World Health Organization
REGIONAL OFFICE FOR Africa

COVID-19 RESPONSE

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR AFRICA SUPPORTS THE COVID-19 RESPONSE

POLICY BRIEF

CONTINUITY OF ESSENTIAL ORAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC IN THE WHO AFRICAN REGION: RESULTS OF A MEMBER STATE SURVEY AND POLICY RECOMMENDATIONS

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Acronyms

AGPs	aerosol generating procedures
IPC	infection prevention and control
LMICs	low- and middle-income countries
NCDs	noncommunicable diseases
PHC	primary health care
PPE	personal protective equipment
UHC	universal health coverage
WHO	World Health Organization

Executive summary

The WHO Regional Office for Africa conducted a rapid assessment of the continuity of essential oral health services in the context of COVID-19 to understand the situation and identify important actions to strengthen oral health promotion and oral disease prevention and control as part of the overall health system. Thirty-five of the 47 Member States (74%) in the WHO African Region completed the survey between 16 and 23 September 2020.

According to the survey, oral health was integrated into the essential health service list in 23 countries during the COVID-19 pandemic but in only one of these did the government provide additional financial support for the continuation of oral health services. In low- and middle-income countries in particular, more than half of the countries offered only urgent or emergency care, as well as avoiding aerosol generating procedures (AGPs).

Around 90% of the countries reported experiencing a complete or partial disruption of their oral health services during phase 1 (February–July 2020) of the pandemic. This went down to 74% of the countries during phase 2 (August–September 2020) of the pandemic following the improvement in the epidemiological situation. In both phases, the top two reasons for the disruption were insufficient personal protective equipment (PPE) levels and decreased outpatient volume, which might have been linked to the fear and stigma surrounding health care settings. Moreover, the strict public health measures instituted in phase 1 such as government and public transport lockdowns hindered access to health facilities for patients. In phase 2, the financial difficulties brought about by the outbreak or lockdowns also constituted an additional factor.

In the light of the recent increase in COVID-19 cases, the information from the rapid assessment in the African Region provides very important insights on how countries have maintained their essential oral health services, which are vital for preserving a person's oral functioning, managing severe pain and enhancing the quality of life.

The following actions have been identified as critical in maintaining oral health services in the context of COVID-19:

- Strengthen the response for each pillar of the COVID-19 Strategic Preparedness and Response Plan, including the continuity of essential health services;
- Integrate oral health into the essential health services package during the COVID-19 pandemic, accompanied by financial protection;
- Prioritize essential oral health services depending on the COVID-19 transmission stage and ensure availability of PPE and human resources, for example for urgent and emergency care, minimum invasive procedures and non-AGPs;
- Ensure infection prevention and control measures, including PPE availability in oral health care settings;
- Facilitate task shifting and role delegation;
- Leverage telemedicine and digital technology solutions to triage patients and improve oral health literacy.

Background

The COVID-19 pandemic has disrupted essential health services globally, raising particular concerns in the African Region on account of the low resilience of its health systems. Overstretched health systems can be overwhelmed easily by the increasing focus on COVID-19 and its response (1). Additionally, health care-seeking behaviour has been affected by various factors, such as movement restrictions and concerns about infection risks at health care facilities, especially during the initial months of the COVID-19 pandemic.

Oral diseases such as dental caries, periodontal diseases, oral cancer and noma are significant public health problems that contribute to the global burden of noncommunicable diseases (NCDs). For example, about half of the global population and more than 480 million people in the WHO African Region suffered from oral diseases in 2019 (2). To deal with this burden, Member States in the Region adopted the Regional oral health strategy 2016–2025: addressing oral diseases as part of NCDs during the 2016 session of the Regional Committee (3).

Despite the heavy burden of oral diseases and the importance of oral health to general health and well-being, low priority has been accorded to oral health compared to other mainstream programmatic disease areas. This has led to insufficient resources, technical capacity, policy guidance and service coverage at the country level. The COVID-19 pandemic has worsened this situation. According to a recent WHO global assessment on the continuity of essential health services during the COVID-19 pandemic, more than 70% of countries had partial or complete disruption of their oral health services at some point. This figure was higher than for any other essential health care service (4).

The WHO Regional Office for Africa conducted a rapid assessment of the continuity of essential oral health services in the context of COVID-19 in the Region to better understand the situation and identify important actions to strengthen oral health promotion and oral disease prevention and control as part of the overall health system. This policy brief summarizes the results of that assessment and provides guidance for Member States on how to maintain their essential oral health services. It also provides insights on how to build back better health systems with integrated oral health services after the pandemic. It takes into account reports and expert recommendations from a webinar on the continuity of essential oral health service in the context of COVID-19 in the WHO African Region, organized on 28–29 September 2020 and attended by more than 300 participants representing Member States, WHO staff and important stakeholders (5, 6).

Methods used in the assessment

In September 2020, the Regional Office distributed a web-based questionnaire to focal points for oral health or NCDs in the ministries of health and WHO Country Offices in the 47 Member States in the Region. The questionnaire sought information related to national policies and plans for oral health prior to the COVID-19 pandemic; the continuity of essential health services, including oral health services before and

during the COVID-19 pandemic; and service disruptions, including the reasons for them and the measures taken to mitigate their impact. Information on areas for technical support by the Regional Office was also requested. The WHO situation report (7) indicates that the Region reported a continued decrease in COVID-19 cases from the end of July 2020 to the period of the assessment in September 2020. The Regional Office therefore asked the countries about disruptions in their oral health services due to the COVID-19 pandemic, the reasons behind them and the main approach to solving them over what was considered as the two phases of the pandemic; phase 1 was from February to July 2020 and phase 2 was from August to September 2020.

As with all self-reported surveys, these findings need to be interpreted bearing in mind the associated limitations, such as respondent bias, the differences in understanding the questions, the lack of information validation from other sources, and the focus on the situation in just public health services without including private health facilities.

Summary of the findings

Out of the 47 Member States in the Region, 35 (74%) completed the survey. Using the World Bank's income classification (8), two of these countries were high-income, 17 were upper- and lower-middle-income, and 16 were low-income. Regarding transmission classification as at 20 September 2020 (7), two of the countries were sporadic cases, seven were cluster cases, and 26 were in the community transmission stage.[1]

Existence of oral health policy, strategy, document and/or action plan, or essential health service package for oral health prior to the COVID-19 pandemic

Of the 35 countries responding to the survey, 19 had an operational oral health policy, strategy and/or action plan prior to the onset of the COVID-19 pandemic. Moreover, 29 had defined a national essential health services package,[2] and 24 of these had oral health services as part of that package.

[1] Transmission classification is based on a process of self-reporting. The categories are: no cases; no confirmed cases; sporadic cases, meaning one or more cases that are either imported or detected locally; clusters of cases, meaning cases that are clustered in time, geographic location and/or by common exposures; community transmission, meaning large outbreaks of local transmission defined through an assessment of factors including, but not limited to, large numbers of cases not linkable to transmission chains, large numbers of cases from sentinel laboratory surveillance, and/or multiple unrelated clusters in several areas of the country/territory/area; pending, meaning that transmission classification has not been reported to WHO (https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200921-weekly-epi-update-6.pdf?sfvrsn=d9cf9496_6).

[2] In the WHO African Region, many countries have been defining the essential health services package as an essential health/basic package that is affordable (https://www.afro.who.int/publications/state-health-who-african-region). The essential health package often consists of a limited list of public health and clinical interventions to be provided at the primary and/or secondary care level (https://www.who.int/oral_health/publications/promoting-oral-health-africa/en/).

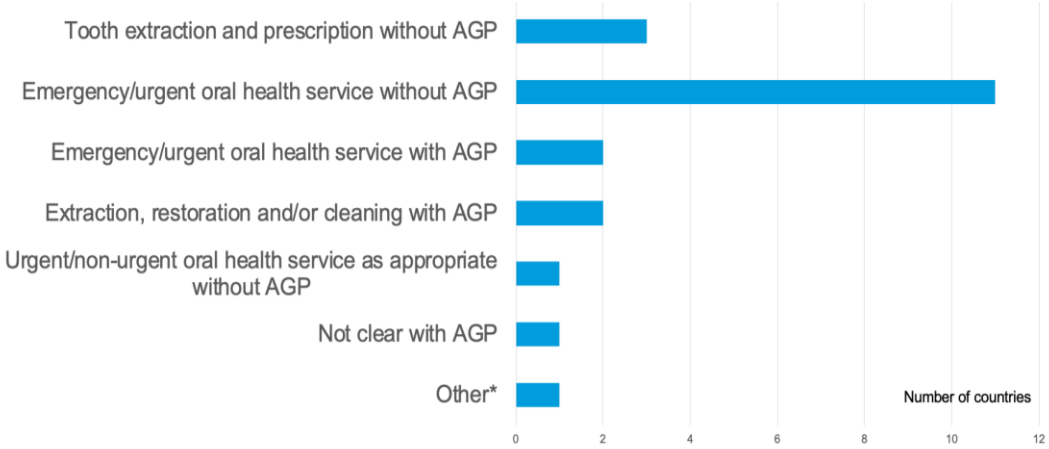
Essential health service and oral health service in the context of COVID-19

Some 29 of the 35 countries identified a core set of essential health services that should be maintained during the COVID-19 pandemic. These countries consisted of both those that had defined or not defined the national essential health service package prior to the COVID-19 pandemic. For 23 of these countries, the core set of essential health services included oral health services. These consisted of two high-income countries and 21 low- and middle-income countries (LMICs).

The two high-income countries were classified as sporadic cases as at 20 September 2020. All their oral health services, including AGPs,[3] were integrated into the essential health service package during the COVID-19 pandemic. For one of the countries the government had provided free oral health services prior to and during the COVID-19 pandemic. In the other country, essential oral health services were financed by the government and out-of-pocket payments prior to and during the COVID-19 pandemic; however, in the context of COVID-19, the government had provided additional financial support to ensure continuity of essential oral health services.

Among the 21 LMICs, COVID-19 transmission was classified as clustered in four countries and as community transmission in 17 countries. Five out of the 21 countries provided AGPs while 11 provided emergency or urgent oral health service without AGPs (Figure 1). None of the countries reported government providing additional financial support to ensure continuity of essential oral health services during the COVID-19 pandemic.

Fig. 1: Oral health service in the COVID-19 essential health services package among 21 LMICs (*Other = emergencies, urgent dental treatment and other dental treatment were the only services permitted initially. However, routine dental procedures such as scaling, polishing and restorations are permitted now because of the availability of adequate PPE).



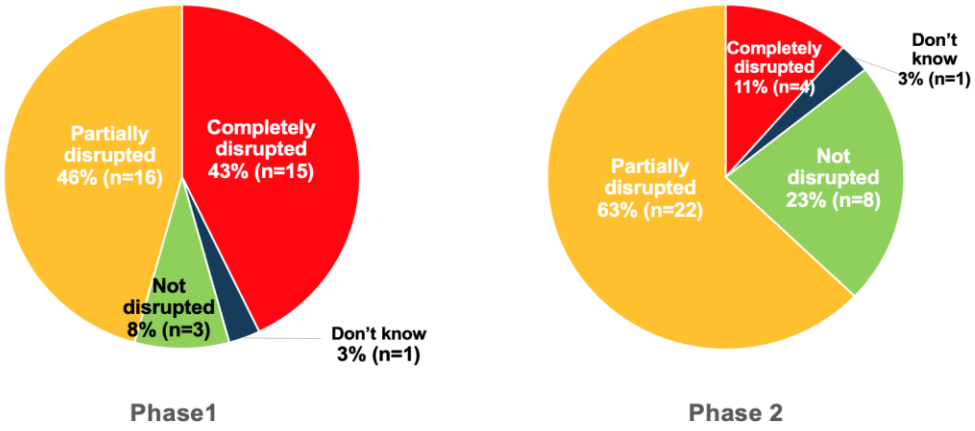
[3] All clinical procedures that use spray generating equipment such as three-way air/water spraying, dental cleaning with an ultrasonic scaler and polishing, periodontal treatment with an ultrasonic scaler, any kind of dental preparation with high or low-speed hand pieces, direct or indirect tooth restoration and polishing, definitive cementation of a crown or bridge, mechanical endodontic treatment, surgical tooth extraction, and implant placement (https://www.who.int/publications/i/item/who-2019-nCoV-oral-health-2020.1).

Disruption of essential oral health services in the context of COVID-19

The countries were asked about the disruption of their oral health services due to the COVID-19 pandemic, the reasons for it and the main approach in addressing it during phase 1 and phase 2.

In regard to phase 1, around 90% of the countries reported having had a complete or partial disruption of their oral health services while 8% had no disruption.[4] For phase 2, seventy-four per cent of countries had a complete or partial disruption while 23% had none (Figure 2).

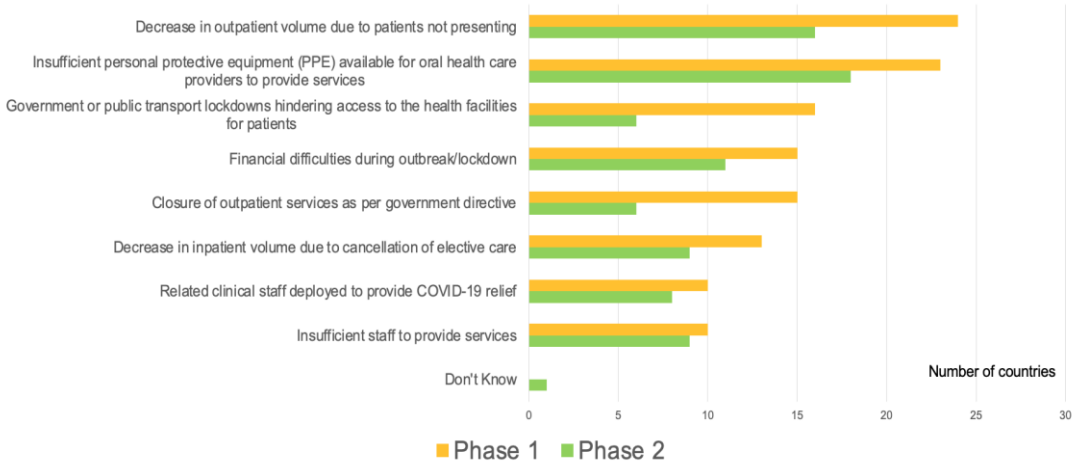
Fig. 2: Countries experiencing disruption of oral health services due to COVID-19 in phase 1 (from February to July 2020) and phase 2 (from August to September 2020)



The top three reasons for the disruption of oral health services in phase 1 were decreased outpatient volume, insufficient PPE levels for oral health care providers, and government or public transport lockdowns hindering access to health facilities for patients. For phase 2, the top three reasons for the disruption were insufficient PPE levels for oral health care providers, a decrease in outpatient volume due to patients not presenting at facilities and financial difficulties associated with the outbreak and lockdowns (Figure 3).

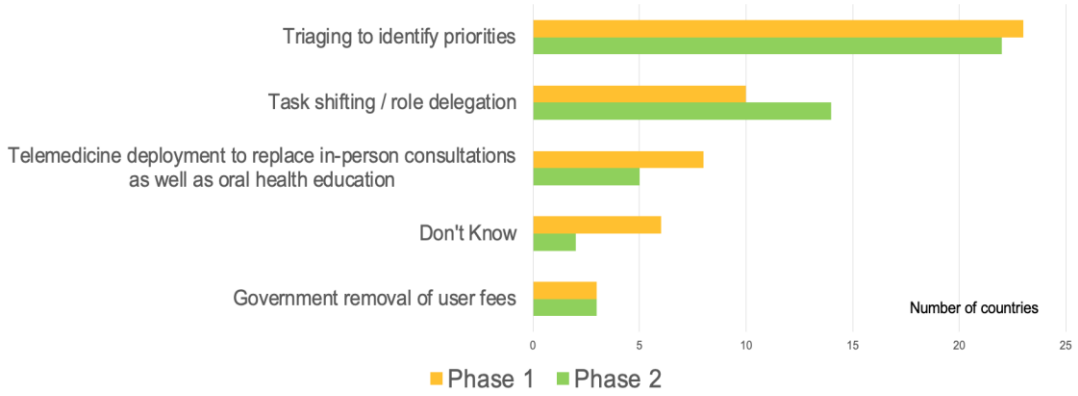
[4]Level of disruption of services: completely (or severely) disrupted (more than 50% of patients not treated as usual), partially disrupted (5% to 50% of patients not treated as usual), and not disrupted (less than 5% of patients not treated as usual).

Fig. 3: Reasons for disruption of oral health service in phase 1 and phase 2



The main approach for solving the oral health service disruptions in phase 1 and 2 was triaging to define priorities. Next was task shifting or role delegation, followed by the use of telemedicine to replace in-person consultations and oral health education (Figure 4).

Fig. 4: Main approaches to solving oral health service disruption in phase 1 and phase 2



Suggestions for technical support

The countries provided numerous and varied suggestions on the tools or technical guidance that the Regional Office could offer during the COVID-19 pandemic. The support requested was in the form of: (1) capacity building in infection prevention and control (IPC), PPE and maintenance of essential oral health services; (2) a guidance document to facilitate continuity of essential oral health services; (3) assistance to develop standard protocols or guidelines for oral health during the COVID-19 pandemic; (4) provision of PPE; and (5) strengthening of disease surveillance through integration of oral health in the existing surveillance system.

Discussion based on the rapid assessment outcome

Like the global pulse survey (4, 9), this assessment, focusing on the continuity of essential oral health services in the African Region, also revealed that these services were fully or partially disrupted in more than 70% of the countries, even in the off-peak transmission phase 2. The main reasons for that were insufficient PPE levels, a decrease in outpatient volume due to patients not presenting at health facilities, government or public transport lockdowns, and financial difficulties encountered following the outbreak or lockdowns.

Twenty-three countries integrated oral health services into their essential health service list during the COVID-19 pandemic, but only one among them provided additional financial support to continue oral health services. Among the LMICs especially, only emergency or urgent care was offered, with more than half of them doing this, as well as recommending avoiding provision of AGPs. High-income countries and those in the less severe COVID-19 transmission stages most likely maintained a wide variety of oral health services with financial protection during the COVID-19 pandemic.

This assessment did not address the impact of oral health service disruption on patients and the wider population. However, it has been reported elsewhere that during the COVID-19 pandemic and especially during lockdowns people with excruciating dental pain and acute oral infections managed their problems with do-it-yourself dentistry, including extracting molar teeth without local analgesia (10). There is no doubt that the COVID-19 pandemic has led to the deterioration of oral health and quality of life and increased oral health inequalities in the African Region.

COVID-19 continues to challenge health systems and expose gaps in health security. It has revealed the weaknesses of health systems, the limited nature of social protection systems and the significant structural inequalities within and between countries. It has shown that universal health coverage (UHC), robust public health systems and emergency preparedness are essential for individuals, communities and economies. The existing gaps in health care coverage are among the reasons why COVID-19 has caused so much pain and suffering (11, 12).

In many countries, unfortunately, oral health receives low priority and is considered an individual rather than a social responsibility. Without its inclusion in UHC, systemic health outcomes will worsen and ultimately contribute to the growing health disparities (13). Indeed, the United Nations High-level meeting on universal health coverage recognized the importance of integrating oral health into UHC in order to achieve the UHC goals (14).

COVID-19 is a human tragedy, but it has also created an opportunity to build a more equitable and sustainable world. For the health sector in each country, this implies that the need for enabling policies to progress towards UHC is more critical than ever. The information obtained through this assessment provides important insights to inform the countries as they strengthen their pandemic response, including in

building back better health systems after the pandemic with the integration of oral health services.

Recommendations

The following paragraphs summarize the critical aspects in maintaining oral health services as part of the pandemic response to COVID-19 and in the context of building back better.

(A) Immediate actions in the context of the COVID-19 pandemic

The epidemiological situation of COVID-19 between August and October 2020 was relatively stable in the African Region compared with many other parts of the world, but increases in cases occurred during November and December 2020 (15). Therefore, it is important to remain vigilant and to maintain and strengthen pandemic preparedness and response capacities. Even under conditions of a resurgence and/or a return to the severe transmission stage, it is necessary to maintain essential oral health services such as urgent or emergency oral health interventions, which are vital for preserving a person's oral functioning, managing severe pain or securing the quality of life (16).

Strengthen the response for each pillar of the COVID-19 plan, including continuity of essential health services

- As per the COVID-19 Strategic Preparedness and Response Plan (SPRP) (17), it is crucial that the COVID-19 response under each pillar of the SPRP be strengthened. This includes continuity of essential health services, IPC, risk communication and community engagement; coordination, planning and monitoring, surveillance, points of entry, national laboratory system, case management, operational support and logistics (including the procurement of PPE).

Integrate oral health into the essential health services package during the COVID-19 pandemic, with financial protection

- Ensure integration of a cost-effective oral health service into the core sets of essential health services during the COVID-19 pandemic with financial protection, for example through government removal of user fees.
- Prioritize essential oral health services depending on the COVID-19 transmission stage and availability of PPE and human resources, e.g. provide for urgent or emergency care only, minimum invasive procedures and non-AGP as opposed to AGP (18).

Ensure IPC measures are implemented, including PPE availability, in oral health care settings

- Oral health care teams work in close proximity to patients' faces for prolonged periods. Their procedures involve face-to-face communication and frequent exposure to saliva, blood and other body fluids and handling of sharp instruments. Moreover, the risk of airborne COVID-19 transmission when AGPs are performed cannot be completely eliminated. Consequently, oral health teams are at high risk of being infected with SARS-CoV-2 or passing it to patients (16).

- In compliance with WHO's interim guidance: Considerations for the provision of essential oral health services in the context of COVID-19 (16), ensure strict adherence to IPC measures by reinforcing the standard operating procedures for facility-based infection control in the oral health care setting, including utilizing appropriate PPE.

Adopt task shifting and role delegation

- In addition to the relatively high scarcity of trained oral health professionals in the African Region, many of those who were in oral health posts have been reassigned to the COVID-19 response. To address the unmet demand for oral health services, one of the solutions is to adopt a task-shifting strategy that provides additional oral health training for primary care workers and enables them to provide essential oral health services in an integrated manner (19).

Leverage telemedicine and digital technology solutions to triage patients and improve oral health literacy

- It is crucial to triage patients using a normal telephone call, telemedicine or digital technology to conduct online consultations for prioritization of patients and their treatment. Moreover, there is need to improve oral health literacy among the population to enable them to take charge of their own oral health and remove the unnecessary fear of seeking treatment in oral health care settings.

As indicated above, WHO has published the interim guidance titled "Considerations for the provision of essential oral health services in the context of COVID-19" (https://apps.who.int/iris/handle/10665/333625) for use by its Member States. This guidance will help them to support the continuation of essential oral health services in the context of the COVID-19 pandemic by providing them advice on the essential oral health services that can be delivered based upon the transmission stage and the available human, financial, facility and PPE resources. It will also ensure the implementation of the necessary IPC measures following the WHO operational guidance on maintaining essential health services.

(B) Build back better health systems with integrated oral health services after the pandemic

In line with the Regional oral health strategy 2016–2025 (3) and the recently launched Operational Framework for Primary Health Care (20), the following recommendations constitute the foundation for building back better oral health services as part of primary health care (PHC) and UHC.

Prioritize oral health in the African Region on the basis of the Regional oral health strategy 2016–2025

- Advocate for increased political commitment at the highest level to address oral health as part of NCDs, PHC and UHC.
- Develop or update national health policies and strategic plans, including the UHC national strategies and roadmaps, to integrate oral health.
- Ensure essential oral health services are integrated into the essential health services package for UHC.

- Integrate cost-effective, minimally invasive essential oral health services into the health insurance benefit package to ensure financial protection.

Strengthen local resource mobilization

- Seek new financing opportunities to integrate oral health into other areas including UHC, as well as to increase government revenue collection through taxation of tobacco, sugars etc., and earmark additional funds for oral health.

Strengthen the oral health policy, strategy or action plan through intersectoral or multisectoral collaboration to provide a population-based approach to oral health with a budget

- Provide essential health interventions across all public health functions, i.e. health promotion, disease prevention, and curative, rehabilitative and palliative services. A population-based approach includes interventions such as fluoridation, taxation of tobacco and sugars, health promotion in school settings and community engagement. A functional oral health policy, strategy or action plan is the necessary basis for budgetary decisions.

Strengthen the capacity of the oral health workforce

- Based on population needs, develop workforce models, for example for task shifting and skill mix, for integration of basic oral health care within primary care, based on clear definitions of competencies and skills. Include a supportive policy framework and systems for follow-up, re-training and continuing education for primary care workers.

Empower and engage communities in oral health issues

- Ensure the political engagement of communities and other stakeholders from all sectors to define the problems and solutions and prioritize actions through policy dialogue, which should include issues related to oral health. This includes capacity building for individuals in health services and their families, lay public and both for-profit and not-for-profit private sector, including civil society organizations, to promote oral health.

Reinforce the integration of oral health into existing disease surveillance systems

- Oral health-related information is not regularly monitored in many African countries. One of the reasons is that its indicators are not integrated into the existing surveillance systems. Integration of such indicators in routine data collection processes and monitoring of the continuity of essential oral health services are required. Data are essential also for evidence-based political decision-making by governments.

Leverage mOral Health, including the community of practice

- Despite experiencing Internet connectivity challenges during the COVID-19 pandemic, the WHO African Region has successfully conducted online consultations, webinars, courses and mass or social media campaigns to raise awareness of COVID-19 among the population. The WHO Global Oral Health Programme plans to launch the mOral

Health programme with its mOral Health literacy, mOral Health training, mOral Health early detection and mOral Health surveillance components, so it would serve as an excellent opportunity to invest in that area.

Strengthen partnerships

- Encourage sustainable collaboration inside and outside the oral health sector with relevant stakeholders, donor agencies and development partners. Through regional cooperation and public–private partnerships, it would be possible to forge multisectoral alliances and mobilize resources, securing oral health materials, including PPE, for the prevention and control of oral diseases as part of whole health and beyond the health agendas.

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