THE LIVERPOOL DECLARATION:
Promoting Oral Health in the 21st Century
A Call for Action

The 8th World Congress on Preventive Dentistry (WCPD) took place from 7-10 September, 2005 in Liverpool, United Kingdom. The WCPD was organized jointly by the International Association for Dental Research (IADR), the World Health Organization (WHO), the European Association of Dental Public Health (EADPH) and the British Association for the Study of Community Dentistry (BASCD). Participants from 43 countries addressed the prevention of oral diseases which are significant burdens on children and adults worldwide. The good news is that oral diseases are preventable and considerable improvements can be made if appropriate public health programmes are established.

The participants emphasized that oral health is an integral part of general health and wellbeing and a basic human right. Participants took note of the World Health Organization's Bangkok Charter for Health Promotion in a Globalized World (Bangkok, Thailand, 2005) and affirmed their commitment to support the work carried out by national and international health authorities, research institutions, non-governmental organizations and civil society for the promotion of health and prevention of oral diseases.

In this Call for Action, the following areas of work for oral health should be strengthened in countries by the year 2020:

1. Countries should ensure that the population has access to clean water, proper sanitation facilities, a healthy diet and good nutrition.
2. Countries should ensure appropriate and affordable fluoride programmes for the prevention of tooth decay.
3. Countries should provide evidence-based programmes for the promotion of healthy lifestyles and the reduction of modifiable risk factors common to oral and general chronic diseases.
4. The school should be used as a platform for promotion of health, quality of life and disease prevention in children and young people, involving families and communities.
5. Countries should ensure access to primary oral health care with emphasis on prevention and health promotion.
6. Countries should strengthen promotion of oral health for the growing numbers of older people, aiming at improving their quality of life.
7. Countries should formulate policies for oral health as an integral part of national health programmes.
8. Countries should support public health research and specifically consider the recommendations of WHO which recommends 10% of a total health promotion programme budget be devoted to programme evaluation.
9. Countries should establish health information systems that evaluate oral health and programme implementation, support the development of the evidence base in health promotion and disease prevention through research and support the international dissemination of research findings.

The participants and Associations support the efforts of the WHO Oral Health Programme which aims at coordinating and supporting inter country sharing of experiences in health promotion and oral disease prevention.

(adopted September 2005)

GLOBAL GOALS FOR ORAL HEALTH
(Joint FDI - WHO - IADR Statement)

Rationale

- The FDI and the WHO established the first Global Oral Health Goals jointly in 1981 to be achieved by the year 2000. A review of these goals, carried out just prior to the end of this period established that they had been useful and, for many populations, had been achieved or exceeded. Yet, for a significant proportion of the world's population they remained only a remote aspiration.
- An FDI Public Health Section Workshop in October 1999 in Mexico City examined the 1981 Global Goals. In parallel, WHO Headquarters and the WHO Regional Offices carried out evaluation of accomplishment of goals and initiated formulation of new goals for the year 2020.
- A Working Group was subsequently appointed including members of FDI, WHO and IADR being chosen from different regions of the world , and this group has prepared new goals for the year 2020. These were submitted for comment to National Dental Associations, WHO Collaborating Centres in Oral Health and other interested individuals and groups.

Evidence

- Having reviewed the Global and Regional Goals set for the year 2000: the uses to which they had been put and the success in achieving them, it was determined that new goals should reflect the overall aspirations of the dental profession for global oral health and that their successful use was dependent upon the details of the targets set reflecting national or more local oral health priorities.
- Existing oral health goals from a number of countries and regions were reviewed to determine the most appropriate format for the new global goals. The format adopted allows both Global Goals and Objectives but encourages the local setting of national and local targets.

Future Research

- There is a need for long-term follow-up on the use and utility of the new goals as well as recording the frequency of their successful attainment.

Public Health Significance

- When planning and evaluating oral health programmes and services global, national and local goals can be invaluable in the shaping and enactment of health policies at all levels.
- If achieved they provide a measure of oral health improvement and of the value of the oral health profession.

Global Oral Health Goals, Objectives and Targets for the Year 2020

Goals

- To promote oral health and to minimize the impact of diseases of oral and craniofacial origin on general health and psychosocial development, giving emphasis to promoting oral health in populations with the greatest burden of such conditions and diseases;
- To minimize the impact of oral and craniofacial manifestations of general diseases on individuals and society, and to use these manifestations for early diagnosis, prevention and effective management of systemic diseases.

Objectives

- To reduce mortality from oral and craniofacial diseases;
- To reduce morbidity from oral and craniofacial diseases and thereby increase the quality of life;

- To promote sustainable, priority-driven, policies and programmes in oral health systems that have been derived from systematic reviews of best practices (i.e. the policies are evidence-based);
- To develop accessible cost-effective oral health systems for the prevention and control of oral and craniofacial diseases using the common risk factor approach;
- To integrate oral health promotion and care with other sectors that influence health;
- To develop oral health programmes to improve general health;
- To strengthen systems and methods for oral health surveillance, both processes and outcomes;
- To promote social responsibility and ethical practices of care givers.
- To reduce disparities in oral health between different socio-economic groups within countries and inequalities in oral health across countries.
- To increase the number of health care providers who are trained in accurate epidemiological surveillance of oral diseases and disorders.

Targets

The targets should be selected to match predetermined oral health priorities at a national or local level. Consideration should be given to the following areas when selecting targets, based on local priorities:

Pain, functional disorders, infectious diseases, oro-pharyngeal cancer, oral manifestations of HIV-infection, noma, trauma, cranio-facial anomalies, dental caries, developmental anomalies of teeth, periodontal diseases, oral mucosal diseases, salivary gland disorders, tooth loss, health care services, health care information systems.

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(adopted 2003)

THE USE OF TOBACCO

The International Association for Dental Research (IADR) takes the following position regarding the use of tobacco by humans: Tobacco products come in many forms. Some are smoked and others are not, but none is safe for human consumption. In addition to their serious systemic effects, all have adverse oral health consequences, and risks usually are in proportion to the intensity and duration of tobacco use. The use of tobacco products is a major risk factor for oral and pharyngeal cancers. It also increases the risk of periodontal disease and decreases the ability of oral tissues to heal. Other oral effects include halitosis (bad breath), decreased ability to taste, and increased staining of teeth, gingival pigmentation, and a variety of mucosal lesions. In addition, tobacco smoking during pregnancy increases the risk of developing fetal anomalies such as cleft lip and cleft palate. The IADR encourages continued research to further elucidate the health effects of tobacco use, identify the biological mechanisms and behavioral patterns and relative risks involved in producing these effects, and to develop and evaluate effective methods for prevention and cessation. The IADR further encourages the development of collaborations with other organizations and

institutions to help inform members and the public of research findings about the conditions and risks associated with tobacco use.

FLUORIDATION OF WATER SUPPLIES

The International Association for Dental Research (IADR), considering that dental caries (tooth decay) ranks among the most prevalent chronic diseases worldwide; and

recognizing that the consequences of tooth decay include pain, suffering, infection, tooth loss, and the subsequent need for costly restorative treatment; and

taking into account that over 50 years of research have clearly demonstrated its efficacy and safety; and

noting that numerous national and international health-related organizations endorse fluoridation of water supplies;

fully endorses and strongly recommends the practice of water fluoridation for improving the oral health of nations.

(adopted 1979, updated 1999)

DIETARY FLUORIDE SUPPLEMENTS

The International Association for Dental Research (IADR), realizing that dental caries (tooth decay) ranks among the most prevalent chronic diseases world-wide; and

Recognizing that the consequences of tooth decay include pain, infection, tooth loss, the subsequent need for costly restorative treatment, and absence from work and school; and

Recognizing that, while fluoridation of water supplies is the most effective and least expensive measure to prevent tooth decay, large numbers of people do not currently have access to the benefits of community fluoridation; and

Taking into account that over 20 years of research have clearly demonstrated the safety and efficacy of dietary fluoride supplements; now, therefore,

1. Strongly recommends use of dietary fluoride supplements in areas where optimal fluoridation of water supplies is not available, and
2. Urges researchers and health authorities of countries within each IADR Division to develop and promote dosage schedules for dietary fluoride supplements that are suitable for their particular area.

REFERENCES

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(adopted 1983)