



# Global oral health status report

Towards universal  
health coverage for  
oral health by 2030

Regional summary  
of the South-East  
Asia Region



World Health  
Organization

Global oral health status report: towards universal health coverage for oral health by 2030. Regional summary of the South-East Asia Region

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# Foreword



Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3.5 billion people. The burden is increasing, particularly in low- and middle-income countries.

Good oral health is essential for eating, breathing and speaking, and contributes to overall health, well-being and confidence in interacting with others. But oral health is challenged by a range of diseases and conditions, and stark and persistent inequalities in the burden of disease and access to oral health care. Disadvantaged and marginalized people are more likely to be at risk of oral diseases and their negative consequences.

The good news is that many oral diseases can be prevented and treated. Cost-effective preventive and clinical interventions are available, together with approaches to tackle risks common to all noncommunicable diseases, with the potential to be effective in a range of contexts, including low- and middle-income countries.

Oral health has long been neglected in the global health agenda. Our biggest challenge now is ensuring that all people, wherever they live and whatever their income, have the knowledge and tools needed to look after their teeth and mouths, and access to prevention and care when they need it. For this to happen, all countries need sufficient staff trained in oral health, and oral health services must be included in national health coverage packages, either free of charge or at a price that people can afford.

The adoption by WHO Member States of a historic resolution on oral health at the World Health Assembly in 2021 was an important step forward. The development and adoption of a comprehensive Global Strategy on Oral Health, with a bold vision for universal coverage of oral health services by 2030 was another milestone. The Global Oral Health Action Plan to be discussed in 2023 will include a monitoring framework, with clear targets to be achieved by 2030. These policies will provide us with a clear path towards ensuring oral health for all.

This WHO *Global Oral Health Status Report* provides a comprehensive picture of the oral disease burden, the resources available for oral health, and the challenges ahead.

The report also includes country profiles, and will serve as a baseline for tracking progress. Integrating oral health promotion and care into primary health care and UHC benefit packages will be key to success. WHO is committed to providing guidance and support to countries to help make this happen.

I am confident that this report will contribute to continued and increased efforts to improve oral health globally, so that no one is left behind with preventable and treatable oral diseases.

A handwritten signature in black ink, which appears to read 'Tedros Adhanom Ghebreyesus'. The signature is fluid and stylized, with a large initial 'T'.

Dr Tedros Adhanom Ghebreyesus  
Director-General, World Health Organization



## What is oral health?

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The 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. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential.







1

# Towards global oral health equity through universal health coverage





Oral diseases, while largely preventable, pose a significant global health burden and affect people throughout their life course, causing physical symptoms, functional limitations and detrimental impacts on emotional, mental and social well-being.

In 2021 at the Seventy-fourth World Health Assembly, the landmark resolution WHA74.5 on oral health was adopted (1). It recognizes that oral health should be embedded within the noncommunicable disease (NCD) agenda and that essential oral health care intervention should be included in universal health coverage (UHC) benefit packages. As such, it calls on Member States to shift from the traditional curative approach to oral health care towards a promotive and preventive approach.

The World Health Organization (WHO) South-East Asia Region is home to more than one quarter of the world's population. The South-East Asia Region comprises 11 diverse Member States, all of which are greatly impacted by oral diseases. Oral diseases (excluding lip/oral cavity cancer) affected more than 903 million people (45% of the population) in 2019.

This regional summary draws on WHO's *Global oral health status report* (2), published in 2022, which provides a comprehensive overview of the global oral disease burden, the global health importance of oral health and the impact of oral diseases over the life course. The summary focuses on the oral health status in the South-East Asia Region and is split into four sections: (a) oral diseases are global and regional health problems; (b) the burden of the main oral diseases; (c) key challenges and opportunities towards oral health in the South-East Asia Region; and (d) road map towards UHC for oral health 2030.

# 2

Oral diseases are  
global and regional  
health problems



## Oral diseases present an increasing global and regional burden

- Oral diseases are the most widespread of the more than 300 diseases and conditions that affect humanity. About 3.5 billion people worldwide were affected by oral diseases in 2019. Between 1990 and 2019, estimated case numbers of oral diseases increased by more than 1 billion. This translates to a 50% increase, which is larger than the population increase of about 45% during the same period.
- Over the last 30 years (1990–2019), estimated case numbers of major oral diseases (caries of deciduous and permanent teeth, edentulism, severe periodontal disease and other oral disorders combined) in the South-East Asia Region grew by more than 345 million – a 61.4% increase, higher than the estimated population increase of 53.8% during the same period.
- Among all six WHO regions, the South-East Asia Region had the highest number of cases (almost 903 million) of all the major oral diseases combined in 2019, reflecting the Region's large population size.

## Oral diseases share risk factors with other NCDs and have impacts along the life course

- Shared, modifiable NCD risk factors include high intake of free sugars, all forms of tobacco use and harmful alcohol use. Taking a common risk factor approach to the prevention of oral diseases by embedding oral health within the broader NCD agenda ensures that progress can be made across a range of NCDs, including oral diseases, diabetes, cancer and cardiovascular diseases.
- In 2019, two thirds of all deaths in the South-East Asia Region were due to NCDs, equating to approximately 9 million deaths. Almost half of those were among people under the age of 70 (3).
- In 2017, 9.8% of the population in the South-East Asia Region was over the age of 60. By 2030, 13.7% of people will be 60 years of age or older, and this is projected to increase to 20.3% by 2050 (4). Poor oral health among older people can negatively affect daily activities and result in specific challenges related to pain, impaired chewing and nutritional deficiencies.

## Oral diseases disproportionately affect disadvantaged populations in society

- Stark and persistent inequalities in oral health status exist across different population groups. Inequalities result from a complex array of interconnecting factors, many of which are beyond individuals' control. Oral diseases disproportionately affect poor and vulnerable members of societies, often including people who are on low incomes; people living with disability; older people living alone or in care homes; people who are refugees, in prison or living in remote and rural communities; and people from minority and/or other socially marginalized groups.
- Access to oral health services is uneven within and among countries. Availability of oral health services is not aligned with the needs of the population. Those with the greatest need often have the least access to services.



### The economic burden of oral diseases is very high

- Expenditure for oral health care is highly unequal across the 11 countries of the South-East Asia Region. In the Region, the total direct expenditure due to oral diseases is about US\$ 0.8 billion. At the same time, productivity losses from oral diseases are more than US\$ 13 billion.
- Within the South-East Asia Region, five countries spend less than US\$ 1 per person per year on oral health care, while six countries spend between US\$ 1 and US\$ 10 per person per year.
- Oral health care is often associated with high out-of-pocket expenditures because private practitioners predominantly provide the services, which are usually only partially or not at all covered by government programmes and/or insurance schemes.

### There are gaps in the oral health workforce

- Oral health care is often characterized by low workforce numbers, a predominance of private provision models, underresourced public services, inadequate task sharing and skill mixes within teams, limited or no access for rural, remote or disadvantaged populations, and lack of financial protection and coverage.
- Inequalities in access to oral health services exist within and among countries in the South-East Asia Region, but the overall numbers of those working in the oral health workforce as dentists, dental prosthetic technicians and dental assistants and therapists are low. For example, the number of dentists per 10 000 population ranges from 0.1 to 2.4, with a regional average of 1.6, compared with the global average of 3.3. For countries where data are available, the number of dental prosthetic technicians per 10 000 population is between 0.0 and 0.5, with a regional average of 0.04, and for dental assistants and therapists, it is between 0.0 and 1.0, with a regional average of 0.1; the global averages are 0.6 and 1.9, respectively.



# 3

## The burden of the main oral diseases



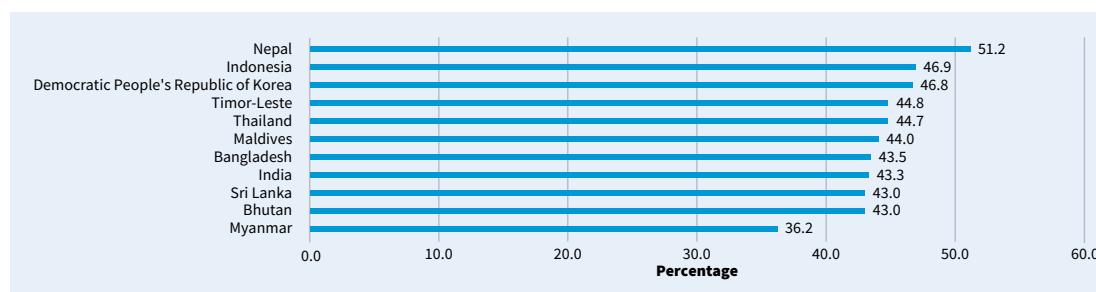


## Dental caries

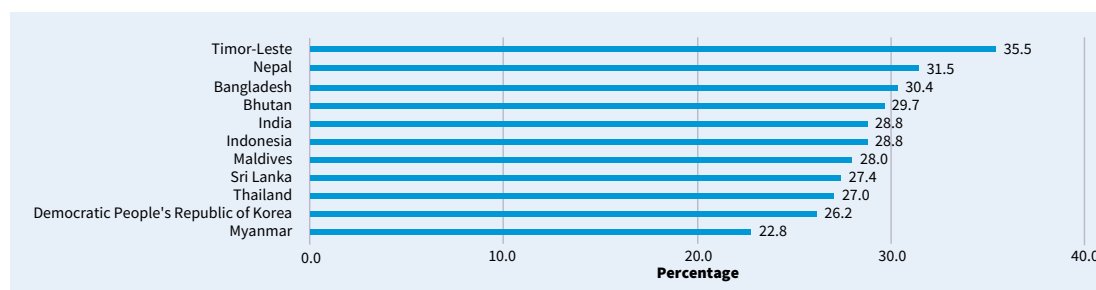
Dental caries is a gradual loss and breakdown of tooth hard tissues that results when free sugars contained in food or drink are converted by bacteria into acids that destroy the tooth over time. Dental caries affects all age groups, starting with the eruption of the first teeth, increasing in prevalence until late adulthood and remaining at high levels until older age. Dental caries is the most common NCD worldwide, with more than one third of the global population living with untreated dental caries. Consumption of free sugars is the main dietary factor in the development of dental caries.

At the regional level, the prevalence of dental caries in the deciduous and permanent teeth remained largely unchanged between 1990 and 2019. Among the WHO regions, the South-East Asia Region has the third highest prevalence (43.8%) of caries of deciduous teeth in children between 1 and 9 years old (Fig. 1). With an estimated 135 million cases in 2019, the Region has the highest number of cases in children, reflecting its large population. The Region has the largest overall burden of caries of deciduous and permanent teeth among WHO regions, with more than 660 million cases in 2019 (Fig. 2.).

**Fig. 1. Estimated prevalence of caries of deciduous teeth in people aged 1–9 years per country in the South-East Asia Region (2019)**



**Fig. 2. Estimated prevalence of caries of permanent teeth in people aged 5 years or older per country in the South-East Asia Region (2019)**

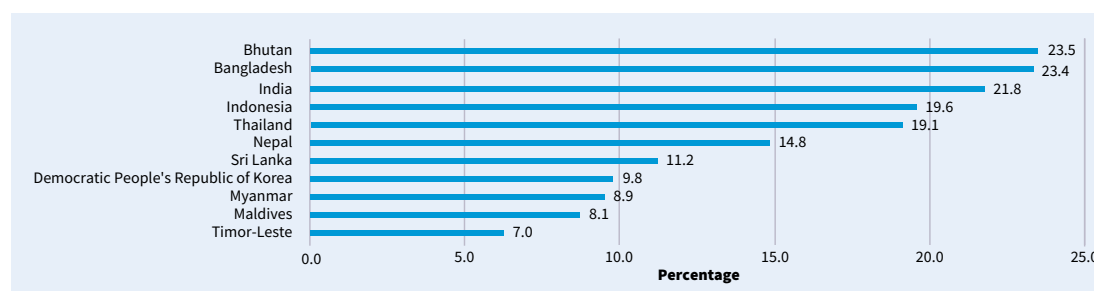


## Severe periodontal disease

Periodontal disease is a chronic inflammation of the soft and hard tissues that support and anchor the teeth. Severe periodontal disease, defined as the presence of a pocket of more than 6 mm depth, is a condition of public health concern. Poor oral hygiene is a major behavioural risk factor for periodontal disease, in addition to common NCD risk factors like tobacco use. Between 1990 and 2019, the South-East Asia Region recorded a 22.7% increase in prevalence, with a prevalence of 20.8% in 2019 among persons aged 15 years or older (Fig. 3).

Prevalence of severe periodontal disease peaks around 55 years of age and remains high until old age. It is likely the South-East Asia Region will experience a higher regional burden of disease in the future because of the growing ageing population.

**Fig. 3. Estimated prevalence of severe periodontal disease in people aged 15 years or older per country in the South-East Asia Region (2019)**



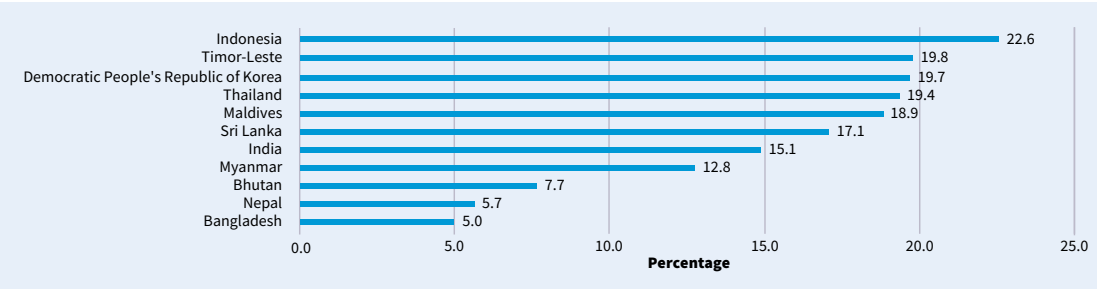
## Edentulism

Losing teeth is generally the end point of a lifelong history of oral disease, primarily advanced dental caries and severe periodontal disease, but tooth loss can also result from trauma; all can possibly lead to tooth extraction. Edentulism is a stark indicator of social and economic inequalities, with disadvantaged populations disproportionately experiencing total tooth loss.

The South-East Asia Region accounts for 15.1% of edentulism cases in the WHO regions. The Region had the second lowest prevalence of edentulism (4.1%) among the WHO regions in 2019, at about 53 million people aged 20 years or more, but the Region had the second largest increase in prevalence (16.4%) between 1990 and 2019, double the global average increase of 8.0%. Country prevalence of edentulism in this age group ranges from 1.2% in Bangladesh to 6.6% in Thailand.

Maintaining functional teeth is critical for supporting healthy ageing. In 2019, 15.4% of adults above 60 years of age in the South-East Asia Region suffered from complete tooth loss, compared with the global average of 22.7% (Fig. 4).

**Fig. 4. Estimated prevalence of edentulism in people aged 60 years or more per country in the South-East Asia Region (2019)**



Oral cancer

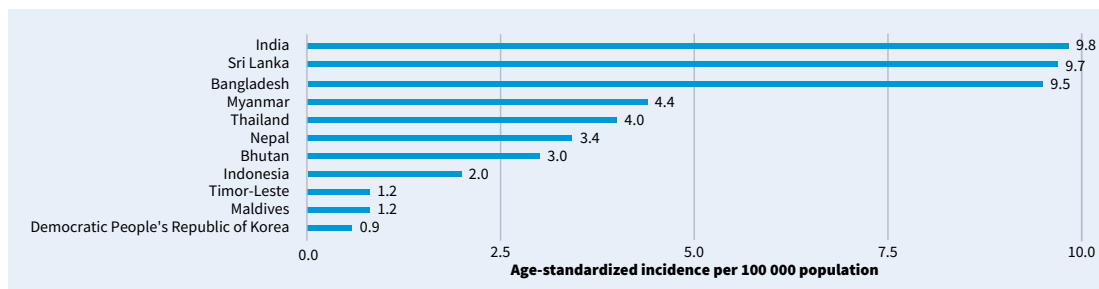
In the South-East Asia Region, oral (lip and oral cavity) cancers ranked fourth among all cancers by incidence and fifth by mortality in 2020.

The South-East Asia Region has the highest incidence and mortality rates of oral cancer in the WHO regions, reflecting the Region’s high use of tobacco, including smokeless tobacco. The Region had the largest number of new cases in 2020, with an estimated 166 900 cases, which equated to 44.2% of the total cases of oral cancers in all the WHO regions.

Deaths from oral cancer in the Region account for 52.0% of deaths from oral cancers worldwide, with India alone accounting for more than 40%. This equates to more than 92 000 deaths within the South-East Asia Region. The country incidence rate of oral cancer ranges from 0.9 to 9.8 per 100 000 population (Fig. 5). See the case study: Two betel nut consumers and their battles with oral cancer (India) on page 12.



**Fig. 5. Estimated age-standardized incidence rates of lip and oral cavity cancer in people of all ages per 100 000 population per country in the South-East Asia Region (2020)**





## Case Study – Two betel nut consumers and their battles with oral cancer (India)

Oral cancer contributes to about 30% of cancer cases in India, with more than 130 000 new cases diagnosed in 2020, according to the Global Cancer Observatory (5). This represents two thirds of registered cancer cases of the National Cancer Registry Programme (6). In 2021, it was reported that nearly one out of every four adults in India consumes betel nut, of which around 10% is mixed with tobacco (7). The large number of users of betel nut, a known carcinogen and risk factor for oral cancer, presents a huge public health challenge for the country.

Shashank Wani, a 31-year-old teashop owner from Jabalpur, was diagnosed with Stage 2 oral cancer in 2021. He started using betel nut products when he was a senior at secondary school and continued consuming four to five packs a day, occasionally mixed with smokeless tobacco, until he learned that the ulcer in his mouth, which had not been healing, was oral cancer.

“I started this habit after taking over our family teashop when my father passed away. We ate betel nuts when chatting to pass time with my friends at the shop,” Wani says, pointing out the lack of awareness about the harmful effects of betel nut. “Teenagers need to be informed and educated about the consequences and should not fall into the trap of addiction. Only then the future generations could be safe,” he adds. As chewing betel nut is a socially acceptable habit in most parts of India, community leaders show indifference towards it. Further, betel nut or its products can be easily found and purchased in small shops.

Wani feels lucky that the cancer was diagnosed at an early stage and his surgeries were successful. He has a 1-year-old daughter. “I had to stay strong and fight the cancer for her sake. Thank God that I am alive and healthy today. I have been granted a second life, which I intend to live to the fullest with my family and friends,” he says, feeling grateful to all those who cared for him during the stressful time of his illness.

Betel nuts are also widely consumed by people who work long hours as they are believed to help improve mood and concentration. Rahul

Wankhede, a 35-year-old engineer in computer science from Indiranagar, started eating betel nuts in his twenties when he worked in the army. Other soldiers who were habitually taking betel nuts to reduce stress and exhaustion introduced them to Wankhede. Three years ago, he was diagnosed with oral submucous fibrosis (OSMF), an abnormal collagen deposition in the oral cavity (8, 9). After being informed by the medical team about the disease’s debilitating outcomes, such as restriction in the mouth opening and formation of a malignant tumour, Wankhede started getting treatment and stayed away from betel nuts for a while.

“Unfortunately, after some time I went back to eating betel nuts again to cope with the consistent stress,” Wankhede explains. His OSMF later worsened, forming blisters and ulcers and causing him difficulty with opening his mouth. A biopsy taken from one of the tongue ulcers that did not respond to treatment showed that he had oral cancer. Despite having a radical surgery, during which part of his tongue was removed and replaced with some muscles from his arm, as well as his ongoing radiotherapy, Wankhede is hopeful to be in remission and looking forward to life beyond cancer.



# 4

## Key challenges and opportunities towards oral health for all in the South-East Asia Region



Challenges	Opportunities
1. Oral health governance	
<ul style="list-style-type: none"><li>■ Seven countries (63.6%) did not have a national oral health policy, action plan or strategy in place.</li><li>■ Three countries (27.3%) did not have dedicated staff for oral diseases in the NCD Department of the Ministry of Health.</li><li>■ Of the five countries represented, all were in the process of phasing down the use of dental amalgam in line with the Minamata Convention (10).</li></ul>	<ul style="list-style-type: none"><li>■ Develop new national oral health policies that align with the WHO Global Strategy on Oral Health (11) and national NCD and UHC policies. The Global Oral Health Action Plan (12) outlines 100 proposed actions (for Member States, the WHO Secretariat, international partners, civil society organizations and the private sector) across six strategic objectives. The accompanying global monitoring framework identifies 11 core and 29 complementary indicators to track and monitor progress on implementation of the global oral health action plan.</li><li>■ Allocate dedicated staff for oral health at the Ministry of Health or other national governmental health agency, ensuring integration with the NCD and UHC agendas.</li><li>■ Four countries (36.4%) are parties to the Minamata Convention on Mercury, which aims to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds. Become a party to the Minamata Convention on Mercury and accelerate implementation of measures to phase down the use of dental amalgam in accordance with the Minamata Convention on Mercury.</li></ul>

Challenges	Opportunities
<b>2. Oral health promotion and oral disease prevention</b>	
<ul style="list-style-type: none"> <li>■ Six countries (54.5%) have not implemented a tax on sugar-sweetened beverages.</li> <li>■ Fluoride toothpaste was unaffordable in Bangladesh and Nepal and was affordable in Indonesia, Myanmar and Thailand. The remaining six countries (54.5%) had no data available.</li> <li>■ The South-East Asia Region has high rates of tobacco use.</li> </ul>	<ul style="list-style-type: none"> <li>■ Implement policy measures aiming to reduce intake of free sugars, such as (a) nutrition labelling: front-of-pack or other interpretative labelling to inform about sugars content, including mandatory declaration of sugars content on prepackaged food; (b) reformulation limits or targets to reduce sugars content in foods and beverages; (c) public food procurement and service policies to reduce offering food high in sugars; (d) policies to protect children from the harmful impact of food marketing, including for foods and beverages high in sugars; (e) taxes on sugar-sweetened beverages and sugars or foods high in sugars.</li> <li>■ The addition of fluoride toothpaste to the WHO model lists of essential medicines in 2021 (13) is an opportunity to improve affordability and availability of fluoride toothpaste and products.</li> <li>■ As the South-East Asia Region has witnessed the fastest decline in tobacco use among all WHO regions (14), there is impetus to continue curbing tobacco use by banning electronic nicotine delivery systems, expanding cessation services and imposing higher taxes.</li> </ul>



Challenges	Opportunities
2. Oral health promotion and oral disease prevention	
	<ul style="list-style-type: none"><li>■ Optimize digital technologies for oral health care to improve oral health literacy, health worker training, early detection of oral diseases and oral health surveillance within national health systems.</li></ul>

Challenges	Opportunities
3. Oral health workforce	
<ul style="list-style-type: none"><li>■ Inequalities exist in the ratio of the oral health workforce to the population between upper middle-income and lower middle-income countries, with the exception of one country. The Democratic People’s Republic of Korea is the only low-income country in the South-East Asia Region, but it has the second highest ratio of dentists per 10 000 population at 2.2. Maldives and Thailand are upper-income countries and have higher ratios of dentists per 10 000 populations compared with lower middle-income countries, except for India, which is on par with Maldives at 2.0.</li></ul>	<ul style="list-style-type: none"><li>■ Integrate oral health care into primary health care at all service levels, including required staffing, skill mixes and competencies.</li><li>■ Develop an innovative workforce model for oral health to respond to population oral health needs. Workforce trained and legally permitted to respond to the oral health needs of all population groups may include oral health professionals and other primary health care workers, including community health workers.</li></ul>

Challenges	Opportunities
<b>4. Oral health care in primary health care</b>	
<ul style="list-style-type: none"> <li>■ Integration of oral health care into NCD management and primary health care is fragmented and, in some countries, nonexistent.</li> <li>■ The predominance of private oral health care models in many countries leads to high out-of-pocket expenses, particularly for disadvantaged populations.</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase access to safe, effective and affordable essential oral health care as part of national UHC benefits packages with improved financial protection. See the case study: Oral health benefits and school oral health as part of [Thailand] on the next page.</li> <li>■ In primary care facilities in the public health sector, there was high availability of (a) oral health screening for early detection of oral diseases in 10 countries (90.9%); (b) urgent treatment for providing emergency oral care and pain relief in nine countries (81.8%); and (c) basic restorative dental procedures to treat existing dental decay in nine countries (81.8%). Despite this, the South-East Asia Region reported the lowest total and per capita direct expenditure on oral health among the WHO regions. Expand coverage of essential oral health care by planning for the availability, accessibility, acceptability and quality of skilled health workers able to deliver an essential package of oral health care for all.</li> </ul>

## Case Study – Oral health benefits and school oral health as part of UHC (Thailand)

Thailand has achieved UHC since 2002, thanks to three public health insurance schemes that together cover the entire population. Unlike in many other countries with UHC, the package of services available in Thailand includes an oral health benefits package, making oral health services accessible to the entire population (15, 16).

The components of the oral health benefits package differ across the three insurance schemes, each of them providing slightly different coverage. A wide range of oral health services, including prevention, curative care and rehabilitation services, are covered under the Universal Coverage Scheme for the general population, as well as for those insured under the Civil Servant Medical Benefit Scheme for civil servants and their dependents. Private-sector employees are covered by Social Health Insurance, which is limited to removable dentures and has an annual coverage ceiling for scaling, extraction, surgical removal of impacted teeth and restorations. Once the ceiling are exceeded, members have to pay the difference. All three programmes cover oral health promotion and prevention services, including pit and fissure sealants and fluoride applications.

Oral health promotion programmes for school-age children have been implemented for decades by the Ministry of Public Health, helping children to start good oral habits early. The programmes are now co-financed with oral health services being part of UHC and school environment improvements being supported by schools and local governments. Over the years, collaboration between the education and health sectors has grown and has proven to be crucial in creating and maintaining school-based oral health programmes. Teachers, parents, communities and local health workers take combined responsibility to keep children's teeth healthy at home and school.

“The critical success factor of the school oral health programme is the participation of all sectors, including oral health self-care by students themselves, children's oral health care at home by parents, oral health education by schoolteachers, the healthy school lunch programme by the school chef, health care services by health and oral health personnel, a budget for health-promoting activities by local government, and a healthy environment surrounding the school (not selling candies and soft drinks) created by the whole community,” says the director of a primary school in Angthong province. “Oral health personnel are not the key people at school oral health programmes,” adds an oral health professional based in Nakhon Pathom province.

The education sector-led school-based oral health programme complements the UHC oral health benefits package driven by the health sector. Both together offer a multifaceted approach to ensuring oral health for all.



5

## A road map towards UHC for oral health





Adoption of resolution WHA74.5 on oral health (1) was a significant milestone towards repositioning oral health as part of the global health agenda in the context of UHC.

As a first step in the implementation of the resolution on oral health, Member States adopted the Global Strategy on Oral Health at the Seventy-fifth World Health Assembly in 2022 (11). The Global Oral Health Action Plan (2023–2030) is the second step in the implementation of the resolution on oral health (12). It is grounded in the Global Strategy on Oral Health's vision, goal, guiding principles, strategic objectives and roles outlined for Member States, the WHO Secretariat, international partners, civil society and the private sector. The Global Oral Health Action Plan provides concrete guidance to progress the oral health agenda in countries and proposes a monitoring framework with targets to track progress towards 2030.

Member States endorsed the Action plan for oral health in South-East Asia (2022–2030) at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia (17). The plan has two regional targets to track progress in oral health by 2030: a 33.3% relative reduction of premature mortality due to oral cancer by 2030 and a 25% relative reduction of the prevalence of untreated dental caries of permanent teeth by 2030. The plan has six strategic action areas: oral health governance, leadership and resources; oral health promotion and oral disease prevention; life-course disease priorities and healthy settings; oral health workforce for UHC for oral health; surveillance, monitoring and evaluation; and oral health research, digital innovation and emerging issues.

Recognition of oral diseases as global and regional public health problems will continue to generate momentum and action by all stakeholders, guided by the Global Strategy on Oral Health (11). This will be possible only with the concerted efforts of all stakeholders, including governments, the United Nations system, intergovernmental bodies, nonstate actors, nongovernmental organizations, professional associations, youth and student organizations, patients' groups, academia, research institutions and the private sector. Working together, these stakeholders can achieve the ambitious targets put forward in the draft Global Oral Health Action Plan (12) and make substantial progress towards closing the global gaps in oral health by 2030 – UHC for oral health.

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