EPISODE 45. FRAMING GLOBAL HEALTH ISSUES: THE CASE OF ORAL HEALTH

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Garry Aslanyan [00:00:08] Hello and welcome to the Global Health Matters podcast. I'm your host, Garry Aslanyan. With so many pressing global health challenges and limited resources, what determines whether an issue makes it into the global health agenda? What factors shape its priority status? In this episode, we will be taking a closer look at the framing of global health issues and to do so by using oral health as a case example. Oral health affects 3 .5 billion people around the world, yet its status as the most common non-communicable disease is often unrecognized. In 2021, the World Health Assembly adopted a historic resolution to achieve universal health coverage for oral health services by 2030, but as my two guests, Habib Benzian and Bulela Vava will explain, there is still a long road ahead to turn this goal into a reality. Habib Benzian is a dentist, a professor of epidemiology and health promotion at the New York University and a co-director of the WHO's Collaborative Center on Oral Health. Bulela Vava is a dentist and the president of the Public Oral Health Forum in South Africa. Let's dive in. Hi Habib, hi Bulela, how are you today?

Bulela Vava [00:01:35] Hi Garry, I'm good, how are you?

Garry Aslanyan [00:01:38] Good.

Habib Benzian [00:01:38] Same here, thanks for the invitation and for bringing us together for this conversation Garry.

Garry Aslanyan [00:01:44] Both of you are dentists and also, most importantly, you are very strong advocates of public health. You have a very clear vision for oral health. And maybe you could start by sharing with our listeners how this vision realized, would look like at global level and at national level in South Africa.

Habib Benzian [00:02:12] I think we are facing a major generational challenge where half of the world's population has no access to any kind of oral care, and they live with untreated oral disease every day and there's no other disease group that affects so many people. We have a new WHO global oral health strategy and action plan covering 2023 to 2030. In this plan there is a vision formulated which says that everyone should have access to essential oral health care services which include prevention, care, and rehabilitation by 2030, and this is the vision for universal health coverage for oral health.

Bulela Vava [00:02:57] If I can chop in, this vision for us looks like is an integrated, accessible, and affordable oral health care for everyone living within the borders of South Africa. Now, what that means for us is that it must be foregrounded, of course, on wellbeing and dignity. So beyond just oral health access, what we are talking about, we are talking about this oral health access being integrated within the general health program. And for the longest time, we all know the position of oral health having been on the sidelines for the most part, and we are pushing for the integration of oral health in key priority programs like maternal and child health, adolescent health, oral health for aging populations. And at least within our context, a new program, which was even men's health.

Garry Aslanyan [00:03:46] Now that you both so clearly articulated the global and the local vision for oral health, I'd like for us to have a critical discussion reflecting on why we're still experiencing this divide

between general and oral health in this day and age. Bulela, what factors do you think are responsible for this divide?

Bulela Vava [00:04:10] I think the development of dentistry as a profession was problematic in itself and has always developed parallel to medicine. But dentistry is as old as the medical health care profession. And that, for me, is one of the issues. And again, when these professions had the opportunity now to move from chop shops or whatever you want to call them to professionalized entities, they each went their separate ways. and they never looked back.

Garry Aslanyan [00:04:42] Interesting. And Habib, what do you think?

Habib Benzian [00:04:44] I agree with Bulela and the process of professionalization, defining dentistry as a profession, as a medical profession, as a pathway over more than 150 years, from barber and street makeshift work to a reputable health profession. And in this process, of course, there was always emphasis on the specifics of oral health care that is so different from medicine that it requires a separation. It relates to the training, the education of professionals, the organization of oral healthcare, the financing, the public health messaging etc. So, this separation has led to a lack of understanding. The general public health mainstream does not know much about oral health and vice versa. Our dental community doesn't know very much about what is going on in the broader public health sphere. There's also another fact that I would like to mention, this is, that there is a widespread conception that oral diseases are a private matter, while other health issues are recognized and addressed as public health and public problems. This has, of course, consequences to how oral health is viewed and how the governments, the public sector engage in oral health. As a consequence, I would say that there is in many countries a complete disengagement of the public sector with regards to oral health. They leave it to a deregulated private sector to provide the healthcare. Whereas in general health, in maternal child health, in essential surgery, vaccinations, there are government run programs that are open and free or available at reasonable cost to everyone. Whereas oral healthcare is usually a private thing that is paid out of pocket or covered by private insurance. So, the silo and the separation really goes very deep and has a long-standing history.

Garry Aslanyan [00:06:45] I think you both touched on really important points. Historical professionalization of oral health as a separate entity and then also the framing of oral health as a private matter have hindered it from being included as part of government funded healthcare. What other factors have separated oral health from being seen as part of universal healthcare?

Bulela Vava [00:07:13] Oral health would also suffer that the consequences of a system that was increasingly looking at investing in technology to drive oral health outcomes. But with an investment in technology became another problem, the industrialization technically of healthcare. And we of course then further, then entrenched ourselves in an intuitive focus to health without actually thinking very much about the primary basis of primary care, which is actually prevention. Whereas our focus was actually in the wrong lane, rather than actually a focus that should have been centred on prevention, which is less sexy, which is less this and that. So, I think Habib has a lot more to say about this.

Garry Aslanyan [00:07:58] That's interesting, Bulela. For a long time, oral health sidelined prevention in favour of cure, and curative care still requires significant technology. Habib, why do you think oral health was never included as part of the 1978 Alma Ata Declaration?

Habib Benzian [00:08:19] I like this point that you make Bulela, about the technology, because part of Alma Ata is also to use appropriate technology that responds to the need of the communities that should

be served. And there is this idea that dentistry and oral health care is only possible with these high tech, expensive gadgets, which also increases the cost of care and of training. So, it's kind of opposite to each other. I think the absence of dentistry and oral health in Alma Ata goes even deeper. At the time when

Alma Ata happened, there was a fraction of stakeholders who thought that primary healthcare is something that is better suited to the realities of communities in a socialist or more centralistic government financed health system, so, very opposite to the prevailing model of privately organized dental practice with independent entrepreneurs at the top, at the helm. In this market-based thinking and model of healthcare, the state should interfere as little as possible and leave things to professional self-regulation. And that has been dominated by protectionist approaches. The dental associations are protecting the profession in every respect. Many of them act as trade unions for the profession rather than as advocates and promoters of oral health for the entire population. As a consequence, then the private sector has always said that primary health care is simple, is low quality and they have portrayed it in a negative way, to enhance, of course, the standing of private care, which was the opposite model, was high quality, full spectrum of interventions, high tech approach that Bulela mentioned. So, I think this is part of the reasons why oral health was not part of the Alma Ata discussions. And now when there was this rebirth of primary health care, UHC for oral health means free and cheap oral health care for everyone, which dental association said this is impossible, who is supposed to pay for that? So they were, this attitude and the misconception of what UHC actually is, was very widespread with many professional associations who were concerned about government involvement and about a dent in their income as private free entrepreneurs.

Garry Aslanyan [00:10:50] Great point Habib. Yes, this notion of oral health being framed as part of the private sector and to some degree kept in place, as you mentioned, by the dental associations is even currently impeding it from being seen as part of the universal health coverage. Maybe I'd like to ask you more about oral health's lack of inclusion in current key disease agendas, for example, as part of the non-communicable diseases or NCDs. Habib, despite growing evidence that oral diseases are among the most common and preventable contributors to NCDs, they are rarely mentioned in, let's say global NCD declarations. What challenges are preventing oral health from being recognized as critical component of the NCD agenda?

Habib Benzian [00:11:50] Yeah, that's the key question, I think, and one that is not easy to answer. It's not a simple thing to resolve. I think advocates have tried over many decades to end the neglect of oral diseases and to address the silo mentality that we talked about earlier and move towards more integrative thinking with oral health as part of general health, then framing oral diseases as part of the NCD movement when it started some 15 years ago, and now pushing for integration with UHC. All of this, I would say with varying success, not a real breakthrough. I think there are some fundamental issues related to the oral disease, to oral diseases. They are widespread, but they have low mortality. So, people do not die from them. The nature of oral diseases is also particular because, they are generally chronic, but as you know, if you ever had toothache, it comes and goes. You have periods with intense pain that impact you terribly in your daily life and your performance, and then you have long periods where you don't feel anything and you think, oh, the problem is gone, until it comes back even more forceful. There is also, to some degree, a social acceptance of, that oral diseases are part of life, of aging. So, when you, as you age, you lose teeth, and you end up with a denture. That's kind of the socially accepted or when you're pregnant, there's the saying one child, one tooth, because during pregnancy, you have a higher risk for gum disease, which may lead to tooth loss. There is this complacency, the lack of understanding that oral diseases are actually affecting your whole body and should be taken seriously. Also, I think around the NCD movement there is a whole, another political economy that has developed over time, in the last 10 years maybe, it is a very competitive environment. We know that NCDs are not getting the recognition that they deserve, even though they are the major disease group across all countries and

population groups. They compete for political priority, for funding, for resources, and the NCD movement started by combining four diseases and four risk factors into a package of four by four. Diabetes, cardiovascular disease, respiratory disease, and cancer and the four risk factors that go with

it. Then a couple of years ago in 2018-2019 mental health was added to the picture and indoor pollution as a common risk factor. We are now at a five-by-five matrix for NCDs, where the space for oral health and for oral diseases and for sugar as a specific key risk factor for oral diseases is very limited. So, when we see an outcome document of a high-level political meeting organized by the UN and there were three already on NCDs, oral health is usually mentioned with one word in a 60 or so page document, just acknowledging, yes that oral diseases are also a problem, but without any further detail. A year ago, two colleagues and I, we published a paper in Lancet Public Health where we argued that we need to expand the thinking and the framing of NCDs. We have no NCD on the planet that affects so many people like oral diseases so why not include oral health in the mainstream of NCD framing of policy, of resource allocation and political priorities. So have oral diseases as the sixth NCD and sugar, which is now kind of hidden in unhealthy diet as a risk factor, single sugar out, and make it a more prominent risk factor that needs specific attention because it not only affects oral disease but also all the other NCDs. The reaction on this was interesting. The oral health community of course likes the concept, and they try to integrate it in their advocacy and messaging, but the NCD community is very hesitant, probably because of the competitive nature that I mentioned, they are so geared towards the main NCDs that they consider main, and they are even struggling to integrate mental health. If we come along now and say, we want to see oral health at the same level as these NCDs, we get a lot of resistance.

Garry Aslanyan [00:16:47] That's fascinating. Yes, when it comes to the framing of health issues having global importance, there is so much at stake. As you said, Habib, oral health may lack the urgency as it is rarely a cause of death. I'd like to underscore your comment about the fierce competition for resources that exist in the global health sphere and how this can breed silos and ultimately limit integration. Habib, what guidance may you have for listeners in different fields who are also working hard to have their issues recognized? What influences how global, or national health priorities are shaped?

Habib Benzian [00:17:39] Yes, I think we are getting now really to the core of the issues. You know Ilona Kickbusch, my German colleague in global health, she says that health is a political choice, which means decision makers and governments have a lot of power to address these capital flows that influence the environment that people live in and the choices that they have available and the way that governments and regulations and laws are enacted. The governments also have a role in prioritizing certain things, and the concept of how global health priorities or national health priorities are shaped, how they come together is still not fully understood. And there are many researchers working on this, but there are some concepts around it, you need of course at first a problem definition that is agreed and where everybody can align to. I think in our fragmented global health arena and in the oral health community itself, there is no clear definition of what the problem is. What is the key problem? And then following on that, what are the key solutions that we could offer? We are a sector that is relatively small with very few international global stakeholders, so there is not a big community that can advocate and lobby for the issue. We have not found a way to build compelling arguments that are backed by science and where there is a full agreement from all those stakeholders to actually push and convince. And the last factor that we see in oral health is there is a complete absence of civil society, of what we now call people affected by a disease. We see in other health areas that this voice of people living with a certain condition is very powerful and very strong in demanding from national governments, we need support, we need this type of care, we need access to these services. For every condition under the sun, you will have a self-help group, you have a representation of patients, of people affected, sometimes even paid and sponsored for by the pharmaceutical industry, yes, there were some specific challenges around this, but

in oral health, there's not a single patient advocacy group. Their social integrationism is complicated, so we have zero of that, and that complicates our advocacy case.

Garry Aslanyan [00:20:15] Thank you for mentioning those three very practical things that influence the framing and prioritization of global health issues as a clearly articulated need, strong evidence, and civil society support. Previously, we had an episode focused on disability and looking at Noma and oral health disease. In that example, civil society played a critical role in Noma being recognized as a neglected tropical disease. Bulela, your organization, the Public Oral Health Forum, is very active in engaging civil society. Can you tell us more about your work in South Africa?

Bulela Vava [00:20:59] So the Public Oral Health Forum is a network of oral health professionals who have demonstrated a commitment to advancing oral health equity and wellbeing but foregrounding all of this in the need to recognize society's dignity. Our biggest focus is actually oral health professionals on the one hand and the communities that they serve. And what we are trying to do is to bridge this gap and perhaps to some extent actually respond to the concern that Habib has raised, this issue that there is no patient advocacy groups for oral diseases. An example, as you've mentioned, is Noma, which of course we know is endemic in particular parts of the world. But needless to say, there are other conditions that society could always mobilize around. However, what we identified as a gap was yet again, the problem with the professions. The professions who often thought or had this misconception that research equals policy change. Not in many of the contexts that we operate in, is this actually the case? What is always often required for us to see the change we need is number one, yes, the evidence is important, but the evidence must have a context of application and the context of advocacy driving it into the mainstream corridors of policymakers, of community-based advocates. You take the case study of South Africa around the treatment action campaign, which recruited community members who were affected by HIV as advocates and trained them and made them advocates for access to antiretroviral treatment. That campaign was perhaps South Africa's biggest success story to date. This is not what we are doing in the professions, and this is not what we are doing in oral health, therefore the public oral health forum has come in with this idea of trying to say what we need to do is to partner with our communities. They have agency, but the problem is that often communities are stuck in agency and never is that agency leveraged to action. This is the gap we are trying to fill. The profession needs to become part of the community. And the profession needs, with the knowledge, experience and evidence that we have, engage communities, not as recipients, not as beneficiaries, but as equal stakeholders to advance oral health.

Habib Benzian [00:23:36] I couldn't agree more, Bulela. The challenge really is not the part of the training that oral health professionals get when they graduate from university. They are trained in clinical skills, looking after one patient, but not looking after the needs of communities. Public health is largely absent in dentistry training in most universities around the world. And the practitioners who graduate do not see themselves as change makers, as advocates for a cause. They see themselves as the perfect clinicians to address a problem with one patient at a time.

Garry Aslanyan [00:24:19] I think that is very insightful, and it challenges us all to see our role not only as providers of care, but as mobilizers of community agency. As we draw to the close, what advice from your advocacy journeys would you offer to support listeners who would like to see their health topic or issue be included in the broader global health agenda. Bulela, do you want to share your thoughts and then Habib?

Bulela Vava [00:24:51] Whenever I'm asked this question, I always try to figure out if there actually is a right way of doing this. But what I believe foregrounds and holds, what we can do is I think the ability to organize, I always say, find others like you. And this ability of trying to find people like you is very important because whether or not you are a front facing clinician trying to make a difference in a community, whether you are in an academic setting or sit at the highest levels of power, it becomes

important to find other people who speak the same language. This idea of organization becomes particularly important to make sure that we gain momentum, we bring these conversations to the table. But I also believe that before that, a fundamental psychological shift is needed away from ego, away from entrenching ourselves on the hierarchies, this idea that hierarchies are there and should never be challenged. As an organization, we are challenging hierarchies because we are saying no to professional exceptionalism and dictating who gets involved in the fight for health. I mean, at this point in time, no one owns the struggle. The struggle doesn't belong to an individual or a particular organization. It belongs to people. And I think if we go back to that, remembering that we are people first before we are professionals is an important thing to keep in mind as we engage other peers, as we engage communities around the table as equal stakeholders.

Habib Benzian [00:26:43] I like what you said Bulela, that nobody owns this struggle. That means if you spin that further, it means we all own this struggle, and everyone has a place in advocacy, and I couldn't agree more with that. I think on a personal level, for me, it is important to be consistent and persistent with core messages, but that the framing of these messages needs to vary according to the audience that you speak to and that you want to convince of your case. You also need a high tolerance level for frustration because advocacy is not a linear process. It goes in zigzag, and you think you have done one step forward and the next day there are two steps backward, and this will happen all the time. So, you are in this for the long haul, and you need to be clear about this as an advocate for whatever health issue you are working. And if you are part of an organization or as a team, while I agree with you, Bulela, that you need to put ego aside, there's also an important element to think about in a way of self-reflection, who am I? And what is my positionality towards the issue? What makes me an expert to speak out on this issue? How do other people perceive me, my authority, to address this problem? And if I present a solution, why should they listen to me and not to someone else who may be proposing something else? So, there is a process of self-reflection that is also quite important and to be clear about, to make sure your arguments are more impactful. I think on the professional level, many people think that advocacy is kind of a hobby, that you do, because you feel personally concerned about something, but we need to make sure that everyone understands advocacy is a serious business, there is a science behind that. There are grounded concepts and tested and tried methodologies to make advocacy effective. It needs proper planning; it needs a set of skills that can be trained and learned. And we should try to professionalize our advocacy as well to improve the impact and that ranges includes the highest levels that as you mentioned of decision making but also grassroots experience and community level because this is where the change is most needed and as advocates we have to work on this entire spectrum, everyone and not everyone at the same time we can choose our battles and our areas but we need to it in the most professional way possible.

Garry Aslanyan [00:29:33] Thank you, Bulela and Habib, for this great conversation. I'm sure our listeners will find it extremely insightful and help with their advocacy. Thanks again for joining us today. As Habib and Bulela highlight, both historical and current factors shape the prioritization of health issues. While specialization drives innovation and advancement, it often reinforces silos within healthcare. For them and other advocates in the field, the task at hand is clear, to build bridges across the silos so that oral health can become part of universal primary health care. Regardless of our specific health disciplines, may we be reminded by this example that holistic population-based health can only be achieved when we step beyond our specialties, engage with colleagues across fields, and foster

collaborative understanding and action. To learn more about the topic discussed in this episode, visit the episode's webpage, where you will find additional readings, show notes, and translations. Don't forget to get in touch with us via social media, email, or by sharing a voice message. And be sure to subscribe or follow us wherever you get your podcasts. Global Health Matters is produced by TDR, a

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