

World Health Organization global policy for improvement of oral health – World Health Assembly 2007

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The World Health Organization (WHO) Global Oral Health Programme has worked hard over the past five years to increase the awareness of oral health worldwide as an important component of general health and quality of life. Meanwhile, oral disease is still a major public health problem in high income countries and the burden of oral disease is growing in many low- and middle income countries. In the World Oral Health Report 2003, the WHO Global Oral Health Programme formulated the policies and the necessary actions for the improvement of oral health. The strategy is that oral disease prevention and the promotion of oral health needs to be integrated with chronic disease prevention and general health promotion as the risks to health are linked. The World Health Assembly (WHA) and the Executive Board (EB) are supreme governance bodies of WHO and for the first time in 25 years oral health was subject to discussion by those bodies in 2007. At the EB120 and WHA60, the Member States agreed on an action plan for oral health and integrated disease prevention, thereby confirming the approach of the Oral Health Programme. The policy forms the basis for future development or adjustment of oral health programmes at national level.

Key words: Oral health, general health, WHO, EB120, WHA60

In 2002, the World Health Organization (WHO) Global Oral Health Programme was reoriented according to a new strategy of integration with chronic disease prevention and general health promotion. Chronic diseases, which continue to dominate in middle- and high income countries, are becoming increasingly prevalent in many of the poorest developing countries. They create a double burden on top of the infectious diseases by which these countries continue to be afflicted¹. A somewhat similar pattern is observed for the unresolved burden of oral disease²⁻⁹. As for the major chronic diseases, socio-environmental factors are distal causes of oral disease¹⁰, moreover, a core group of modifiable risk factors is common to many chronic diseases and injuries, and most oral diseases. These common risk factors are however preventable as they relate to lifestyles, such as dietary habits, use of tobacco and excessive consumption of alcohol, and the standard of hygiene.

The objectives of the WHO Global Oral Health Programme, one of the technical programmes within the

Department of Chronic Disease and Health Promotion, imply that greater emphasis is put on developing global policies based on common risk factors approaches and which are coordinated more effectively with other programmes in public health. The policy of the WHO Global Oral Health Programme emphasises that oral health is integral and essential to general health, and that oral health is a determinant factor for quality of life. The policy is detailed in the World Oral Health Report 2003². The report provides a comprehensive analysis of the global burden of oral disease and additional information of oral health is further described in a Special Theme of the *Bulletin of the World Health Organization*, September 2005¹¹.

WHO priority action areas for the improvement of oral health worldwide are:

- Effective use of fluoride¹²⁻¹⁵
- Healthy diet and nutrition¹⁶⁻¹⁷
- Tobacco control¹⁸⁻²¹

- Oral health of children and youth through Health Promoting Schools^{22,23}
- Oral health improvement amongst the elderly²⁴
- Oral health, general health and quality of life²⁵
- Oral health systems²⁶
- HIV/AIDS and oral health^{9,27}
- Oral health information systems, evidence for oral health policy and formulation of goals²⁸⁻³⁰
- Research for oral health³¹⁻³².

Major actions undertaken by the WHO Global Oral Health Programme are detailed in the references given and further information is available from the WHO web site www.who.int/oral_health. Elements of the global priorities are also part of the activities undertaken by the oral health programmes of WHO Regional Offices. The Office for the Americas (<http://www.paho.org/>, 10-year Regional Plan on Oral Health/CE138/14) and the Office for Africa (<http://www.afro.who.int/oralhealth>) have distinct oral health programmes whereas the four other regional offices incorporate oral health into programmes for prevention of chronic disease.

Some activities have been carried out in collaboration with the 32 WHO Collaborating Centres in Oral Health, the two non-governmental Organizations in official relationship with WHO, i.e. Federation Dentaire Internationale/World Dental Federation, and International Association for Dental Research (IADR), or other Organizations such as Aide Odontologique Internationale working for oral health. Several WHO co-sponsored meetings have contributed to sharing of experiences within the oral health community and dissemination of essential messages to the general public, e.g. the WHO/FDI/IADR Global Consultation on use of fluoride for oral health 2006; FDI/WHO/IADR fluoride consultation for China and South-East Asia 2007; WHO/IADR symposium on diet and nutrition 2005; Global conference on tobacco or health 2003; Health Promoting Schools meetings in Thailand, China and India 2003-5; IADR/WHO 5th global workshop on HIV/AIDS in oral health 2004; WHO/IADR symposium on oral health in elderly; WHO/IADR meeting on oral health in Africa and the Middle-East 2004; WHO/FDI meeting on planning of oral health in Africa 2004; WHO/IADR/BASCD meeting on preventive dentistry 2005, and the WHO/AAPD meeting on preventive dentistry in Asia.

The WHO Global Oral Health Programme works from the principles of the Ottawa Charter for Health Promotion³³. As underlined by the most recent Bangkok Charter for Health Promotion³⁴, the promotion of health and disease prevention both have established repertoires of evidence-based strategies which need to be fully utilised, especially for low- and middle income countries. The Liverpool Declaration³⁵ is an oral health follow-up of the Bangkok Charter, which provides information about the necessary actions to be undertaken by countries for the improvement of oral health.

Progress towards a healthier world requires strong political action, broad participation and sustained advocacy. The WHO Oral Health Programme has worked hard over the years to put oral health high on the health agenda of policy and decision makers worldwide. Recently, the WHO was given the mandate for strengthening the work for oral health by its two governing bodies, i.e. the Executive Board, and the World Health Assembly. The WHO statement will be an impetus for countries to develop or adjust national oral health programmes, and the policy is a strong support to the global actions carried out by the WHO Oral Health Programme.

WHO governance

The World Health Assembly is the supreme decision-making body for WHO. It meets each year in May in Geneva, and is attended by delegations from all 193 Member States. The Executive Board is composed of 34 members technically qualified in the field of health. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions are adopted for forwarding to the Health Assembly, is held in January.

In January 2007, the Executive Board at its 120th session discussed the subject of oral health on the basis of the report prepared by the WHO Oral Health Programme³⁶, and the Board subsequently considered a related draft resolution (EB120.R5).

Below is the WHO Oral Health Programme's contribution to the Sixtieth World Health Assembly held from 14-22 May 2007 which is entitled 'Oral health: action plan for promotion and integrated disease prevention', and the subsequent final Resolution WHA60.17³⁷, as confirmed by the Member States.

Oral health: action plan for promotion and integrated disease prevention - Report by the WHO Secretariat

Oral disease, such as dental caries, periodontal disease, tooth loss, oral mucosal lesions, oropharyngeal cancers, oral manifestations of HIV/AIDS, necrotising ulcerative stomatitis (noma), and orodental trauma, is a serious public-health problem. Its impact on individuals and communities in terms of pain and suffering, impairment of function and reduced quality of life, is considerable. Globally, the greatest burden of oral diseases lies on disadvantaged and poor populations. The current pattern of oral disease reflects distinct risk profiles across countries related to living conditions, behavioural and environmental factors, oral health systems and implementation of schemes to prevent oral disease. In several high-income countries with preventive oral-care programmes prevalence of dental caries in children and tooth loss among adults has dropped. Globally, the

burden of oral disease is particularly high among older people and has a negative effect on their quality of life. In most low- and middle-income countries, the general population does not benefit from systematic oral health care, nor have preventive programmes been established. In some countries the incidence of dental caries has increased over recent years and may further increase as a result of the growing consumption of sugars and inadequate exposure to fluorides.

Tobacco-related oral diseases are currently prevalent in several high-income countries. With the growing consumption of tobacco in many low- and middle-income countries, the risk of periodontal disease, tooth loss and oral-cavity cancer is likely to increase. Moreover, periodontal disease and tooth loss are linked to chronic diseases such as diabetes mellitus; the growing incidence of diabetes in several countries may therefore have a negative impact on oral health. People living with HIV/AIDS suffer from specific oral disease; HIV infection has a negative effect on oral health and quality of life because of, for example, pain, dry mouth and difficulty in chewing, swallowing and tasting food.

Noma, a debilitating orofacial gangrene, is an important contributor to the disease burden in certain low- and middle-income countries, particularly in Africa and Asia; the key risk factors are poverty, severe malnutrition, unsafe drinking water, deplorable sanitary practices and such infectious diseases as measles, malaria, and HIV/AIDS.

Oral disease is the fourth most expensive disease to treat. In high-income countries, the burden of oral disease has been tackled through the establishment of advanced oral-health services which offer primarily treatment to patients. Most systems are based on demand for care provided by private dental practitioners, although some high-income countries have organised public oral-health systems. In most low- and middle-income countries, investment in oral health care is low and resources are primarily allocated to emergency oral care and pain relief.

Most oral diseases and chronic diseases have common risk factors. As is the case for major chronic diseases, oral diseases are linked to unhealthy environments and behaviours, particularly widespread use of tobacco and excessive consumption of alcohol or sugar. In addition to healthy behaviour, promotion of oral health depends on clean water, adequate sanitation, proper oral hygiene and appropriate exposure to fluoride. National health programmes that include health promotion and measures at individual, professional and community levels are cost-effective in preventing oral diseases.

Framing policies and strategies for oral health

Promotion of oral health is a cost-effective strategy to reduce the burden of oral disease and maintain oral health and quality of life. It is also an integral part of

health promotion in general, as oral health is a determinant of general health and quality of life.

One of the main lines of WHO's global strategy for the prevention and control of chronic non-communicable diseases is to reduce the level of exposure to major risk factors. Prevention of oral disease needs to be integrated with that of chronic diseases on the basis of common risk factors.

Some high-income countries have built national capacities in oral-health promotion and oral-disease prevention over the past decades, mostly as isolated components of national health programmes. A number of low- and middle-income countries do not yet have policies on, or financial and human resources for, sustainable, effective oral-health programmes to counter risks and their underlying determinants.

To strengthen the formulation or adjustment of policies and strategies for oral health and its integration in national and community health programmes, particular emphasis should be laid on the following elements:

- Promotion of a healthy diet, particularly lower consumption of sugars and increased consumption of fruits and vegetables, in accordance with WHO's Global Strategy on Diet, Physical Activity and Health, and reduction of malnutrition.
- Prevention of oral and other diseases related to tobacco use (smoking and use of smokeless tobacco), by involving oral-health professionals in tobacco cessation programmes and discouraging children and young people from adopting the tobacco habit.
- Provision of access to clean drinking water, general hygiene and better sanitation for proper oral hygiene.
- Establishment of national plans for use of fluoride, based on appropriate programmes for automatic administration of fluoride through drinking-water, salt, or milk, or topical use of fluoride such as affordable fluoride toothpaste. Salt fluoridation programmes should be linked to iodisation schemes.
- Prevention of oral-cavity cancer and oral pre-cancer by involving oral health professionals or specially trained primary health-care workers in screening, early diagnosis and referral for care, and appropriate interventions on the risks of tobacco use and excessive consumption of alcohol.
- Strengthening of management of HIV/AIDS through oral-health professional screening for HIV/AIDS-related oral disease, early diagnosis, prevention and treatment, with emphasis on pain relief and improved quality of life and on reduction of the double burden of oral disease and HIV infection in low- and middle-income countries.

- Building of capacity in oral-health systems oriented to disease prevention and primary health care, with special emphasis on meeting the needs of disadvantaged and poor populations. Oral-health services should be set up, ranging from prevention, early diagnosis and intervention to provision of treatment and rehabilitation, and the management of oral health problems of the population according to needs and to resources available. In countries with critical shortages of oral-health personnel, essential care may be provided by specially trained primary health-care workers.
- Promotion of oral health in schools, aiming at developing healthy lifestyles and self-care practices in children and young people. An integrated approach that combines school health policy, skills-based health education, a health-supportive school environment and school health services can tackle major common risk factors and contribute to effective control of oral disease.
- Promotion of oral health among older people, aiming at advancing oral health, general health and well-being into old age through a life-course perspective in health promotion, integrated disease prevention and emphasis on age-friendly primary health care.
- Development of oral-health information systems as an integral part of national surveillance of oral health and risk factors, in order to provide evidence for oral health policy and practice, formulation of goals and targets, and measurement of progress in public health. Instruments have been designed in the framework of the WHO Global InfoBase and the WHO STEPwise approach to surveillance (STEPS).
- Promotion of research in oral health, aimed at bridging gaps in research between low- and middle-income, and high-income countries, conduct of operational research, and translation of knowledge about oral-health promotion and disease prevention into public-health action programmes.

Future action

Working with other international entities involved in oral health, WHO will provide support to Member States in raising awareness of the determinants of oral and general health, and fostering health-promoting environments, healthy behaviour and prevention-oriented oral-health systems. WHO will further strengthen its support for building capacity at national and community levels to plan and implement comprehensive and integrated oral-health programmes, particularly in low- and middle-income countries and for poor and disadvantaged groups.

WHO will continue to provide technical support for, and guidance on, the design, implementation and evaluation of evidence-based community demonstration projects worldwide, contribute to sharing of experiences among countries and disseminate lessons learnt through the publication of guidelines. Its expanded evidence base provides a basis for oral-health policies and for investigating the cost and effectiveness of national and community oral health interventions. WHO will also offer technical advice on establishment of integrated oral-health surveillance systems, based on the WHO Global InfoBase and the STEPS methodology. It will also further expand its work with the WHO collaborating centres on oral health and nongovernmental organizations, including the FDI World Dental Federation and the International Association for Dental Research.

In order to respond to the many global changes and trends that directly or indirectly affect oral health and well-being, WHO will further expand its interaction and partnership with other international entities involved in oral health and the private sector within the framework of its overall leadership in health promotion and integrated disease prevention.

Resolution

SIXTIETH WORLD HEALTH ASSEMBLY WHA60.17

Oral health: action plan for promotion and integrated disease prevention

The Sixtieth World Health Assembly,

Recalling resolutions WHA22.30, WHA28.64 and WHA31.50 on fluoridation and dental health, WHA36.14 on oral health in the strategy for health for all, WHA42.39 on oral health; WHA56.1 and WHA59.17 on the WHO Framework Convention on Tobacco Control; WHA58.22 on cancer prevention and control; WHA57.14 on scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS; WHA57.16 on health promotion and healthy lifestyles; WHA57.17 on the Global Strategy on Diet, Physical Activity and Health; WHA58.16 on strengthening active and healthy ageing; WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA58.26 on public-health problems caused by harmful use of alcohol;

Acknowledging the intrinsic link between oral health, general health and quality of life;

Emphasizing the need to incorporate programmes for promotion of oral health and prevention of oral diseases into programmes for the integrated prevention and treatment of chronic diseases;

Aware that the importance of the prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015;

Appreciating the role that WHO collaborating centres, partners and nongovernmental organizations play in improving oral health globally,

URGES Member States:

(1) to adopt measures to ensure that oral health is incorporated as appropriate into policies for the integrated prevention and treatment of chronic noncommunicable and communicable diseases, and into maternal and child health policies;

(2) to take measures to ensure that evidence-based approaches are used to incorporate oral health into national policies as appropriate for integrated prevention and control of noncommunicable diseases;

(3) to consider mechanisms to provide coverage of the population with essential oral-health care, to incorporate oral health in the framework of enhanced primary health care for chronic noncommunicable diseases, and to promote the availability of oral-health services that should be directed towards disease prevention and health promotion for poor and disadvantaged populations, in collaboration with integrated programmes for the prevention of chronic noncommunicable diseases;

(4) for those countries without access to optimal levels of fluoride, and which have not yet established systematic fluoridation programmes, to consider the development and implementation of fluoridation programmes, giving priority to equitable strategies such as the automatic administration of fluoride, for example, in drinking-water, salt or milk, and to the provision of affordable fluoride toothpaste;

(5) to take steps to ensure that prevention of oral cancer is an integral part of national cancer-control programmes, and to involve oral-health professionals or primary health care personnel with relevant training in oral health in detection, early diagnosis and treatment;

(6) to take steps to ensure the prevention of oral disease associated with HIV/AIDS, and the promotion of oral health and quality of life for people living with HIV, involving oral-health professionals or staff who are specially trained in primary health care, and applying primary oral-health care where possible;

(7) to develop and implement the promotion of oral health and prevention of oral disease for preschool and school children as part of activities in health-promoting schools;

(8) to scale up capacity to produce oral-health personnel, including dental hygienists, nurses and auxiliaries, providing for equitable distribution of these auxiliaries to the primary-care level, and ensuring proper service back-up by dentists through appropriate referral systems;

(9) to develop and implement, in countries affected by noma, national programmes to control the disease within national programmes for the integrated management of childhood illness, maternal care and reduction of malnutrition and poverty, in line with internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(10) to incorporate an oral-health information system into health surveillance plans so that oral-health objectives are in keeping with international standards, and to evaluate progress in promoting oral health;

(11) to strengthen oral-health research and use evidence-based oral-health promotion and disease prevention in order to consolidate and adapt oral-health programmes, and to encourage the intercountry exchange of reliable knowledge and experience of community oral-health programmes;

(12) to address human resources and workforce planning for oral health as part of every national plan for health;

(13) to increase, as appropriate, the budgetary provisions dedicated to the prevention and control of oral and craniofacial diseases and conditions;

(14) to strengthen partnerships and shared responsibility among stakeholders in order to maximize resources in support of national oral health programmes;

REQUESTS the Director-General:

(1) to raise awareness of the global challenges to improving oral health, and the specific and unique needs of low- and middle-income countries and of poor and disadvantaged population groups;

(2) to ensure that the Organization, at global and regional levels, provides advice and technical support, on request, to Member States for the development and implementation of oral-health programmes within integrated approaches to monitoring, prevention and management of chronic noncommunicable diseases;

(3) continually to promote international cooperation and interaction with and among all actors concerned with implementation of the oral-health action plan, including WHO collaborating centres for oral health and nongovernmental organizations;

(4) to communicate to UNICEF and other organizations of the United Nations system that undertake health-related activities, the importance of integrating oral health into their programmes;

(5) to strengthen WHO's technical leadership in oral health, including increasing, as appropriate, budgetary and human resources at all levels.

Oral health services development and adjustment

The WHO Global Oral Health Programme gives priority to the organization of oral health services that matches the needs of the population^{2,26}. In several industrialised Western countries, oral health services are made available to the population, either based on public or private systems. Meanwhile, people in deprived communities, homebound and disabled individuals, old-age persons, and certain ethnic minorities are not sufficiently covered by oral health care. Social inequality in oral health status and use of services is somewhat universal, even in the Nordic countries with public responsibility in financing and delivery of oral health care remarkable differences are observed by social class³⁸. Outreach services may be necessary to tackle the burden of poor oral health of people with limited resources and lack of tradition of regular oral health care.

By and large, the industrialised countries show appropriate numbers of dentists whereas there is shortage of dental ancillary personnel to carry out preventive care and health promotion. The problem of production of inappropriate types and numbers of oral health professionals is still being faced by most of the industrialised countries. In some countries, the introduction of ancillary personnel has been delayed. It has been reported, particularly in countries where over-production exists and the oral health of the population has improved, that duties which traditionally have been performed by assisting personnel are now being carried out by dentists themselves.

While there is a need for adjustment of oral health services in high-income countries, services are often not available or accessible for the general population in the majority of developing countries. This is particularly the case for Latin America, Asia and the poor countries of Africa. There is significant lack of oral health personnel, the WHO Global Oral Health Programme has drawn a global map demonstrating that Sub-Saharan countries have a critical shortage of oral manpower²⁶. Moreover, cost of oral health services is high, the use of services is often prompted by symptoms and services are mostly oriented towards relief of pain³⁹. Oral health care is generally provided by hospitals located in urban centres whereas limited care is offered in rural areas. In the majority of countries in Africa and Asia little attention is given to oral health of people living with HIV/AIDS who are less aware of the oral manifestations of infection than the general symptoms⁴⁰.

The lack of oral health services highly reflects the low priority to oral health by policy makers and decision makers in these countries and oral health staff or chief dental officers are most often not available within ministries of health. In the future, strong emphasis should be given to the effective implementation of integrated primary oral health care according to the WHO Primary Health Care concept in 1979⁴¹.

Worldwide, the priority given to prevention of oral disease and health promotion is far too low. In 1986, the so-called Ottawa Charter on Health Promotion³³ emphasised that health services should be effectively oriented towards prevention and health promotion. The need is still high for adjustment of programmes in countries with existing oral health services and for countries in the process of developing oral health programmes strong efforts should be made towards the implementation of prevention and health promotion. For all countries the adjustment or development of national oral health programmes should incorporate systematic activities towards oral cavity cancer and the oral manifestation of HIV/AIDS, including early diagnosis and referral for specialist care.

The 2005 Bangkok Charter for Health Promotion in a Globalized World³⁴ states that the evidence is available on the effectiveness of chronic disease prevention and health promotion, and the challenge for national health authorities and health care providers is urgently to translate this knowledge into practise for the benefit of the disadvantaged people or nations. Health services should be financially fair and be based on outreach principles in order to cover the whole population. The Liverpool Charter on Oral Health Promotion³⁵ gives direction to oral health planners and oral health providers for implementation of appropriate oral health programmes based on the wealth of evidence on oral disease prevention and oral health promotion. As underlined by the WHO Global Oral Health Programme², it is most relevant to ensure that such programmes are not isolated activities but integrated with national health programmes. WHO has designed an operational plan for oral health globally and the WHO Global Oral Health Programme is prepared to assist the national health authorities in this effort and in partnership with non-governmental Organizations.

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