the basis for linking action on oral disease prevention with the wider NCD agenda. This can be seen most notably in relation to the integrated action on improving unhealthy diets, tackling tobacco use and reducing harmful alcohol consumption.

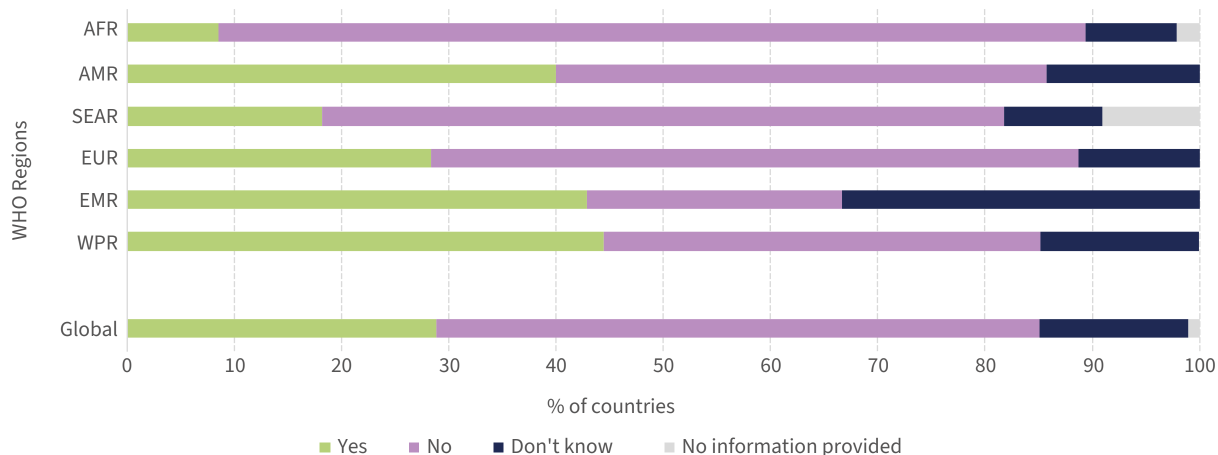
WHO has developed a number of guidance documents to support countries in design and implementation of the mandatory measures that define the criteria for this target *(13-16)*.

Global target 2.2: Optimal fluoride for population oral health

In 2023:

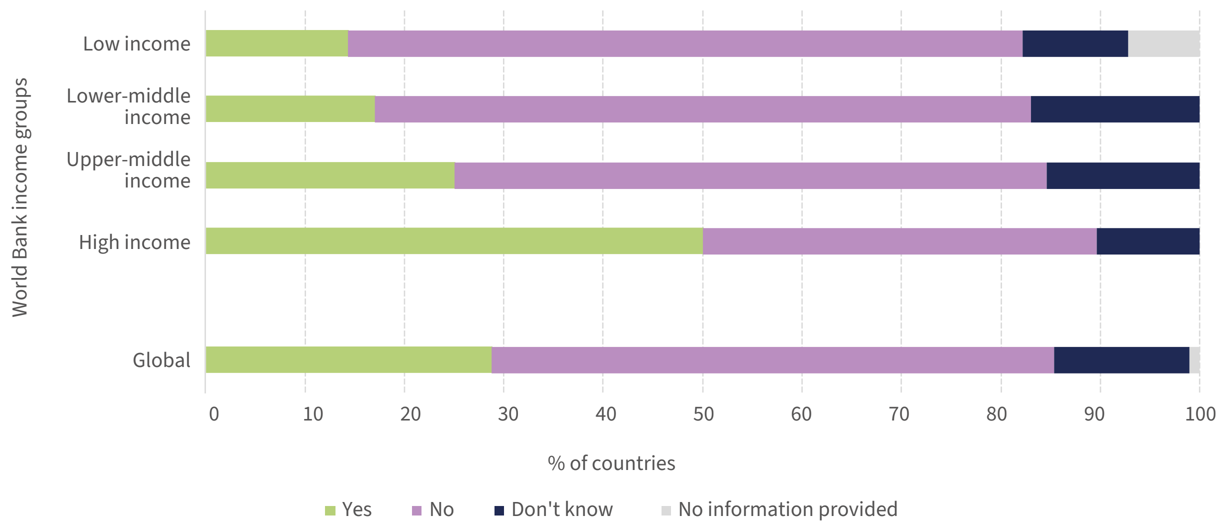
- Globally, more than half of Member States (56.2%, n= 109) do not have any national guidance on optimal fluoride delivery (Figures 12 and 13).
- Only 28.9% (n=56) of Member States reported having national guidance on optimal fluoride delivery (Figure 12).
- Over three quarters (80.9%, n=38) of Member States within the WHO Region for Africa have no national guidance on optimal fluoride delivery, followed by 63.7% (n=7) in the WHO Region for South-East Asia and 60.4% (n=32) in the WHO Region for Europe (Figure 12).
- More high-income countries (50.0%, n=29) report the presence of national guidance on optimal fluoride delivery compared to low-income countries (14.3%, n=4) (Figure 13).

Figure 12: Percentage of countries with national guidance on optimal fluoride delivery for oral health of the population, by WHO region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

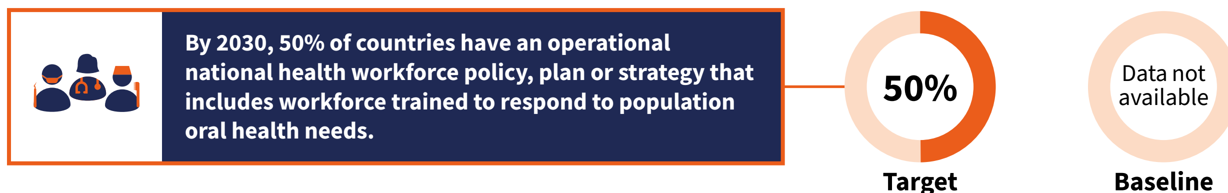
Figure 13: Percentage of countries with national guidance on optimal fluoride delivery for oral health of the population, by World Bank income groups, 2023



Discussion

The purpose of this target is to monitor progress on national level guidance on approaches to managing the access and affordability to fluoride, a major protective factor in the prevention of dental caries. The addition of fluoride to toothpaste and public water supplies remains an important strategy to address the alarming levels of dental caries in many parts of the world. Other fluoride containing products (such as fluoride mouth rinse, varnish or gel) were listed on the WHO Model Lists of Essential Medicines (EML) for adults and children in 2023 because of the strong evidence of their effectiveness in the prevention of dental caries. However, fluoride has well-known positive and some potentially negative effects on health, depending on the level of exposure. WHO encourages Member States to have national guidance to ensure optimal levels of fluoride in drinking water, either through addition of fluoride where natural levels are low, or by removing excess fluoride where natural levels are high. The specific approaches taken are highly context specific which is why the indicator seeks to understand the level of national guidance available across countries, rather than advocating for one approach over another. For example, in some settings it may be appropriate to reduce the level of fluoridation in the public water supply, while in other contexts it may be more appropriate to consider government subsidies or local manufacturing opportunities to improve the affordability of fluoride toothpaste *(17, 18)*.

Strategic objective 3: Health workforce
Global target 3: Innovative workforce model for oral health



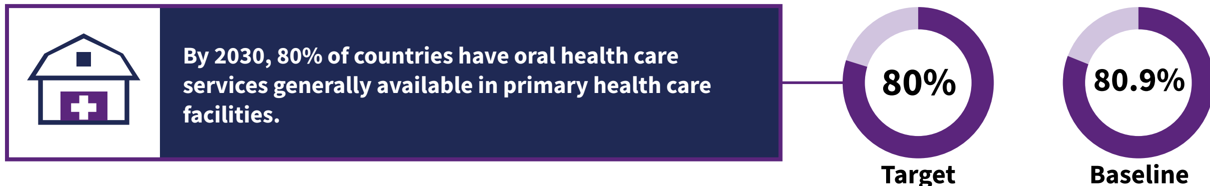
Data on this target is currently unavailable.

Progress towards oral health services as part of UHC requires health workers who are educated and empowered to provide the oral health services that populations need at PHC level as a priority. Central to this objective is the availability of skilled health workers in adequate numbers to ensure the delivery of an essential package of oral health care. Planning and prioritization of oral health services must be included in all national health workforce policies, plans or strategies and investment plans.

Although there has been significant momentum on the global oral health agenda, there have been challenges identifying a comprehensive and reliable data source that aligns with the ambition of this strategic objective. Since the goal of this global target is to foster innovative workforce models with appropriate task-sharing, it is important to strike a balance between the ambition of GOHAP and the feasibility of data collection. In this regard, collaboration with the WHO Department of Health Workforce is ongoing to review this global oral health target, identify suitable data sources and reconsider potential indicators.

Strategic objective 4: Oral health care

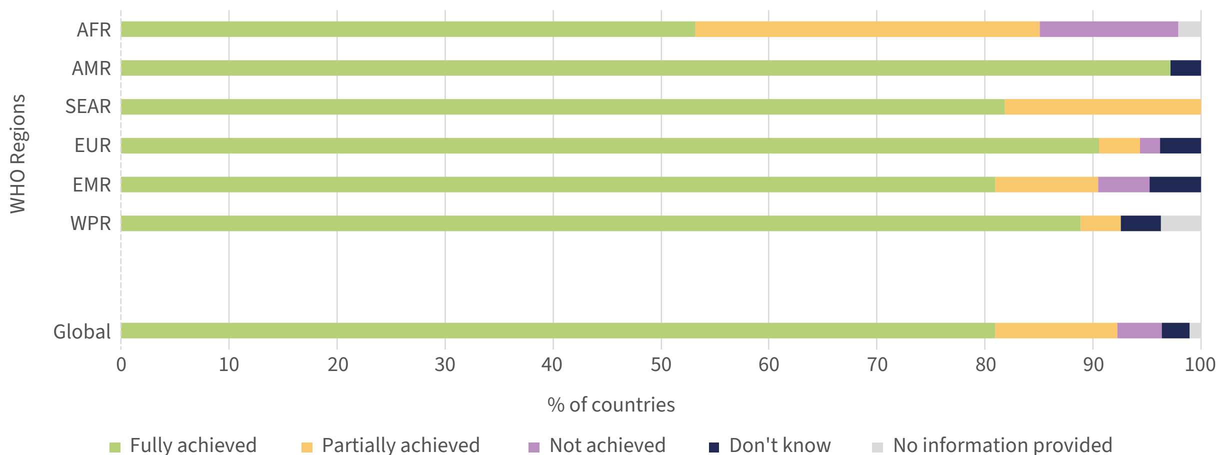
Global target 4.1: Integration of oral health in primary care



In 2023:

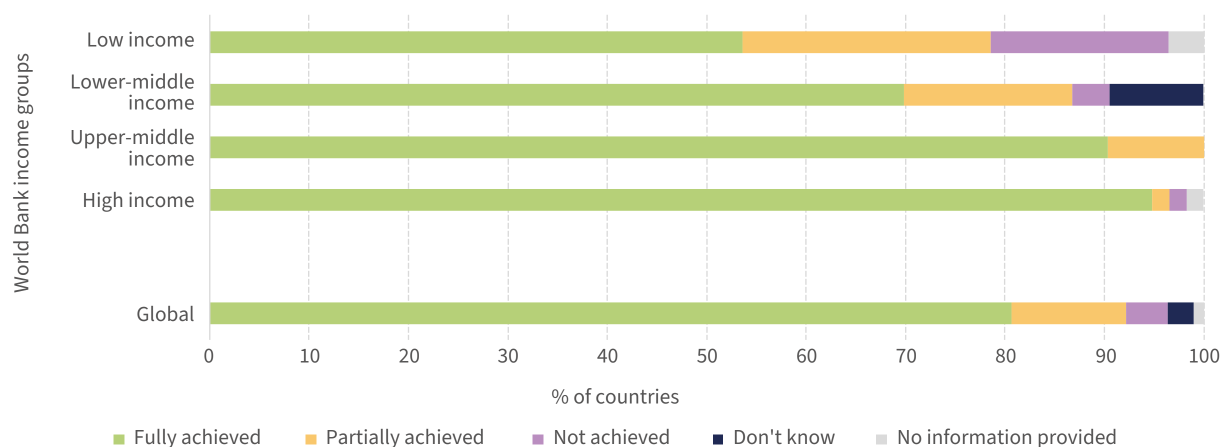
- The majority (80.9%, n=157) of Member States reported that oral health care services are generally available in their primary health care facilities, thereby fully achieving this target (Figure 14 and 15).
- The WHO Regions for the Americas (97.1%, n=34), Europe (90.6%, n=48) and the Western Pacific (88.9%, n=24) report the highest proportion of Member States with oral health care services generally available in their primary health care facilities (Figure 14).
- More high- and upper-middle income (94.8%, n=55; and 90.4%, n=47; respectively) countries report oral health care services generally available in their primary health care facilities compared to lower-middle and low-income countries (69.8%, n=37; and 53.6%, n=15; respectively) (Figure 15).
- For Member States reporting only one or two of the oral health care services —oral health screening for early detection of oral diseases, urgent treatment for emergency oral care and pain relief, and basic restorative dental procedures to treat existing dental decay—as generally available in their primary health care facilities, partially achieving the target, the highest proportion was in the WHO Region for Africa (31.9%, n=15) (Figure 14).

Figure 14: Percentage of countries that have oral health care services generally available in primary health care facilities, by WHO Region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 15: Percentage of countries that have oral health care services generally available in primary health care facilities, by World Bank income groups, 2023



Discussion

The purpose of this target is to understand progress on the availability of oral health services at PHC level. In principle, it appears that the global target has already been met. However, it is important to note that the definition for fully achieving this target, does not specify whether oral health care services are generally available through public or private PHC facilities.

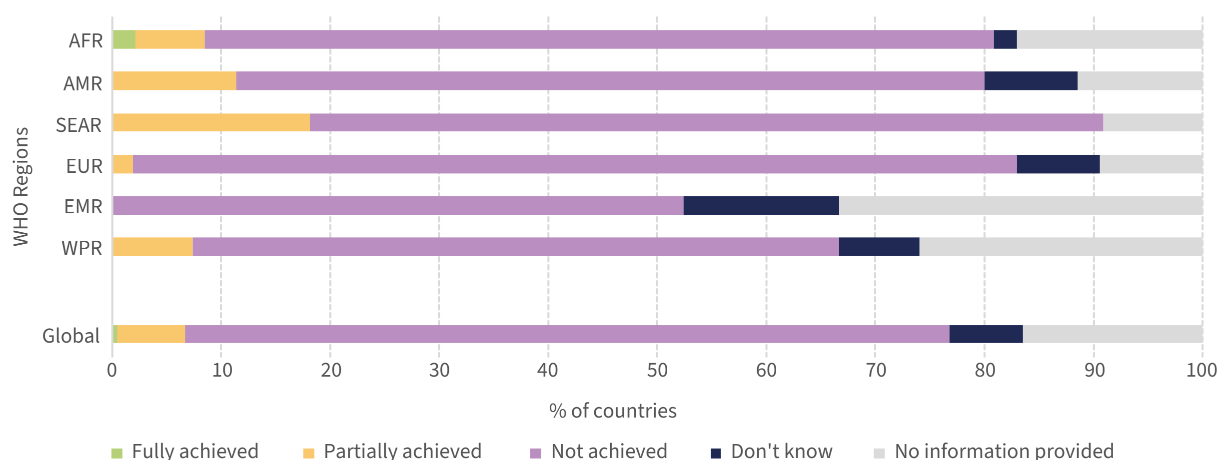
When considering only public PHC facilities, excluding for-profit and not-for-profit providers, the percentage of countries fully achieving the criteria for this target drops to 66.0% (n = 129). This raises concerns on population wide coverage of accessible essential oral health care services, when individuals relying solely on public facilities may face greater barriers to accessing essential oral health care services.

Global target 4.2: Availability of essential dental medicines

In 2023:

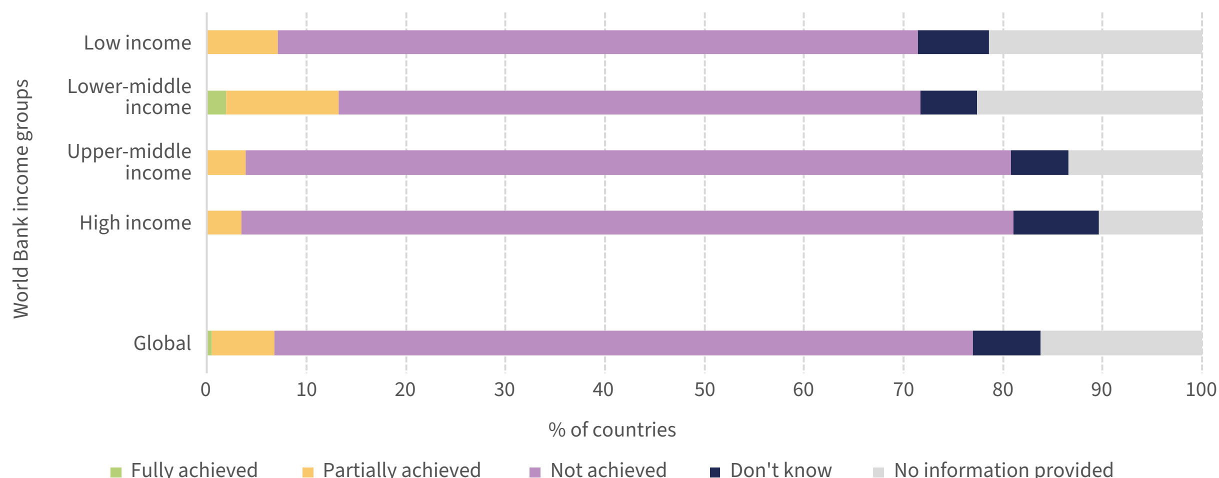
- Globally, only one (0.5%) Member State in the WHO Region for Africa fully met the criteria to achieve the target of including all three dental medicines and preparations—fluoride gel, paste, or cream (1000-1500 ppm fluoride), glass ionomer cement, and silver diamine fluoride—in its essential medicines or equivalent list (Figures 16 and 17).
- Most Member States (70.1%, n=136) have not achieved this target, as none of the dental preparations were included in their essential medicines or equivalent lists (Figure 16).
- The WHO Region of South-East Asia reported the highest proportion of countries to have included one or two of the EML dental medicines and preparations in the national EML list or equivalent (18.2%, n=2), thereby partially achieving the target, followed by the WHO Region for the Americas (11.4%, n=4) (Figure 16).
- Lower-middle income countries had the highest proportion of countries either fully achieving or partially achieving this target (1.9%, n=1; and 11.3%, n=6; respectively) (Figure 17).

Figure 16: Percentage of countries including dental medicines and preparations listed in the EML on their national essential medicines or equivalent list, by WHO Region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 17: Percentage of countries including dental medicines and preparations listed in the EML on their national essential medicines or equivalent list, by World Bank income groups, 2023



Discussion

The purpose of this target is to track progress on the integration of the dental medicines and preparations from the EML, into the equivalent national lists in different countries. At baseline, there is only one Member State that has successfully included all three medicines and preparations: fluoride gel, paste, or cream containing 1000-1500 ppm fluoride, glass ionomer cement, and silver diamine fluoride. While having these specific dental medicines and preparations list on the national list does not guarantee wide uptake and use, it is a necessary condition to lead to scale up of use of these materials which are key to prevention of oral diseases and delivery of essential oral health care interventions that can be delivered in PHC.

The very low reported implementation rate reflects a timing issue with recent updates to the dental medicines and preparations listed on the EML, which came into effect in 2021. In 2023, the EML was further updated to include a dedicated section on dental medicines and preparations, which now encompasses various forms of fluoride (such as gel, mouth rinse, toothpaste, cream, or varnish), glass ionomer cement, resin-based composites, and silver diamine fluoride. Member States have not had enough time to update their equivalent national essential medicines list to align with the 2021 and 2023 updates to the EML. For a country to fully meet this target, it is necessary align with the 2021 update to include three key dental medicines and preparations: fluoride gel, paste, or cream containing 1000-1500 ppm fluoride, glass ionomer cement, and silver diamine fluoride. The higher percentage of countries partially achieving the target demonstrates that progress is underway.

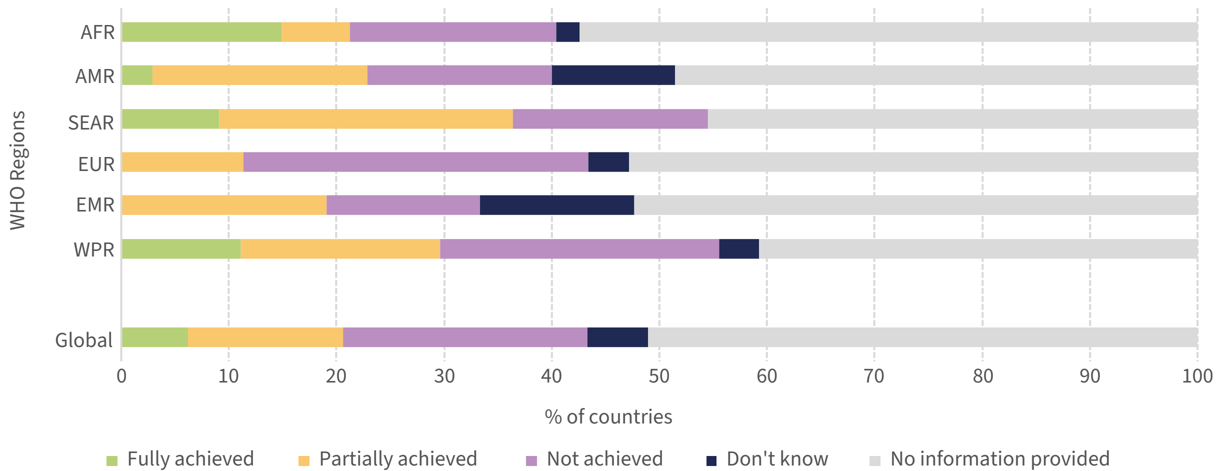
Strategic objective 5: Oral health information systems

Global target 5: Monitoring implementation of national oral health policy

In 2023:

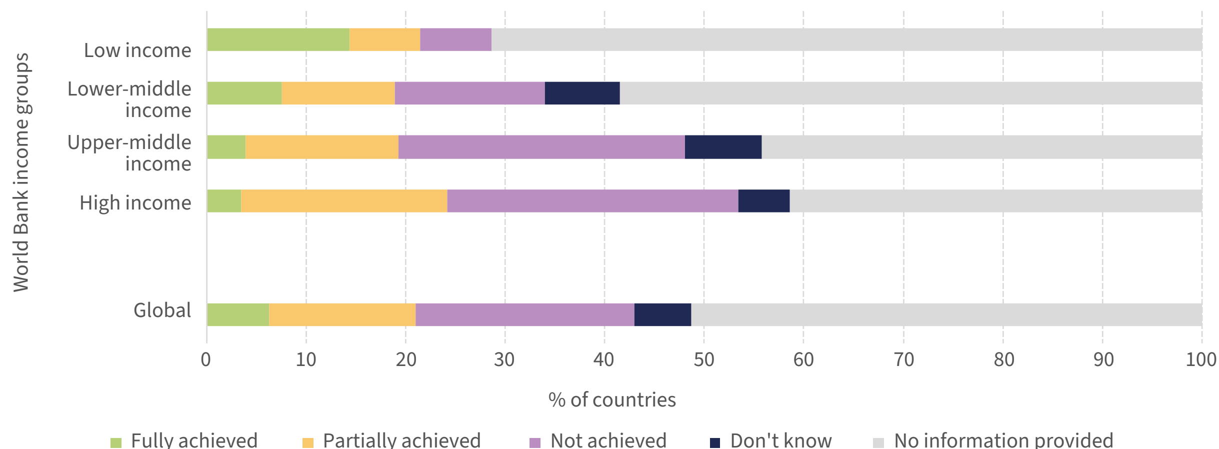
- Globally, 6.2% (n=12) of Member States reported the presence of a monitoring framework for their national oral health policy, strategy, or action plan, fully achieving this target (Figures 18 and 19). A further 14.4% (n=28), partially met the criteria for achieving this target.
- The proportion of Member States reporting the presence of a monitoring framework for their national oral health policy, strategy, or action plan, thereby fully achieving the target, was the highest in the WHO Region for Africa (14.9%, n=7), followed by the WHO Region for the Western Pacific (11%, n=3) (Figure 18).
- Low-income countries had the highest proportion of countries fully achieving the criteria to meet this target (14.3, n=4) (Figure 19).
- Less than a quarter of Member States (22.7%, n=44) reported not having a monitoring framework in place to track the implementation of their national oral health policies, strategies, or action plans (Figure 18).

Figure 18: Percentage of countries with a monitoring framework for the national oral health policy, strategy, or action plan, by WHO Region, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 19: Percentage of countries with a monitoring framework for the national oral health policy, strategy, or action plan, by World Bank income groups, 2023

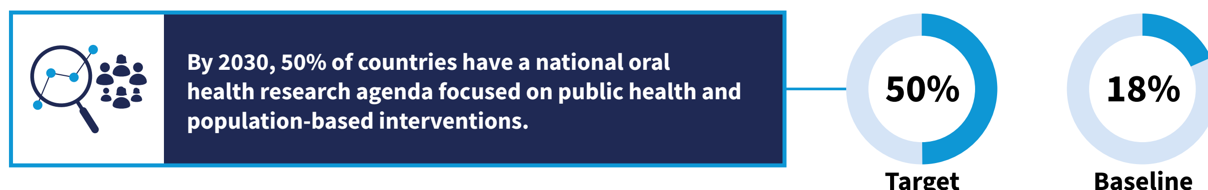


Discussion

The purpose of this target is to track countries' capacity to monitoring their own progress towards implementing key oral health initiatives as outlined by their national oral health policy, strategy or action plan. Overall, more than half of the countries did not have a monitoring framework. This could be partially explained by not all countries having a national oral health policy, strategy or action plan to then subsequently monitor. Additionally, some countries had a monitoring framework in place, but it was not aligned with the GOHAP due to its recent release in 2023.

Effective monitoring provides standard, robust, and comparable data to track progress in implementing a national action plan ensuring that the plan's objectives are being met effectively and efficiently. A monitoring framework informs decision-making process and supports global, regional, and national priority setting and resource allocation. In addition, a monitoring framework should guide and support the development and implementation of an oral health information and surveillance system integrated with existing NCD systems. Combined with global target 1.1: National leadership for oral health, the ambition is that all national oral health policy, strategy or action plans established in countries, will also include a monitoring framework for the country to track national progress leading to more successful and sustainable outcomes.

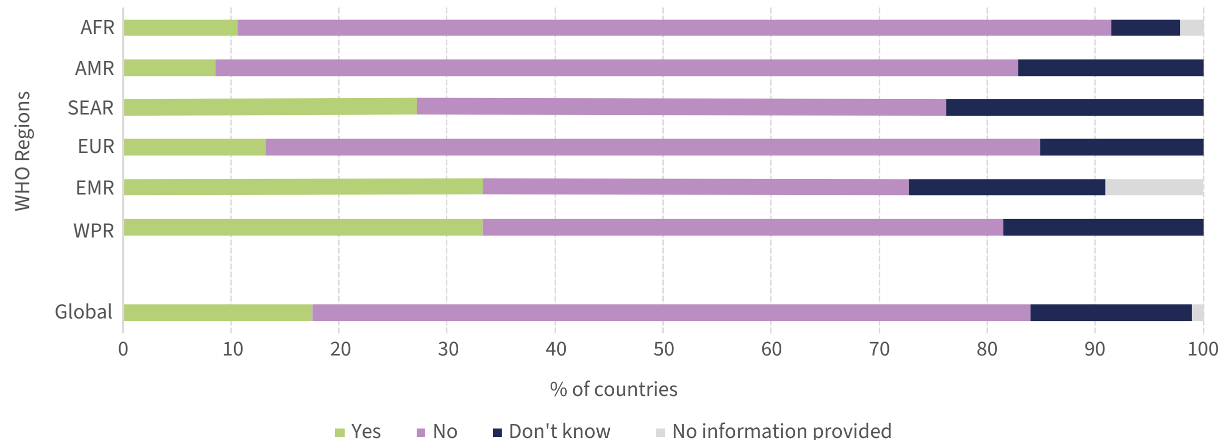
Strategic objective 6: Oral health research agendas
Global target 6: Research in the public interest



In 2023:

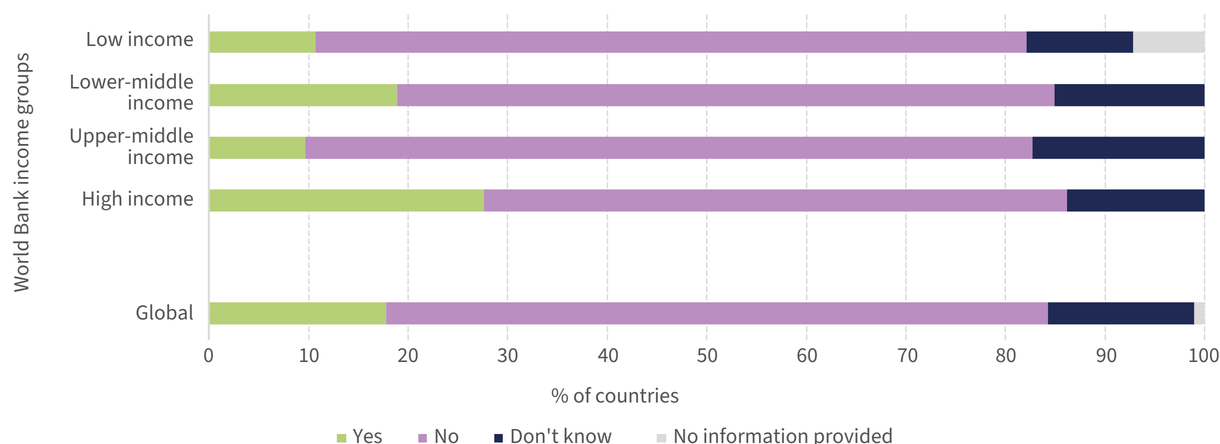
- Globally, 34 Member States (17.5%) reported having a national oral health research agenda focused on public health and population-based interventions, thereby meeting the criteria to fully achieve the target. However, 66.5% (n=129) of Member States did not meet the criteria for this target (Figure 20 and 21).
- In the WHO Regions for the Western Pacific, Eastern Mediterranean, and South-East Asia, over one quarter of Member States reported having a national oral health research agenda (33.3%, n=9; 33.3%, n=7; and 27.3%, n=3; respectively) (Figure 20).
- High-income countries had the highest proportion of countries with a national oral health research agenda focused on public health and population-based interventions (27.6%, n=16) (Figure 21).

Figure 20: Percentage of countries reporting presence of a national oral health research agenda focused on public health and population-based interventions, by WHO Regions, 2023



AFR: African Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region; WPR: Western Pacific Region.

Figure 21: Percentage of countries reporting presence of a national oral health research agenda focused on public health and population-based interventions, by World Bank income groups, 2023



Discussion

The purpose of this target is to follow progress globally in reorienting oral health research agendas towards public health programs and population-based interventions. The regional variation in achieving criteria for this target highlights the variation in the role of researchers and publicly funded research institutions.

Researchers play an important role in supporting the development and evaluation of population oral health policies and evaluating the evidence generated by public health interventions. Such operational and implementation research approaches provide opportunities to better evaluate, understand and improve population-based initiatives, thereby facilitating an autonomy in evidence-informed decision-making, adapted to country context.

Examples of such an agenda include: a prioritized list of oral health research areas, guidance on key research topics, the inclusion of a dedicated research component within the national oral health policy, and the integration of oral health research into the broader national research agenda.

Conclusion

This first comprehensive baseline report provides an overview of the baseline situation for implementation of the GOHAP, by WHO regions and by country income group. Despite the efforts made by Member States since the adoption of the 2021 Resolution on oral health (WHA74.5), the report highlights a number of gaps that need to be filled to achieve the global oral health targets by 2030. Bridging these gaps will require increased resources and stronger political commitment in most countries and regions in the coming years along with other priorities on the NCD agenda.

Oral diseases continue to be a leading cause of morbidity, affecting more people than any other NCD. The GOHAP advocates for the PHC approach, integrating essential oral health care into PHC settings and national UHC benefit packages, for the prevention and management of oral diseases. This approach also feeds countries' broader agenda to achieve UHC. Although some countries have succeeded in integrating essential oral health care services into PHC, significant global and regional disparities persist in the inclusion of essential oral health care within national UHC benefit packages that could ensure sufficient coverage. This discrepancy in availability of essential oral health services when compared to coverage, raises concerns about accessibility for those who rely on public services. The importance of this overarching target in demonstrating progress on UHC in the coming years is further highlighted through its addition as an outcome indicator in GPW14.

In addition to the overarching global oral health target on UHC, there is an urgent need to implement actions in line with the six strategic objectives of the GOHAP. These are represented by input, process and output indicators, which in turn lead to outcomes and impacts related to improved health and well-being.

In terms of governance, a national oral health policy, strategy or action plan, managed by dedicated staff at the Ministry of Health, is essential for coordinated efforts. Although some countries have made progress, many still lack updated national policies or sufficient staff. In the context of environmentally friendly oral health care, the global target tracks progress on phasing down or out the use of dental amalgam in accordance with the Minamata Convention on Mercury. High-income countries and the WHO Region for Europe are leaders in the implementation of regulatory measures, while low- and lower-middle income countries require additional support. Data on the inclusion of dental medicines and preparations from the WHO EML into national lists reveals that the limited progress is largely due to the time delay in implementing nationally, the recent 2021 updates to the EML which define the core indicator for the global oral health target.

In terms of risk factors, consumption of free sugars is a significant risk factor for dental caries and other NCDs. At baseline, Member States are already close to halfway to achieving the global target on polices to reduce free sugars intake. However, it is a timely process to coordinate the country specific policy instruments to implement the mandatory measures needed to fully meet the achievement criteria. In terms of protective factors, fluoride has a well-established and important role in the prevention of dental caries. The challenge for Member States lies in the need for locally adapted solutions that require national technical guidance. Over a quarter of Member States have developed such guidance.

Regarding evidence-informed decision making, data on the capacities of Member States to monitor and evaluate the progress of national oral health initiatives show that more than half lack a comprehensive monitoring framework integrated into existing health information and surveillance systems. Progress on reorienting oral health research towards public health programs and population-based interventions reveals notable regional disparities in its achievement and underscores differences in the roles of researchers and the availability of publicly funded research institutions.

Further work is needed to better understand how health workforce models are structured to respond to

population oral health needs. Globally, it has been difficult to capture this information consistently across all Member States, using a method that goes beyond data on the density of health care workers. The ambition of the GOHAP is focused on the development of innovative workforce models and application of competency-based education. WHO will continue to search for more suitable data sources and a reconsideration of potential indicators that respond to the ambition of the strategic objective on health workforce while enabling regular monitoring at a global level.

This first comprehensive baseline report on implementation of the GOHAP underscores the urgent need to better prioritize oral diseases control within other national health priorities. Oral health programs should be planned and implemented within the framework of NCD programs and under the auspices of national agendas aimed at achieving UHC for all. The WHO is committed to supporting countries in achieving the objectives of the GOHAP and will continue to monitor progress every three years, with the next report anticipated for 2028.

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Annex: Indicators and data dictionary

This annex provides full details on all global targets reported in this comprehensive baseline report.

- There are a total of 11 global oral health targets.
- The targets are presented and organized by their alignment with the six strategic objectives of the GOHAP.
- For each target, the following information is provided: the name, corresponding core indicator, definition of the indicator, criteria for achieving the indicator, the data source, and question/s (with original question number as used in the source survey), method of computation and additional notes if needed.

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

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

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

Data type	Percentage
Indicator definition	Percentage of population entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes. The term “largest” is defined as having the highest total population eligible to receive services. The term “government” is defined as including any public-sector scheme for health service provision, including coverage for groups such as the general population, public sector employees and/or the military. Essential oral health interventions include, but are not limited to: • Routine and preventive oral health care (including oral health examination, counselling on oral hygiene with fluoride toothpaste, fluoride varnish application, glass ionomer cement as a sealant and early detection of oral cancer in high-risk groups, linked with timely diagnostic work-up and comprehensive cancer treatment, in settings with a significant disease burden) • Essential curative oral health care (including topical silver diamine fluoride, atraumatic restorative treatment, glass ionomer cement restoration and urgent treatment for emergency oral care and pain relief, such as non-surgical extractions and drainage of abscesses).
Data Source	WHO Health Technology Assessment/Health Benefit Package (HTA/HBP) Survey.
Questions	**Q 86** In terms of coverage, what are the five largest, in terms of population covered, government health financing schemes in your country? Please name the schemes and rank them in order of size, 1 being the largest. (Largest here refers to the scheme which has the highest total population eligible to receive services). **Q 87** Is this a national or a subnational level scheme? Please choose only one of the following: ☐ National ☐ Subnational **Q88** What percentage of the national or associated subnational population does the above scheme cover? Please write your answer(s) here: Largest scheme as listed above. **Q 127** Oral Health: For the listed condition group, kindly indicate which of the interventions are covered in the health benefit package for the identified scheme. Please check all that apply. • Routine and preventive oral /dental care • Essential curative oral /dental care (including non-surgical extraction and drainage of abscesses) • Advanced curative oral /dental care (including resin composite and dental amalgam including x-rays, complex fillings, root canal treatment) • Rehabilitation oral /dental care (including crowns and bridges, dentures, orthodontics, dental implants)
Computation	**Numerator:** number of people entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes. **Denominator:** total global population listed in World Population Prospects by the United Nations Department of Economic and Social Affairs (UN DESA).
Baseline	2021
Notes	Only Member States that could provide data on the percentage population scheme coverage at national level were included. Subnational data was excluded. The disaggregation by World Bank income group includes 192 countries.

Overarching global target B.1: Prevalence of the main oral diseases and conditions

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

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

Data type	Prevalence and number of cases of the main oral diseases and conditions for all ages and both sexes
Indicator definition	Estimated prevalence of the main oral diseases and conditions as defined by the Global Burden of Disease (GBD) study. The main oral diseases and conditions include: • untreated dental caries of deciduous teeth • untreated dental caries of permanent teeth • edentulism • severe periodontal disease • other oral disorders (excluding lip and oral cavity cancer and orofacial clefts).
Data Source	The Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease (GBD) Study.
Questions	-
Computation	-
Baseline	2021
Notes	The disaggregation by World Bank income group includes 192 countries.

Global target 1.1: National leadership for oral health

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

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

Data type	Percentage
Indicator definition	Percentage of countries that have an operational national policy, strategy or action plan for oral health available and technical/professional staff in the unit/branch/department working on NCDs at the Ministry of Health (or other national governmental health agencies) dedicating a significant portion of their time to oral health, such as a Chief Dental Officer. Achievement criteria for indicator: **1.** Fully achieved: The country reports it has both: • an operational policy, strategy or action plan for oral health – if the policy, strategy or action plan expiration date has been reached or is not clearly stated (e.g., ongoing), it would only be considered a "positive response" if it has been updated within the last five years; and • technical/professional staff in the NCD unit/branch/department dedicating a significant proportion of their time to oral health. **2.** Partially achieved: The country reports it has one of the two criteria. **3.** Not achieved: The country reports it has neither of the two criteria. **4.** No information: Data are not reported by the country.
Data Source	WHO NCD Country Capacity Survey (CCS). Completed every two years by country representative.
Question	**NCD CCS Module I – Q1** **Q1** Is there a unit/branch/department in the ministry of health or equivalent with responsibility for NCDs and their risk factors? ☐ Yes ☐ No ☐ Don't Know IF NO: Go to Question 2 If Yes: 1b) Are there technical/professional staff in the unit/branch/ department dedicating a significant proportion of their time to oral health: ☐ Yes ☐ No ☐ Don't Know **NCD CCS Module II B – Q8** **Q8** Is there a policy, strategy, or action plan for **oral health** in your country? ☐ Yes ☐ No ☐ Don't Know IF NO: Go to Question 9 If yes: 8a) Write the title ____ 8b) Indicate its stage: ☐ Operational ☐ Under development ☐ Not in effect ☐ Don't know If Operational: 8b-i) What was the first year of implementation? ____ 8b-ii) What year will it expire? ____
Computation	**Fully Achieved;** If Q1b = yes, Q8 = yes, and the supporting documents and follow up verification provided evidence demonstrating meeting the below criteria: • The policy, strategy, or action plan for oral health is operational • The policy, strategy, or action plan has clear dates for year of implementation and year of expiry. **Partially achieved;** Q1b = yes, or Q8 = yes. **Not achieved;** Q1b = no, and Q8 = no. **No information provided;** data was not reported by the country.
Baseline	2023

Notes	If the policy, strategy, or action plan expiration date has been reached or was not clearly stated (e.g., ongoing) the supporting documents were reviewed. If the policy or plan included an expiration year, the status of the country was modified accordingly. The response was only considered a "positive response" if the plan was updated within the last five years. The disaggregation by World Bank income group includes 191 countries.

Global target 1.2: Environmentally sound oral health care

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

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

<table>
<tr><td>Data type</td><td>Percentage</td></tr>
<tr><td>Indicator definition</td><td>Percentage of countries that have implemented measures to phase down the use of dental amalgam in accordance with the provisions of the Minamata Convention on Mercury and decisions made by the Conference of the Parties or have phased it out.

Achievement criteria for indicator:
1. Fully achieved: The country reports implementation of option (a) or option (b) as follows:

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

Option b) Phased out dental amalgam: Country does not use dental amalgam and does not allow its manufacture, import or export.

2. Partially achieved: The country reports using dental amalgam but has implemented only one or two of the requirements to phase down its use.
3. Not achieved: The country reports using dental amalgam but has not implemented any of the requirements to phase down its use.
4. No information: Data are not reported by the country.</td></tr>
<tr><td>Data Source</td><td>WHO and Minamata Convention Secretariat 2023, Minamata Convention Secretariat 2021, WHO Informal Consultation, 2021, COP4 submissions to the Minamata Convention on Mercury 2021</td></tr>
</table>

Questions

For each country, a determination on their level of achievement towards this target was based on one of the following data sources. The data sources were prioritized in the following order, with the highest priority given to official submissions by the country to the Secretariat of the Minamata Convention (including the survey conducted jointly with WHO in 2023), and based on the most recent data available.

Prioritized data source #1: 2023 WHO and Minamata Convention survey

Q. Is dental amalgam used in the country?
☐ Yes, it is still used and there are no plans or implemented measures to phase it down
☐ Yes, but in process of phasing it down
☐ No, dental amalgam is not used at all – complete phase out

Q. Please indicate if the following measure to phase down the use of dental amalgam has been implemented in your country:

- Setting national objectives aiming at dental caries prevention and health promotion, thereby minimizing the need for dental restoration.
  ☐ Yes ☐ No, but currently under development ☐ No
- Setting national objectives aiming at minimizing its use.
  ☐ Yes ☐ No, but currently under development ☐ No
- Promoting the use of cost-effective and clinically effective mercury-free alternatives for dental restoration.
  ☐ Yes ☐ No, but currently under development ☐ No
- Promoting research and development of quality mercury-free materials for dental restoration.
  ☐ Yes ☐ No, but currently under development ☐ No
- 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.
  ☐ Yes ☐ No, but currently under development ☐ No
- Discouraging insurance policies and programmes that favor dental amalgam use over mercury-free dental restoration.
  ☐ Yes ☐ No, but currently under development ☐ No
- Encouraging insurance policies and programmes that favor the use of quality alternatives to dental amalgam for dental restoration.
  ☐ Yes ☐ No, but currently under development ☐ No
- Restricting the use of dental amalgam to its encapsulated form.
  ☐ Yes ☐ No, but currently under development ☐ No
- Promoting the use of best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land.
  ☐ Yes ☐ No, but currently under development ☐ No
- Exclude or not allow, by taking measures as appropriate, the use of mercury in bulk form by dental practitioners;
  ☐ Yes ☐ No, but currently under development ☐ No
- 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.
  ☐ Yes ☐ No, but currently under development ☐ No

Prioritized data source #2: 2021 Full national reports submitted to the Minamata Convention
Q4.3. Has the party taken two or more measures for the mercury-added products listed in Part II of Annex A in accordance with the provisions set out therein?
☐ Yes ☐ No

If yes, please provide information on the measures.

Prioritized data source #3: COP4 submissions to the Minamata Convention on Mercury
Qualitative assessment of submissions made by countries

Prioritized data source #4: 2021 informal global WHO consultation with policymakers in dental public health:
Q3. Is dental amalgam used in your country?
☐ Yes ☐ No ☐ I don't know

	Q4. In your opinion, where would you place your country regarding phasing down the use of dental amalgam? For your answer, please consider the nine measures listed above. Please select one and explain your response. ☐ No plans to start phase-down process ☐ Initial consultations have been organized to start phase-down process ☐ Few phase down measures are underway (2 or 3 measures implemented) ☐ Phase down is underway in moderation (4 to 6 measures implemented) ☐ Phase down is at an advanced stage (7 to 9 measures implemented) ☐ Ready to phase out dental amalgam ☐ Already phased out dental amalgam **Q32.** In your opinion, by which year would 'phase-out the use of dental amalgam' be achievable in your country ? ☐ Already phased out (mention year in the comment section) ☐ By 2025 ☐ By 2030 ☐ After 2030 (please mention the probable year) Note: In order to attribute that a country had phased out the use of dental amalgam, the respondent would have had to consistently report the phase out across 3 separate questions: Question 3 ("Is dental amalgam used in your country?"), Question 4 ("In your opinion, where would you place your country regarding phasing down the use of dental amalgam?"), and Question 32 ("In your opinion, by which year would 'phase-out the use of dental amalgam' be achievable in your country?").
Computation	**Fully achieved;** The country reported implementation of option (a) or option (b) as follows: Option (a) The country is still using dental amalgam and has implemented the mandatory measures adopted in COP4, in addition to two or more of the measures to phase down the use of dental amalgam. Option (b) Dental Amalgam phase out achieved. **Partially Achieved;** The country reports using dental amalgam but has implemented only one or two of the requirements to phase down its use. **Not Achieved;** The country reports using dental amalgam but has not implemented any of the requirements to phase down its use. **No information provided;** data was not reported by the country.
Baseline	2023
Notes	The data for this indicator was compiled using four data sources: the results from the 2023 WHO and the Minamata Convention Secretariat survey, 2021 full national reports submitted by Parties of the Minamata Convention, COP4 country submissions to the Minamata Convention on Mercury in 2021. When country-specific data was unavailable through the previously mentioned data sources, data from the 2021 informal global WHO consultation with policymakers in dental public health was used. Since the publication of the 2023 WHO and Minamata Convention survey, Uruguay's response was added and Qatar's response was amended after considering qualitative responses. The COP4 submissions to the Minamata Convention on Mercury informed the response for two countries, Nepal and Moldova. The disaggregation by World Bank income group includes 191 countries.

Global target 2.1: Policies to reduce free sugars intake

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

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

<table>
<tr><td>Data type</td><td>Percentage</td></tr>
<tr><td>Indicator definition</td><td>Percentage of countries that implement policy measures aiming to reduce free sugars intake.
Measures include:
• nutrition labelling: front-of-pack or other interpretative labelling to inform about sugars content, including mandatory declaration of sugars content on pre-packaged food.
• reformulation limits or targets to reduce sugars content in foods and beverages.
• public food procurement and service policies to reduce offering food high in sugars.
• policies to protect children from the harmful impact of food marketing, including for foods and beverages high in sugars.
• taxes on sugar-sweetened beverages (SSBs) and on sugars or foods high in sugars.

Achievement criteria for indicator
1. Fully achieved: The country reports it has implemented mandatory policy measures to reduce free sugars intake (as captured by scores 3 or 4 on the WHO Sugars Country Score Card).
2. Partially achieved: When the country reports it has:
• implemented voluntary policy measures to reduce free sugars intake (as captured by score 2 on the WHO Sugars Country Score Card); and/or
• implemented national-level SSB taxes.
3. Not achieved: The country reports it has not implemented any policy measures (listed in the achievement criteria) to reduce free sugars intake.
4. No information: Data are not reported by the country.</td></tr>
<tr><td>Data Source</td><td>The Global Database on the Implementation of Food and Nutrition Action (GIFNA).
WHO NCD CCS. Completed every two years by country representative.</td></tr>
<tr><td>Questions</td><td>WHO GIFNA Sugars Country Score Card

Score 1: National policy commitment to reduce sugars intake: National policies, strategies or action plans that express a commitment to reduce sugars intake

Score 2: Voluntary measures to reduce sugars: Voluntary measures that reduce sugars in the food supply or encourage consumers to make healthier food choices about sugars

Score 3: Mandatory measures adopted for sugars reduction: Mandatory measures to reduce sugars in the food supply or encourage consumers to make healthier food choices, including mandatory declaration of sugars on all pre-packaged food

Score 4: Multiple mandatory measures adopted for sugars reduction: Multiple mandatory measures to reduce sugars in the food supply or encourage consumers to make healthier food choices, including mandatory declaration of sugars on all pre-packaged food

Validation by NCD CCS Module I – Q3
Q3 Is your country implementing any of the following fiscal interventions? (for taxes, please respond “Yes” only if excise taxes and/or special VAT/sales tax rates are applied)
taxation on alcoholic beverages ☐ Yes ☐ No ☐ Don’t Know
taxation on tobacco ☐ Yes ☐ No ☐ Don’t Know
taxation on sugar sweetened beverages ☐ Yes ☐ No ☐ Don’t Know
taxation on foods high in fat, sugars, or salt ☐ Yes ☐ No ☐ Don’t Know
price subsidies for healthy foods ☐ Yes ☐ No ☐ Don’t Know
taxation incentives to promote physical activity ☐ Yes ☐ No ☐ Don’t Know
others (specify)</td></tr>
</table>

Computation	**Fully achieved;** If the country reported it had implemented mandatory policy measures to reduce free sugars intake, as captured by scores 3 or 4 on the WHO GIFNA Sugars Country Score Card. **Partially achieved;** The country has implemented voluntary policy measures to reduce free sugars intake as captured by score 2 on the WHO GIFNA Sugars Country Score Card, and/or if NCD CCS Q3= Yes. **Not achieved;** The country has not implemented any policy measures (listed in the achievement criteria) to reduce free sugars intake, and if NCD CCS Q3= No. **No information;** Data was not reported by the country.
Baseline	2023
Notes	The WHO GIFNA report on SSBs taxation was cross-checked with the country's response to Q3 in the CCS to verify whether the country was implementing any excise taxes on SSBs. The disaggregation by World Bank income group includes 191 countries.

Global target 2.2: Optimal fluoride for population oral health

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

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

Data type	Percentage
Indicator definition	Percentage of countries that have national guidance related to fluorides for oral health of the population that addresses the universal availability of systemic or topical fluorides. Depending on the country context, this includes consideration of addition or removal of fluoride from drinking water to provide safe and optimal levels for prevention of dental caries. Fluoride delivery methods may include, but are not limited to: • topical fluorides: self-applied (e.g., fluoride toothpaste) and professionally applied (e.g., fluoride gels or foams, fluoride varnish, silver diamine fluoride) • systemic fluorides (e.g., water fluoridation) • defluoridation methods in fluorosis-endemic areas. The national guidance should include the optimum levels of fluoride concentration for the delivery method(s).
Data Source	WHO NCD CCS. Completed every two years by country representative.
Questions	**NCD CCS Module II B– Q10** **Q10** Does your country have national guidance on optimal fluoride delivery for oral health of the population that addresses the universal availability of systemic or topical fluorides? ☐ Yes ☐ No ☐ Don't Know
Baseline	2023
Computation	Yes; If Q10 = Yes No; If Q10 = No Don't know; If Q10 = Don't Know No information provided; Data was not reported by the country
Notes	The disaggregation by World Bank income group includes 191 countries.

Global target 3: Innovative workforce model for oral health

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

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

Data type	Percentage
Indicator definition	Proportion of countries that have an operational national health workforce policy, plan, or strategy and whether a workforce trained to respond to population oral health needs is included in the strategy. Workforce trained and legally permitted to respond to the oral health needs of all population groups may include: • oral health professionals (e.g., dentists, dental assistants, dental therapists, dental hygienists, dental nurses, and dental prosthetic technicians) • other primary health care workers, including community health workers.
Data Source	No data available

Global target 4.1: Integration of oral health in primary care

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

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

Data type	Percentage
Indicator definition	Percentage of countries with procedures for detecting, managing and treating oral diseases that are generally available in primary health care facilities (public and/or other sectors). “Generally available” refers to reaching 50% or more of patients in need whereas “generally not available” refers to reaching less than 50% of patients in need. Achievement criteria for indicator: **1.** Fully achieved: The country reports that all of the following oral health care services are generally available in primary health care facilities (public and/or other sectors): • oral health screening for early detection of oral diseases • urgent treatment for emergency oral care and pain relief • basic restorative dental procedures to treat existing dental decay. **2.** Partially achieved: The country reports that one or two of the oral health care services above are generally available in primary health care facilities. **3.** Not achieved: The country reports that no oral health care services are generally available in primary health care facilities. **4.** No information: Data are not reported by the country.
Data Source	WHO NCD CCS. Completed every two years by country representative.
Computation	**Fully achieved;** If the country reported that all the following oral health care services are generally available in primary health care facilities (public and/or other sectors): • oral health screening for early detection of oral diseases • urgent treatment for emergency oral care and pain relief • basic restorative dental procedures to treat existing dental decay. **Partially achieved;** If the country reported that one or two of the oral health care services above are generally available in primary health care facilities (public and/or other sectors). **Not achieved;** If the country reported that no oral health care services are generally available in primary health care facilities (public and/or other sectors). **No information;** Data was not reported by the country.
Baseline	2023
Notes	The disaggregation by World Bank income group includes 191 countries.

Global target 4.2: Availability of essential dental medicines

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

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

Data type	Percentage
Indicator definition	Percentage of countries that include dental preparations in the WHO Model Lists of Essential Medicines (Essential Medicines List and Essential Medicines List for Children) in their national essential medicines list (or equivalent guidance). Achievement criteria for indicator: **1.** Fully achieved: The country reports that all of the following dental preparations are included in the national essential medicines list or equivalent guidance: • paste, cream or gel containing between 1000 and 1500 ppm fluoride (any type) • glass ionomer cement • silver diamine fluoride. **2.** Partially achieved: The country reports that one or two of these dental preparations are included in the national essential medicines list or equivalent guidance. **3.** Not achieved: The country reports that none of these dental preparations are included in the national essential medicines list or equivalent guidance. **4.** No information: Data are not reported by the country.
Data Source	WHO NCD CCS. Completed every two years by country representative.
Questions	**NCD CCS Module IV – Q6** **Q6** Is there a national essential medicines list or equivalent in your country? ☐ Yes ☐ No ☐ Don't know
Computation	Fully Achieved; If Q6= Yes, and the supporting documents and follow up verification provided evidence demonstrating meeting the below criteria: All the following dental preparations were included in the national essential medicines list or equivalent guidance: • paste, cream or gel containing between 1 000 and 1 500 ppm fluoride (any type) • glass ionomer cement. • silver diamine fluoride. **Partially achieved;** If Q6 = yes, and one or two of these dental preparations were included in the national essential medicines list or equivalent guidance. **Not achieved;** If Q6 = no, and none of these dental preparations were included in the national essential medicines list or equivalent guidance. **No information;** Data was not reported by the country.
Baseline	2023
Notes	For countries that indicated "yes" to having a national essential medicine list but did not provide a copy of the current list as supporting documentation, it was not possible to verify whether dental medicines and preparations were included in their EML Lists. Therefore, "no information provided" was recorded for those countries. The disaggregation by World Bank income group includes 191 countries.

Global Target 5: Monitoring implementation of national oral health policy

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

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

Data type	Percentage
Indicator definition	Percentage of countries that have a monitoring framework to track progress on implementation of the national oral health policy, strategy or action plan. Achievement criteria for indicator: **1.** Fully achieved: The country reports it has a national monitoring framework for the national oral health policy, strategy or action plan that meets the following criteria: • includes a set of indicators with baselines and targets based on the national oral health policy, strategy or action plan • specifies data collection methods and reporting of key indicators using existing and/or new health information systems • aligns with the monitoring framework of the Global Oral Health Action Plan by being able to report on the core indicators. **2.** Partially achieved: The country reports it has a national monitoring framework for the national oral health policy, strategy or action plan, but it does not fully meet the achievement criteria. **3.** Not achieved: The country reports it does not have a national monitoring framework for the national oral health policy, strategy or action plan. **4.** No information: Data are not reported by the country.
Data Source	WHO NCD CCS. Completed every two years by country representative.
Questions	**NCD CCS Module II B – Q8c** Q8c Is there a monitoring framework with a set of time-bound national targets for oral health based on the national oral health policy, strategy, or action plan? ☐ Yes ☐ No ☐ Don't Know
Computation	**Fully achieved;** If Q8c = yes, and the supporting documents and follow up verification provided evidence demonstrating a monitoring framework meeting the below criteria: • includes a set of indicators with baselines and targets based on the national oral health policy, strategy, or action plan. • specifies data collection methods and reporting of key indicators using existing and/or new health information systems. • aligns with the monitoring framework of the Global Oral Health Action Plan by being able to report on the core indicators. **Partially achieved;** If Q8c =yes, but it does not fully meet the achievement criteria. **Not achieved;** If Q8c = no. **No information;** Data was not reported by the country.
Baseline	2023
Notes	Supporting documents were reviewed for countries that responded 'yes' to Q8c, indicating they have a monitoring framework for oral health to ensure the framework met the established criteria. If a country responded 'yes' but did not provide supporting documents to verify their response, the status for this country was marked as 'partially achieved '. The disaggregation by World Bank income group includes 191 countries.

Global target 6: Research in the public interest

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

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

Data type	Percentage
Indicator definition	Percentage of countries that have a national oral health research agenda that focuses on public health programmes and population-based interventions. Examples of a national oral health research agenda include: • a list of oral health research priorities in the country • guidance on research focus • a specific research component in the national oral health policy • a specific oral health research component in the national research agenda.
Data Source	WHO NCD CCS. Completed every two years by country representative.
Questions	**NCD CCS Module II B – Q9** **Q9** Is there a national **oral health** research agenda in your country that focuses on public health programmes and population-based interventions (e.g., a list of oral health research priorities in the country, guidance on research focus, a specific research component in the national oral health policy or in the national research agenda)? ☐ Yes ☐ No ☐ Don't Know
Computation	Yes; If Q9 = yes No; If Q9 = no Don't Know; If Q9 = Don't know No information provided; Data was not reported by the country
Baseline	2023
Notes	The disaggregation by World Bank income group includes 191 countries.

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