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Advancing Global Oral Health Research Through Community and Academic Partnerships: An Overview of the CORE Programme

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ABSTRACT

Background: The increasing burden of oral diseases in low- and middle-income countries (LMICs) and limited access to and affordability of oral care disproportionately impact disadvantaged groups. Oral health research has been dominated by professional academic perspectives with limited contribution from the communities involved. The aim of this commentary is to provide a broad overview of the aims and objectives, principles, values, and study design of the CORE programme.

Programme Aims: The CORE (Community focused Oral health Research for Equity) programme is a multinational research initiative which aims to reduce oral health inequalities and improve access to dental services through collaborations between disadvantaged communities and academic and community partners in Brazil, Colombia, India and Kenya. Public health research interventions will be co-created and tested with local communities through a participatory action research approach and active community engagement and involvement. In addition, the programme aims to strengthen local oral health research capacity and advocacy.

General Programme Design: The CORE programme is comprised of three elements: (1) Programme management and governance; (2) Research components focused on oral health inequalities, commercial determinants and oral health system reform; (3) Overarching components including (i) community engagement and involvement, (ii) training and capacity building, (iii) monitoring, evaluation and learning. Through a collaborative community-based approach, the CORE programme will undertake high-quality research in LMICs to inform future pro-equity and health system reform policies.

1 | Introduction

Oral diseases are a significant but largely neglected global public health problem [1, 2]. Many low- and middle-income countries (LMICs) are experiencing a growing prevalence of oral diseases, alongside pronounced oral health inequalities that disproportionately impact vulnerable populations, including those in lower socioeconomic positions and from ethnic minority groups

Abbreviations: CEI, community engagement and involvement; CORE, Community focused Oral health Research for Equity; EIAG, External International Advisory Group; LMIC, low- and middle-income countries; MEL, monitoring, evaluation and learning; MRC, Medical Research Council; NIHR, National Institute for Health and Care Research; PMG, Programme Management Group; TCB, training and capacity building; WP, work package.

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[3, 4]. Moreover, many LMICs face a situation where dental services are typically disconnected from primary health care, posing significant barriers in terms of access and cost for large segments of the population, particularly disadvantaged groups. Therefore, very high levels of unmet oral health needs are often found in these populations, leading to significant impacts on quality of life, psychosocial well-being, health and educational/employment opportunities [5].

This situation is caused by the social, commercial and political determinants of oral health and colonial legacies that shape the conditions in which people live including systems of class, race, and gender. Colonial legacies, referred as the long-lasting impacts and consequences of colonialism, one of the expressions of imperialism [6], include how current social, economic and political structures were shaped by colonial rule. These legacies can manifest in various ways, including economic reliance, governance struggles, cultural identity issues, and marked social inequalities [7]. Moreover, colonial legacies live on in the way LMICs dental care systems are structured and delivered, training of oral health work force is organised and research activities are conducted [8]. In terms of research, overcoming colonialism requires shifts in how research objectives are determined, the approaches and methodologies used, and the dynamics of financial support and partnership [9, 10]. Global oral health research initiatives have the potential to contribute to tackling power imbalances and colonial legacies by establishing meaningful partnerships with a fair distribution of influence and responsibility, that generate research ideas which reflect local realities and needs, all while honouring and recognising the culture, local traditions, and indigenous systems [10].

The CORE programme (Community focused Oral health Research for Equity) is a multinational research programme (https://thecoreprogramme.co.uk/) established in July 2022 in response to the need for more community-focused and decolonising global oral health research collaborations. This on-going 5-years-long programme was built upon long-term, strong existing research networks and established working relationships, including those created in the context of the Lancet Commission on Oral Health. Using an equitable collaboration model with academic and community partners in the four partner countries (Brazil, Colombia, India, and Kenya), in partnership with supporting UK academic institutions, priorities for research were identified as well as needs to develop local research capacity and community engagement and involvement (CEI) activities. Ideas that emerged from the partnership were further refined using a combination of primary and secondary data collection strategies, and quantitative and qualitative approaches during the project design and refinement phase of the research work packages, which lasted 7 months. In addition, areas for development and strengthening in local oral health research capacity were identified through local mapping processes and training needs assessments exercises. Finally, the CEI component was discussed to include marginalised and disadvantaged local communities, with the underlying principle of co-creating strategies and empowering them to transform realities related to their oral health.

The CORE programme is funded by the UK National Institute for Health and Care Research (NIHR 132731) and has been registered with Research Registry (research registry UIN: 11508). The aim of this commentary is to provide a broad overview of the aims and objectives, principles, values, and study design of the CORE programme.

2 | Programme Aims and Objectives

The overall strategic aim of the CORE programme is to develop meaningful collaborations between local disadvantaged communities and academic and community partners in order to reduce oral health inequalities and improve access to dental services in four diverse middle-income countries: Brazil, Colombia, India, and Kenya. These countries are different from each other in many obvious respects (including global region, population density, and colonial histories), but they also share many similarities, thereby providing a unique opportunity to compare and contrast different settings in terms of oral health research. The four countries all have fragmented oral health systems, stark oral health inequalities, major challenges from the increasing impact of commercial determinants linked to globalisation, and existing oral health research capacity with opportunities to be further developed [11, 12].

The four specific objectives of the CORE programme are outlined as follows:

1. To develop and undertake a programme of research focused on oral disease prevention, to inform the co-design and feasibility testing of public health interventions to reduce oral health inequalities and promote oral health, and to reform and strengthen oral health systems in each country.
2. To build and strengthen dental public health research capacity and collaborative networks amongst early to mid-career oral health researchers in each country, through the provision of funding for small scale local research projects, postgraduate short course training (both in person and online), Masters degree studentships, and local/international mentoring opportunities.
3. To establish and develop meaningful engagement with local communities in each country, particularly with those from socioeconomically excluded and marginalised groups, to better understand their experiences of oral diseases and use of dental services, and to identify, as part of the lessons learned from the programme, strategies that facilitate community participation when developing oral health policies, research projects, and providing dental care services.
4. To engage and advocate with key local interest holders in each country on the public health importance of oral diseases and the need for a sustainable oral health policy and research agenda focused on addressing population oral health needs and tackling oral health inequalities.

3 | Programme Principles and Values

The methods and approaches employed by the CORE programme are guided by a set of underlying principles and values which align with the overall focus on health equity (Table 1).

The CORE programme acknowledges the necessity to embed community engagement and involvement (CEI) in all aspects of the research programme to ensure that community needs, views

and priorities are understood and addressed, and ensure that communities are equal partners in developing interventions and their evaluations. As is essential for effective community engagement [13], respect and transparency are key values to build trust between interest holders and communities, and across the participant institutions and collaborators. Equality and diversity are also embedded in all aspects of the programme: (1) to enable the inclusion of vulnerable and marginalised groups in the research, training, and CEI activities; and (2) to facilitate the representation and inclusion of researchers from implementing country settings in research outputs. The CORE programme acknowledges the longstanding impact of colonialism on the power dynamics of oral health research systems [8] and in order to work to address these issues it embraces values of mutual learning and sharing of expertise across the research consortium, including 'Global South' to 'Global South', and 'Global South' to 'Global North' collaborations. For example, expertise in qualitative research that exists in some partner countries has been shared with colleagues in other countries through team meetings, direct communications and webinar sessions. Finally, the development and strengthening of local dental public health research capacity amongst early career researchers in all implementing country settings is a key principle to support long-term research sustainability.

4 | Programme Design

Figure 1 demonstrates the overall programme design, which is comprised of three key elements: (1) Programme management and advisory groups, (2) Research components, and (3) Overarching components.

4.1 | Programme Management

An international research consortium has been established to identify key strategic research priorities, based on principles of equitable collaboration [14] between researchers based in UK collaborating institutions (University College London, University of Glasgow, University of Staffordshire, Queen Mary University of London), alongside partners based in academic and community organisations in each implementing country; National University of Colombia (Colombia), Federal University of Pernambuco (Brazil), University of Nairobi (Kenya), Jamia Millia Islamia University, Public Health Foundation India, Self Employed Women's Association (India). Overall programme leadership is shared between academic professors based at University College London and National University of Colombia.

The Programme Management Group is comprised of nine lead representatives from each participating organisation and three support staff who oversee the development and delivery of all aspects of the programme. Further governance and strategic oversight of the overall programme is provided by an independent panel of nine academic, public health and global health representatives (External International Advisory Group). A group of five academics with expertise linked to the research components comprises the team of International Collaborators, who deliver ongoing support for the activities of both the research components of the programme and also the training and capacity building element of the overarching components. Community Engagement and Involvement (CEI) forums, composed of approximately 12 local community members, have been established in each country to provide valuable local advice, guidance, and support for research components involving recruitment of participants and for the CEI activities.

4.2 | Research Components

The CORE programme has adopted a mixed methods approach for the research components, using both qualitative and quantitative methods. There are three distinct but interconnected Work Packages (WP) which are conducted in each implementing country setting: WP1 Oral health inequalities; WP2 Commercial determinants; WP3 Oral health system reform and innovation. For each WP, a situation analysis has been conducted involving

TABLE 1 | Summary of the CORE programme values.

1. Community focused approaches	Embed CEI in all aspects of the research to address community needs, views and priorities Use creative, participatory and innovative community-based approaches in oral health research to challenge professional dominated perspectives
2. Equitable collaboration	Use co-creation to ensure that communities are equal partners in developing interventions/evaluations
3. Respect, transparency and trust	Respect and transparency are necessary to build trust between interest holders, communities, institutions and collaborators
4. Equality, diversity and inclusion	Embed equality and diversity in all aspects of the programme to facilitate inclusion of vulnerable and marginalised groups and researchers from all implementing countries in the research process and outputs
5. Mutual learning	Sharing of expertise across all settings (e.g., South-to-South, South-to-North, North-to-South working) and bidirectional learning through programme components
6. Capacity building and strengthening	Strengthen and build dental public health research capacity amongst early career researchers through training and research outputs

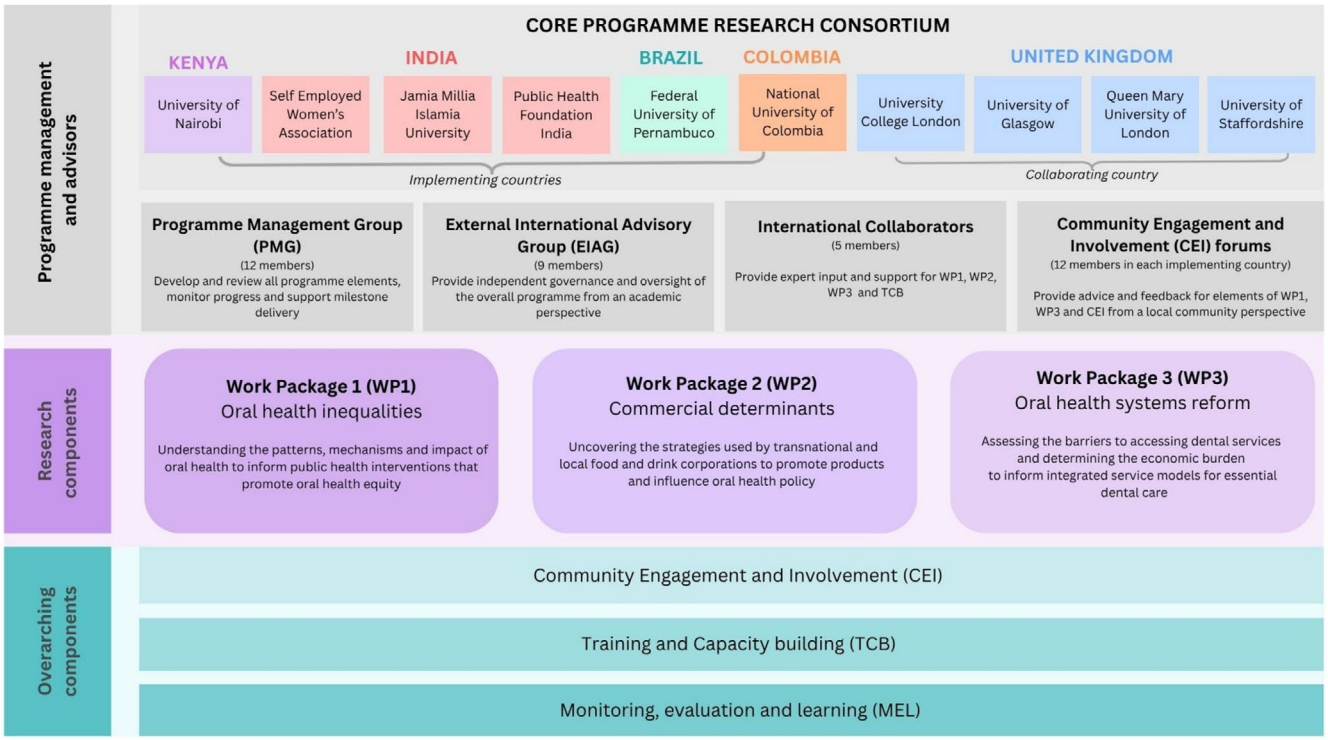

FIGURE 1 | Schematic overview of the CORE programme.

the collection of empirical data and/or secondary analysis of existing survey data/publicly available documents. The analysed data is then used to inform policy analysis and/or simulation modelling of different intervention strategies. Exploratory and developmental research is also planned in each country to inform a more detailed future oral health research plan for the development and evaluation of public health inequality interventions and system/policy reforms in each setting. The research components involving participants are conducted in accordance with ethical principles of informed consent that comply with the Declaration of Helsinki [15]. In addition, special considerations for vulnerable populations are being acknowledged, that is, the research is justified as it is responsive to their health needs and priorities and the community stands to benefit from the resulting knowledge or interventions [15]. Ethics approving bodies are the UCL Research Ethics Committee and local ethics committees at University of Nairobi (Kenya), Universidade Federal de Pernambuco (Brazil), Universidad Nacional de Colombia (Colombia), Public Health Foundation of India and Jamia Milia Islamia University (India).

4.2.1 | WP1: Oral Health Inequalities

In light of the known pervasive inequalities in oral health [4], WP1 is comprised of four studies which aim to better understand both the patterns and impact of oral health inequalities in each country to inform the development of public health interventions to promote oral health equity.

In study 1.1, a secondary analysis of nationally representative health survey data is conducted to provide a baseline profile of oral health inequalities across the selected countries in order to facilitate comparisons on the extent and nature of oral health inequalities across country settings. In study 1.2, qualitative semi-structured interviews or focus groups (according to local research team decisions and feasibility considerations) are conducted in a sample of adults from disadvantaged communities to explore their opinions on the meaning of good oral health, their experiences of oral diseases, its impact on their daily lives, and their use and views of local dental services. The study uses an exploratory qualitative research approach and is taking place in the communities, facilitated by research associates and community outreach networks. The sampling process follows principles of maximum variation to ensure a broad spectrum of perspectives across countries as well as urban and rural settings and is therein purposive to specifically target communities experiencing oral health inequalities. The number of participants ranges from 29 in Kenya to 41 in Colombia. Thematic analysis is being conducted, using a deductive approach and open coding to explore themes.

Study 1.3 utilises national oral survey and demographic data to create simulation models that explore the effectiveness of different upstream public health interventions, like sugar taxes or fluoridation interventions, on reducing oral health inequalities in the partner countries. Utilising the principles of proportional multistate lifetable simulations, closed cohort Markov-based macrosimulation models are being developed, which tailor three state (healthy, sick and dead) cohort-state-transition models for multiple health conditions. The input parameters include population demographic characteristics, risk factor epidemiology, input parameters on intervention as well as disease epidemiology. Models stratified by socioeconomic conditions are employed to generate impacts of interventions on social inequalities in oral health outcomes. Sensitivity analysis uses a tornado

plot to quantify the key reasons for uncertainty in the estimated parameters.

Based on findings from studies 1–3, and the input from the on-going community engagement and involvement activities, study 1.4 is the co-creation and testing of a tailored public health intervention in each country. The intervention is developed in response to the needs and characteristics of the local disadvantaged communities, and guided by co-production principles, allowing for a platform to engage community members in a process of analysing the vital changes required to tackle oral health inequalities in their contexts. The exact design of the intervention will depend on the nature and local context of each setting and will be co-designed through existing partnerships involving researchers and community-based organisations. Co-design and co-implementation will be further achieved through the enrolment of community researchers who live in the communities. A participatory action research approach will be used to co-produce with communities and interest holders relevant interventions and evaluate them together against three criteria: feasibility, acceptability, and appropriateness. Although the specific interventions cannot be defined prior to this process, initial discussions with communities about potential options include, for example, training local people to advocate for change and improve access to services 'Community led oral health champions'. This study will combine participatory qualitative analysis across its three phases of reflection, reflection to action, participatory evaluation and recommendations [16].

4.2.2 | WP2: Commercial Determinants

There is growing global evidence regarding the importance of the activities of corporations on a range of non-communicable diseases, including oral health [17, 18]. WP2 therefore aims to uncover the strategies used by transnational and local food and drink corporations in each country to promote their products and influence oral health policy.

In study 2.1 a critical discourse analysis of publicly available industry documentation, media reports and other publicly available documents is conducted to uncover the strategies used by the food and drinks industries to promote their products, increase profit margins and influence oral health policy in each country and compare strategies across country settings. A modified version of the Mialon et al., 2015 framework [19] is employed to identify diverse corporate political activities (CPA) undertaken by the food industry, including lobbying, providing financial incentives, supporting corporate social responsibility activities, and the use of regulatory or legal mechanisms. The first step of this study is to identify major global and local ultra-processed food and sugary drinks actors. Then, publicly available information sources including websites for the food industry, universities, professional associations, University of California San Francisco Industry library and relevant international organisations are systematically identified. Steps 3 and 4 involve data collection and analysis using a thematic iterative process. The final step involves reporting the results with a narrative summary based on the data analysis.

Study 2.2 is the conduct of qualitative interviews with key interest holders from food and drinks industries, policy makers, public health representatives, academics, and community groups to explore the political, market and non-market strategies used by industry to promote products and influence oral health policy and research agendas. In addition, study 2.3 convenes a panel of local experts (local policy makers, public health leaders, senior clinicians, representatives from civil society and community organisations) using a modified Delphi method to discuss and agree policy opportunities moving forwards to mitigate industry influence on oral health. A questionnaire is being prepared in each country outlining a selection of possible policy options to mitigate industry influence. Participants will be then asked to rank each policy option in terms of importance and return this information prior to the panel discussion event. A panel meeting event will be organised to review, discuss and agree the top five consensus policy opportunities identified through the questionnaire. In each country, approximately 15–20 participants will be asked to join the panel discussions (a total of 60–80 participants). The sample size estimations for this study are based upon a combination of pragmatic concerns and the principle of thematic saturation. The questionnaire data will be analysed and reported as descriptive statistics (e.g., mean/median) with a standard deviation (SD) of 1.0 accepted as a reasonable level of agreement [20, 21]. Consensus will be achieved in the panel meeting discussions when 70% of the panel members agree on the top five policy options.

4.2.3 | WP3: Oral Health System Reform and Innovation

The access and affordability of oral health care in many countries, particularly LMICs, is a major challenge which requires fundamental system change and reform [22]. The aims of WP3 are to assess the existing barriers to accessing dental services amongst disadvantaged populations in each country and to determine the economic burden of oral diseases on marginalised groups. Opportunities for future financing mechanisms for oral health care and the closer integration of oral health in broader health and development programmes are identified and tested in exploratory field studies.

In study 3.1 national data sets on out-of-pocket health care expenditure (2014 and 2017–2018) are analysed to determine the proportion of the expenditure on dental care and its potential impact on household budgets of the most economically vulnerable populations. A population survey is conducted in study 3.2 in a community sample of adults living in informal settlements and rural areas in each country, to assess the use of dental services, barriers to access, and preferences for reformed dental service provision. In each country, a sample of approximately 300–500 participants will be recruited into the survey. The minimum required sample size for each country is determined using a simplified sample size calculation for cross-sectional studies [23, 24] where the proportion of adults who have attended dental services in each country is considered together with a precision of 0.05 and Z value (desired level of confidence) of 95%. Whenever possible, considering the characteristics of the local vulnerable settlements selected for the study in each country, a two-stage cluster sampling for household selection

is used, and then a random within-household selection method is employed to avoid interviewer bias. A sample of survey participants is selected for follow-up interviews to gain a more in-depth understanding of their survey answers.

In study 3.3 qualitative interviews are conducted with a purposive and diverse sample of key participants in each country to explore opportunities and barriers for reform and development of dental service provision for disadvantaged and vulnerable population groups. In particular, the interviews explore options for closer integration of dental service provision within primary health care delivery and opportunities for the provision of financial protection for a core package of essential dental care. Finally, study 3.4, informed by the findings of WP3 studies 1–3, involves a feasibility study of the newly developed dental care delivery models. In each setting, the exact nature and details of the models of dental care will vary in response to the nature of the local health systems, political contexts, population characteristics, and needs. However, each model will provide more integrated dental care delivery and financial protection schemes designed to facilitate access to affordable essential dental care for disadvantaged population groups in each setting. The feasibility testing of these models will adopt a single group pre-post design with an embedded process evaluation. A comprehensive evaluation framework will be developed to assess the impact of the new models on availability, accessibility, and affordability outcomes.

4.3 | Overarching Components

4.3.1 | Community Engagement and Involvement

In this research programme, CEI contributes to all elements of the planned research. The process of community engagement, empowerment and partnership with communities and civil society organisations is essential to the development, implementation, and evaluation of the research activities. Community forums are established in each country and led by a CEI coordinator. The forum members are local community members from the research sites and meet at key stages in research development to provide input and advice from a community perspective. All decisions regarding community activities and research studies conducted in the communities are made collectively between researchers and forum members. For example, CORE teams and forum members in each country discussed the principles of the CEI component and then those were shared and agreed in our PMG meetings. Based on those discussions, strategies that could be used for CEI were collectively identified, such as art-based outreach activities. Additionally, community link workers are recruited and trained to act as community liaison on oral health topics and advocates in their local communities. Further details on the CEI component of the CORE programme will be provided in a separate publication.

4.3.2 | Training and Capacity Building

To support longer term research sustainability, it is critically important that this programme invests in the training and capacity development of early career oral health researchers in each partner country, both at an individual and institutional level. In year one of the programme, a comprehensive training needs assessment was conducted to determine the oral health training currently delivered in each country, their strengths and weaknesses, and to identify gaps in research training. Based upon the findings of the training needs assessment, each partner country has developed a training programme tailored to the identified training needs. The planned training and capacity building activities are outlined in Figure 2.

4.3.3 | Monitoring, Evaluation and Learning

Based upon the UK Medical Research Council's guidelines on complex interventions [25], a programme theory has been developed and refined by the CORE Programme Management Group, comprised of representatives from each country partner and UK institutions. The process involved several discussions and iterations during PMG meetings until agreement was reached. In addition, CORE partner country representativeness engaged with interest holders/networks in their country during the process. Figure 3 displays the overall logic model for the CORE programme research components. Detailed logic models and indicators have been developed to outline the activities, outputs, and impacts for each research work package, the CEI component, and the TCB component. An example of the logic model and indicators for WP1 is provided in Figures S1 and S2.

In the context of this paper, it is worth mentioning that a programme of this nature, conducted across four diverse middle-income countries, involving marginalised communities and sensitive topics (such as industry influence) comes with inherent risks and challenges. Some of them are related to external factors such as political issues at national and local levels where communities live, and others are more internal in nature like delays in obtaining ethical approvals and potential problems with appointing local researchers in the partner countries. The CORE team across partner countries and UK institutions has worked on developing a risk register, in accordance with NIHR policies, where risks and mitigation strategies are identified and revised on a regular basis.

Results from the CORE programme are disseminated across policy, professional, and community networks within Brazil, Colombia, India, and Kenya but also more widely across existing international networks. A range of methods are used to share our results with different interest holders, including conference presentations, scientific papers, policy briefings, community events, social media activity, and traditional media outputs.

Plans to continue the work after the funding period ends include applying for additional resources and developing a transition or exit plan with the communities and CORE teams from all partner countries. In addition, different elements of the training and capacity building component are helping to build capacity and therefore sustainability. For example, the MSc scholarships awardees have signed an agreement to return to their countries for at least 2 years after their studies completion, and long-term relationships developed through the mentoring initiative, and cross-country opportunities for further research collaboration will also contribute to making partnerships sustainable over time.

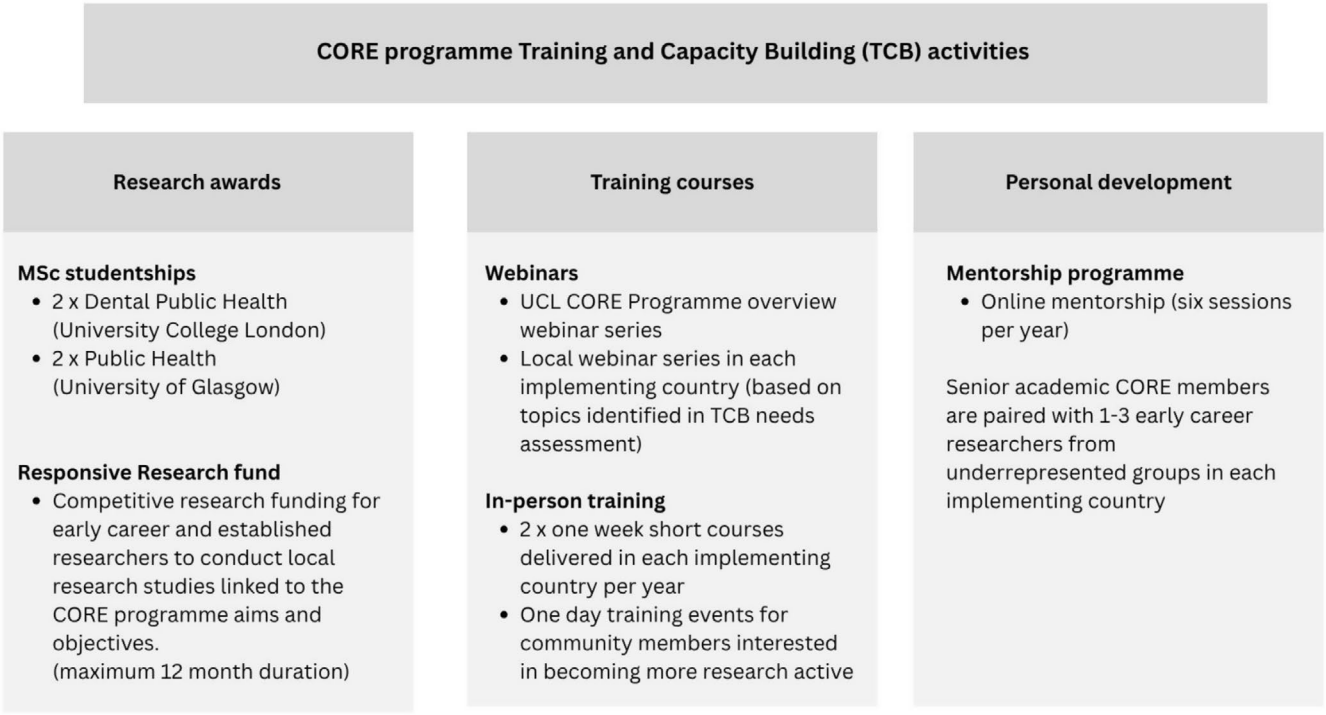

FIGURE 2 | Schematic overview of the CORE programme training and capacity building activities.

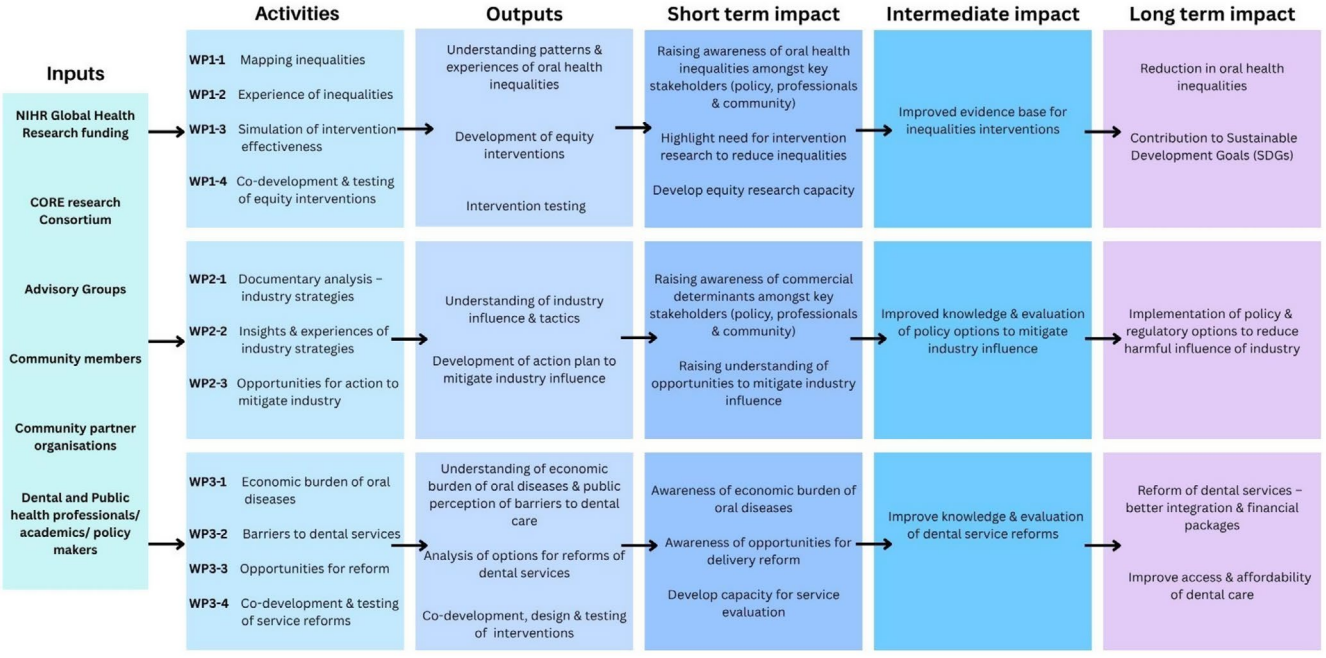

FIGURE 3 | Logic model of the research elements of CORE programme.

5 | Conclusion

Creating equitable and sustainable partnerships in global oral health research is essential. CORE is an excellent example of participatory approaches used to develop and co-design a global oral health research programme. The anticipated impact of this programme includes raising understanding and awareness of the public health importance of oral diseases and inequalities, developing the evidence base for population interventions and system reforms, and developing public health policies which will ultimately promote better oral health in LMICs.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Figure S1:** Logic model of the WP1-oral health inequalities. **Figure S2:** Indicators developed for WP1-oral health inequalities.