



Making prevention a priority

Advocacy Toolkit



LEADING THE WORLD TO OPTIMAL ORAL HEALTH





PART 1

Executive briefing

The international community has recognized oral health as a basic human right. Yet, in many countries this awareness has so far failed to be translated into programmes and actions.

This Advocacy Toolkit assists national dental associations (NDAs) in shaping initiatives focused on policy implementation for the prevention and management of dental caries, also referred to as tooth decay.

Elevating oral health on political agendas

Although oral health is recognized as an integral component of the right to health, it has long failed to be prioritized on the health agendas of governments and international organizations – perhaps because poor oral health affects morbidity rather than mortality. However, the notion of health has changed overtime, moving from a focus on mere survival towards notions of holistic health and well-being, i.e. the focus today is not anymore on *how long*, but on *how we live*. Newer models of health do not focus only on pain and symptoms, but also on physical functioning and emotional and social well-being. They resonate with the fact that we now live longer, often affected by one or more chronic conditions, meaning that quality of life becomes just as important as disease status.

In this perspective, oral health has now been endorsed as an important contributor to overall health. Oral disease shares many common risk factors and determinants with other noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, chronic respiratory diseases and diabetes.

FDI is committed to building on the momentum gained at the United Nations (UN) High-Level Meeting on NCDs in 2011, where it successfully advocated for oral disease to be recognized as a major health burden

for many countries. By ensuring its inclusion alongside other major NCDs in the Political Declaration, which was issued as an outcome of this meeting, this recognition offers a real opportunity for oral health to be elevated on global health agendas.

The Political Declaration states: “We [...] recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to NCDs”.

The prominent role of caries in oral health

Dental caries is the most prevalent NCD and continues to be a major public health issue worldwide. As is the case for other major NCDs, dental caries is largely preventable through cost-effective public health and individual-level measures. Thus, understanding the aetiology, pathogenesis and distribution of caries is a prerequisite to correctly assessing the disease risk factors, timely diagnosis and classifying its severity, as well as addressing the common causes of NCDs and designing appropriate evidence-based interventions.

Dental caries is a complex disease process and needs to be managed accordingly. Historically, the focus has only been on biological and dietary influences (sugar, processed foods high in carbohydrates). However, evidence shows that in addition to these key factors, wider social, economic and environmental factors also influence the disease. The impact is cumulative and affects all age groups; therefore, a life-course approach to caries prevention and management is crucial.



Providing a multilevel framework of intervention

The multifactorial nature of caries calls for a multilevel framework of intervention, to include:

- ▶ Broad-based efforts to address socioeconomic determinants
- ▶ Public health measures that shape the context of health (such as water fluoridation programmes, tobacco bans)
- ▶ Protective interventions that have long-term benefits (such as the use of sealants)
- ▶ Direct dental care
- ▶ Individual counselling and education

For oral health advocacy, this means that action must be taken on several levels. First, on an individual level, initiatives must target patients and the community specifically, to address issues of oral health literacy (e.g. dietary behaviours, oral hygiene) and of person-centred holistic care (e.g. direct dental care). In parallel, wider policy measures are needed to support adequate caries prevention and management (e.g. food policies, remuneration models, educational reforms). In turn, building partnerships and carrying out communications and advocacy activities are essential instruments towards acceptance and successful implementation of such measures.

Translating objectives into actions

Advocacy is a means by which to achieve policy change. This Advocacy Toolkit presents a range of goals and objectives which support the overall aim of the FDI-Colgate Caries Prevention Partnership (CPP), namely

to reduce the burden of caries by shifting the focus from a restorative to a preventive approach. Depending on local settings, resources and priorities, your advocacy campaign might focus on one or several goals and objectives. Delineating the exact scope of the advocacy campaign is therefore a first essential step in ensuring it succeeds. Once this is done, objectives must be translated into a set of actions, such as convening a meeting, seeking an appointment with local authorities or high-level officials, starting a mass media campaign or a staging a public event. To support these actions, different types of advocacy materials can be prepared, such as fact sheets, leaflets, press releases, blog posts, tweets and so on.

WORLD ORAL HEALTH DAY 2016 INFORMATION EVENT
IN LOCAL SCHOOLS ORGANIZED BY ASSOCIAZIONE
ITALIANA STORIA ORALE (AISO) IN ITALY



Key messages

FDI offers three key messages for NDAs to communicate in their high-level discussions with national policymakers.

1. **Dental caries is the most prevalent noncommunicable disease (NCDs) worldwide.** The current scientific understanding of the disease underscores its dietary-sugars dependent, progressive and behavioural nature. At the same time, it acknowledges socioeconomic and political factors, resulting in variations in disease levels. Consequently, the current conceptual frameworks and practice of caries management need to address the major shifts from invasive-only interventions to prevention, from treatment to management and control of the disease, and to define the evolving role of the oral health professional to accommodate these changes.
2. **The oral health profession is committed to contributing its longstanding expertise in prevention to the fight against NCDs,** given the shared risk factors with oral disease. Thus, the oral health profession needs to be recognized and included as a full partner in the development of national NCD action plans that use the common risk factor approach.
3. **A combination of preventive population-based and individual approaches are key to reducing the burden of caries.** This requires buy-in of multiple constituencies, including patients and the community, policymakers, other health professions, as well as product manufacturers.

An opportunity for the oral health profession

The association between prevention of caries and other major NCDs represents an opportunity to increase visibility for the oral health profession at the highest levels of government. By contributing invaluable preventive skills to tackle the major contemporary public health challenge of NCDs, it will help further enhance the credibility of the profession. Whilst fostering the profession's greater integration into the overall health system and maintaining oral health on national and global health agendas.



VIEW OF THE TECHNICAL BRIEFING ON "GETTING TO 2018: PREPARING FOR THE THIRD UN HIGH-LEVEL MEETING ON NONCOMMUNICABLE DISEASES" AT THE SIXTY-EIGHTH WORLD HEALTH ASSEMBLY

An opportunity for national governments

NDAAs can offer their expertise to ministers and officials, notably in the field of prevention, also referred to as "the cornerstone of the response" to NCDs in the UN Political Declaration. This will help frame policy interventions that will positively influence oral health and overall population health outcomes, whilst bearing the potential to decrease direct and indirect oral healthcare costs.



PART 2

Situation analysis: the global burden of caries

Aetiology and pathogenesis

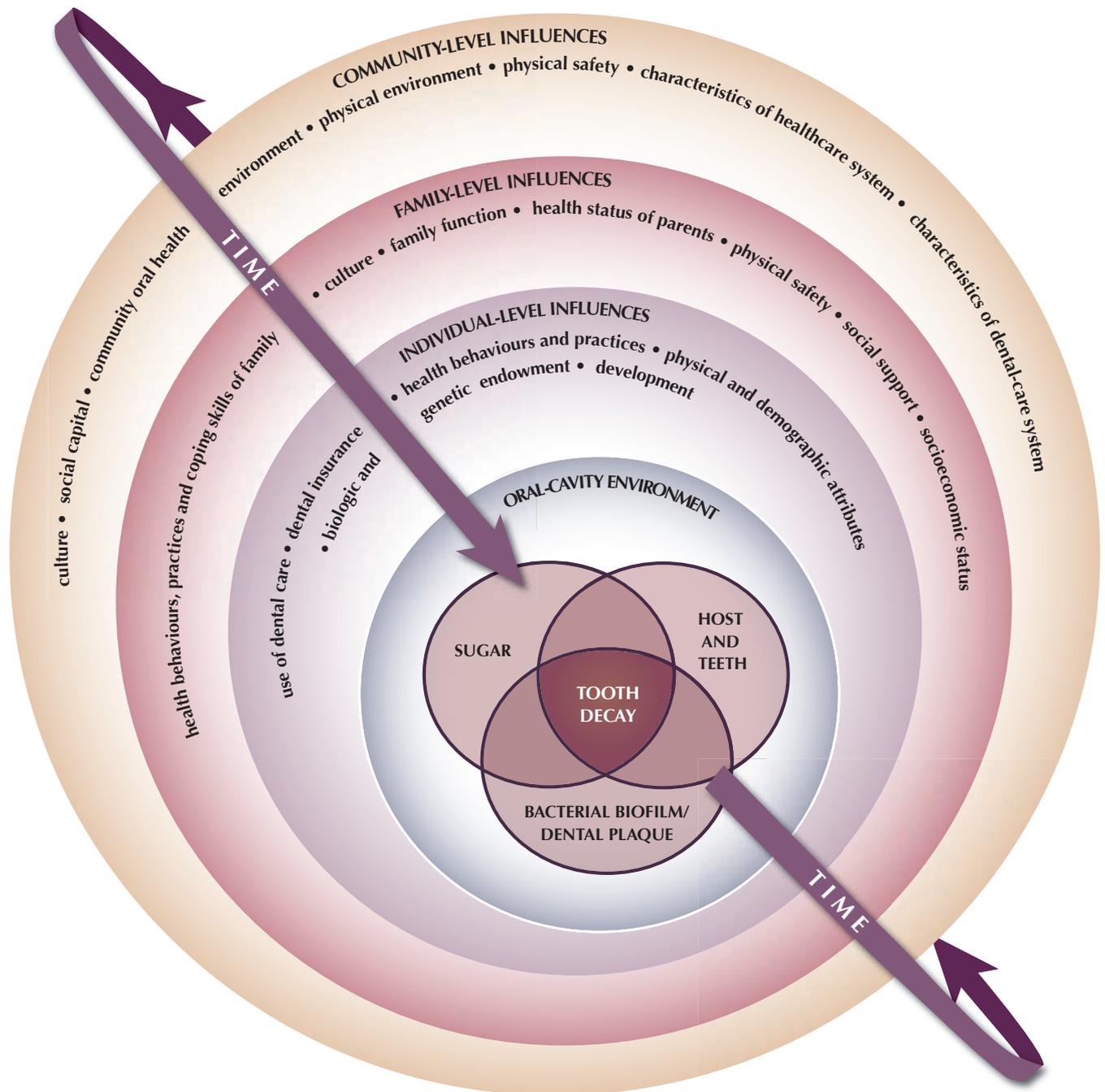
Dental caries (tooth decay) is a multifactorial disease. It is caused by the interaction between the surface of the tooth and the dental biofilm (also called dental plaque) in the presence of dietary sugars. Biofilm microorganisms metabolize sugars and produce acids, which over time break down tooth enamel¹. In their early stages, caries can be halted and even reversed, but in later stages, a cavity forms. Treatment then becomes necessary to restore tooth function, as if left untreated, the disease can lead to extensive destruction of the tooth, pain and infection¹.

Most of the factors which lead to dental caries are modifiable and can be acted upon at both individual and community levels. For example, a change in dietary habits and a reduction in the amount and frequency of sugars consumed leads to a reduction in acid attacks on the tooth enamel; adequate exposure to fluoride helps protect the tooth surface and repair the damage; and good oral hygiene exerts positive action on the microbial biofilm. In addition, external factors such as living circumstances, access to water and sanitation, and access to care will also affect the possible development of caries¹.

Epidemiology

Despite the fact that it is largely preventable, dental caries is the most common NCD worldwide. Current data from the Global Burden of Disease Study² show that untreated caries affects approximately 45% of the world's population, which is more than double the frequency of other common NCDs such as tension-type headaches (21%), severe periodontitis (11%) or diabetes (8%)².

Figure 1 Tooth decay is a multifactorial disease. Tooth decay develops over time and is triggered by acid production resulting from the breakdown of sugars. However, a wide range of other factors influence the development of tooth decay and its severity. These factors act over time at the level of the community, the family and the affected individual.



Reflecting a strong socioeconomic gradient, individuals from lower socioeconomic and minority groups are more often affected.

As a rule, caries is measured and reported on through the DMFT index used at the caries into dentine level. This index records the number of decayed (D), missing (M) and filled (F) teeth (T). However, caries classification systems are not universal, and caries detection thresholds are set at different levels depending on the country and setting, resulting in great difficulty in assessing and comparing prevalence data.

Adopting a Common Risk-Factor Approach

Oral diseases, including tooth decay, share a wide range of risk factors among them. Some, such as age and genetics, are intrinsic to the individual, and can therefore not be changed. Other risk factors are considered modifiable because individual action on a specific behaviour is possible. These factors are often related to lifestyle and include an unhealthy diet, particularly one rich in sugars, overuse of alcohol and tobacco use.

In addition to individual behaviours and lifestyle risk factors, a range of external factors on which individuals have only marginal influence also play a role in caries. These determinants include low education, limited access to safe water and sanitary facilities, poor living conditions, unemployment and limited access to oral healthcare.

These major risk factors are also shared with all other major NCDs such as cardiovascular disease, chronic respiratory disease, cancer and diabetes. The Common Risk Factor Approach (CRFA) therefore provides the basis for the inclusion of oral diseases in NCD prevention and control programmes.

In reality, changing behaviours to adopt a healthier lifestyle can be difficult without additional supportive interventions. Therefore, policy approaches which focus only on changing individual behaviour often have limited effectiveness. Tackling risk factors should therefore always consider the broader determinants of risk behaviour.

Evolution of caries treatment approaches

Historically, dentistry has always applied *curative* rather than *preventive* approaches. However, with regards to caries there has been a gradual shift from an extractive phase to a restorative phase and now to a preventive phase. Today, oral health professionals are asked to adopt a modern approach to caries management. FDI's 2012 policy statement on the 'Classification of Caries Lesions and Tooth Surfaces and Caries Management Systems' acknowledges that "the disease process can be treated and reversed in its earliest stages; early recognition and arrest or reversal is therefore highly desirable and possible in most cases, without restoration ('surgical treatment') of the tooth". As a result, FDI recognizes the need for minimal intervention approaches to caries management. This involves detecting and assessing caries lesions at an earlier stage, determining the patient's caries risk status, applying intervention strategies focused on preventing, arresting, and possibly reversing the carious process, and delaying restorative treatment until absolutely necessary³. Caries risk assessment along with early caries detection is the foundation of modern patient-centred personalized caries management.

Forming a caries prevention initiative

The FDI-Colgate Caries Prevention Partnership (CPP) was formed in 2015. This initiative was launched to enhance oral disease prevention through information, education, advocacy and other activities. The CPP targets oral health professionals, decision makers, patients and the general public. Such a broad partnership is deemed essential in shifting the focus of oral health professionals from surgical management towards prevention in order to alleviate the burden of caries. This Advocacy Toolkit complements other materials developed within the partnership framework: a White Paper on Dental Caries Prevention and Management, a Smile Award, a series of online webinars and a dedicated website.

Advocacy objectives and framework of interventions

Framework of intervention

Moving towards a more preventive approach to caries management is a multifaceted undertaking, as described in *Figure 1*. Box 1 shows the involvement of a wide range of stakeholders whose buy-in is needed to initiate change. Box 2 describes the change needed in different areas, such as education, practice and policy. Such change can only be achieved if it is supported by relevant stakeholders (box 1). Box 3 outlines a range of tools which are available to support your advocacy initiatives. These might differ depending on your change target (box 2) and on the involved stakeholders (box 1). Finally, box 4 outlines desirable outcomes of the present CPP.

Figure 1 The Caries Prevention Partnership is a multi-faceted approach to contemporary caries prevention and management



A focus on prevention

- ▶ **Primary prevention** aims at impeding caries before it occurs. It is most effective when exposure to disease causes is controlled, by modifying unhealthy behaviours and increasing resistance to the disease.
- ▶ **Secondary prevention** occurs in the early stages of caries and aims to reduce its impact as early as possible. It is done through early detection and prompt care in order to halt, slow or reverse caries progression. This is further achieved by encouraging personal strategies to prevent deterioration or recurrence of caries, as well as taking measures to restore people's original health and function, while continuing to prevent new lesions.
- ▶ **Tertiary prevention** occurs in later stages of caries and aims to soften its impact. It is done by helping individuals cope with, as well as manage, their caries status to improve or sustain their ability to function and their quality of life, while continuing to prevent new lesions.

At all levels, prevention is a shared responsibility of individuals, dental professionals and the community at large. This is particularly true for primary caries prevention. Since caries is largely preventable, the earlier the prevention is done (i.e. the further away from a carious lesion), the more likely it is that the intervention will be effective. *Table 1* illustrates the different responsibilities that individuals, oral health professionals and the community share in primary, secondary and tertiary prevention. However, the subsequent part of this toolkit focuses on possible actions that can be undertaken in terms of policy-making, not in terms of individual behaviours or professional practice.

Table 1

	Primary prevention	Secondary prevention	Tertiary prevention
Individuals	<ul style="list-style-type: none"> ▶ Adequate oral hygiene ▶ Use of fluoride toothpaste ▶ Limit consumption of free sugars ▶ Regular preventive dental check-ups 		<ul style="list-style-type: none"> ▶ Regular use of preventively oriented oral health services
Oral health professionals	<ul style="list-style-type: none"> ▶ Patient education ▶ Plaque control ▶ Diet counselling ▶ Topical application of fluoride ▶ Pit and fissure sealants 	<ul style="list-style-type: none"> ▶ Thorough examination detecting the early stages of caries ▶ Pit and fissure sealants ▶ Topical application of fluoride 	<ul style="list-style-type: none"> ▶ Prompt treatment of progressing lesions ▶ Minimum invasive treatment of lesions ▶ Continuing prevention for other sites
Community	<ul style="list-style-type: none"> ▶ Oral health education programmes ▶ Community water fluoridation ▶ School fluoride tooth brushing or mouth rinse programme 	<ul style="list-style-type: none"> ▶ Periodic screening (ex: school screening) ▶ School sealant programme ▶ School fluoride varnish applications 	<ul style="list-style-type: none"> ▶ Provision of preventively oriented oral health services

Advocacy objectives

The section below offers a range of relevant advocacy goals and objectives to achieve the overall aim of reducing the burden of caries. Their main focus is on primary prevention. These are meant to help you shape your own advocacy programme. Depending on local circumstances, only selected suggested objectives and measures might apply.

Policy measures

Fluoride

The use of fluorides to prevent tooth decay is safe, efficient and highly cost-effective. Access to fluorides has been recognized as a part of the basic human right to health. Universal access to fluorides bears the potential for reducing inequalities in the burden of caries. Increased efforts are needed to promote access and use of appropriate fluorides, in particular fluoride toothpaste, to achieve universal access. Advocacy goals and objectives include a range of measures, such as:



- ▶ **Application of the most appropriate delivery method of fluorides** depending on local context and resources (water, salt or milk fluoridation, fluoride toothpaste)
- ▶ **Implementation of extensive monitoring and evaluation of population-wide fluoridation interventions** to strengthen the evidence-base for effective programme planning
- ▶ **Exemption of fluoride products – mainly fluoride toothpaste – from taxation** so as to increase affordability; conversely, taxation of oral health products without fluoride is increased to discourage the use of such products
- ▶ **Reinforcement of national food and drug administration's** capacity to better monitor toothpaste quality
- ▶ **Enforcement of ISO 11609 regulations**, which defines the minimum standards for toothpaste quality and labelling

A detailed assessment of the use of fluoride products (in clinical practice and by individuals) is provided in Section 6 of the CPP White Paper on Dental Caries Prevention and Management.

Food policies

The main dietary advice in caries prevention is to reduce the amount and frequency of sugar consumption. The latest guidelines on sugar intake from the World Health Organization (WHO) contain a strong recommendation to limit the intake of free sugars below 10% of total energy, for both adults and children, and a conditional recommendation for a further reduction to below 5% of total energy. In

addition to educating the population to adopt healthy dietary behaviours, public policies aiming to reduce sugar consumption have a high potential in preventing caries and promoting better oral health. Such policy measures also address other major NCDs, such as diabetes, cardiovascular diseases and cancers. Advocacy objectives include a range of structural measures, such as:



- ▶ **Introduction of higher taxation of sugar-rich foods and sugar-sweetened beverages** (sometimes referred to as *sugar tax*)
- ▶ **Enforcement of transparent food labelling systems** to foster informed consumer choices
- ▶ **Limited marketing and availability of sugar-rich foods and sugar-sweetened beverages** to children, adolescents and other vulnerable populations
- ▶ **Implementation of strict regulations governing sugar levels** in baby foods and sugar-sweetened beverages

Professional practice

As previously outlined, treatment of caries has evolved over time, with a need for oral health professionals to move away from a traditional *drill and fill* mentality and provide a preventive approach. Nevertheless, caries can still develop, so adequate caries management and treatment remains important. In such instances, oral health professionals should focus on early detection and prompt treatment, and rely on minimal intervention approaches as much as possible. Advocacy objectives include a range of measures, such as:

- ▶ Pit and fissure sealants are routinely used in clinical practice
- ▶ Approaches favouring early detection, prompt non-invasive treatment and minimum invasive interventions are remunerated in an equitable fashion so as to avoid perverse incentives
- ▶ Oral health professionals and their teams are adequately trained, skilled and equipped to deliver such treatments

More in-depth information on state-of-the-art dental caries prevention and management strategies is provided in the CPP White Paper on Dental Caries Prevention and Management.

Education

Professional education

There is a pressing need to educate oral health professionals, but also to reach out to other health professions (e.g. inter-professional education), to ensure that oral health practice reflects the latest advances of science. While improving oral health is a major population health goal, curricula in some dental schools address tooth decay in an outmoded way – with oral health being almost absent from most curricula in the health sciences (medical schools, nursing schools, etc.). Educational reform should encompass undergraduate, postgraduate and continuing education. Advocacy goals and objectives include a range of measures, such as:

- ▶ **Review of curricula** for dental schools, undergraduate and graduate programmes, to account for new advances in science, particularly with regard to caries prevention and management approaches
- ▶ **Inter-professional education** available in undergraduate and graduate schools to shape a collaborative-practice ready workforce
- ▶ **Basic oral healthcare packages** (including caries prevention) introduced in undergraduate curricula for all the health sciences (medical school, nursing school, etc.)
- ▶ **Continuing dental education** activities have a particular emphasis on up-to-date knowledge and practice regarding preventive measures

Patient education (oral health literacy)

Prevention on the individual level still remains a problem and burden for many, where aggressive caries challenges can overwhelm normal fluoride regimens. Therefore, successful primary prevention also relies on collective and individual prevention through appropriate home behaviour and care, i.e. good oral health hygiene through usage of appropriate toothbrush and fluoride toothpaste, knowledge of brushing techniques and frequency, as well as control of sugar intake. Advocacy goals and objectives can include a range of measures, such as availability of oral health education programmes and targeting vulnerable groups, including:

- ▶ Schoolchildren
- ▶ Minority groups
- ▶ Mothers (whose dietary preferences play an important role in shaping their children's dietary habits, mainly in relation to sweets and snacking)
- ▶ Elderly, frail and non self-sufficient individuals

Remuneration

The economic dimension of addressing caries is essential. As stated elsewhere, cost-benefit analyses always play an important role when deciding upon the implementation of a policy. With regard to caries, prevention is not only better than cure, it is also cheaper: a study in the US for example showed that for every dollar spent on salt fluoridation, US\$250 were saved in future dental treatment costs¹. In addition, the indirect cost of caries, in terms of lost productivity, particularly in settings where access to care is an issue, is often ignored. Advocacy goals and objectives include a range of measures, such as:

- ▶ **Implementation of outcome-based remuneration models** ensuring that time spent by oral health professionals on prevention and education activities is fully accounted for and perverse incentives avoided
- ▶ **Regular preventive check-ups** targeting specifically the more vulnerable populations (e.g. in schools for children, elderly care-homes, refugee centres, etc.) are implemented
- ▶ **Basic healthcare coverage packages** including regular preventive check-ups



PART 4

Translating advocacy objectives into actions

Be it at an international, regional, national or local level, quite often policies are available but sit on a shelf due to a lack of:

- ▶ Awareness from those in charge of implementing them
- ▶ Prioritization
- ▶ Financial means

Advocacy, which is the process of building support for an issue or cause and influencing others to take action, is a means to achieve policy change⁴. Implementing an advocacy strategy must be considered as a means to:

- ▶ Ensure that key decision makers know about existing policies and are informed of their responsibility to implement them
- ▶ Foster the development of new policies which support your aims
- ▶ Help secure financial resources to deliver relevant programmes and services
- ▶ Foster prioritization of specific approaches, programmes or services
- ▶ Generate support among community members to create demand for the implementation of government policies⁴

In order to achieve results, an advocacy campaign must be carefully planned and prepared. It usually starts with background work (collecting information, facts and figures, analyzing the situation, identifying your target audiences), followed by the elaboration of clear goals and objectives for relevant activities and materials to be developed. Only then is the campaign ready to be rolled out.

Getting your facts right

In order to meet your advocacy objectives, you need to ensure that you build a solid case, generate sufficient support, and reach the right people (i.e. influential). The policymakers you will contact or meet are usually not oral health experts. They are very busy people, who must oversee different priorities and requests. When prioritizing actions and programmes, potential return on investment will always weigh heavily on their final decisions. Therefore, you need to make sure that you are able to bring convincing facts and evidence to support your argument. Data-driven requests will help build your case and convince policymakers. Therefore, prior to convening a meeting, or holding a press or a public event, it is advised to carefully compile any relevant data available to support your argument/request (see examples in Table 2).

Table 2

	Examples of useful data
Data related to disease status	Traditional DMFT data or data relating to both enamel and dentine caries; aggregated for your own country or a specific target group (e.g. children, disadvantaged groups, etc.) possibly compared with global data; missed work or school days.
Data related to psychosocial function	Oral health-related quality of life data, such as satisfaction with physical appearance, feelings of shame in social interactions, etc.
Driving determinants	<ul style="list-style-type: none"> • workforce statistics • fluoridation programmes • sugar consumption • financing mechanisms for oral healthcare

Look into any solid data available, existing programmes which might have been evaluated, or any robust study published and use the most striking elements to argue your case. As a rule, relying on existing data when available is more powerful than trying to create your own data.

Identifying and analyzing government policies and commitments

Reviewing existing government policies constitutes an essential step in understanding the government's position on the issue at hand. A range of diverse national policies, strategies, guidelines, parliamentary acts, laws and regulations might be available, which can potentially affect dental caries and its prevention and management. Table 3 outlines a few examples, which might differ depending on your country and setting.

Table 3

Type of policy	Decision-making bodies
National health strategy	Ministry of Health
National oral health strategy	Ministry of Health
Water fluoridation programme	Local government
Sugar consumption guidelines	Ministry of Health, scientific societies (dental associations, diabetes associations etc.)
Regulation on availability of sugary foods in schools	Local or national government
School oral health education programme	Ministry of Education
Reimbursement schemes for regular dental check-ups – or preventive care	Ministry of Health
Tax on fluoride products	Ministry of Trade
Tax on sweetened beverages	Ministry of Trade

Formulating goals and objectives

Goals are outlined in a broad statement which describes some general outcomes of the advocacy campaign.

Objectives are more specific and describe concrete results or outcomes to be achieved over a certain period of time. Setting “SMART” objectives is usually recommended, whereby:

Specific

Measurable

Achievable

Realistic

Time-bound

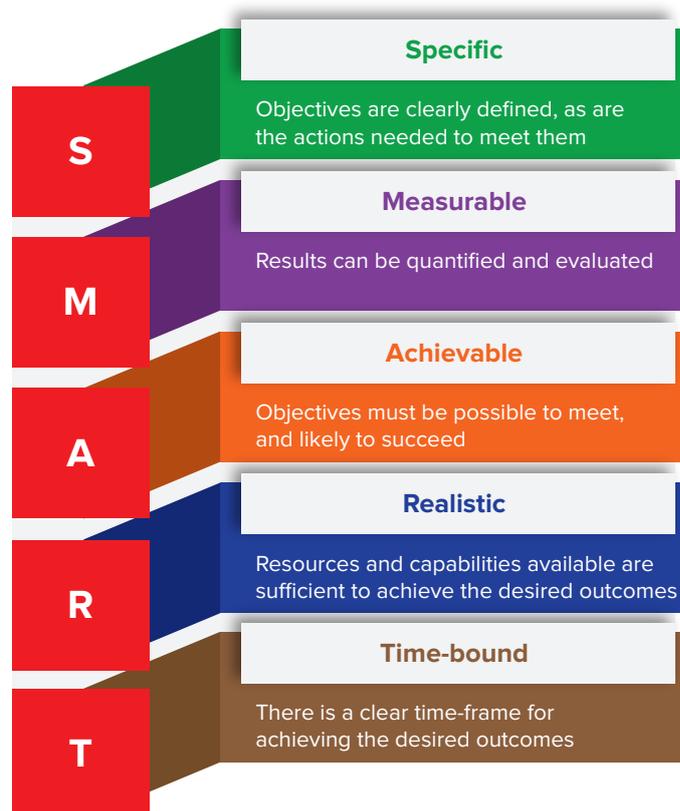


Table 4 Examples of goals and objectives

Goal	Objective
Strive for universal access to adequate fluorides	<ul style="list-style-type: none">▶ Pass a law on water fluoridation in 10 local communities within the next three years.
Reduce the rate of tooth decay among schoolchildren in community A by 20%	<ul style="list-style-type: none">▶ Convince the local school authorities of community A to remove vending machines offering sweetened beverages and sugary snacks from their grounds and replace them with portable water and milk (where culturally appropriate).▶ Roll out an oral health education programme for all school children who live in community A.▶ Convince an industry partner to sponsor toothbrushes and fluoride toothpaste for distribution to all pupils attending community A schools.

Identifying target audiences

An essential step in achieving advocacy goals and objectives is to determine the right target audiences. These include individuals who are:

- ▶ Interested in the topic
- ▶ Influential
- ▶ Supportive
- ▶ Influential opponents

In addition to identifying individuals or groups who can directly affect your desired outcomes, i.e. decision makers, you also need to identify potential individuals or groups who can influence your primary audience.

Once you have identified your potential target audiences, you need to focus on those who are likely to be the most influential. Do not forget that strong opponents are also an important target audience, as adequate information and education might turn them into allies rather than opponents. Depending on your advocacy objectives, your primary target audience might be a Minister of Health, a group of elected officials, local community leaders, a group of school principals, the wider public etc.

Forming partnerships

Partnerships on many levels are essential to ensure adequate prevention, management and control of caries. Partnerships in the field of caries prevention can be formed with several stakeholders on many different levels:

- ▶ Patients
- ▶ Coalition of oral health professionals
- ▶ Other health professionals

- ▶ Government/policymakers
- ▶ Product manufacturers
- ▶ Payers

Selecting the right partners strongly depends on the objectives that have been set. For example, if your aim is to convince your national government to implement a tax on sugar-sweetened beverages, then you might wish to seek an alliance with other health associations (diabetes, obesity, etc.), and with the public health community. If your aim is to introduce large-scale oral health education programmes in schools, then you might wish to collaborate with educators and perhaps with product manufacturers, as they might be able to provide materials such as toothbrushes and fluoride toothpaste.



Partnerships are very important because they allow you to reinforce your action. They can be long-term but also temporary.

Keep in mind that when multiple partners work together on an advocacy initiative, there might be some overarching goals and objectives. However, each partner might also set a few separate, complementary goals and objectives. This is not in itself an issue, but it should be clarified from the onset to ensure that individual objectives are not in contradiction with your own goals and objectives.

Choosing the right advocacy activities and materials

Once your target audiences are identified, their characteristics can be determined (position, age, level of education, access to media, social media, knowledge about the issue, etc.). These characteristics should help you select the most appropriate advocacy activities and materials. Based on the likely preferences of your target audiences, different types of advocacy activities can be set up.

- ▶ **Workshops and meetings:** setting up meetings and workshops with a target group of individuals (local officials, community leaders) to present and discuss the issue can be a powerful means to raise awareness and generate support for your advocacy objectives.
- ▶ **High-level meetings:** scheduling a meeting with a high-level official is a further means to drive forward your advocacy efforts. This needs thorough preparations as you will have little time to present a convincing case. Direct support from a high-ranking elected official, such as a Minister of Health, can however be instrumental in successfully achieving your advocacy goals and objectives.

- ▶ **Public events:** such events can be helpful in engaging the wider community in your advocacy efforts. They can take different forms, such as an awareness raising campaign in a busy public place, interactive games and quizzes, a toothbrushing contest, etc. World Oral Health Day (www.worldoralhealthday.org), celebrated annually on 20 March in many countries around the world, can serve as a powerful instrument to organize public events that will engage a wider audience and will obtain good media coverage, which in turn helps raise awareness among local and national authorities.
- ▶ **Mass media campaign** (newspapers, radio, TV): the strength of mass media is in its potential to reach large audiences. It can help generate support from the community to build pressure on elected officials to take action. It is however not very well suited to reach a well-defined, narrow group of individuals, such as decision makers.
- ▶ **Social media** (websites, blogs, Facebook, Twitter): social media increasingly represents a powerful channel to communicate advocacy goals and objectives. It can amplify your advocacy efforts by reaching more people in very little time. The use of social media has a very low set-up cost and offers new opportunities to engage with your target audiences. Preparing and disseminating a set of messages (blog posts, Facebook posts, tweets) pertaining to your advocacy goals and objectives can therefore represent a powerful support to achieve your aims.
- ▶ **Printed materials:** such materials (booklets, leaflets, factsheets, etc.) are valuable to support your advocacy activities. It is useful to distribute printed materials to document your advocacy goals and objectives when you organize a meeting or activity. However, disseminating printed materials to target audiences without any supporting activities is unlikely to be sufficient to achieve your aims.



ANNEX

Tools

Key messages

FDI offers three key messages for NDAs to communicate in their high-level discussions with national policymakers.

1. **Dental caries is the most prevalent noncommunicable disease (NCDs) worldwide.** The current scientific understanding of the disease underscores its dietary-sugars dependent, progressive and behavioural nature. At the same time, it acknowledges socioeconomic and political factors, resulting in variations in disease levels. Consequently, the current conceptual frameworks and practice of caries management need to address the major shifts from invasive-only interventions to prevention, from treatment to management and control of the disease, and to define the evolving role of the oral health professional to accommodate these changes.
2. **The oral health profession is committed to contributing its longstanding expertise in prevention to the fight against NCDs,** given the shared risk factors with oral disease. Thus, the oral health profession needs to be recognized and included as a full partner in the development of national NCD action plans that use the common risk factor approach.
3. **A combination of preventive population-based and individual approaches are key to reducing the burden of caries.** This requires buy-in of multiple constituencies, including patients and the community, policymakers, other health professions, as well as product manufacturers.

Template letter to elected official

Dear [insert name],

As a dentist and member of the [insert name of your National Dental Association], I would like to take this opportunity to draw your attention to the current challenges of dental caries prevention and management.

Today, despite the fact that it is largely preventable, dental caries is the most prevalent noncommunicable disease. In our country, it affects [X% indicate percentages according to available data from your country] of our population, among which many children. Dental caries is impairing and significantly affects quality of life. It generates pain, sleeplessness, leads to a significant number of missed school and work days and generates heavy costs in the absence of early treatment [add any useful, striking data you might have].

Dental caries share a range of risk factors with other major noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes. In particular, an unhealthy diet, particularly one rich in sugars, is a major shared risk factor. Because supportive policy interventions are capital in fostering individual behaviour changes, I would like to request a meeting to discuss possible cost-effective measures to improve the oral health, and hence general health, of our population.

You may reach me at [insert your contact details].

I look forward to addressing this major public health challenge with you.

Sincerely,

[insert your name and title].

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