www.sada.co.za / SADJ Vol. 81 No.5
https://doi.org/10.17159/sadj.v81i05.25165
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Policy Analysis of South Africa's National Oral Health Policy and Strategy (2024-2034)

SADJ JUNE 2026, Vol. 81 No.5 P336-P342
N Rampersad,[1] S Naidoo,[2] KJ Ramphoma,[3] D Smit[4]

ABSTRACT

South Africa (SA) faces a mounting OH crisis shaped by apartheid-era inequities, a quadruple disease burden, workforce shortages, and chronic under-investment. This article presents an analysis of SA's National Oral Health Policy and Strategy (NOHP&S) 2024–2034 using the Walt and Gilson Policy Triangle Framework. The policy content, context, actors, and processes to assess alignment with global best practice and feasibility of implementation were examined. The NOHP&S demonstrates strong conceptual alignment with the WHO Global Strategy and Action Plan on Oral Health (2023–2030) and the Minamata Convention, with emphasis on prevention, integration into primary health care, universal health coverage, and environmental stewardship. However, significant gaps threaten translation into practice, including funding constraints, workforce maldistribution, weak service integration, the omission of a targeted early childhood caries prevention strategy, and surveillance shortcomings driven by limited indicators. Actor mapping highlights diffuse leadership and uneven coordination across government levels, with fragile NGO capacity and under-leveraged public–private partnerships. Process analysis indicates broadly framed strategies without operational detail, risking fragmented implementation and weak accountability. A pragmatic implementation roadmap anchored in policy-capacity assessment, strengthened monitoring and evaluation with quality, standardised outcome indicators, and investment in prevention-oriented services is proposed to catalyse sustainable improvements in population OH.

Keywords
oral health policy, oral health equity, oral health strategy, workforce, governance

Author's information
1. Nashna Rampersad, Department of Community Dentistry, University of the Western Cape
2. Sudeshni Naidoo, Department of Community Dentistry, University of the Western Cape
4. Khabiso J Ramphoma, Department of Community Dentistry, University of the Western Cape
5. Dirk Smit, Department of Community Dentistry, University of the Western Cape

Corresponding Author:
Name: Nashna Rampersad
Email: nrampersad@uwc.ac.za

Funding
This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest
The authors declare no conflict of interest.

Author Contributions
1. Nashna Rampersad: Conceptualisation, policy analysis, writing – original draft.
2. Sudeshni Naidoo: Writing – review and editing, policy analysis interpretation, critical revision.
3. Khabiso J. Ramphoma: Review and validation.
4. Dirk Smit: Referencing, and manuscript review.

All authors reviewed and approved the final version of the manuscript.

1. INTRODUCTION

Oral health (OH) is an essential, yet often neglected aspect of overall health, with profound negative implications for individual well-being, health system efficiency, and population-level health equity. Globally, oral diseases affect approximately 3.5 billion people and are among the most prevalent noncommunicable (NCD) conditions, disproportionately impacting vulnerable and marginalised populations.[1] However, despite this substantial burden, oral diseases remain siloed from broader health policy frameworks, and inadequately prioritised in universal health coverage (UHC) agendas.[2]

South Africa (SA) is characterised by profound health inequalities, a quadruple burden of disease, and is facing an escalating OH crisis.[3] Its challenges are exacerbated by socioeconomic inequalities, workforce shortages, urban–rural divides, and the long-standing under-prioritisation of OH in health planning and resource allocation.[4] While the 2002 National OH Strategy established a roadmap for service delivery, it lacked the depth, traction, and integration mechanisms to drive systemic change.[5] In light of these challenges, the introduction of the National Oral Health Policy and Strategy (NOHP&S) 2024–2034 marked a pivotal moment in SA's health policy landscape. The policy articulates an expanded vision for OH; however, its potential for success hinges on implementation within a context of resource constraints, fragmented governance, and the historical lack of political will.

This paper presents a comprehensive policy analysis of SA's NOHP&S, examining its alignment with global best practices, feasibility within the public health system, and barriers to implementation. Using the Walt and Gilson Policy Triangle Framework,[6] it deconstructs the policy's content, context, actors, and processes to assess its strengths, limitations, and prospects. As OH gains renewed global attention through World Health Organisation's (WHO) Global Strategy and Action Plan on Oral Health (2023–2030),[7] this analysis offers timely insights into how SA's evolving policy framework could translate global commitments into sustainable, contextually grounded outcomes.

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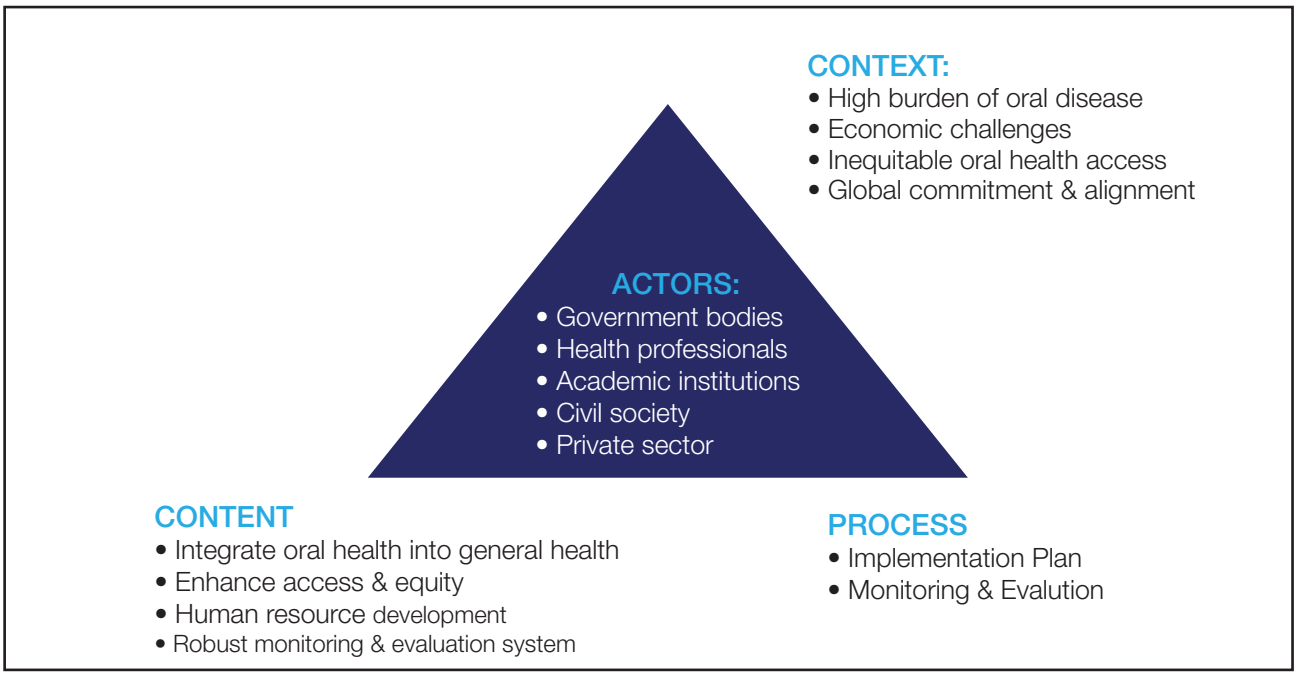

Figure 1: NOHP&S (2024-2034) – Policy Analysis

2. POLICY ANALYSIS: SOUTH AFRICA'S NATIONAL OH POLICY AND STRATEGY (2024-34)

While acknowledging the state of OH in SA, the revised National Oral Health Policy and Strategy (NOHP&S) (2024-2034) provides a critical response to the country's rising oral disease burden. However, although the policy's vision is clear and ambitious, its implementation requires careful coordination and strong leadership to overcome health system challenges.

A policy analysis was necessary to determine whether SA's NOHP&S aligns with global best practices, to evaluate its feasibility within the current healthcare landscape, and identify barriers to successful implementation. Using the Walt and Gilson Policy Triangle Framework,[6] the analysis examined the policy's key actors, context, content, and development processes. A broad overview of the policy analysis findings is illustrated in Figure 1.

2.1 Contextual analysis

2.1.1 Historical Context

South Africa's apartheid legacy resulted in a deeply inequitable, racially segregated health system. Under apartheid, Black people, who constitute 80% of SA's population, were subjected to systemic discrimination through segregation and racist laws. Oral health services were concentrated in the private sector and urban areas, resulting in severely limited access for the majority Black population in rural and township settings. Presently, 80% of South Africans rely on the overburdened public health system, yet 93% of oral health practitioners work in private practice serving only the 20% able to afford private care.[7]

South Africa's NOHP&S was developed to address the country's high burden of oral diseases, entrenched socioeconomic inequalities, and resource constraints that continue to hinder equitable access to OH care.[3] The policy operates within a complex public health environment, where local and global challenges affect its implementation feasibility.

2.1.2 High Burden of Oral Disease in SA

In its problem statements, the policy emphasises that the prevalence of oral diseases in SA remains alarmingly high, particularly among children and marginalised groups. Oral diseases such as dental caries, periodontal diseases, oral cancers, and trauma-related conditions continue to pose major public health challenges, while having limited access to timely diagnosis and treatment further exacerbate the crisis. [3]

Dental caries is widespread, affecting more than 60% of six-year-olds,[9] highlighting the severe unmet need for early intervention and preventive measures such as fluoride applications and school-based programmes. Periodontal diseases and oral cancers are also rising, fuelled by modifiable risk factors including tobacco use, excessive alcohol consumption, and poor oral hygiene.[3] These conditions are often undiagnosed and untreated due to limited access to dental professionals in rural and disadvantaged communities. The maldistribution of OH professionals leaves underserved areas with minimal care, exacerbating inequities.[10] Furthermore, dental workforce production does not meet national needs, and insufficient incentives hinder the attraction and retention of professionals in the public sector and rural locations, contributing to persistent service gaps.[11]

The policy further highlights the impacts of the OH complications of HIV/AIDS, with conditions such as oral candidiasis, Kaposi's sarcoma, and necrotising ulcerative gingivitis being more common among immunocompromised individuals. Therefore, this intersection between infectious diseases and OH underscores the need for integrated care models. Within the broader public health sector, policy trade-offs between efficiency and equity often result in OH being deprioritised in favour of high-profile health priorities such as HIV/AIDS, tuberculosis, and maternal-child health,[4,12] further limiting resources available for OH programming and services.

2.1.3 Economic Challenges

The cost of treating oral diseases is among the highest healthcare expenditures worldwide, causing a significant

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financial burden for both governments and individuals.[1] In SA, limited public OH funding and competing disease burdens,4 coupled with the fiscal constraints and economic stagnation in SA,[13] further restrict investments in OH care. Furthermore, many public OH care facilities lack the necessary resources to provide comprehensive care, resulting in long waiting times, inconsistent service delivery, and a reliance on emergency extractions rather than preventive or restorative treatments.[10]

Consequently, individuals, particularly the most vulnerable and those from lower-income groups, are often forced to delay or forgo essential OH care, contributing to worsening health outcomes and an increased burden on the broader healthcare system.[14] Recognising these financial and systemic challenges, the NOHP&S prioritises oral disease prevention and health promotion as a cost-effective approach to addressing OH disparities. The policy emphasises integrated healthcare as a critical strategy for improving OH outcomes by aligning OH initiatives with NCD prevention strategies, maternal and child health programmes, and other key public health interventions. By shifting the focus towards preventive and population-based interventions, the policy seeks to reduce the prevalence of oral diseases, alleviate financial pressures on the healthcare system, and ensure long-term sustainability of OH services.[3]

2.1.4 Inequitable OH access

Rural and underserved communities in SA face the greatest barriers to OH care. The limited availability of OH professionals in the public sector,[10] inadequate infrastructure, and geographic inequalities continue to exacerbate unequal access to essential health care, including OH care services.[15]

There remains a significant urban–rural divide in the distribution of OH.[11] In many rural areas, shortages of dentists and oral hygienists result in limited access to even basic care. For example, in the Western Cape Province, less than one-third of public OH clinics offered the basic OH care package, with rural clinics particularly disadvantaged at only one-quarter, compared to 50% in the Cape Metropolitan area.[10] Consequently, services are often extraction-focused, with minimal preventive interventions, further entrenching inequities.

Infrastructure and resource limitations in secondary and tertiary OH services reinforce these disparities.[16] Many clinics lack essential materials and specialised equipment, resulting in long delays for advanced treatment or forcing patients to rely on costly private options. These delays worsen health outcomes, increase emergency-care demand, and escalate treatment costs for the public health system.[17]

2.1.5 Global Commitments and Policy Alignment

To ensure that national interventions remain evidence-based, globally relevant, and adaptable to international best practices, the SA's NOHP&S aligns with key international public health priorities. A key influence on the policy is the WHO Global Strategy and Action Plan on Oral Health (2023-2030), that emphasises the integration of OH into general healthcare systems. This strategic approach underscores the importance of preventive and population-based interventions, aimed to reduce the prevalence of oral diseases and enhance access to quality care across all demographics.[3]

Additionally, SA's NOHP&S aligns with the Minamata Convention on Mercury,[3] a global initiative that is aimed at phasing out mercury-containing dental amalgam. This commitment is reflected the in country's dedication to environmental sustainability, patient safety, and a move toward the adoption of modern, non-toxic dental treatment alternatives. These international commitments strengthen the NOHP&S strategic direction.

Collectively, this context demonstrates that while the NOHP&S is grounded in strong global principles and national priorities, its success depends on the health system's capacity to address persistent inequalities, resource limitations, and competing health demands. An understanding of these contextual dynamics is essential for evaluating whether the policy can be operationalised effectively and achieve its intended impact.

2.2 Policy Actors

Aligned to the comprehensive primary health care (PHC) approach, successful implementation of SA's NOHP&S relies on the involvement of multiple stakeholders, each of which play a crucial role in shaping and executing the policy.[3] These actors include government bodies (such as, National Treasury), healthcare professionals, academic institutions, international partners, civil society, as well as partnerships with the private sector.

The SA National Department of Health is the central government authority with oversight on the development, implementation, and evaluation of the policy, and is responsible for resource allocation, monitoring progress, and ensuring that the strategy aligns with broader health system reforms, such as National Health Insurance (NHI).[3] At provincial and district levels, health departments also play a significant role in tailoring OH services to meet local needs, addressing regional disparities, as well as ensuring that underserved communities receive adequate OH care which are responsive to their needs.[3] However, the leadership and governance structures for OH at these levels are not explicitly defined by the NOHP&S, and this may lead to challenges in determining responsibility for coordinating and sustaining the implementation of the NOHP&S. It is pivotal to establish clear roles and accountability mechanisms at each level of a health system for effective execution and long-term sustainability of policies.[18]

Additionally, a wide range of health professionals, including dentists, dental therapists, oral hygienists, and community health workers, are tasked with service delivery as per the NOHP&S, to provide preventive and curative OH care, educate communities on oral hygiene, and manage oral diseases. However, a major stumbling block to this is the maldistribution of resources,[3] particularly human resources in rural and underserved areas, where access to qualified OH professionals remains limited[10] and several disparities in OH service delivery persist. For instance, a study in the Western Cape Province revealed that a low dentist-to-population ratio of 1:71,875 exacerbated the challenge of OH access, with public clinics averaging only 7.3 dentist days per month. Satellite clinics fared worse, with dentists available just 3.2 days per month.[10] Without addressing these structural imbalances, existing OH inequities are likely to worsen, particularly for vulnerable populations who are the key benefactors of the NOHP&S.[3]

The policy proposes that Universities and Oral Health Training Institutions play an essential role in developing a workforce

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that meets SA's OH needs. These institutions are responsible for equipping future dental professionals with the necessary skills and expertise to work in diverse settings, including public healthcare facilities and rural areas. As a method of addressing the workforce shortages and maldistribution, the NOHP&S emphasises reforming dental education and training programmes to produce "fit-for-purpose" professionals capable of serving in high-need communities.[3] However, academic institutions' ability to meet these expectations requires careful consideration. Dental schools in SA already face significant financial, infrastructural, and staffing constraints,[16] limiting their capacity to expand training output or adopt community-oriented curricula without new investment. Developing a workforce aligned to national needs will depend on universities receiving targeted funding, adequate clinical training platforms, and additional human resources to strengthen rural placements and integrate preventive, PHC-focused competencies.

Furthermore, the policy proposes that equitable access to OH services requires active engagement with civil society organisations and non-governmental organisations (NGOs) are required to facilitate with OH advocacy, education, and outreach programmes. These organisations are intended to bridge the gap between policy and implementation by raising awareness about OH, providing community-based interventions, and advocating for policy reforms that address systemic inequalities.[3] However, over-reliance on NGOs remains a pitfall of SA's public health system, particularly given the fiscal pressures that constrain their operations. Organisations operating in SA are financially weak, and their sustainability vulnerable. Following the 2008 economic downturn, a significant number of NGOs ceased operations, partly due to the fragile state of SA's economy.[20] As such, reliance on these organisations to fill critical gaps in OH care service delivery may not work as envisaged, as their financial instability may compromise long-term sustainability and accessibility of services.

The NOHP&S suggests engendering public-private partnerships to expand access to both preventive and curative OH services. The involvement of private dental practitioners, corporate sponsors, and healthcare providers are proposed to alleviate the strain on public health resources and improve service delivery.[3] However, collaboration with the private sector remains a challenge, as there are gaps in coordination and concerns regarding cost accessibility for low-income groups. Greater alignment between public health goals and private sector contributions are required to ensure sustainable partnerships that benefit all communities. Furthermore, despite its potential to play a more significant role in expanding OH care services, engagement with the private sector is limited. The lack of structured partnerships with private providers and organisations restricts opportunities for resource mobilisation and service enhancement.

Moreover, despite the broad and inclusive involvement of various stakeholders, the effectiveness of such collaborations hinges on overcoming significant challenges in co-ordination, particularly across different levels of governance. Ensuring seamless collaboration between national, provincial, and district health departments remains a persistent hurdle, often leading to fragmented implementation and inefficiencies in service delivery, as evidenced in the implementation of the previous National Oral Health Policy.[5]

Additionally, stakeholder participation is often uneven, with grassroots organisations and community-based groups frequently having limited influence in decision-making processes, resulting in policies that do not address local needs. Another critical challenge lies in ensuring accountability among all actors involved in OH governance. Without clear mechanisms to align efforts and responsibilities, achieving the policy's overarching goal of universal access to OH care may prove difficult. Therefore, addressing these systemic coordination issues is crucial to fostering an integrated and efficient OH care system that is responsive, equitable, and sustainable.

2.3 Content Analysis: The NOHP&S (2024–2034) and Global Alignment

South Africa's NOHP&S indicates a strong commitment to aligning with international OH priorities, particularly those promoted by the WHO Global Strategy and Action Plan on Oral Health (2023–2030). A comparative assessment between the two frameworks highlights points of policy convergence, areas of partial alignment, and some critical implementation gaps. Figure 2 provides a critical comparison of the two frameworks and the narrative below interrogates the implications for policy effectiveness.

2.3.1 Vision, Goals and Paradigm Shift

Conceptually, the NOHP&S embraces the WHO's vision of universal access to essential OH care and the integration of OH within general health systems. Both frameworks promote a shift from curative, hospital-centric dentistry toward preventive, population-based approaches that aim to reduce oral disease burden while improving equity in access. The NOHP&S articulates four strategic goals that reflect this shift, highlighting the need for strengthened health system capacity, improved monitoring and evaluation, better workforce planning, and equitable service delivery.[3] However, inadequate funding4 and persistent service fragmentation[10] in OH continue to hinder meaningful progress toward achieving a truly preventive and integrated model of care. Thus, while rhetorical alignment is strong, practical realisation of the NOHP&S's vision remains uncertain.

2.3.2 Integration into PHC and UHC

The WHO strongly advocates for OH to be integrated into UHC and NCD prevention strategies, recognising the shared risk factors which underpin both systemic and oral diseases.[7] The NOHP&S closely reflects these priorities, as OH forms part of the PHC Services Programme alongside 'Nutrition and Health Promotion Interventions' (South African Government, 2020). The NOHP&S supports community-based interventions, which include fissure sealant programmes, fluoride applications, and oral health education delivered through the Integrated School Health Programme (ISHP).[3] However, implementation of the School OH Policy through the ISHP is highly inconsistent and often poorly functional. Implementation is constrained by inadequate planning, limited resources, and weak school infrastructure, among others.[22]

National public health measures such as the health promotion levy on sugar-sweetened beverages illustrate a broader commitment to WHO strategies aimed at reducing population-wide sugar consumption, subsequently lowering dental caries risk.[23] However, oral diseases were not explicitly included and is constantly omitted in the levy's public messaging or national media campaigns,

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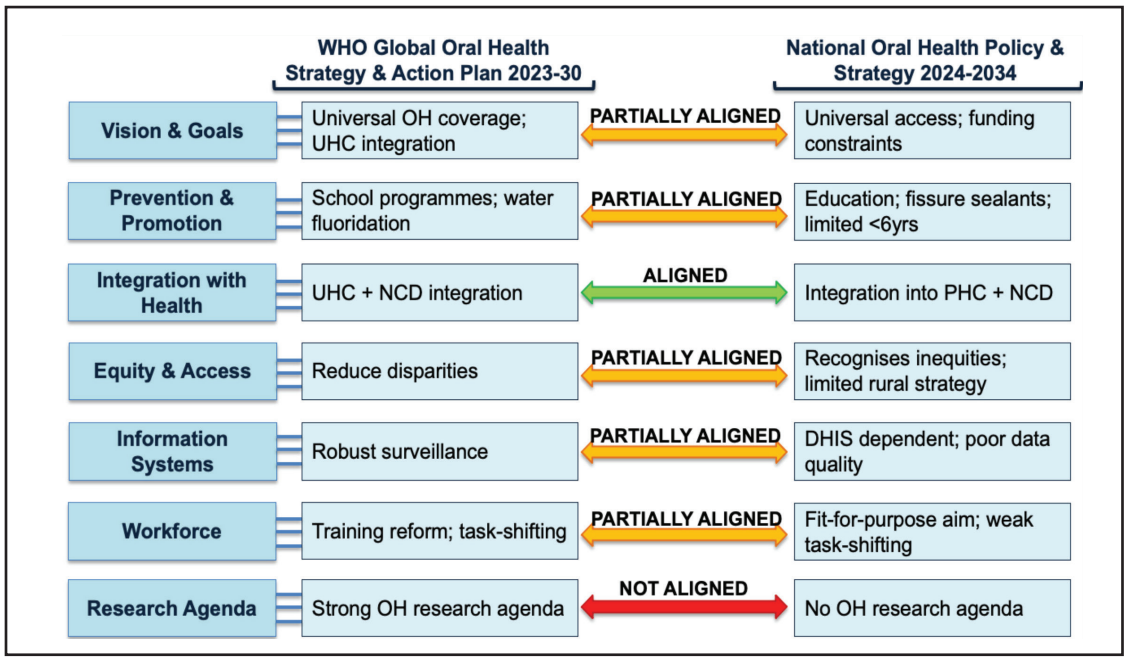

Figure 2: Alignment of Global OH Strategy and Action Plan and SA's NOHP&S (Adapted[3,7])

reflecting the broader marginalisation of oral health within health promotion platforms. Therefore, despite these structural alignments, implementation challenges, such as limited operational guidance, under-resourced PHC teams (Maphumulo and Bhengu, 2019), and weak referral pathways,[16] risk diminishing the benefits of this strategic integration.

2.3.3 Prevention and Promotion of OH

Preventive services remain a fundamental pillar of both the WHO's Global Strategy and the NOHP&S. While SA has embraced school-based oral health interventions, the exclusion of children under six-years from the ISHP programme represents a major limitation, especially considering the high prevalence of early childhood caries and its detrimental impact on developmental outcomes.[24,25] Furthermore, the lack of community water fluoridation, despite decades of policy endorsement, represents a missed opportunity to advance cost-effective caries prevention at scale. Additionally, preventive care remains overshadowed by the urgent treatment needs that are generated by late presentation and limited community-level resourcing. This demonstrates the tension between policy aspirations of the NOHP&S and ground-level realities.

2.3.4 Equity, Access and Service Delivery Structure

Equity is a core priority in both global and SA policy frameworks. However, gaps between policy commitment and service delivery remain significant. The NOHP&S outlines a tiered OH care model intended to streamline access between primary, secondary and tertiary OH services. However, in practice, infrastructure limitations, chronic equipment shortages and inefficient referral processes hinder continuity of care, especially in rural areas.[10,16] Without targeted investment to strengthen rural and underserved regions, inequities in OH access will persist, thereby, constraining the NOHP&S's ability to meet its stated equity goals.

2.3.5 Oral Health Workforce Capacity

The NOHP&S acknowledges long-standing OH workforce shortages and proposes interventions to improve training outputs and a more "fit-for-purpose" workforce.[3] However, SA continues to face a severe maldistribution of OH professionals, with the majority concentrated in urban private practices.[11] Currently, dentists make up 77% of the registered workforce, while oral hygienists , who are central to the delivery of preventive care, account for only 15% of the OH workforce.11 This imbalance limits the country's capacity to shift toward prevention-focused service delivery. In contrast, the WHO strongly supports task-sharing and workforce reallocation strategies to improve accessibility and reduce cost barriers.[7] However, these recommendations are not integrated into the NOHP&S. Without addressing workforce deployment, production and skills-mix reform in a coordinated manner, the NOHP&S risks entrenching existing disparities in service access.

2.3.6 Oral Health Information Systems and Research Agenda

Monitoring and evaluation systems are another critical area of partial alignment. While the NOHP&S identifies the DHIS as the central system for national OH surveillance, existing output-based indicators, such as service volumes for extractions, restorations and fissure sealants,[3] offer limited insight into disease status, care quality, outcomes, or equity. The lack of recent national epidemiological data remains a major obstacle to evidence-informed planning, given that the last national OH survey was conducted over two decades ago.[5] In contrast, the WHO advocates for strengthened surveillance with standardised indicators including DMFT, untreated decay rates, edentulousness, modifiable risk factors and access-related measures.[26] The NOHP&S recognises this gap and proposes data quality improvements and a future national survey; however, the absence of a clearly defined OH research agenda limits the potential for continuous evidence generation and learning within the system.

The NOHP&S does however demonstrate strong alignment with the WHO Global Strategy in terms of the conceptual direction and strategic intent, particularly in its commitment to prevention, PHC integration and equity.[3] However, longstanding systemic constraints relating to funding, workforce disparity, surveillance weaknesses and inadequate preventive reach raise significant concerns about implementation feasibility. Without focused investment, operational reforms and strengthened governance to ensure

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accountability, global alignment is at risk of remaining largely symbolic. Therefore, meaningful improvements in OH outcomes may only be realised if these policy commitments are matched by context-sensitive implementation strategies which respond directly to the realities of SA's diverse and unequal health system.

2.4 Process Analysis: Implementation, monitoring and evaluation of the NOHP&S (2024-2034)

The NOHP&S (2024-2034) was developed through a consultative and collaborative process, engaging with a spectrum of stakeholders, including provincial health departments, professional associations, training institutions, and NGOs.[3] This consultative approach was aimed at enriching the policy's formulation by incorporating diverse perspectives and expertise to outline the processes that should facilitate implementation, as well as monitoring and evaluation of the NOHP&S.

Despite the structured approach of the NOHP&S, systemic inefficiencies in OH service delivery within SA's public OH clinics10 remain a significant challenge for policy implementation. While the policy outlines "strategies and an implementation plan",[3] these remain broad and lack specific operational details, which make successful implementation uncertain. A policy's success ultimately depends on practical implementation,[18] yet in SA, limited political will and budgetary constraints frequently delay the rollout of key initiatives, and hinder the ability of many programmes to achieve their intended impact within the proposed timeframe.[15] Therefore, as emphasised by the WHO,[7] the development of national roadmaps are essential for securing commitment, establishing priority areas, and accelerating the implementation of both national and global OH strategies.

Beyond the fragmented service delivery in OH care, a major challenge in the implementation process is the reliance on cross- and inter-sectoral coordination, which has historically been a weak link in SA's healthcare system. Research by Skeen *et al*.,[7] suggested that strong political commitment and leadership from the health sector are necessary to advocate for inter-sectoral collaboration and improve coordination between key stakeholders. The lack of cohesion in governance structures negatively impacts policy integration, funding distribution,[28] and the alignment of OH initiatives with broader healthcare priorities, further complicating the implementation of the NOHP&S.

Moreover, at provincial and district levels, the absence of clearly defined OH leadership roles with the appropriate dental qualifications and authority presents an additional barrier to effective policy implementation. The NOHP&S does not explicitly outline mechanisms to support and strengthen OH leadership at these levels, leaving a significant gap in accountability and oversight. Additionally, fragmentation in governance weakens coordination between national, provincial, and district health authorities, move SA further away from achieving UHC and increases the risk of inconsistencies in policy execution, resource allocation, and service delivery.[29] Addressing these structural weaknesses is essential for ensuring that the NOHP&S achieves its intended outcomes and contributes to equitable, effective, and sustainable OH care services in SA.

To track progress and ensure accountability, the NOHP&S established a monitoring and evaluation (M&E) framework, which outlines timelines for regular monitoring, mid-term reviews, and final evaluations for each goal and objective.[3] The DHIS is the primary tool for monitoring, with key performance indicators KPIs that were derived from the National Clinical Data Elements and has been proposed to assess service delivery outcomes and identify areas for improvement.[3] However, concerns persist regarding the effectiveness and relevance of these health indicators, as they primarily rely on basic counts rather than comprehensive quality measures. Issues related to data accuracy, completeness, and the reliability of reporting mechanisms further undermine the DHIS's potential as a robust monitoring tool. Importantly, the data collection infrastructure at different levels of government may require significant strengthening to ensure accurate reporting, meaningful evaluation, and evidence-based decision-making.

Comprehensive M&E for health strategies, such as the NOHP&S, depends on a functional OH surveillance system which is integrated into a standardised and reliable OH information management system. OH in SA has long been ineffectively addressed, in large part due to the absence of a systematic surveillance strategy.[4,5] Therefore, public health action, as envisioned in the NOHP&S, relies on linking surveillance data to planning, resource allocation, and policy revision. However, without contextually appropriate, standardised indicators, monitoring efforts risk becoming a procedural exercise rather than a transformative one.

3. POLICY CHALLENGES, GAPS AND BARRIERS

The integration of global OH initiatives into SA's NOHP&S is hindered by a complex set of structural and systemic challenges. These include misconceptions about cost, limited technical capacity, weak health information systems, regulatory deficits and longstanding socioeconomic inequalities. Collectively, these barriers have implications for the feasibility, effectiveness and equity of OH service delivery. Figure 3 outlines the relationship between key policy gaps, their implications on implementation and their broader systemic consequences.

This figure illustrates the major policy barriers affecting oral health integration in SA's NOHP&S, the resulting implementation-level implications, and the broader consequences for health system performance and equity. The framework highlights that upstream policy weaknesses translates into downstream service delivery failures and population-level disparities. For example, the NOHP&S fails to address the affordability of essential preventive OH products, such as fluoridated toothpaste. South Africa ranks among the countries with the highest toothpaste costs relative to average income.[30] This creates a substantial barrier to maintaining daily oral hygiene, particularly for low-income populations. It is a critical omission in the policy, which could have considered measures such as subsidies, pricing regulations, or public–private partnerships to improve access and affordability to this essential item.

Furthermore, a key obstacle is the resistance to change, which may arise at organisational, political, and technical levels, whereby stakeholders hesitate to embrace transformative shifts in health policy. Industry opposition compounds this challenge, particularly from sectors such as the sugar industry, which are resistant to public health efforts to reduce sugar consumption. Countries with strong commercial links to these industries may oppose health

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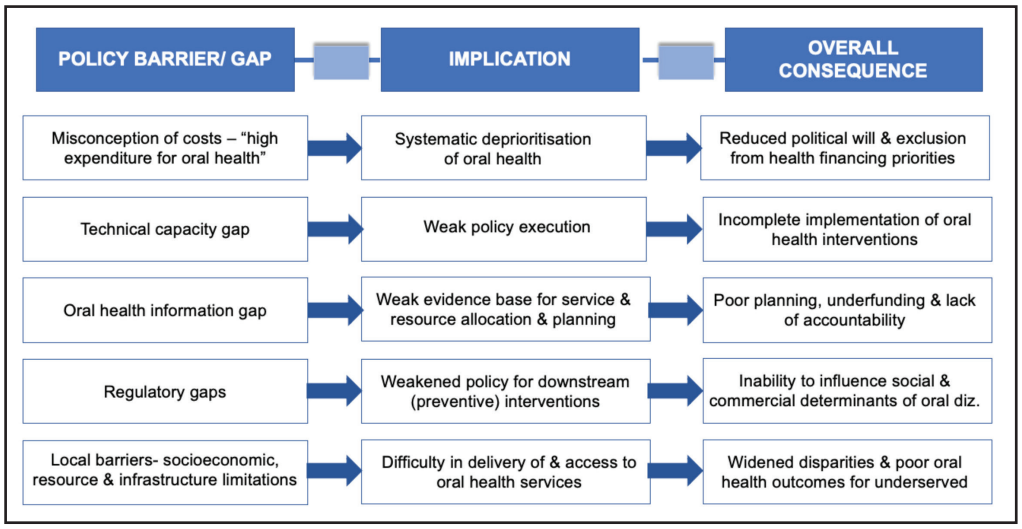

Figure 3: Policy barriers of the NOHP&S

promotion policies aimed at reducing population sugar intake. Additionally, competition among advocacy groups could impede progress, whereby established health sectors may resist incorporating new disease prevention measures, with a fear that additional health priorities could divert funding away from their causes.[2]

CONCLUSION

Persistent socioeconomic disparities, resource constraints, and infrastructure limitations within SA's public health system[15] present major challenges to the equitable implementation of the NOHP&S. The current fragmented and predominantly extraction-based model of OH service delivery falls short of the preventive and comprehensive care envisioned in the policy. These structural barriers have created a two-tiered system, where access to OH services is largely determined by geography and socioeconomic status. This undermines SA's commitment to UHC, and may further erode the public trust in the health system's capacity to address the needs of marginalised populations. Misconceptions about cost and the poor prioritisation of oral health, combined with limited advocacy and leadership, have resulted in its continued marginalisation in health planning and budgeting. Consequently, OH continues to be chronically underfunded and excluded from major health platforms, reinforcing inequities in access and outcomes.

A shift from aspiration to implementation urgently requires a clear implementation roadmap. This roadmap must be supported by a comprehensive policy capacity analysis that assesses the feasibility of implementation across governance, financing, human resources, infrastructure, data, and community engagement. This assessment will identify systemic weaknesses, highlight opportunities for integration, and ensure strategic resource allocation.[31] Without these foundational steps, the NOHP&S risks remaining a symbolic commitment rather than a transformative strategy for improving OH outcomes in SA.

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