



# *Towards a Better Oral Health Future*

A paper prepared by the  
WHO Oral Health Programme

as a background  
document for  
**World Health Day 1994**

and

as a contribution to the  
celebration of the **Year  
of Oral Health in 1994**

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May 1993

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Dear Sir or Madam,  
Dear Colleague,

This mailing constitutes the first general announcement to the whole oral health community on World Health Day to be held on 7 April 1994 and on the activities proposed by the World Health Organization (WHO) to the whole profession. It is also appropriate to provide a note on the history leading to celebration of a Year of Oral Health closely linked with the World Health Day.

### *1. History*

In 1990, the International Dental Federation (FDI) observer at the WHO Regional Committee for South East Asia made the suggestion that WHO should celebrate a year of oral health. That request was transmitted by the WHO Regional Office for South East Asia to WHO Headquarters in Geneva and the proposal was submitted to the Director-General of WHO suggesting 1993 as an appropriate year. The alternative decision was taken to have oral health as the theme for World Health Day in 1994. It was explained that WHO did not have a policy of dedicating a year to any theme, but there was no objection to WHO encouraging the whole dental profession, especially through its international federations and associations, to celebrate 1994 as a Year of Oral Health, linked with the World Health Day event on 7 April.

### *2. A Collaborative effort*

Following discussions with the International Dental Federation leadership, it was clear that this idea was supported, as was evidenced by their council's resolution in May, 1992. The four major international dental bodies, the International Dental Federation, the International Association for Dental Research, the International Federation of Dental Hygienists and the International Federation of Dental Education Associations, were approached to ascertain their different interests in participation in World Health Day and the Year of Oral Health and in coordination of their activities.

The attached paper entitled "*Towards a Better Oral Health Future*" was prepared as a result of responses and in relation to the initiative of the IADR to develop an International Leadership Forum; clearly an appropriate body through which to coordinate the interests in the Year of Oral Health, not only of the main oral health professional bodies, but also of industry related to oral health. This paper formed the basis of discussions at several meetings held in Chicago last March during the International Association for Dental Research Annual Sessions, the first meeting of the International Leadership Forum, a meeting called by the American Association for World Health and an ad hoc meeting of similar composition to the inaugural International Leadership Forum. These meetings reached an encouraging consensus based on:

- a. the intimate relation of the WHO's World Health Day, which supplies the year long theme, and the Year of Oral Health which is the property of no single body, but of the whole oral health sub-sector;
- b. the areas described in the attached paper for which different oral health bodies will have a major interest in at least one;
- c. development of a steering group comprised of highly respected and experienced consultants none of whom hold executive or administrative positions in the main international organizations. The role of this group will be to review the projects/proposals made for the Year of Oral Health and to make recommendations for funding; it will be chaired by Professor D.O'Mullane, Department of Preventive and Paediatric Dentistry, University College, Cork, Ireland and technical advice will be provided by the Oral Health Programme of WHO;
- d. the establishment of a fund for the Year of Oral Health based on the interrelationship with the World Health Day 1994 celebration. It is hoped that this fund will outlive 1994/5 and become a source for funding worthwhile research and development projects in the years to come.

### **3. WHO World Health Day - 7 April 1994**

Following World Health Day 1993, WHO has been preparing materials for World health Day 1994. These materials will include, at least, a press kit and poster, a slogan sticker, a resource booklet, a set of oral health success stories and a video. Special items of interest to national Ministries of Health and Information may supplement the core materials. We hope to have these materials available for you by November 1993.

#### **4. Your Active Participation**

Apart from describing the approach which WHO is taking, this mailing seeks to ascertain how each of you wish to contribute. I am inviting your response in a number of ways:

. The paper "*Towards a better oral health future*" may be used in its entirety, or in sections, as appropriate, as contributions to information, advocacy and fund raising. Thus, your suggestions both for eventual texts and in relation to the approach and expected outputs are welcome.

. Most important, at this stage, is the planning of your activities, be they on *World Health Day, 7 April*, or/and on special occasions like national oral health days or weeks, during national or international meetings, or in specific oral health or health projects. You will have the use of all the materials we produce and your ideas may stimulate others to do the same or likewise. Those ideas may include plans to have joint activities with neighbouring countries or regionally and involving all interests whether in prevention, treatment, education or research, public or private, insurance or manufacturing.

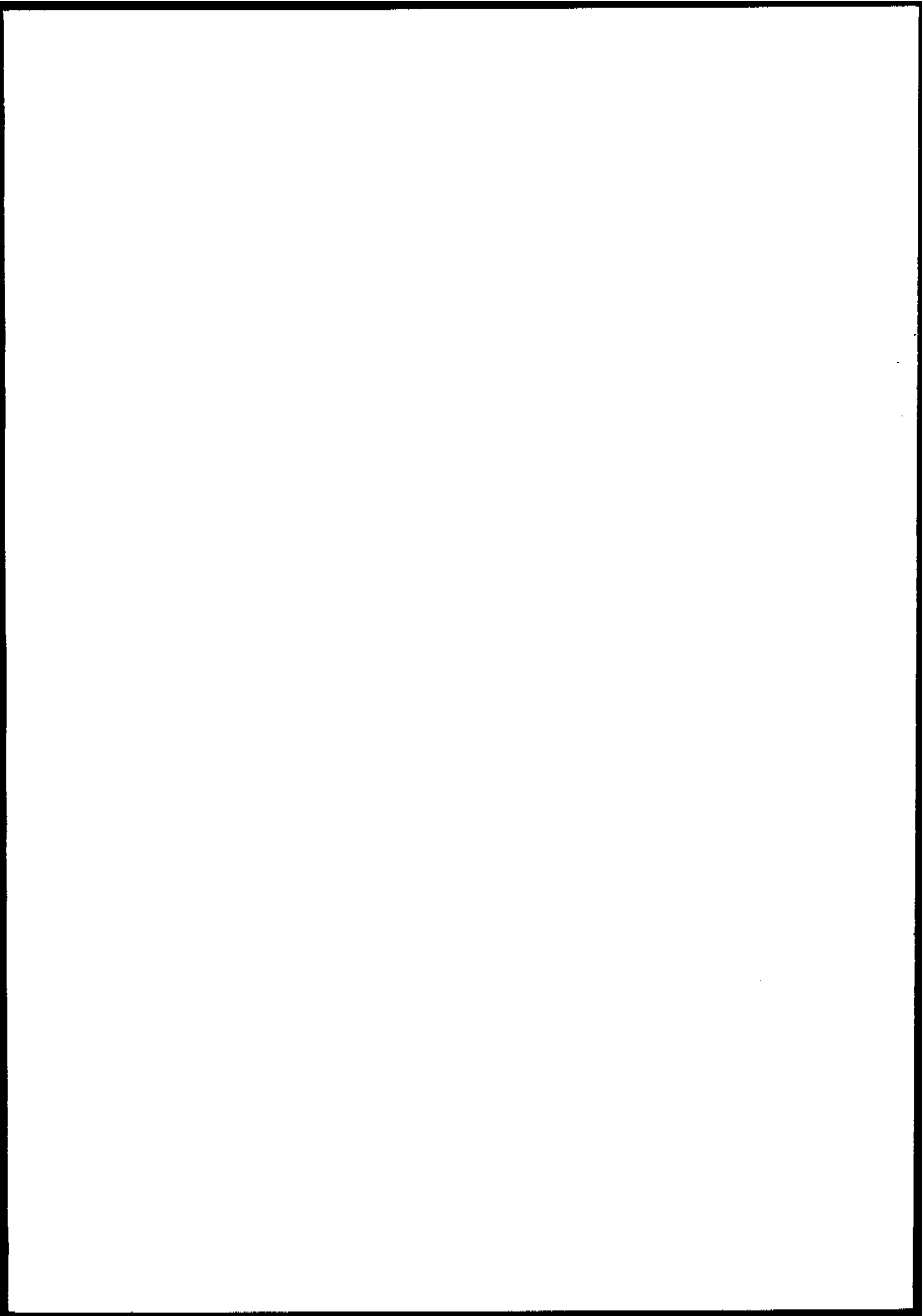
. You are invited to contribute to a special magazine which will be produced for World Health Day and to suggest any visual and/or audio material which may be displayed wherever celebrations take place. We are hoping to accent live or audio-visual displays on World health Day to demonstrate to all other areas of the health sector what oral health can deliver. Therefore, we welcome proposals from groups ready to make such presentations. The initiative of the World Health Day is an activity of WHO as a whole, not purely the Oral Health Programme. Thus there is an internal WHO group which will support the preparations for World Health Day and organize the actual celebration.

As indicated, work is now progressing on the materials and projects mentioned earlier and in the main paper. Your early responses will help us to move ahead rapidly with preparations and to serve your needs for information and coordination.

Yours faithfully,



Dr David Barmes  
Chief, Oral Health



## **What major developments have occurred in oral health in the past half century?**

Prevention and the research which furnished mankind with the powerful preventive tools we have today certainly take first place. From its early days, dentistry promoted oral hygiene though the scientific basis for the effects of tooth brushing were no more than hazy notions, at best. Then came efforts to limit consumption of sugars and/or to limit their effects by cleaning shortly after consumption. Then came fluorides and the beginning of massive changes in oral health status and the profession dedicated to improve it. Taking first and briefly the fluoride story which caused the dramatic reduction in dental caries where the disease was most prevalent, the main steps in its evolution were:

1. The early trials of fluorides as a community preventive measure against dental caries led to the introduction of fluoridation of public water supplies.
2. The potential success of water fluoridation as well as the controversy that surrounded its implementation gave the impetus for extensive and successful research into a wide range of methods for using fluorides.
3. The main additional preventive vehicles which this research has made available to populations are:
  - . fluoride bearing toothpastes, rinses, solutions, varnishes and gels for topical administration, and
  - . fluoridation of salt or milk and fluoride bearing tablets for systemic administration.
4. Following early success in individual communities, the first signs of national reductions in caries experience became evident in 1973 after which unexpectedly large reductions have occurred (>80%) and continue to occur in many industrialized countries. Similar successes have been recorded in a few developing countries and the speed with which any increases in caries experience can be reversed has been greatly increased.

Both the extent of the reduction and the rapidity with which the problem has been overcome relate to a range of systemic and topical fluorides which are now available and proven, amongst the latter toothpastes being, by far the most prominent.

As fluoride research continued, so did research into other preventive procedures, notably hygiene, surface care of teeth (sealants, re-mineralizing agents), dietary improvements, control of the oral flora and vaccination.

Fundamentally significant for assessing oral health status as well as success or failure of prevention has been development, testing and implementation of better methodologies for surveys, clinical trials and, more recently, clinical records.

As a result of all this research and promotion of prevention as an essential of healthy lifestyles another success, perhaps even more far reaching than fluorides per se, is the acceptance and practice of oral hygiene as part of total bodily hygiene. The application of fluoride through toothbrushing has become arguably the most effective way of preventing dental caries, while achieving by the same action reduction in the severity of periodontal diseases and in the premature loss of teeth.

While these preventive successes and related public health procedures were happening, there were vast improvements in treatment modalities and management in every area of oral health practice. Apart from those relevant to the common oral diseases, there has been a broadening of the dental profession's approach to care of the wide range of rarer oral conditions occurring primarily in the oral cavity or as a manifestation of systemic disease. A powerful stimulus for this development has been the advent of HIV infection for which there is a large list of oral conditions which may be associated with HIV infection, including some conditions which had virtually disappeared.

Expanding capabilities to preserve intact dentitions are promising an important change in expectations of aging populations.

Consistent with these developments there have been huge changes in the education of dental personnel, both professional and auxiliary. These developments have passed through stages of a broadening biological base for routine conservative, restorative, surgical and medical procedures, massive improvements in dental materials and equipment and increasing emphasis on prevention, risk assessment, tissue conservation and preservation of a functional dentition back to an even broader approach to and reorientation of dental education. Growing acceptance of the health sciences and extended career development approach is a very important recent development as are computer assisted learning techniques.

Research was mentioned first in relation to fluorides, but needs further mention because it has become much more sophisticated and broadly based than it was 50 years ago when fluoride use was the main stimulus. The results have been the production of a wide range of preventive, restorative and rehabilitative materials as well as the instruments and equipment to go with them. As examples the air rotor, sealants, glass ionomers, improved amalgam, implant materials, periodontal instrumentation and infection control equipment and materials may be mentioned in addition to what has already been discussed.

The future promises many more advances in oral health and health in general during the next 50 years as research succeeds in such areas as microbiology, immunology and genetic engineering.

Informatics and telematics have exploded onto the scene in recent decades, having already affected all areas of oral health and care technology, with the potential to have an even greater effect in the ensuing decades. A fundamental impact has been and will be felt in information management, in analysis of quality of care, in assistance for diagnosis and treatment and in education of personnel involved in oral health and care.

### **Who were the major actors?**

The "golden thread" running through all these advances has been the dental profession as a whole. From the very first realization that special training and practice were needed to confront deteriorating oral health status in industrializing countries to the present day the profession has been in the vanguard of the quest for improvement. This should never be overlooked as we salute the improvements in dental curricula to produce ever more relevant oral health personnel or as we marvel at the advances in scientific knowledge and its implementation by researchers and their institutions.

Nor should we forget the contribution of other health professions in supporting, enabling and participating in the advancement of oral health status of communities at all levels of development. Changing philosophies in the whole health sector have converged consistently towards more empowerment of communities, first by promoting awareness and then by progressively following a healthy lifestyle and demanding higher quality care.

Whatever has been the role of the health professions, especially dentistry, in all of these developments and whatever has been the partitioning of that role between the public, private, teaching, research and clinical part of those professions in achieving these major changes, industry has been in some way involved in all of them. For most of these items that involvement has been major and essential. It can be said confidentially that the symbiosis of industry with the dental and other health professions, in all areas of the development of better oral health and care, has been an important part of the success story. The multiple contribution of all forms of research support from clinical trials, through equipment and materials development to health services evaluation and testing has been massive. It has led to better prevention, better education and better care.

## **What has WHO done to promote these major changes?**

As we prepare to celebrate the first WHO World Health Day which has oral health as its theme and as the major international dental federations have taken this opportunity to declare a Year of Oral Health (YORH) linked to WHD, in collaboration with WHO, it is appropriate to look at the contribution of WHO to achievement of these advances.

1. Expert opinion and guidance has been provided for the oral health sub-sector in the form of 15 Expert Committees authorized by the World Health Assembly between 1958 and the present, 6 of them prior to 1970 at which time the Oral Health Programme (ORH) intensified and diversified its activities. These Committees covered all the main areas of concern in oral health.
2. A priority focus was directed towards epidemiology in 1965 from which the preliminary editions of Oral Health Surveys: Basic Methods (OHS) and the International Classification of Diseases: Application to Dentistry (ICD-DA) were produced in 1969.
3. The Global Oral Data Bank (GODB) was also established in 1969. From data stored in the GODB early indications of a reducing trend in caries intensity in a number of industrialized countries were reported for the first time.
4. Collection of epidemiological data was promoted in general and, specifically, by offering data analysis free of cost to all who used the standard methods and forms of the OHS. Especially for areas with minimal resources of personnel and money, a 'pathfinder' methodology was offered in the OHS to enable administrators to obtain working estimates of oral health status at minimal cost in time and money from which to develop national oral health plans.
5. As comparable data accumulated from countries at all levels of development and as several sets of data became available for many countries over an extended period, the global status and trends of oral health became clear enough for development of a coherent strategy both for the secretariat of WHO and its Member States. The volume of these data can be appreciated from the fact that 20 to 30 pathfinder surveys have been received for analysis at WHO every year since 1980 in addition to other comparable data received or identified before and during that period.

6. The earliest formal policy of WHO on oral health appeared in 1969 with the resolution WHA 22/30 on water fluoridation, followed by two more resolutions in 1975 and 1978, respectively, extending the variety of recommended uses of fluorides in line with research developments. Then, in 1983 and 1989 there followed WHA resolutions stating a common strategy for oral health and recognizing it as an integral component of the primary health care approach.
7. The strategy is based on establishing national oral health plans with measurable goals as part of national health plans with prevention always taking first priority place. Complementary to prevention are treatment programmes which respect the primary health care concept, define population coverage targets and maintain adequate quality in both routine and emergency care. Servicing both prevention and treatment programmes is the planned production of personnel appropriate in both type and numbers. Research appropriate to perceived needs and periodic monitoring, evaluation and replanning complete the strategy menu.
8. As this global oral health strategy was developing and based on data in the GODB, a global measurable goal for the year 2000 of no more than 3 DMF (decayed, missing or filled) teeth per 12 year-old child was proposed in 1979 and widely accepted as an indicator around which national oral health programmes could be built and national goals could be defined. The level of three had not yet been reached globally, the global weighted average in 1980 being 2.4. However, it represented a very desirable target on the way to lower levels of the disease for industrialized countries and a 'barrier' not to be exceeded by developing countries which were experiencing increasing intensity of dental caries. What actually happened was an annual increase in the global mean to 2.9 by 1984 and a reduction since then to 2.3 in 1992.
9. Following the announcement of the 3 DMF goal by WHO, measurable goals for other age groups were developed through a working group of the International Dental Federation and WHO. These goals relate to ages 6, 18, 35 to 44 and 65 to 74, the latter three dealing with tooth loss rather than dental caries specifically.
10. The vast gap between dental caries and periodontal diseases epidemiology was recognized, as was the consequent lack of an agreed measurable goal related to periodontal health. Accordingly, a Scientific Group meeting authorized by the World Health Assembly tackled that problem in 1978 and produced the prototype of the Community Periodontal Index of Treatment Needs (CPITN) which rapidly became the standard index for oral health surveys and has provided with amazing rapidity a robust data base pertaining to 113 countries. Those data have not only given the world a basis for goal setting but have changed significantly global and national estimations of the need for prevention and treatment of periodontal diseases.

11. While this standardized assessment of oral health status was developing, WHO also embarked in 1970 on an international study of oral health delivery systems. Major central funding came from the government of the USA and 10 nations participated. The study title in full was the International Collaborative Study of Dental Manpower Systems, but it is now more conveniently referred to as ICS I, as it has been followed 15 years later by ICS II, which has the modified full title of the International Collaborative Study of Oral Health Outcomes.

The basis for these studies has been the combination of clinical and sociological data collection in a standard form and the inclusion of data from care providers and administrators. The main objective was to ascertain what different delivery systems, or parts of such systems had and could achieve in the hope of helping not only participating nations to improve their delivery systems, but also to provide guidance drawn from the study to other Member States.

The ICS I had tremendous impact on participating countries, in some cases bringing about fundamental changes in their oral health delivery systems. It also gave us the anticipated material on which to base guidance to other countries not the least of which was the affirmation that prevention needs to be the top priority for any system. ICS II is still in progress, but promises to serve our efforts to improve oral health just as well as ICS I.

12. During the period from 1970 to the present a number of Joint Working Groups were developed with the FDI. These dealt with a large variety of topics:

- . further development of the CPITN (JWG 1) and approaches to management of periodontal diseases (JWG 10),
- . biostatistics applied to oral health (JWG 2),
- . development of a standard measurement system for dento-facial anomalies (JWG 3),
- . curriculum development for all categories of oral health personnel (JWG 4),
- . trends in the common oral diseases (JWG 5) and development of a system for estimating oral health personnel needs (JWG 6),
- . curriculum (JWG 7) and equipment (JWG 8) development for Latin America,
- . development of a system for standard measurement of the economic aspects of oral health care, both prevention and treatment (JWG 9),
- . criteria for classification of dental products (JWG 11) for Latin America,
- . oral health status of young adults (JWG 12),
- . evaluation of educational programmes (JWG 13),
- . the role of oral health personnel in the campaign against HIV infection, with special on oral manifestations of the infection (JWG 14),
- . international collaborative oral health research (JWG 15).

Outcomes from these working groups have been plentiful. The major ones have been:

- . the final definition, testing and evaluation of the CPITN, its uses and effects on the management of periodontal diseases care,
- . the emergence of the DAI as a standard measure of need for orthodontic care, a development which eventually occurred outside the work of JWG 3, but which had its international beginnings in that JWG,
- . confirmation of the reducing trends in caries intensity which had been repeatedly reported from the GODB and the need for the dental profession to reorient itself to this fundamental change,
- . a guidance manual for production of oral health personnel appropriate to the changing needs,
- . preparation of a manual and computer programme on planning under the title of 'Health through Oral Health' for estimating oral health personnel needs for changing and planned situations,
- . provision of an instrument for data collection on economic aspects of oral health care,
- . development of a standard package for collection of data on oral manifestations of HIV infection and guidance materials on epidemiology, health promotion, infection control and treatment related to HIV and the oral health facility,
- . definition of priority research areas for international collaborative research.

13. Also during that period since 1970, health services research projects were performed to find new ways of delivering oral health services. One study focused on the performance concept as it related to both training and practice. Close collaboration with the Universities of Maryland and British Columbia in this study meant that the system was studied simultaneously in industrialized and remote village communities. The latter participated in the study through the Intercountry Centre for Oral Health in Chiang Mai. Training of personnel who had very little formal schooling was achieved in an amazingly short time to perform high quality routine care to the level of scaling and to bring adequate coverage to village communities through schools and health centres at low cost. The success of the study pertained not to the acceptance of the system as a whole but to the expanding use of the most practical elements of the system, notably non-invasive care provided with simple, low cost equipment and using practical ergonomic procedures.

14. A further study of such an approach, named Atraumatic Restorative Treatment (ART) of dental caries, is in progress now which uses many of those elements. Clinical trials and community preventive programmes in collaboration with industry promise to reveal ART as a very effective means of achieving better coverage of deprived communities.

15. Whereas Chiang Mai was the first of the Intercountry Centres for Oral Health, there followed Damascus, Syria, Jos, Nigeria and Minsk, Belarus. All of these centres have played an effective role in extending the policies and strategies of WHO to neighbouring countries and continue to do so.

There is also a supportive and effective network of 35 WHO collaborating centres which cover a wide range of expertise.

16. In the 80s an initiative was developed under the name of the International Collaborative Oral Health Development Programme to respond to specific requests from WHO Member States. It is now more simply referred to as the IDP. The concept is also simple, the usual steps being a national situation analysis performed with or without external help, followed by a national plan from which areas which require expertise not nationally available are identified. At that stage WHO's role is to link the requesting country with a Member State or institution which is willing and able to help. Though the concept is simple the implementation is anything but simple and a number of requests remain unfulfilled. However, many successful projects have been launched and have or are having the effect of improving oral health in the requesting countries that would not have been possible without the IDP.

Strong support has been received from the National Dental Associations of Denmark, France, Japan, and the Netherlands, whereas those of Sweden and the USA have undertaken specific projects. Especially effective has been the support and work of the Aide Odontologique Internationale (AOI) in IDP projects for several francophone countries in Africa and the efforts of World Concern in collaboration with Dutch experts amongst refugee groups in Asia.

17. Many projects have been undertaken and much effort is continuing to demonstrate effective prevention at community level. Early projects supported by industry were performed in French Polynesia, Philippines and Thailand. Current projects are using milk fluoridation, fluoride bearing toothpastes and sealants bearing preventive agents in an attempt to extend the preventive choice and to convince communities of the prime importance of prevention.

18. Presently, there is much activity in updating or producing new methodologies. The fourth edition of the Oral Health Surveys: Basic Methods is in final draft form as is the third edition of the International Classification of Diseases: Application to Dentistry which is compatible with the tenth revision of the parent classification. A manual on collection of data from clinical records is in the advanced draft stage and

is aimed at improving data availability for better management and planning of oral health services right from the practice to the national level. Epidemiological methodology applied to the oral manifestations of HIV infection is the subject of material which is in proof to be followed shortly by material on education, infection control, data collection and treatment which is now in the advanced draft stage. Computer assisted learning methodology has been used to provide essential training in a standard and rapid way. Documents are available and more are being produced on specifications for oral health settings, instruments, materials and drugs to help those trying to provide services in a cost-effective way.

19. A special project is developing to address the problem of noma or cancrum oris which appears to be increasing in deprived communities; an added fear is a possible relation of HIV infection with ANUG and thus noma. This project aims to combine a primary prevention approach with a moderately complex treatment availability locally and a referral system for very complex care. It is hoped that this project in helping to manage this maiming and killing disease will demonstrate one way in which the dental profession can broaden its approach consonant with changing oral health status; the efforts made in managing HIV cases in oral health facilities are also part of that objective.

20. All these activities lead us to the most pressing need to orchestrate a fundamental change in the oral health sub-sector appropriate to changes in oral health status. At all levels there is the need for much greater integration with all other health services than presently exists. Training is the key to that process and WHO strongly focuses on the health sciences approach for oral health personnel or personnel involved in promoting and delivering oral health and care. Use of computer assisted learning methodologies is emphasized as the only practical way of achieving these changes in a rapid and efficient manner. It is hoped that the WHD 1994 and the YORH activities will provide the necessary stimulus to accelerate this process so that oral health can play an appropriate part in health in the 21st century.

It is important to reflect here that those 20 items and plans for the future have only been and will only be achieved by the concerted efforts of all the Member States of WHO and the collaboration of the health and other professions. Whether it concerns methodology development or data for the Global Data Bank or study and application of new preventive and treatment programmes nothing could be achieved without that involvement and support.

**What will be the specific outcomes which WHO will aim to produce or promote as a concerted effort of the whole dental world?**

**1. PREVENTION**

. a *compendium* will be produced *with a large graphic component* to show what proven preventive methods are available, what can be achieved by each method, how to choose for different situations and what is in prospect.

. *special posters and videos* on specific preventive items will be produced, areas to be considered being salt and milk fluoridation, oral hygiene including a range of toothpastes and a special effort to relate to hygiene in general, healthy lifestyles promoted by oral health personnel, HIV and oral health, deprivation and oral health, non-invasiveness and oral health, 3rd party payment and oral health and orthodontic care and the DAI.

. *a set of brochures on self care* in oral health taking the broad canvas view.

**2. EDUCATION**

. *a protocol for the development of an international health sciences curriculum* in oral health outlining the whole concept and the proposed first generation curriculum.

. *40 multimedia self-training packages.*

**3. QUALITY of CARE**

. *state of the art guidelines* on the use of new materials such as implants and adhesives and on rehabilitative care in general.

. *state of the art guidelines on* tooth loss and restorative care.

. *a computer programme* for assessing the quality of care and enhancing practice management from aggregated clinical records.

. *a compendium of accepted and innovative settings* related to oral health practice integrated with health services in general.

. *a document on equipment and instruments* specifications in various settings plus lists of materials and drugs.

#### 4. SPECIAL PROJECTS

. *the first ICS II monograph.*

. *three videos on oral manifestations of HIV infection* in French and English.

. *two IBM versions*, one low and one high technology, of the Computer Assisted Learning on the Oral Manifestations of AIDS (CALOMA) programme which is available on Mackintosh.

. *a version of CALOMA* in book form.

. *a video on noma* and the campaign to contain its destructive impact.

. *a self learning manual and video on ART.*

. *a video on cross infection*, especially in relation to minimal acceptable levels in low resource communities.

#### 5. RESEARCH

. *a WHO Technical Report Series publication from an Expert Committee meeting to be held late in 1993*

. *a paper on main thrusts of the International Collaborative Oral Health Research Agenda.*

. *a protocol for etiological research* on ANUG/noma.

. *a protocol for epidemiological research* on ANUG/noma

. *a review on demographic changes* in relation to their impact on research priorities.

## 6. METHODOLOGY

- . *the 4th edition of OHS:BM.*
- . *the 3rd edition of the ICD-DA.*
- . *a series of booklets on health education, infection control, epidemiology and treatment related to oral manifestations of HIV infection plus visual supporting material.*
- . *the 1st edition of the Oral Care Management Systems manual.*
- . *the 1st edition of a manual linking sociological data to the OHS:BM.*
- . *a manual on calibration of examiners.*

From this list of intended outcomes only the first item under EDUCATION, items 4 & 5 under QUALITY of CARE, items 1 to 5 under SPECIAL PROJECTS, item 1 & 4 under RESEARCH and all the items under METHODOLOGY are well advanced. Even most of those items need technical and /or funding support to a considerable degree. All the rest are offered as items that may be taken up by one or more institutions/associations in close or distant collaboration with WHO. Furthermore, the list is not intended to be exclusive or restrictive. Suggestions for other relevant projects and for replacement of some that have been suggested are welcome, the only restraining element being the need to communicate and coordinate all our efforts in a timely and efficient manner.

### **What can other organizations, charitable trusts, industry and countries do in relation to the list of intended outcomes or on their own initiative?**

It is important to realize that despite the successes that have been achieved, we are not even half way. Caries still has to be completely conquered, especially in some countries where the trends are negative, either nationally or for some communities. Periodontal diseases are even further away from being satisfactorily prevented and controlled. Management of oral cancer, oral manifestations of systemic diseases and a long list of oral mucosal diseases is more distant still, not forgetting that hitherto unknown health risks may appear and realizing that these elements herald a more complex basis for oral health care.

Demographic changes are posing the three way problems of increased numbers, increased lifespan and a shift in the percentage distribution towards the elderly which introduces a further complicating factor into regular oral health care. At the same time there is a lack of even minimum care for some 75% of most communities in developing countries.

Additionally, success itself is posing a potential problem because the situation for dental caries and what is preventable, presently, for periodontal diseases is fundamentally different to other forms of complete (for example smallpox) or large scale prevention. Unless preventive behaviour is maintained long after the target oral diseases are no more than a vague memory they will reappear in abundance and set up a vicious cycle of repair and prevention phases. With those thoughts in mind potential collaborative activity is discussed under the four categories named in the title of this section.

### *1. INTERNATIONAL ORGANIZATIONS*

In referring to the four organizations listed below, it is not intended to be exclusive, but only to link obvious areas of interest. Other interested bodies are very welcome to participate, one which has already expressed its enthusiasm being the International Association of Dental Students. Suggestions for main theme interests follow:

. International Association of Dental Research -- this body should take the theme on focused research and decide what activities and promotion it would engage in for the World Health Day and/or the Year of Oral Health in collaboration with its regional divisions and specific national research bodies. From the list of specific outcomes it might take the lead in preparing the paper on main thrusts and in providing expertise for the WHO Expert Committee on research and in the etiological research on ANUG and noma and any relations with HIV (see 5, page 11).

. International Dental Federation -- quality of care should be the main thrust of this body and, whereas there may be many items which the headquarters office, the regional organizations and the member associations wish to concentrate upon, an important contribution to the restorative part of the paper on tooth loss would seem to be very appropriate. The European Regional Organization might well be specially interested on material on oral health developments in European Member States which were formerly socialist economies and also in the computer programme on clinical records. The American Dental Association may have a special interest in the ICS II continuation beyond the sites included in the monograph.

. International Federation of Dental Education Associations -- the international health sciences curriculum in oral health is of fundamental interest for this federation. It could take a prominent role in both preparation of the paper and in promoting production of computer assisted learning modules. Its component bodies from Europe, Latin America and the USA may wish to add initiatives in the field of dental education.

. International Federation of Dental Hygienists -- the theme on prevention is of special interest to this body and especially the compendium, several of the poster and video subjects and the paper on self care (see 1, page 10).

These main theme interests do not preclude the four organizations from exercising their interest in other named or unnamed themes. For example, the International Association of Dental Research could be very enthusiastic about involvement in the compendium on prevention (see 1, page 10) and the International Federation of Dental Hygienists is likely to take a keen interest in the curriculum area (see 2, page 10).

Furthermore, each organization should realize that, whereas they may have many occasions during 1994 to take a leading role in the celebration of the Year of Oral Health, they are also very welcome to propose items for the celebration of World Health Day at WHO HQ, Geneva, to participate on that occasion in a prominent role and to participate in as many as possible of the celebrations in the 186 Member States of WHO.

Whereas the World Health Day is the prime responsibility of WHO, but hopefully with the active collaboration of the international dental federations, there may be a need for an 'umbrella' structure to coordinate the Year of Oral Health with the active collaboration of WHO. Such a structure could be provided by the Leadership Forum proposed by the president of the International Association of Dental Research.

## **2. CHARITABLE TRUSTS**

A specific example of such a trust is the Borrow Dental Milk Foundation which may well wish to develop the material on milk fluoridation in collaboration with WHO. However, there is the American Fund for Dental Health and trusts with general interests like the Carter Foundation which are likely to have a lively interest in the WHD programme and in the Year of Oral Health.

### ***3. INDUSTRY***

The wholehearted involvement of industry in these celebrations is both highly desirable and well earned. There is something in each of the themes to interest various areas of the dental industry and there are no doubt other themes which members of the different corporations might wish to propose and pursue. In some areas industry might wish to take the lead, for example in producing certain parts of the preventive compendium and some of the poster and video material or in items under quality of care dealing with dental settings, equipment and materials.

### ***4. COUNTRIES***

It is hoped that many, if not all nations will develop programmes for World Health Day. They should have at their disposal all the materials we are hoping to produce in the whole collaborative effort described in this paper and they should be encouraged to produce items special to their own cultures and interests. Their celebrations might take the form of special media coverage over the whole year or for specific periods, oral health months, weeks, the actual World Health Day on 7 April, special services to promote better oral health behaviour or life styles in general, or any other special initiative that can be developed in one or several countries.

The network of WHO Collaborating Centres (see page 8, point 15) will be an important resource at national and international levels. Also, there are many national bodies, some of them WHO Collaborating Centres, which have important international as well as national roles that could give strong support to the World Health Day and the Year of Oral Health. Those that spring readily to mind are the National Institute of Dental Research, American Association of Public Health Dentistry, Centres for Disease Control, American Fund for Dental Health and American Association for World Health in the USA, the Union Francaise Santé bucco-dentaire in France and the British Dental Health Foundation in the UK.