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Promoting Oral Health in the 21st Century

Proceedings of a forum held on 13th September 2000 University College Cork

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Promoting Oral Health in the 21st Century

Proceedings of a forum

Edited by Ms D. Sadlier and Dr H. Whelton

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PREFACE

The Dental Health Foundation, Ireland, initiated this forum in response to a growing need for closer cooperation among key professionals at national and international level concerned with oral health promotion.

It was one of a number of programmes the Foundation embarked on in 2000 as part of its ongoing commitment to improving oral health.

The forum provided a unique opportunity for the panel of international experts and delegates to discuss pivotal issues facing oral health promotion at the turn of the 21st century, and provided a platform for delegates to explore experiences while identifying and drawing on important lessons for the future.

In partnership with the WHO Collaborating Centre for Oral Health Services Research, University College Cork, and the Health Promotion Unit, Department of Health and Children, the Dental Health Foundation identified significant areas of interest and structured the programme for the forum accordingly.

The aims of the forum were:

- To explore the implications of current health promotion policy formation at national, European and international level in shaping the role for the promotion of oral health in the 21st century;
- To provide delegates with an opportunity to reflect on the practical issues that challenge the promotion of oral health on a daily basis;
- To play an important complementary role to the conference entitled 'Reducing Inequalities in Oral Health in Europe: Role of Fluoride', (organised jointly by the British Association for the Study of Community Dentistry and the European Association of Dental Public Health).

The publication of this report represents a significant development in the area of oral health promotion and identifies what measures are necessary to improve the oral health of people not just in Ireland, but globally.

We would like to take this opportunity to thank everyone involved in the production of this report, which we are confident will act as a stimulus for future multinational collaboration and research in the area of oral health promotion.

Dr Gerard Gavin
Chief Dental Officer, Department of Health and Children

Mr Chris Fitzgerald
Principal Officer, Health Promotion Unit Department of Health and Children

Professor Denis O'Mullane

President of the British Association for the Study of Community Dentistry

Professor O'Mullane extended a warm welcome to all those attending the conference and congratulated the organising committee for inventing such an aptly titled conference name. He said he believed it would fuel discussion and prompt lively debate.

Professor O'Mullane pointed out that oral health promotion is grounded in general health promotion. Oral diseases and general diseases have many common risk factors and indicators. For example, smoking is associated with an increase in periodontal disease, oral cancer, heart disease and lung cancer. Furthermore, recent studies indicate that oral health is an important determinant of the quality of life. From this perspective oral health promotion is relevant to the promotion of health and quality of life generally.

Professor O'Mullane commented on the excellent turnout which exceeded initial expectations, and paid tribute to all who played a part in organising the day's events and in particular, the hygienist students and hygienists of the Cork Dental School and Hospital.

Following his acknowledgement of the work and efforts of Deirdre Sadlier and the Dental Health Foundation, Professor O'Mullane launched the forum's busy programme and wished delegates an enjoyable and interesting day.

Ms Deirdre Sadlier

Executive Director

Dental Health Foundation, Ireland

Ms Deirdre Sadlier, Executive Director, Dental Health Foundation, Ireland, outlined the background to the day's forum, which she hoped would provide delegates with the opportunity to consider the policies and new challenges that face organisations and individuals with responsibility for oral health promotion.

The theme of the forum originated at a meeting of the European Association of Dental Public Health in Strassburg in 1999. It was here that the concept of an oral health promotion forum was suggested on the basis that such a forum would encourage collaboration and convergence on issues relating to oral health.

As part of its mission to promote oral health by providing effective resources or interventions and by influencing policy through a multi-sectoral, partnership approach, the Dental Health Foundation, Ireland, accepted this challenge.

Organising the forum was a collaborative effort in which the Dental Health Foundation, Ireland, worked in partnership with the World Health Organisation Collaborating Centre for Oral Health Services Research, University College Cork, and the Health Promotion Unit, Department of Health and Children. An inventory of oral health promotion in European countries was also commissioned at this time.

The Dental Health Foundation in Ireland was pleased to support this very important research, as Ireland's contribution to oral health promotion at European level. The forum's programme would play an important complementary role to the joint British Association for the Study of Community Dentistry (BASCD) and the European Association of Dental Public Health Conference (EADPH) taking place on the 14th and 15th September 2000.

In conclusion, Ms Sadlier introduced Mr Chris Fitzgerald, Chairperson of the first session. Mr Fitzgerald, Principal Officer, Health Promotion Unit Department of Health and Children, has responsibility for strategic direction of health promotion at national level and was responsible for the commissioning and development of the 'Second National Health Promotion Strategy 2000-2005'.

Dr Gerard Gavin
Chief Dental Officer
Department of Health and Children, Ireland

Dr Gerard Gavin's paper entitled, 'New Challenges for a New Era', reinforced the notion that the 21st century certainly will be different. The new millennium is, according to Dr Gavin, experiencing the emergence of a variety of challenges and threats to the established order and, in particular, to the way in which experts operate. (1)

Dr Gavin presented a bleak picture of the way health professionals are perceived in the modern world. Highlighting the increasing diminution of authority and respect for all professionals at both national and international level, Dr Gavin stated that "the politics of professionalism are being exposed in Ireland and overseas and the public are not impressed." Dr Gavin commented that the public's confidence in professionals had been undermined by a series of scientific controversies, including the outbreak of BSE, 'Bristol Babies' problem in the United Kingdom (2), contaminated blood products, child abuse and the retention of children's organs. (3)

The media's treatment of these controversies has profoundly affected how professionals are regarded. Dr Gavin said, "The authority of scientists and scientific methods are being challenged by the lay public in an unprecedented way". He predicted that non-governmental organisations as advocates for the public will play an increasingly larger role in how our society is being shaped.

Dr Gavin believes that the traditional sources of "truth" (4) about health are being continually challenged in the media. The public pay more attention to sources emerging from the media than they do to health experts. This is a cause for concern for professionals according to Dr Gavin, given the fact that these sources are not always accountable. Dr Gavin recalled a recent debate regarding vaccination programmes where the health promotion messages advocated by professionals were repeatedly challenged by the media, which in turn gave rise to a loss of confidence in vaccinations.

Looking beyond the influence of mainstream media, Dr Gavin examined the increasing role of the Internet as a source of knowledge for the general public. An array of information, much of which is unregulated, is available instantaneously. The challenge of the Internet is, according to Dr Gavin, experienced on a daily basis in the general practitioner's surgery by patients who are increasingly pitting information they have downloaded from the Internet against more traditional sources of knowledge.

Turning to oral health specifically, Dr Gavin suggested that the concept of oral health is changing. The attention of the public has shifted to appearance, while at a policy level there is concern about the oral health of special needs groups. This is creating a dilemma with a lot of pressure being exerted to increase funding into aesthetics at a time when health professionals know that the greatest oral health needs exist with special need groups. (5)

Dr Gavin stated that oral health in Ireland, as measured by traditional indices, has improved dramatically through a combination of public health measures and secular changes in society. These improvements are also reflected at international level. (6) Dr Gavin provided an example of a communication challenge that presents itself when trying to explain to the public the reasons why oral health is improving. An academic debate within the profession on the relative merits of water fluoridation, fluoride toothpaste, fissure sealants, dietary changes, improved oral hygiene and better access to services, has spilled over into the wider public domain causing much confusion. (7) The challenge to the profession is; how should it communicate a hierarchy of evidence-based truths to the public? Dr Gavin commented that while special interest groups were adept at using new information technologies and the media to disseminate their messages, oral health

professionals had fallen behind in this regard. Oral health professionals have a good understanding of the issues, but are failing to communicate certain messages effectively to the public. To communicate more effectively, Dr Gavin suggested that oral health professionals must adopt a radical new approach to the media, and embrace new technologies.

Dr Gavin cited the Food Safety Authority of Ireland (FSAI) as an organisation that has launched a number of highly effective health information campaigns. The FSAI's efforts to educate the public regarding the dangers of E.coli and other food borne pathogens has been one of its greatest achievements. Dr Gavin believes that the FSAI's effectiveness regarding communication is reflected in its structure, where a high percentage of resources are engaged in communications. (8)

Dr Gavin concluded on a positive note by looking to the future. He advocated the development and implementation of communication strategies within health organisations. Such strategies, he believes, will empower health professionals and health organisations to regain public confidence.

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Dr Desmond O'Byrne
Senior Advisor, Health Promotion,
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World Health Organisation

In response to Dr Gerard Gavin's presentation and as an introduction to his own paper, Dr Desmond O'Byrne continued to discuss the concerns being expressed by the general public regarding health professionals. "The basis of health promotion is that we have a view, we have a foundation, we ask questions and we participate in matters that affect our lives," said Dr O'Byrne. He cited the theme of the '5th Global Conference on Health Promotion: Bridging the Equity Gap' which encouraged different sections of society to work in partnership with the aim of enhancing the health status of all members of society. Such partnerships could only be achieved through open and transparent dialogue.

Turning to Mexico 2000, Dr O'Byrne explained how the World Health Organisation (WHO), the Pan American Health Organisation (PAHO) and the Ministry of Health in Mexico collaborated to prepare the Mexican conference. The event focused on how health promotion, by addressing the social determinants of health, can improve the lives of economically and socially disadvantaged populations. The conference was built on the advances of four previous events: Jakarta 1997, Sundsvall 1991, Adelaide 1988 and Ottawa 1986.

This five-day conference comprised two main components; a two-day ministerial component followed by three days of conference presentations. The objectives of the conference were as follows:

- To illustrate how health promotion makes a difference to health and quality of life, especially for people living in adverse circumstances;
- To place health high on the development agenda of international, national and local agencies;
- To stimulate 'partnerships for health' between different sectors and at all levels of society.

The conference had, as its sub-themes, the five priorities for health promotion for the 21st century, which were identified at Jakarta and confirmed in the Health Promotion Resolution adopted by the World Health Assembly in May 1998. An additional sub-theme taken from the Ottawa Charter was also included. These comprised:

- Promoting social responsibility for health;
- Increasing investments for health development;
- Increasing community capacity and empowering the individual;
- Securing an infrastructure for health promotion;
- Strengthening the evidence base for health promotion;
- Reorienting health systems and services.

Over 200 case studies were reviewed throughout the duration of the conference, 15 of which were selected to illustrate particular themes under discussion. Dr O'Byrne referred to one case study, which reported contamination in 80% of food sold by street vendors in Calcutta. The efforts of local policy, vendors, and non-governmental organisations in overcoming this problem provide an illustration of the effectiveness of partnerships.

A total of 87 Ministers of Health, or their designates, showed their commitment to health promotion by

signing the Mexico Ministerial Statement on Health Promotion 'From Ideas to Action (MMS)'. These signatures subscribed to:

- Positioning the promotion of health as a fundamental priority in local, regional, national, and international policies and programmes;
- Taking the leading role in ensuring the active participation of all sectors and civil society in the implementation of health promotion actions, which strengthen and expand partnerships for health;
- Supporting the preparation of the Framework for Country Plans of Action for Health Promotion.

The Framework for Country Plans of Action for Health Promotion, which was developed by conference participants, focussed primarily on equity. Differences in health status between countries are, according to Dr O'Byrne, alarming. The life expectancy, for example, between one of the most developed countries and one of the least developed countries is 43 years. Bridging the equity gap is one of the greatest challenges of our times and promoting health is one effective strategy to reduce inequities, according to Dr O'Byrne.

The objectives of the Framework for Country Plans of Action for Health Promotion are:

- Health as a human right and resource for social and economic development.
- Resources mobilised to address the main determinants of health.
- Address social and gender equity at all levels and sectors.
- Research and training for developing human potential and institutional capacity building.
- Meaningful participation and supportive environments to strengthen community cohesion and build social capital.
- Systematic integration of health promotion into the healthcare reform agenda.

The principles for the success of the framework are, according to Dr O'Byrne, clear aims and objectives, clear and agreed responsibilities, transparent mechanisms for accountability, comprehensive strategies, and mechanisms for monitoring and evaluation.

Dr O'Byrne said that health promotion is expanding outside the health profession due to the demystification of health professionalism. He recommended a partnership approach whereby all sectors, for example, transport, agriculture or housing, should work together in tackling health promotion issues.

Dr O'Byrne believes that the availability of evidence is pivotal in enhancing the profile of health promotion and identified the technical papers, case studies and poster sessions presented at the Mexico conference as a rich source of data. In addition, the report on 'The Evidence of Health Promotion' published by the IUHPE and co-sponsored by the European Commission, was cited as providing an up-to-date review and listed many examples of the effectiveness of health promotion. Finally, the publication 'Quality, Evidence and Effectiveness in Health Promotion' edited by Davies and MacDonald-Routledge 1998, was recommended as providing useful insights into the problems regarding the evaluation and effectiveness of health promotion.

Dr O'Byrne concluded his presentation by mentioning a forthcoming meeting in Pretoria, at which the implications and actions of the Mexico Ministerial Statement will be discussed. Dr O'Byrne said he would be proud to show the report on Oral Health in Ireland and to discuss Ireland's National Health Promotion Strategy.

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Further information on the 5th Global Conference on Health Promotion, (Mexico, June 2000), including conference report, technical papers, Mexico Ministerial Statement, Framework for Country Plans of Action, is available from: www.who.int/hpr/conference

Professor Cecily Kelleher
Centre for Health Promotion Studies
National University of Ireland, Galway

Professor Kelleher commenced her presentation by outlining the difficulties faced by those responsible for formulating policy documents and stressed policy makers must consider the implications of the health initiatives they introduce for all members of society.

The changing economic climate in Ireland, from high unemployment and emigration in the 1980s to the recent emergence of the Celtic Tiger was, according to Professor Kelleher, an additional factor to consider when formulating policy. She cautioned that despite the strength of the economy, health inequalities remain.

Outlining her presentation, Professor Kelleher identified three key aims:

- To outline the general principles of the health promotion strategy;
- To report oral health behaviours from SLAN and HBSC;
- To highlight health education initiatives.

GENERAL PRINCIPLES OF THE HEALTH PROMOTION STRATEGY

The Health Promotion Strategy is characterised by three factors. Firstly, it offers a holistic approach to health promotion. Secondly, it has a broad socio-demographic focus. Thirdly, it offers a strategic approach to target specific populations.

An examination of the global nature of health promotion, in addition to more specific health issues, embraces the holistic approach adopted by the strategy. Such an approach promotes the interaction of qualitative data, quantitative data and other sources of knowledge, which Professor Kelleher believes is essential to the health promotion movement.

The broad socio-demographic focus adopted by the strategy addresses the huge demographic variations that exist both within and between countries. "The specifics of the social context of different groups must be implemented in strategy," said Professor Kelleher.

Turning to the strategic approach of the strategy, Professor Kelleher commented that population-specific, setting-specific and topic-specific aims allow a more practical approach to health promotion.

The Health Promotion Strategy has three major challenges:

- 'Health Proofing' public policies: this ensures that consideration is given to the health implications of public policy for all members of society;
- Cross-sectorial debate: this examines how diverse groups of people with specific problems can be brought together to talk about relevant issues;
- Implementing a range of strategies in different settings and sections: the key settings include family, community, school, health services and workplace. Priority population groups refer to women, children, disadvantaged, maternal health, sexually active and elderly. Priority areas comprise specific health issues, including oral health.

Turning specifically to oral health, Professor Kelleher outlined the five recommendations of good oral health cited in 'The Health Promotion Strategy' which are:

- Fluoride toothpaste promotion for those in socio-economic groups and non-fluoridated areas.
- Education on oral health for carers and parents of children under seven years.
- Priority for special needs groups.
- Work in partnership to promote oral health.
- Support the implementations of the recommendations in existing relevant strategy documents.

Examining the goals of the 1995 Health Promotion Strategy pertaining to oral health, Professor Kelleher identified the overall goal as one of improving the level of oral health in the general population. More specific objectives included:

- Implement the 1994 four-year Dental Health Action Plan;
- Review Dental Treatment Services Plan;
- The allocation of 30 dental auxiliary personnel to oral health promotion;
- Evaluation of oral health promotion;
- Oral health component in public research;
- Specialist certificates in oral health promotion.

Professor Kelleher noted that while quantitative 'output' measures are an index of the success of achieving these goals, emphasis should also concentrate on the 'process' and day-to-day practice of oral health. She concluded by stating that one of the pilot projects of the strategy will be completed in October 2000, at which time 62 people from the public sector will be trained in oral health promotion. Six of these have completed a diploma in health promotion, one of which is completing a master's degree in health promotion.

ORAL HEALTH BEHAVIOURS FROM SLAN AND HBSC

The Survey of Lifestyles, Attitude and Nutrition (SLAN) collated oral health data from over 6,500 adults in the Republic of Ireland by means of a self-completed questionnaire. Respondents were asked questions regarding their dental status, the amount of toothpaste used, gender, age, general medical services (GMS), locality, dietary habits and smoking.

Oral health data from the survey indicated that only 23% of respondents reported having all their own teeth, while 33% of the sample reported having dentures. The use of a pea-sized amount of toothpaste was reported by 14% of respondents, with women having significantly higher rates than men (17% versus 11%). This may reflect a 'cohort effect' relating to educational messages targeted at these populations when they were younger.

The Health Behaviour in School-aged Children (HBSC) survey of school-going children provides another rich source of data. Findings indicated that while gender did influence the frequency with which children brushed their teeth on a daily basis, (68% girls versus 47% boys); age and socio-economic status were not influential.

Professor Kelleher commented that the findings from surveys such as SLAN and HBSC would be beneficial in guiding health promotion initiatives to specific populations.

HEALTH EDUCATION INITIATIVES

Turning to health education initiatives, Professor Kelleher reviewed a recent oral health initiative targeting primary school children. The initiative combined school visits with a television advertising campaign. Professor Kelleher commented that multi-faceted approaches to oral health were highly successful with this target audience and made reference to the 'Mighty Mouth' project supported by the Dental Health Foundation, Ireland, which seeks to increase parents' and teachers' knowledge of nutrition and oral health.

In conclusion, Professor Kelleher commented on the recent fluoridation debate. "I see the issue of fluoride and public dialogue as a challenge that must be met, as it captivates what health promotion is about." She finished by saying that this controversy highlights the need to address issues of civil liberty, public consultation and accountability as in any public health campaign. In this regard, Professor Kelleher urged health professionals to make scientific/public health cases more coherently, to facilitate genuine public consultation and to assimilate the conclusions into public policy.

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Chaired by Mr Chris Fitzgerald

Principal Officer
Health Promotion Unit
Department of Health and Children

Opening the discussion, Mr Chris Fitzgerald invited Dr Desmond O'Byrne to elaborate on mechanisms that would increase the profile of oral health.

Dr O'Byrne acknowledged that oral health has not been afforded 'the visibility or priority that it deserves' and made reference to a visit he paid to a country in sub-sahara Africa where the major causes of illness and diseases were being examined. To his surprise oral health was listed among the main health priorities. "I couldn't believe it because there is the myth that everyone from that part of the world had excellent teeth, ate plenty of fruit and vegetables and didn't eat chocolate."

Dr O'Byrne cited health education surveys and school health promotion initiatives as highly successful methods of promoting oral health and stressed the importance of targeting interventions at younger audiences. He drew the audience's attention to a controversy in the early 1980s in Ireland, when the then Minister of Health had toothbrushes delivered to every school in the country. While the Minister was criticised for engaging in 'politics', Dr O'Byrne believed the initiative helped to highlight the importance of oral health. Finally, Dr O'Byrne suggested that one could maintain the place of oral health as an essential part of public health by lobbying relevant bodies, including the WHO, requesting that continued importance be given to oral health promotion.

A delegate from the audience commented that oral health should be presented within a broader arena. According to the speaker, the word 'integration' has extremely limited use within the discipline. The speaker urged oral health professionals to view themselves as part of a general health service.

Dr Gerard Gavin was asked in relation to his presentation, 'New Challenges for a New Era', to illustrate how health professionals can improve their relationship with the media. Dr Gavin suggested that, to become adept communicators, health professionals should receive training in media and communication studies.

One delegate spoke of her recent experience in South Africa at a HIV/AIDS conference. She raised the issue that the representative countries that were very active in oral health promotion did not have access to their Ministers for Health. She concluded by saying that visibility at WHO level was critical to give those countries and those individuals the entrée to the policy makers and the national plans that are established.

Mr Fitzgerald then brought the first session of the forum to a close and thanked the speakers for their valuable contributions.

SOCIOLOGICAL CRITIQUES OF HEALTH PROMOTION: THEIR RELEVANCE FOR ORAL HEALTH PROMOTION

Orla O'Donovan
Department of Applied Social Studies
University College Cork

Orla O'Donovan argued that assessments of the relevance of sociology and of the social sciences more generally for oral health promotion, are rooted in understandings of what the oral health promotion projects entails. For example, if one adopts an understanding of oral health promotion that views it as being confined to promoting attitudinal and behavioural changes that have been shown to be effective in 'scientific' research, it is likely that one will regard sociology as being of only marginal relevance. This understanding of oral health promotion is likely to only accommodate an instrumental approach to sociology, where, as in the tradition of medical sociology, it can be of service to oral health promotion. This is what is referred to as 'sociology for health promotion' and involves the incorporation of sociological insights into health promotion in order to refine and develop its techniques and practices (Nettleton and Bunton 1995).

Understandings of oral health promotion that see it as being confined to the pragmatic promotion of healthy lifestyles are unlikely to see a relevance for what is referred to as 'sociology of health promotion'. In this case, the focus is on developing critical sociological analyses of oral health promotion itself and of the assumptions that inform it. The focus is on exploring both how social forces shape the discourses and practices of health promotion and on exploring the social consequences of these discourses and practices. Rather than servicing oral health promotion, this kind of endeavour is driven by inherently sociological questions. An understanding of oral health promotion that views it as part of a wider social and political project where public health cannot be separated from social change, and where the social and biological dimensions of health are viewed as being inextricably linked, is likely to view sociological concerns as being of central relevance. As noted by one long time advocate of this understanding of health promotion, David Werner (1988, p.1), 'the biggest obstacles to 'health for all' are not technical, but rather social and political'. From this understanding of the oral health promotion project, the relevance of sociological analyses centres on their potential to foster a critical reflexivity within the institutions of oral health promotion.

Ms O'Donovan discussed the argument made by some social scientists that health promotion does not represent a departure from the clinical paradigm, particularly in relation to its individualised approach to health and its reification of expert knowledge (O'Brien 1994). Such commentators argue that the shift towards health promotion is merely a reformulation of many of the key assumptions that underpinned medicine. It is argued that there has been a 'medical misappropriation' of the WHO's principles of health promotion, where targets that fit in with the medical model, such as goals for lifestyles changes, preventive medicine and the reduction in mortality from specific medical conditions, are the focus of attention. Other targets, such as those concerning community participation, it is argued, are ignored or distorted (Farrant 1986,1991).

Ms O'Donovan outlined the structural critiques of health promotion that argue that it generally fails to recognise the socio-economic determinants of health, and places undue emphasis on behavioural change as a means to promoting good health. These critiques argue that many health promotion initiatives obscure the structural influences on health and therefore depoliticise it. While medicine is guilty of reductionism in that it pathologises social problems, health promotion is similarly guilty as it reduces broad social inequalities, of which health inequalities are manifestations, to variations in lifestyles. Ms O'Donovan suggested that the section on oral health in the recently published 'National Health Promotion Strategy 2000-2005' could be regarded as reflecting such reductionism.

Ms O'Donovan highlighted that a recurring theme in some social scientific analyses of health promotion is the disparity between its rhetoric and practices. Internationally, commentators on health policy documents

concerned with reducing health inequalities, have noted that emphasis is placed on the need for interventions at a number of levels ranging from the macroeconomic level to the individual level. Generally, however, it is argued, no specific recommendations or targets are set in relation to change at the macroeconomic level, as these are deemed to be beyond the remit of health promotion (Wainwright, 1996). Again, Ms O'Donovan argued that this rhetoric / action gap is evident in Irish health policy documents. For example, the 1995 health promotion strategy document devoted considerable space to highlighting the connection between economic status and health, yet the actions aimed at reducing inequalities in health were confined to educational initiatives aimed at behavioural change in relation to nutrition, smoking, alcohol and substance misuse (Department of Health, 1995).

Ms O'Donovan then discussed how the production of scientific knowledge and the assumptions that underpin it have become central social scientific concerns. Such analyses are not necessarily concerned with finding out what is true and is false in debates that are regarded as reflecting a crisis in expert knowledge that some claim characterises late modernity, such as the debates about GMOs, immunisations, pylons, home births, mobile phone masts, fluoridation of water supplies; rather the interest is in how certain truths become established and in the social consequences of these truths. It is argued that the process whereby something becomes established as being true is socially and historically contingent. In the sociology of medicine, there is extensive research into the processes involved in the production of medical knowledge. Much of this research has focused on the relationships between the state, trans-national pharmaceutical industries and the medical research community, what is called the medical-industrial complex, and on the implications of this complex for the production of scientific knowledge. In exploring the consequences of the increasing industrialisation of science, sociologists have begun to empirically document the process by which scientific knowledge is produced within the medical-industrial complex. An example of such research is the case study by John Abraham (1995, p.167) of the fate of research papers concerning the drug benoxaprofen, in which he concluded that 'within the medical-industrial complex conformity to industrial interests can be a major criterion in defining the kind of reception given to a scientific paper and the professional autonomy of the authors in the paper's production, rather than an ethos of scientific scepticism or commitment to paradigmatic conventions'. This kind of analysis of the medical-industrial complex can be applied to world of oral health where we could talk in terms of the dental-industrial complex and ponder upon the consequences of the complex for the production of knowledge in relation to oral health.

These issues concerning the nature of knowledge were then discussed with reference to the 'community participation' element of health promotion. Here, Ms O'Donovan questioned how oral health promoters should respond to situations where there is a disparity between the scientific evidence and popular knowledge. This led her back to her initial point about differing understandings of the nature of the oral health promotion project. If one adopts a view of oral health promotion as involving the promotion of behaviours and understandings that are supported by scientific research, then the response to situations where there are competing understandings of health would be to engage in some kind of social marketing exercises that aim to promote understandings that are in line with the scientific thinking. Many sociologists would be sceptical about the potential success of such an approach in the epistemological climate of late modernity, although Ms O'Donovan argued that we need to be careful not to over-state the extent of the crisis in expert systems An alternative approach, and one that harks back to some of the early radical writings about health promotion and primary healthcare, would be to reconsider the conventional distinction and hierarchy between scientific and non-scientific knowledge. One call for such reconsideration has been made by Jenny Popay and Gareth Williams (1996). They make a case 'for more systematic dialogue and reflexivity within scientific research, between researchers and policy makers, and between professional and lay experts' (1996, p.760). Returning to the question of the relevance of sociology, Ms O'Donovan suggested that the sociology of health promotion could play a crucial role in fostering such dialogue and reflexivity.

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Dr Richard Watt's presentation aimed to critically examine the methodologies and findings of effectiveness reviews conducted on oral health promotion literature, and to discuss the implications for future practice and development of an evidence-based approach to health promotion. The emergence of such an approach to healthcare delivery is placing increasing pressure on health promotion and public health practitioners to demonstrate the effectiveness of their work. The methodologies used to assess the value and effectiveness of health promotion interventions have prompted a lively debate in oral health.

Five reviews on the effectiveness of oral health promotion have been conducted in the past 10 years - Brown (1994), Kay and Locker (1998), Schou and Locker (1994), Kay and Locker (1996) and Sprod, Anderson and Treasure (1996). The international focus of these reviews has contributed to the extensive interest that has been generated in the evidence for oral health promotion.

Evaluating the contribution of these reviews to oral health promotion, Dr Watt identified several shortcomings of this approach. Most reviews are restricted to English publications from a limited number of sources such as Medline. Some studies reviewed are nearly 30 years old, and the inclusion and exclusion criteria that reviewers use to select studies vary considerably. Of the papers comprising each review, Dr Watt commented that many were poorly designed with a restricted study period. Data analysis was limited and intervention designs lacked a strong theoretical base and Dr Watt said "the outcome measures used often focus on clinical outcomes, which may not be appropriate to help those in practice. Many of the outcomes were not comparable, with no standard being set." He also stated that while health promoters may be cautious in their interpretation of the findings from these reviews, such limitations are common throughout all public health studies.

Three major findings are consistent across oral health promotion reviews:

- An extensive body of literature exists supporting the use of fluoridation;
- Oral health knowledge of the client base can be successfully improved. However, its translation into improvements in oral health behaviour is questionable;
- Information alone is not enough. Information leaflets, for example, do not influence changes in behaviour. They must be used in conjunction with other forms of oral health promotion.

With regard to periodontal health, the literature shows that plaque levels can be reduced on a short-term basis, but long-term results are disappointing. School tooth-brushing campaigns have little long-term effect. There is a lack of evidence in relation to sugar consumption and dietary behaviour changes.

According to Dr Watt, these reviews call for a wider focus in terms of the criteria and outcome measures used. Oral health promotion is long-term, so it is vital that long-term changes are measured. In addition, the reviews concentrate on a hierarchy of evidence. The use of randomised control trials as the only evidence base is being challenged.

Dr Watt insisted that the key challenge of oral health promotion interventions is to examine the underlying factors that influence oral health. He said to do this; oral health promoters must consider the economic, cultural and environmental factors that drive lifestyles. The emphasis should be on long-term sustained changes rather than quick fixes. This has been recognised by the British government in its paper 'Our Healthier Nation'.

Dr Watt outlined the importance of the common risk factor approach. He said that diet is the key determinant of many diseases, so the promotion of an overall balanced diet should be encouraged. This necessitates the collaborative effort of various health professionals. Dr Watt argued that partnership with the public, other professionals and politicians is the way forward and that participation in interventions creates a sense of ownership in terms of achieving change.

What have these reviews taught us about the adoption of appropriate practices in the future? Firstly, it is important to acknowledge that using health education in isolation has its limitations. As outlined in the Ottawa Charter WHO (1986), a complementary range of approaches is required, in addition to utilising a range of appropriate settings. To illustrate this, Dr Watt gave the example of the 'MRFIT' programme in the US. Despite being the largest health education project developed in US, it did not sustain change in the health of the American population. Dr Watt argued that the educational approach adopted by the programme was limited and that a more integrated approach is necessary.

Previous healthy eating campaigns in the UK have adopted the approach of blaming the victim for his or her ill health rather than concentrating on others, such as the food producers. Dr Watt said this approach is unlikely to succeed and that emphasis should be placed on changing the environment rather than changing the individual. He noted that in terms of sending out clear messages regarding public health policy and environmental changes, the Ottawa Charter is the most influential World Health Organisation (WHO) document produced in oral health promotion.

Reviewing the evaluation of health promotion initiatives, Dr Watt cited the WHO recommendation that randomised control trial methodologies are not always appropriate or necessary for health promotion evaluation (WHO, 1998). For Dr Watt, comprehensive evaluation demands a variety of methodologies that are more likely to capture the true 'essence' of the intervention. Professor Nutbeam's evaluation model of health promotion, for example, encapsulates the whole process from environmental changes and policy guidelines to outcomes and effectiveness (Nutbeam, 1998). This model has been used extensively throughout the UK. Dr Watt stated that he is currently involved in the development of standardised evaluation measures that can be applied to health promotion interventions.

In conclusion, Dr Watt made reference to the Institute of Health's 'Promoting Health' document. According to its editors, Smedley and Syme (2000), in order to achieve meaningful change, oral health promotion interventions require the following:

- Increased focus on the determinants of disease, injury and well-being;
- Multiple/combination approach;
- Consideration for special needs groups;
- Long-term view of health outcomes;
- The involvement of sectors beyond health services.

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Chaired by Dr Helen Whelton

Deputy Director
WHO Collaborating Centre for Oral Health Services Research
University College Cork

Dr Helen Whelton concluded the second session of the forum by inviting delegates to ask questions or make comments relating to the presentations. In reference to Ms Orla O'Donovan's comment on scientific knowledge, one delegate believed that within dentistry, a minimal knowledge about people, attitudes, experiences, feelings, and the connection between the mouth and quality of life exists. He said that explorative interviews with patients into how they view their mouths are required. This information could be used in formulating oral health promotion strategies. He concluded by saying there is evidence of a mismatch in today's planning between what dental professionals do and what their patients think.

Ms O'Donovan said she attempted to highlight the two types of research in the sociology of knowledge. One pertains to lay health belief research. However, Ms O'Donovan pointed out that her presentation concentrated on the way in which the scientific / clinical knowledge that informs oral health interventions does not take place in a social vacuum. She believes that research is not sealed off from social, political and cultural considerations. Similar to lay health beliefs, scientific knowledge is a belief system.

Ms O'Donovan was then asked if she thought there was a problem with the oral health profession working with industry, as she had alluded to the impact of industry on the production of knowledge. The delegate also asked if Ms O'Donovan believed that academics should work in a vacuum rather than working together with the structures that are in place to promote oral health.

In reply, Ms O'Donovan said, "We must think about the implications of the close working relationship between the scientific community and industry. That relationship has implications for the nature of knowledge production." Ms O'Donovan said it was her intention to promote increased awareness of the consequences of the relationship and how it bears upon the production of knowledge, and made reference to the efforts being made to prove that this relationship does have an impact on what is established as being 'true'.

Another delegate made the point that knowledge of the lay perspective is quite vast and yet it is not used because it is not necessarily convenient to use it. She asked Ms O'Donovan to cite an example of where the lay perspective had been adopted and its success rate. Ms O'Donovan pointed out that in his work, David Werner believes that there is a tendency to ignore the lay perspective. An example of the use of non-professional knowledge in an effective way is in oral rehydration therapy in a response to diarrhoea. Lay expertise has been quite successful in this field, yet there is still a tendency to promote pharmaceutically produced sachets. Ms O'Donovan believes that initiatives built on this type of lay knowledge can be used as part of the wider process of health promotion.

One delegate asked whether oral health could be placed higher on the political agenda. He made reference to the success of the health promotion campaign in relation to tobacco, stating that this success can be attributed to its placement on the political agenda, which resulted in higher taxation, reduction of advertising, smoke-free areas and anti-smoking strategies. Dr Richard Watt acknowledged that the UK's White Paper on smoking is a perfect example of oral health promotion. However, he cautioned the motivation of some political advocates. "Are we doing it for our own interests, or are we genuinely trying to change the structures for oral health? Political advocacy is important, but hopefully community development and involvement would be some things that I would place further up the agenda to create more meaningful change."

One delegate agreed with Dr Watt's comments regarding randomised control studies and asked Dr Watt if

he thought that the greater role lay with ecological research. Dr Watt said that he believed that randomised control trials do have some value and there is firm evidence of this in the smoking cessation programme. He acknowledged, however, that such trials are not appropriate for all interventions and stated that he is currently challenging the very strict hierarchy that exists with regard to interventions.

Dr Watt had highlighted the importance of the Ottawa Charter in terms of health promotion in his presentation. He was asked how relevant the additional recommendations of the Jakarta Conference in 1997 were in this regard. Dr Watt commented that the Ottawa Charter is still the most important document in terms of health promotion, and said the Jakarta recommendations had been excellent in refining the overall public health agenda. He added, "For me, Ottawa was the first one to set out a radical political change, which we still have to address in many different ways".

When asked to comment, Dr Desmond O'Byrne said that he agreed with Dr Watt in relation to the Ottawa Charter and its broad remit. In 'Mexico 2000', efforts were made to obtain written commitments to examine the goals outlined. The aim is to encourage countries to identify their priorities and work together to a common goal. Dr O'Byrne added that while the WHO has often been accused of using a lot of rhetoric and high-sounding language, Mexico 2000 provided an example of its desire to instigate more practical action.

Dr Whelton drew the discussion to a close at this point and thanked all those who participated.

ORAL HEALTH PROMOTION - AN INVENTORY OF EUROPEAN COUNTRIES (RESULTS OF A BASELINE SURVEY)

Williams SA*, Sadlier D, Eaton K, Cohen L, Csikar J*
Professor Sonia Williams
WHO Collaborating Centre for Research on Oral Health and Migration
University of Leeds, UK

Ms Julia Csikar commenced the presentation by reviewing the background and methodology to the study 'Oral Health Promotion - An Inventory of European Countries (Results of a Baseline Survey)'. Firstly, she referred to the definition of health promotion as outlined by the Ottawa Charter (1986). This definition identifies the principle aim of health promotion as 'making healthier choices easy'. Ms Csikar said that health promotion should be a positive concept that emphasises social and personal resources, as well as clinical capacity. Creating supportive environments, strengthening community action, developing personal skills and re-orientating health services contribute to achieving the desired goal of making healthier choices easy.

The Ottawa Charter, recognising that political, social, cultural, environmental, behavioural and biological factors influence health, attempted to reflect such variables in health promotion strategies. It states, "Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account different social, cultural and economic systems".

Ms Csikar said that public health had achieved an increasingly important profile within the European community in recent years. Health promotion was now higher on the European agenda. There was evidence of a pooling of ideas and experiences and the adoption of healthy lifestyles and behaviour. Public awareness had increased and there was a move to more inter-sectoral and multi-disciplinary approaches.

According to Ms Csikar, working partnerships within Europe shared five priorities for health promotion activities: Population groups, training, settings, technical development and quality improvements & issues, (e.g. diet, alcohol, mental health, etc). Health inequalities provided the key health promotion challenge in addressing the needs of, for example, the socially excluded.

Ms Csikar commented that there was a general air of encouragement to examine oral health promotion both internationally and within Europe. While challenging targets existed, Ms Csikar pointed out that oral health promotion activities are frequently restricted to issues pertaining to children and dental caries. Ms Csikar commented that oral health promotion includes a considerably broader remit.

Concluding her presentation, Ms Csikar introduced 'Oral Health Promotion - An Inventory of European Countries'. The survey aimed to provide baseline data regarding general and oral health promotion activities in Europe. A piloted semi-structured questionnaire was disseminated to Chief Dental Officers, World Health Organisation Collaborating Centres, dental schools and national dental associations. Sixty-two responses were received from 27 countries, with the highest response rate coming from Spain, Ireland and the Netherlands. The majority of non-respondents were from Eastern European countries. Ms Csikar then handed the floor to Professor Sonia Williams.

Professor Sonia Williams commenced her review of the findings by examining the activities respondents listed when asked to define 'oral health promotion'. Over half of respondents (55%) cited the development of public policy, while just under half (48%) commented that oral health promotion involves 'setting targets and priorities'. Other responses included the development of resources, evaluation, training, research and development. Professor Williams commented that while these responses indicated a broad remit for oral health promotion, a significant minority of respondents (18%) stated that oral health promotion is restricted to 'teaching people to change by adopting healthier behaviours'.

The definitions of 'oral health' spanned a broad spectrum. It was seen as part of 'quality of life', 'general

health', or 'well-being and self-esteem'. Professor Williams said that in relation to oral health, dental caries and periodontal disease were mentioned most frequently. These were followed by oral cancer, malocclusion and fluorosis. Apart from children, population groups of interest included the institutionalised, disabled, elderly people, people living in socially deprived areas, ethnic minorities, migrants and refugees.

According to Professor Williams, the locations at which oral health promotion most commonly takes place are schools or institutions (for people with disabilities, special needs, elderly). In addition, non-dental staff that might be involved include school staff (teachers, catering) and medical personnel (nurses, health visitors, doctors, pharmacists). As discussed in earlier presentations, water, marketing and dental companies would also be involved in oral health promotion, in addition to the media and non-governmental organisations.

Eighteen of the 27 countries that replied to the questionnaire reported having an action plan for oral health promotion. Professor Williams presented some of the more interesting findings with regard to specific countries. Documentation supplied from the University College Cork, and the Dental Health Foundation, Ireland, was, according to Professor Williams, highly impressive. An effectiveness review document from Wales and an action plan from Scotland were also commended by Professor Williams.

Professor Williams was particularly impressed with documentation sent from Latvia. It reported details of an Oral Health Centre and fund that was set up in 1994 and was based in the Stomatology Institute in the Medical Academy of Latvia. A five-point National Preventive Programme in dentistry had been formulated with the Health Department State Dental Clinic. The Institute of Stomatology provides the following services:

- The provision of information and motivation for children and parents.
- Education programmes for dental and general medical staff.
- Epidemiology.
- Prevention, in cooperation with Sickness Funds and local government.
- Databank, assessing the effectiveness of preventive and curative work.

Spain was equally innovative. Its health administration system is regionally based. 'The Health Plan of the Canary Islands', for example, places emphasis on dental fluorosis, and dental health in older people, with top priority being given to toothbrushing for children. Documentation from Andalusia revealed different priorities; the completion of the implementation of water fluoridation, the promotion of toothbrushing with fluoride and the implementation of fissure sealant programmes. For Professor Williams, this is a clear example of contrasting priorities within the same country.

Professor Williams provided the following quotations to illustrate the priority of oral health promotion in different countries:

- "There are ideas but little money in our country."
- "Oral health promotion gets no priority in health policy in our country."
- "Our health law has been modified recently, but public dentistry was not included."
- "Due to a very small public health sector, activities in dental public health also very limited."

Professor Williams concluded her presentation by stating that the present survey has provided an initial baseline from which more substantial enquiries could be developed. Efforts will be made to follow up those non-respondents where possible. It is envisaged that in-depth interviews will be carried out to ensure that national and regional perspectives are covered. According to Professor Williams, the results of the survey will eventually culminate in the formulation of a complete definitive database that will be made available on the Internet and will provide for ongoing oral health promotion networking, development and support.

Ms Cathy Stillman-Lowe
Public Health Advisor - Oral Health
Health Development Agency, UK

Ms Stillman-Lowe was scheduled to speak at the conference but was unable to attend. The following is a copy of her paper presented on her behalf by Dr Richard Watt.

In England, Saving Lives: our healthier nation (1) stated that 'by working together, we can tackle poor health, and achieve the aim of better health for everyone, and especially for the least fortunate'. It also proposed a 'new balance in which people, communities and Government work together in partnership to improve health'. The NHS Plan - A plan for investment. A plan for reform (2) emphasised that 'the NHS cannot tackle health inequalities alone. The wider determinants of ill health and inequity call for a new partnership between health and local services'. The key question is how to translate these ideas into practice: according to Plamping (3) there has been 'an explosion of partnership boards and meetings'...and 'now there is talk of partnership fatigue'. In her analysis of partnerships, she describes 'co-ordinating partnerships', which can be high maintenance, and difficult to sustain beyond the 'trailblazer' stage. 'Co-operative partnerships' by contrast are low maintenance, and based on enlightened self-interest, trust and reciprocation. Plamping recommends that to help partnerships identify a shared goal; the focus should be on the needs of patients and their whole experience, rather than professions or institutions.

THE REWARDS OF INFORMAL NETWORKING

Systematic reviews have stressed the importance of working in partnership for oral health promoters. For example, Brown (4) stated that 'the practice of dentistry has suffered by its isolation from others...dental researchers need to integrate their activities with health education researchers...structural changes to the practice of dentistry to enable a multidisciplinary approach to the effective delivery of dental health promotion and education are needed'. More recently, Watt and Fuller (5) emphasised the rewards of working across professional boundaries, pointing out the valuable role of health visitors, teachers, voluntary workers, pharmacists and the primary health care team in giving advice on oral care, and creating environments and policies that support health. Several successful oral health projects conducted by the English Health Education Authority, including Smiling for Life (6), and Helping smokers to stop: a guide for the dental team (7), relied on relationships built upon goodwill rather than a statutory compulsion to work together. Communication skills (listening to the agendas of other agencies and professionals) and negotiation and enabling skills were needed to sustain this approach. There were also pitfalls to be avoided. These included: the time and therefore cost involved in nurturing and sustaining a partnership; possible conflicts of interests for example when forging public-private sector partnerships; and the communication blocks created by health service and health promotion jargon. The benefits however were substantial, including improved quality and outcomes of the projects.

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A NORTH/SOUTH INITIATIVE -

A PROGRAMME FOR CHILDREN FROM DISADVANTAGED BACKGROUNDS IN IRELAND

Professor Ruth Freeman
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Queen's University, Belfast, Northern Ireland

The North and South of Ireland are divided, not only constitutionally, but also by the prevalence of dental caries experienced among school-aged children. "It is no surprise to any of us here that inequalities in oral health are linked to materials and social deprivation and this is particularly so in Northern Ireland, where we have the highest prevalence of dental caries in children and adolescents," said Professor Ruth Freeman.

Professor Freeman's presentation based on the study 'A North/South Initiative - A Programme for Children From Disadvantaged Backgrounds in Ireland', discussed a cross-border initiative to promote oral health among these children. The programme, theoretically underpinned by the Ottawa Charter, recognises the strengths and weaknesses of both regions with regard to oral health promotion.

A 1997/1998 study reported a caries-free rate of 58% among five-year-olds in the UK. This figure dropped to 38% in Northern Ireland. A year later, the UK reported a caries-free rate of 46% among 14-year-olds, with a disappointing 22% in Northern Ireland. How did children in the North compare with their counterparts across the border? The picture was equally dim. There was a dmft of 2.97 among five-year-olds in the EHSSB region in the greater Belfast area, compared to 1.00 in the Eastern Health Board region of Dublin. Patterns worsened as one went further west.

How could this difference be explained? Professor Freeman said, "Our children and adolescents know all about caries prevention stories. They know when to eat and when not to eat. They know what to snack on and what not to snack on. They know that they should only eat sugar four times a day with their meals. Some even know the fluoride and dental caries story."

In an attempt to accurately investigate dental health behaviour, as opposed to knowledge, of children from North and West Belfast, the 'Rubbish Bag' method was developed by Bunting and Freeman 1999. The method requires children (aged five to 11 years) to put the 'rubbish' they ate at break-times into bags for a one-week period. Professor Freeman said that the content of the bags revealed diets high in non-milk extrinsic sugar, characterised by carcinogenic snacking. Similar findings were reported in Dublin, with one in four five-year-old children and one in every three 12-year-olds, snacking at least three times a day on carcinogenic snacks.

Professor Freeman informed the conference that 37% of the variance in predictions of carcinogenic snacking could be explained by parental employment status (unemployment) and gender (boys). Therefore, the role of demography in patient deprivation has to be acknowledged in creating supportive environments for oral health promotion. Similarly, in their sociological critique of health promotion, Nettleton and Bunton (1995) proposed that individuals that are 'structurally disadvantaged' are unable to take advantage of improved dental health knowledge and attitudes. Social deprivation limits their ability to act and voluntarily adopt healthier habits, such as oral health behaviour.

Professor Freeman said, "Our programme would have to emphasise healthy public policies in order to create a supportive environment and reduce health inequalities". With this in mind, it was decided that the programme would be based on proposals outlined in the Ottawa Charter for deprived children. The key proposals included building healthy public policies (fluoridation of water supplies in this Irish programme), the settings approach (the school-based system used) and personal skills (toothbrushing and health dietary choices).

Turning to the issue of fluoridation, Professor Freeman informed the conference that 73% of the Republic of Ireland's public water supplies are fluoridated. In Northern Ireland, where the highest prevalence of

childhood/adolescent dental caries in the UK and Ireland exists, water is not fluoridated.

Professor Freeman argued that this could be attributed to enabling legislation in the North (Water Fluoridation Act 1985), which devolves decision-making from central to local level. Professor Freeman said, "If we wish to develop a supportive environment in the North, we must consider an appropriate delivery system for fluoride. If that is to be water fluoridation, then we must consider a change in legislation".

Professor Freeman then outlined a recent cross-border initiative targeted at disadvantaged children. The initiative stemmed from a 1990 toothbrushing programme specifically developed to focus on the needs of structurally and socially disadvantaged children in Dublin. In 1998, the programme was implemented in socially disadvantaged areas in the Republic of Ireland and Northern Ireland and a qualitative evaluation was conducted in the North in 1999.

The aim of the programme was to increase the use of fluoride toothpaste by promoting twice daily toothbrushing. It achieved this aim by using competition between classes and schools as a means of motivation. The content of the programme comprises three visits:

- Visit 1: Children aged between seven and 11 years are invited to take part, parental consent is obtained and the competition is explained.
- Visit 2: Dental health education activities are conducted and a plaque test is taken for each child. The children are required to keep a record of their daily brushing activity for four weeks, which is recorded on a chart in the classroom.
- Visit 3: There is an unannounced visit by the dental health promotion team, more dental health education activities and a final plaque test is administered to each child.

Professor Freeman said, "The programme created an active participating community of children. I understand that each day one child was a 'toothbrushing frequency monitor'. Apparently, if one child didn't brush his or her teeth, the other children made that person aware that the class would lose and encouraged the child to brush."

The children with the lowest plaque scores and the highest frequency of toothbrushing win the competition. All children who take part are given a certificate. Children with a 75% improvement rate are awarded with a medal, while the winning class in each school is awarded a cup. Finally, the winning schools in each region win a shield.

In evaluating the programme, teachers and children said they had enjoyed it, while parents welcomed it as it took the onus of oral health promotion off them. Improvements in dental knowledge and toothbrushing were noted. In addition, the initiative was praised for encouraging children to work together and because it could be easily integrated into the primary education curriculum.

Despite such praise, the oral health promotion team had concerns. The project was time consuming, taking from two to 63 hours to carry out three visits. The oral health promotion team requested more formal evaluation. Professor Freeman said, "Like the 'Rubbish Bag' method where we had actual proof of snacks, there is a need here to find out if they were actually brushing their teeth and using a fluoride toothpaste". Formal evaluation in the future will include assessments of dental health knowledge, attitudes, and self-esteem. In addition, salivary measures of fluoride as a measure of actual toothpaste use will be collated and assessments with parents and teachers will be undertaken.

Formal break-time policies have been implemented in primary schools in Northern Ireland. Professor Freeman is currently evaluating the effectiveness of the 'Boost Better Breaks' programme. Children enrolled in the programme are given milk/water and fruit/vegetable snacks and must avoid high fat/sugar foods.

The Dental Public Health Research Group at Queen's University, Belfast, in conjunction with Armagh and Dungannon HSST in SHSSB, has been evaluating this project as part of the government's research and development programme. Preliminary results suggest that there are no differences in caries experience between participating children from low socio-economic sectors (SES) and middle/high SES. This finding contrasts with the fact that significantly greater proportions of children from middle/high SES were caries-free compared with those from lower SES in non-participating schools. Professor Freeman concluded that the 'Boost Better Breaks' policy was effective in lowering health inequalities.

Professor Freeman concluded, "By using the strengths of each region, it has become possible within the framework of the Ottawa Charter, to forge links and develop initiatives to promote oral health among Irish children from disadvantaged backgrounds. It is this north-south cooperation that will help the development of tailored and focussed programmes to promote oral health amongst these children".

Chaired by Dr Jacinta McLoughlin

Senior Lecturer in Public Dental Health
University of Dublin
Trinity College

Dr Jacinta McLoughlin concluded the third session by inviting delegates to put questions to the speakers of that session. The first question surrounded the issues of formal assessment of oral health promotion programmes. The panel were asked to comment on how they would like to see evaluation of health promotion or education programmes carried out, so that attendees could bring some practical advice home with them.

Dr Richard Watt based his response on evidence. He said that many effectiveness reviews do not provide evidence that toothbrushing programmes in schools are effective. He believes the effectiveness of many interventions is still being questioned, for example, plaque scores. As such, they require more detailed analysis. When there is proof that interventions are effective, they can be evaluated in a more processed way to provide feedback to the participants and providers.

Dr Ruth Freeman said that evaluation should be based on the aim of the intervention. The toothbrushing programme, which she discussed, did not just relate to the removal of plaque, but also to the wider issues of personal skills and getting children working together. She questioned whether or not evaluation of oral health interventions is taking place too soon. "Perhaps we have to keep coming back and doing these programmes again and again in order to help people to change. We need to tailor our interventions and the way in which we assess them."

Professor Sonia William's response referred to measuring effectiveness of oral health programmes with health commissioners by developing healthy public policy. According to Professor Williams, the real challenge lies here and evaluation should be channelled into this area.

Referring to Dr Richard Watt's statement that there is no evidence to support the claim that toothbrushing programmes in schools were effective, a member of the audience asked Dr Watt if it was wise to state this, or if the evidence to support the claim had yet to be identified?

Dr Watt told the audience that based on his understanding of a variety of reviews, there is no evidence to suggest that such programmes work. Given this lack of evidence, he suggested that other methods should be used to promote oral health. He pointed out that there is new evidence suggesting school policies regarding healthy nutrition are effective. Dr Watt questioned such evidence "In my view, toothbrushing theories have been done correctly in terms of salivation. With nutrition policy, the evaluation hasn't been done properly. So, it goes back to the point 'we're not certain they don't work', we just don't have enough evidence."

Ms Deirdre Sadlier said that the Dental Health Foundation, Ireland, is aware of the limited effectiveness of plaque removal and reduction in improving oral health. She reported that it is known and moreover, has been proven, that the toothbrush is an effective fluoride toothpaste delivery system. Effective brushing twice a day with fluoride toothpaste keeps fluoride at optimum levels in the saliva and this is a proven benefit. Therefore, the use of fluoride in saliva as a tangible measure is an integral aspect of the toothbrushing programme.

Professor Sonia Williams was asked to discuss the development of the strategies that were identified in her European study. She was asked if strategies were 'top down' or 'bottom up' and if public participation formed part of them. Professor Williams said that this detailed information was not available. The questionnaire had just ascertained the existence of such strategies. However, she pointed out that it is hoped that such details will be forthcoming in the future.

Dr Ruth Freeman was asked to comment on potential bullying that may arise from the rewards system for toothbrushing that her programme adopted. The delegate recalled Dr Freeman's comment that children would often condemn a child who was not brushing his or her teeth. Dr Freeman did not believe that this was an issue.

One delegate made reference to the terminology that was used in Professor William's study. She drew attention to the finding that approximately 18% of those questioned believed that health promotion was the same concept as health education. The delegate made the point that this could be attributed to many of the questions being interpreted by people who did not use English as their first language, thus creating confusion. Professor Williams appreciated the delegate's comments and said that when the respondents are spoken to again, these issues and interpretations may hopefully be teased out.

Another member of the audience reported on an oral health promotion project, 'Munch & Crunch', that was implemented in schools in Waterford, Ireland. A regional pilot project for healthy lunches is currently in progress also. Eighty-seven school principals were asked if they had a school policy regarding healthy lunches. A diverse range of responses was the result. Fourteen schools were chosen and asked to become 'guinea pigs' for this pilot project. All of the schools in question were visited and information regarding healthy lunches was disseminated. The speaker said that the response was very encouraging. The school principals were taken out to dinner and presented with framed Healthy School Lunch Policy certificates.

Dr McLoughlin asked all the attendees to express their appreciation for the speakers and she then closed the third session of the day's proceedings.

Dr Lois Cohen
Associate Director for International Health
National Institute of Dental and Craniofacial Research
National Institutes of Health, USA

For Dr Lois Cohen this forum provided a rare occasion for a sophisticated international audience to discuss issues of oral health promotion, and also, it provided an opportunity for dialogue and discussion of the highest standard.

Dr Cohen thanked the organisers of the forum and congratulated all of the speakers. She again emphasised a point initially made by Dr Watt who commented that the conference represented a coming-of-age of the field. She then introduced, Dr Kevin Hardwick, International Health Officer at the Office of International Health, who would be assisting her throughout her presentation.

Dr Cohen identified three areas for discussion:

- Challenges: Sharing ideas about some of the greatest challenges in the area of oral health promotion.
- Next Steps and Solutions: Where do we go from here and how can we work together to meet challenges?
- National Institute of Dental and Craniofacial Research (USA): How can it partner with others?

CHALLENGES

Dr Cohen believes the greatest current challenge facing oral health promotion is the integration of oral health into national health programme policies, plans and programmes. Dr Desmond O'Byrne's presentation, 'Mexico 2000 Declaration - The Future Direction for Health Promotion', refered to this challenge as an essential part of the Framework for Country Plans of Action, and in international policies and programmes.

Dr Cohen believes that when integrating oral health into the mainstream of health initiatives, distinct identities must be maintained so that specific risk factors can be examined. Therefore, when looking across categorical disease/health issues, it will become apparent what the common risk factors might be for purposes of planning effective targeted health promotion strategies. Dr Cohen added, "I was glad Sonia Williams said that we need to have specific outcome measures for the purpose of public policy. Knowing when we've attained such measurable objectives will be the greatest challenge." According to Dr Cohen, pressure from the World Health Organisation is forcing this issue to be considered on a global level. Whether the WHO maintains an identifiable identity for oral health in Geneva on its permanent staff is pivotal. Dr Cohen asked could oral health retain its separate identity and still be integrated into a viable and meaningful health promotion strategy across all non-communicable diseases? This question also relates to the issue of whether oral health and other health conditions can be inter-linked. Recent research suggests there might be evidence which links oral health and cardiovascular disease, respiratory illness, diabetes, and perhaps low-birthweight infants. The challenge is how to integrate oral health while remaining strong enough to focus on common risk factors shared with other health conditions.

Another challenge identified by Dr Cohen pertains to closing the gap between the understanding of what health promotion is, and the value of health education as simply one component of a total health promotion strategy. Dr Cohen believes that people appear to be restricted by the traditional notion of health education. This view was reinforced by Professor Sonia William's paper, 'Oral Health Promotion - An Inventory of European Countries'. Dr Cohen said the notion that health promotion should be defined as health education,

has been contested by the Ottawa Charter and other documentation. The 'hard sell' approach, which might generate a deeper understanding of what health promotion really means, is a huge challenge that must be undertaken. Furthermore, the realisation that health is a product of both biological and social determinants and that effective ways to achieve health must come from strategies which target all those determinants at an individual level, at group levels and at institutional/societal levels must be fully understood.

It is imperative that evidence-based interventions are evaluated using the most recent scientific findings. Dr Cohen said that it is troubling that the time taken to carry out research and obtain evidence is so long. Often, by the time the data is collated, it is no longer relevant to the issue at hand.

"As we learn more about the relationship between the mouth and the rest of the body, be it cardiovascular disease, lower birth-rates or diabetes, we need to be able to quickly communicate this evidence to the policy makers to show the relevance to what is happening in contemporary science," said Dr Cohen. The 'Healthy People 2010' initiative in the US is based on the assumption that data accumulated over previous decades is still relevant. While it is laudable that measurable objectives be set and that there is baseline information from which to measure progress, it is difficult to add new objectives in light of more recent scientific findings merely because of the need for retaining past data requirements. Certainly there is a challenge to utilise electronic communications to speed up the accumulation of data, and perhaps rectify the current lag between the state-of-science of measurement tools or even the data points of what should be measured to ascertain disease or health states.

Professor Ruth Freeman's presentation, 'A North/South Initiative - A Programme for Children from Disadvantaged Backgrounds', is, according to Dr Cohen, an excellent example of yet another challenge to ensure that national plans of action bridge equity gaps among groups within and across countries. Equity gaps exist on the grounds of economic, gender, geographic and religious differences. Dr Cohen cautioned the logic of narrowing the equity gap by moving everyone towards the average. "Bringing the 'worst off' people and the 'best off' people to the middle is pretty mean. This is a case where the 'mean' is 'mean'! An explicit attempt of the 'Healthy People 2010' initiative is to take the level of the 'best off' people and bring the 'worst off' people, at the very least, to that level. Additionally, as many decision makers themselves fall into the category of 'best off', we do not want to turn these key change agents off, let alone damage their health," said Dr Cohen.

Finally, Dr Cohen highlighted the challenges of researching, targeting and evaluating the impact of health interventions on specific populations. She commented that specific targeting of groups on the grounds of disadvantage might contribute to a further sense of marginalisation. "The challenge of protecting communities as we work with them to promote health suggests that we need to involve members of those communities in decision-making, informed consent, information disclosure, research conduct, access to data and reporting of the results," said Dr Cohen.

NEXT STEPS AND SOLUTIONS

Dr Cohen suggested that in promoting oral health, science and advocacy must be reconciled and said that experts in the politics of health should advocate health policy that has been informed by science. Informing health policy and advocating it, however, requires different skills. Dr Cohen believes that scientists do not always consider the 'politics of health' - what it takes to implement their decisions. Dr Cohen highlighted the debates surrounding HIV/AIDS and how often the politics overtakes the science, and said the debates about fluorides were comparable. "Here, the politics of health is very important. It might even outweigh what we already know is scientific evidence on water fluoridation; the most commonly argued vehicle for fluoride," said Dr Cohen. Similarly, debates in many countries on the best ways to protect children's oral or general

health, have been fuelled by emotions rather than evidence to support one approach over another. Collaborative teamwork is one step towards reconciling science and advocacy. It ensures that everyone, including politicians and evaluators, work to the same agenda.

The necessity for lay participation in oral health promotion is, according to Dr Cohen, generally accepted but rarely carried out. Traditionally, scientific review groups have tended to criticise lay participation on the grounds that the general public does not have the necessary expertise to review scientific findings. For Dr Cohen, the involvement of the 'effected' should occur throughout the research, implementation and evaluation of initiatives. Her experience with consumer advocacy groups indicates that the general public is surprisingly well informed of health issues. She said that the issue of involving the disadvantaged population groups as participants in the process of research and thus enabling these "targeted" groups to find solutions to their own health concerns, was particularly important.

The reliance on clinical interventions to address behavioural and social determinants of health requires debate. Dr Cohen drew the delegates' attention to the US National Academy of Science's report, 'Promoting Health: Intervention Strategies from Social and Behavioural Research' which was critical of the domination of the clinical approach and argued that political and social influences that implement policy are rarely considered. Dr Cohen highlighted the need for balance, so that biological, gender, environmental, social and behavioural determinants can be examined in a systematic and interactive way. (See the home page of the National Academy Press: www.nap.edu).

Dr Cohen concluded this section of her presentation by advocating the notion of 'transdisciplinary research/activity' - the ability to create something new from an interdisciplinary mix that transcends the mix itself. Transdisciplinary activity involves bringing knowledge and sciences together and merging them with the newest and latest frontiers in genetic, behavioural, social science, epidemiological and health services research.

NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH (NIDCR)

The NIDCR comprises two divisions, extramural and intramural research. The former expends approximately 80% of the institute's budget, which is estimated to be $330 million in the next fiscal year (FY). With a budget of over $268 million dollars in FY 2000, 68% was allocated to research grants, 4% to research training, 4% to research contracts, 18% to intramural research and 6% to administration. Dr Cohen said that similar NIH Institutes spend 2% of their budgets internationally. In FY 1999, the NIDCR spent 2.8% internationally and this figure is expected to increase in the future.

The Office of International Health was established two years ago as a component in the Office of the Director of the NIDCR. Its aim was to globalise the NIDCR's entire research investment by opening its mechanisms of support to others. Dr Cohen noted that some mechanisms are tied to legislation and are only available to US citizens. Where this is not the case, support mechanisms have been offered to scientists working in non-US institutions. Dr Cohen said, "As we convene research workshops, attend research conferences, hear about the products of research and look at the needs of people, we become aware that some questions cannot be answered in the US".

The low incidence of oral gangrene in the US, for example, has forced the NIDCR to liaise with other countries where incidence rates are higher. Similar difficulties have arisen for researchers examining the prevalence of oral cancer. Dr Cohen commented that new advances in molecular biology indicate that oral cancers may differ geographically. "We may be looking at different phenomena in different parts of the world. We need to look at variations in diseases in a global context," said Dr Cohen. Similarly, the low

incidence of cleft lip and palate in the US compared to a high incidence in Brazil and Southeast Asia, has provided a scientific opportunity for international teams to develop, design and carry out pertinent research.

Another international effort cited by Dr Cohen was a research workshop organised by Professor John Clarkson, Trinity College Dublin. While fluoride is variably present in different parts of the US, Dr Cohen explained that variable levels of fluoride may also appear in non-fluoridated areas as a result of foods being consumed that were processed in areas of the country having fluoridated water, or the utilisation of fluoride containing dentifrice and/or fluoride supplements. Comparisons between fluoridated and non-fluoridated areas in the US, therefore, cannot be made with confidence. It is essential that international teams be constituted to re-examine optimum levels of fluoride under various conditions. Other issues warranting international collaborative teams might be developed around questions examining birth defects, micronutrient deficiencies, infectious diseases, head and neck cancers, biodiversity and oral therapeutics, and quality of life and health promotion.

Dr Cohen reported a new mechanism that invites tenders for a two-year International Collaborative Oral Health Research Planning Grant. The two-year time period provides researchers with adequate time to develop a suitable research protocol and establish an international team of researchers. Funding of $75,000 per year is available for each project. The following six projects are currently being funded:

- Oral infections and vascular risk in seven countries.
- International centres against oral cancers.
- Measuring child oral health-related quality of life.
- International consortium for research on Temporo Mandibular Joint (TMJ) disorders.
- Models of health inequalities in childhood dental caries.
- International genetic epidemiology of oral clefts.

The National Institute for Dental and Craniofacial Research has been re-designated by the World Health Organisation and renamed as a 'WHO Collaborating Centre for International Collaboration in Dental and Craniofacial Research'. Its objectives are to support international collaborative research on the etiology, diagnosis, prevention and treatment of oral diseases and conditions and to provide scientific evidence and technical assistance to WHO oral health programmes and other WHO oral health collaborating centres.

It has three primary areas of emphasis:

- Assessment of the interactive roles of behavioural, socio-environmental and biomedical factors in the host susceptibility, prevention, onset, progression, craniofacial diseases and disorders.
- Health promotion and disease prevention to expand adoption of preventive or therapeutic measures, especially for high risk populations, by examining psychosocial, cultural, educational and economic variables affecting diffusion and adoption of new technologies on dental services utilisation, and evaluation of interventions promoting health oriented behaviours.
- Clarification of the relationship between traditional beliefs and practices with components of healthcare systems for the purpose of developing viable oral health promoting strategies.

Dr Cohen concluded her presentation with a brief review of 'Oral Health in America: A Report of the Surgeon General' which was published this year. This 309-page document reports on the actual state of the nation's oral health. Its findings show that while oral health is improving, oral diseases remain common in the US. The report also reveals that the burden of these diseases is spread unevenly throughout the population.

In addition, safe and effective measures, such as fluoride use and tobacco cessation, are underused.

In calling for policy action, the report recommends that:

- The benefits of fluoride should be promoted.
- A national oral health plan should be developed.
- The collection of detailed epidemiological information on the oral health status of diverse segments of the population is recommended.
- Barriers to access should be identified and removed.
- The public and non-dental professionals need to be educated on the links between oral and general health and quality of life.

Chaired by Ms Dora Hennessy

Community Health Division
Department of Health and Children, Ireland

Ms Dora Hennessy invited the speakers of the forum to the platform and asked members of the audience to put any questions to the panel that they may have pertaining to the day's proceedings.

Dr Lois Cohen was questioned about the two-year International Collaborative Oral Health Research Planning Grant that her institute offers. When a protocol has been developed for health research and the relevant nations and disciplines have convened, what happens after the two-year period? Dr Cohen stated that the regular research grant mechanism is one avenue for research programmes. This enables parties to apply for a grant for full-blown research once a protocol has been established.

Dr Cohen pointed out that this research not only introduces the idea of international collaborative research but also international collaborative research funding. In past initiatives, such as those organised by the WHO, the US was responsible for providing some 'start up' funding in addition to financing its own segment of the research, but funding was also available from participating countries. The funding for the WHO International Collaborative Studies of Oral Health Care Systems (ICS-I and ICS-II), for example, was derived from other governments, medical research councils and various other funding organisations. Dr Cohen said that her organisation is looking forward to identifying, approaching and collaborating with funding organisations elsewhere.

One delegate said that she was interested in the issues surrounding industry-sponsored research. She said that she remembered a time when the motive behind government funding of research was also questioned. The delegate asked Dr Cohen to highlight some of the collaborations that she has been involved in, including both industry and non-profit making bodies. The delegate also asked other members of the panel to share their experiences on this point.

Dr Cohen said that industry funding is often viewed in a suspect manner because it is generally believed that industry is only interested in promoting a product. She did acknowledge, however, that much clinical field research, such as vaccine and drug trials, rely almost entirely on industry funding. Dr Cohen reported that collaborative mechanisms, which assist in the management of research, are available and sponsored by industry and non-profit making organisations. In addition, she noted that the government in the US has provided some guidance for collaboratively funded projects to guide ethical conduct of such research.

Dr Cohen explained that the NIDCR website offers a listing and link to other sources of support. "We are trying to disseminate what these other sources are. As we learn more about such sources of research support, we inform the IADR by e-mail and they in turn post this information on their newsletters or their own lists. Some of these other sources are coming from the EU, NATO countries, foundations and private industry," concluded Dr Cohen.

Dr Desmond O'Byrne said that the WHO's new Director General is reaching out to all sections of society, including the private sector. Dr O'Byrne is a member of the committee which drafted provisional guidelines for operations with the private sector. These guidelines have been circulated over the last six months for comment, and will go before the Executive Board in January 2001 when it is anticipated a revised version will be compiled. Dr O'Byrne said, "The big problem is that while the will is there, the idea that we don't have a conflict of interest is absolutely essential. We must define what 'conflict of interest' is. We would be happy to make the provisional guidelines available and get feedback, because it will help all of the sectors to work together, but at the same time, maintain our credibility."

The health promotion conference in Jakarta invited people to speak from the private sector in their private capacities. Quite heated debates ensued among representatives from developing countries who believed that companies from this sector had exploited their countries. Dr O'Byrne recommended caution by those in oral health promotion when collaborating with the private sector.

Dr Gerard Gavin, Chief Dental Officer, Department of Health and Children in Ireland, asked Dr Cohen to outline the areas of research about birth defects in which the NIDCR has sponsored research. Dr Gavin noted that one of the arguments put forward by those opposed to water fluoridation is that fluoride is associated with birth defects. He believes that dental professionals should be well informed about research concerning birth defects. Dr Cohen stated that the research conducted by the NIDCR focuses on birth defects that are present in the general oral, cranial and facial areas. While the NIDCR is not currently examining the relationship between fluoride and birth defects, Dr Cohen stated they would give due consideration to any scientifically meritorious research proposals investigating this area.

One delegate made the point that the director of health promotion is often the Prime Minister and not the Minister for Health. He commented that with regard to health promotion, it is essential that decisions made centrally have a real impact on health. In addition, the delegate was critical of the term 'health promotion' and suggested another term such as 'well being' could be more effective, as 'health promotion' restricts any debate in this area within the health agenda.

With respect to the issue of economic burden influencing politicians, one delegate suggested that it is unwise to collect data on the effectiveness of interventions. Rather, it was suggested that data should be collected on the true cost to the economy if no health promotion interventions were conducted. Another delegate argued, however, that it is essential to establish the evidence base and determine what is effective before the amount of money that can be saved can be evaluated.

Dr Gavin commented that the problem does not lie with a lack of resources for health promotion, but rather with the need to use evidence-based methods and proof that they are effective. Dr Gavin believes that there is a willing agenda, even from a political point of view, to support this kind of work.

In the Amsterdam Treaty within the European Union, Dr Desmond O'Byrne said that every law/statute/directive has to take health consequences into consideration. The new Health Promotion Strategy within Ireland has introduced 'health proofing', which is a similar concept.

According to Dr Richard Watt, health promotion was a local government issue historically and the answer to the delegate's question lies with whether or not public health and health promotion should be moved back to local government level.

One delegate said that 'sanitation' was not touched on by any of the speakers. He said that although oral hygiene is the issue, physicians and dentists tend not to discuss sanitation. The delegate added, "I know it's a dirty subject, but when you are talking about efforts to help the 'really' deprived in 'really' deprived countries, sanitation is of great importance."

The last delegate to speak stated that concern had been expressed throughout the day regarding the visibility of the oral health programme within the WHO headquarters in Geneva. The delegate urged other delegates to support a letter to the Director General at the WHO requesting the continuation of the oral health programme. A draft of the letter was read to delegates and was unanimously approved.

The chairperson then brought the discussion to a close by thanking Ms Deirdre Sadlier and her colleagues at the Dental Health Foundation and all those at University College Cork, who made the forum possible.

ACKNOWLEDGEMENTS

We would like to express our gratitude to the Department of Health and Children for providing the support, which made this forum possible.

Our appreciation is extended to the chairpersons and speakers of each session, for their important and enlightening contributions on a variety of issues relevant to oral health promotion into the 21st century, and for their participation in what was a lively and interesting day.

We would like to acknowledge the delegates who played a central role in ensuring the success of the programme.

We would like to acknowledge the staff and students of the University College Cork for the welcome and cooperation enjoyed in the planning of this forum.

We would like to acknowledge the valuable contribution in formulation of the programme made by Professor John Clarkson, Dean, School of Dental Science, University of Dublin, Trinity College.

We are indebted to Ms Christine Linehan, for her work as science writer on this report and Ms Breeda Hyland, Projects Manager Dental Health Foundation for her involvement in the planning and implementation of the event and the collation of this report.

Finally we would like to pay tribute to Ms Patricia Gilsenan, Dental Health Foundation and Ms Eileen McSweeney, WHO Collaborating Centre for Oral Health Services Research, University College Cork, for their assistance in organising this forum.

Ms Deirdre Sadlier
Executive Director Dental Health Foundation

Dr Helen Whelton
WHO Collaborating Centre for Oral Health Services Research, University College Cork

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Prof.	Ynci	Oktay	Istanbul University	Turkey
Prof.	Gulcin	Saydam	Istanbul University	Turkey
Mrs	Margaret	Woodward	Borrow Dental Milk Foundation	U.K.
Mrs	Deborah	Herbst	Dewsbury Health Care NHS Trust	U.K.
Dr	Peter	Robinson	Kings College Hospital	U.K.
Mr	Christopher	Leopold	Cornwall & Isles of Scilly Health Authority	U.K.
Prof.	Stanley	Gelbier	King's College London	U.K.
Ms	Julia	Csikar	University of Leeds	U.K.
Prof.	Anthony	Blinkhorn	Manchester University	U.K.
Mr	Robert	Anderson	University of Wales	U.K.
Dr	Sara	Roberts	Cornwall & Isles of Scilly Health Authority	U.K.
Ms	Sabrina	Fuller	Tameside & Glossop NHS Trust	U.K.
Mrs	Jenny	Godson	Bradford Community NHS Trust	U.K.
Dr	Michael	Prendergast	Shropshire Health Authority	U.K.
Dr	Pat	Ludiman	Northallerton NHS Trust	U.K.

TITLE	FIRST NAME	SURNAME	INSTITUTION/COMPANY	COUNTRY
Prof.	Raman	Bedi	Eastman Dental Institute	U.K.
Mr	Alan	Yardley	Plymouth Community Services	U.K.
Ms	Annalise	McNair	Cornwall Healthcare Trust	U.K.
Dr	Nigel	Carter	British Dental Health Foundation	U.K.
Mr	John	McMichael	Worchestershire Health Authority	U.K.
Ms	Elizabeth	Liptrot	Wilts & Swindon NHS Trust	U.K.
Mr	Stuart	Boulton	Coventry Health Authority	U.K.
Mr	Kenneth	Eaton	University College London	U.K.
Dr	Brian	Mouatt	Commonwealth Dental Association	U.K.
Mrs	Jennifer	Gallagher	Kings College London	U.K.
Prof.	Ruth	Holt	Eastman Dental Institute, London	U.K.
Prof.	Sonia	Williams	Leeds University	U.K.
Mrs	Sue	Greening	Gwent Health NHS Trust	U.K.
Mrs	Auriol	Miller	Bedfordshire & Luton Community NHS Trust	U.K.
Dr	Paul	Helliwell	South Tyneside H.C. Trust	U.K.
Ms	Marilyn	Clements	Oxford Community Health Trust	U.K.
Ms	June	Nunn	University of Newcastle	U.K.
Dr	Richard	Watt	University College London	U.K.
Dr	Aideen	McQuistin	James Paget Healthcare NHS Trust	U.K.
Prof.	Philip	Holloway	Manchester University	U.K.
Mr	Peter	Bainton	Northampton Community Healthcare Trust	U.K.
Mrs	Olive	Bainton	Northampton Community Healthcare NHS Trust	U.K.
Mr	David	Landes	County Durham Health Authority	U.K.
Ms	Siobhan	Grant	Newcastle & N. Tynesdside Health Authority	U.K.
Dr	Ruth	Nowjack-Raymer	National Institute of Dental & Craniofacial Research	U.S.A.
Dr	Dushanka	Kleinman	National Institute of Dental Research, National Institutes of Health	U.S.A.
Dr	Lois	Cohen	National Institute of Dental & Craniofacial Research	U.S.A.
Dr	David E	Barmes	NIH, NIDCR	U.S.A.
Dr	Kevin	Hardwick	NIH, NIDCR	U.S.A.
Prof.	Elizabeth	Treasure	University of Wales, College of Medicine	Wales
Dr	Paul	Langmaid	National Assembly for Wales	Wales
Mr	Hugh	Bennett	National Assembly for Wales	Wales
Mrs	Gill	Jones	Gwent Health Authority	Wales

DEPARTMENT OF HEALTH & CHILDREN

Ireland's Department of Health & Children has overall responsibility for the development of health policy and for the planning of health services.

The mission of the Department of Health and Children is:

"In a partnership with the providers of healthcare, and in cooperation with other government departments, statutory and non-statutory bodies, to protect, promote and restore the health and well-being of people by ensuring that health and personal social services are planned, managed and delivered to achieve measurable health and social gain and provide the optimum return on resources invested."

OBJECTIVES

The key objectives of the Department of Health and Children are:

- To support the Minister in the formulation, development and evaluation of health policy and in the discharge of all other Ministerial functions;
- To plan the strategic development of services, through partnership and consultation with health boards, the voluntary sector, other relevant government departments and other interests;
- To encourage the attainment of the highest standards of effectiveness, efficiency, equity, quality and value for money in the health delivery system;
- To strengthen accountability at all levels of the health service;
- To encourage the continuing development of a customer service ethos in the delivery of health services;
- To optimise staff performance, training and development;
- To represent the Irish interest in EU, WHO and international fora relating to health matters.

Department of Health and Children website: http://www.doh.ie

UNIVERSITY COLLEGE CORK

Oral Health Services Research Centre
University Dental School, Cork

The Oral Health Services Research Centre is an independent research facility attached to the University Dental School and Hospital, Cork, Ireland. It was established in 1983 for the purpose of conducts of Oral Health Services Research projects.

The Centre conducts national and regional surveys of oral health and provides an epidemiological service for the planning and evaluation of oral healthcare systems.

The Centre has a strong academic base and runs basic research projects through its Masters and PhD postgraduate programmes, including a Masters in Dental Public Health and EU funded projects under the various Framework programmes.

Included in the Centre is a purpose designed clinical trial facility and laboratory.

Professor Denis O'Mullane BDS PhD FDS FFD is Director of the Oral Health Services Research Centre at University College Cork and is Head of the Department of Preventive and Paediatric Dentistry. Dr Helen Whelton BDS PhD MDPH, the Deputy Director of the Centre, has extensive experience in the field of clinical trials and Oral Health Services Research and is a member of a number of national and international research organisations.

University College Cork website: http://www.ucc.ie/dru/

THE DENTAL HEALTH FOUNDATION

The Dental Health Foundation was established 21 years ago as a charitable trust dedicated to raising the profile of oral health in Ireland. Its establishment was initiated by the dental profession with the agreement and support of the Department of Health.

The Foundation plays an important role in facilitating and supporting the promotion of oral health in line with the Department of Health and Children's Dental Health Action Plan. It works closely with the Department's Health Promotion Unit, providing a focus for oral health within the wider context of health promotion in Ireland. It also provides a complementary role to public health bodies on a national basis.

MISSION

"The Mission of the Dental Health Foundation is to promote oral health in Ireland, by providing effective resources or interventions and by influencing policy, through a multi-sectoral, partnership approach."

The mission will become a reality through:

- Taking an inclusive approach that caters for the needs of minority groups, without exception.
- Using the Foundation's independence from vested interests by providing resources and advocating policies for the sole objective of effective oral health promotion.
- Investing resources in initiatives that are based on sound scientific research.
- Taking a broad multi-sectoral approach to raise awareness of oral health.

Dental Health Foundation website: http://www.dentalhealth.ie

ORAL HEALTH PROMOTION FORUM – THE 21ST CENTURY WILL BE DIFFERENT

PROGRAMME

8:30am Registration

9.00am Welcome Conference
Professor Denis O'Mullane, Chairperson, Joint BASCD/EADPH

SESSION 1

Chairperson: Mr Chris Fitzgerald, Department of Health and Children, Ireland

9.10am **New Challenges for a New Era**
Dr Gerard Gavin, Chief Dental Officer, Department of Health & Children, Ireland.

9.30am **Mexico 2000 Declaration - The Future Direction for Health Promotion**
Dr Desmond O'Byrne, Senior Advisor, Health Promotion, NCD Prevention and Surveillance (HPS), World Health Organisation

10.00am **Considerations & Policy Issues for Oral Health Promotion**
Professor Cecily Kelleher, Centre for Health Promotion Studies National University of Ireland, Galway.

10.30am Questions

11.00am Coffee break

SESSION 2

Chairperson: Dr Helen Whelton, University College Cork

11.30am **Sociological Critiques of Health Promotion: Their Relevance for Oral Health Promotion**
Ms Orla O'Donovan, Department of Applied Social Studies, University College Cork

12.00pm **Evidence-based Oral Health Promotion - Its Application to Our Programmes**
Dr Richard Watt, Senior Lecturer, Department of Epidemiology and Public Health, University College London Medical School, UK.

12.30pm Questions

1.00pm Lunch

SESSION 3

Chairperson: Professor John Clarkson, School of Dental Science, Trinity College, Dublin

2.00pm **Oral Health Promotion - An Inventory of European Countries (results of a baseline survey)**
Professor Sonia Williams, WHO Collaborating Centre for Research on Oral Health and Migration, University of Leeds, UK

2.30pm **The Benefits of Informal Networking**
Ms Cathy Stillman Lowe, Public Health Advisor - Oral Health, Health Development Agency, UK

2.45pm **A North/South Initiative - A Programme for Children From Disadvantaged Backgrounds in Ireland**
Dr Ruth Freeman, Senior Lecturer in Dental Public Health, Queen's University, Belfast - a partnership project

Dental Health Foundation, Southern and Northern Ireland Health Boards, Queens University, Belfast, the WHO Oral Health Services Research Centre, Cork Ireland and Health Promotion Unit, Department of Health and Children, Ireland

3.15pm Questions

3.30pm Coffee

SESSION 4

Chairperson: Ms Dora Hennessy, Department of Health and Children, Ireland

4.00pm **Going Forward - Reflections on the Day's Proceedings**
Dr Lois Cohen, Associate Director for International Health, National Institute of Dental and Craniofacial Research, National Institutes of Health, USA

Followed by Discussion

5.00pm CLOSE

Ms Deirdre Sadlier, Executive Director, Dental Health Foundation, Ireland

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