Global goals for oral health 2020

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How to use this document

It is anticipated that dentists and other health planners in many different circumstances will use this document for guidance when developing their plans for oral health. We recognise that no document can provide an exact blue print for each and every set of circumstances where oral health plans are to be developed. What is presented here is a range of possible areas that need to be taken into consideration when plans are being developed. It also provides a useful checklist against which existing plans might be examined to determine if there are any possible gaps.

Fundamental to the success of any plan is a clear understanding of what resources are already available or might become available once the plan has been adopted officially. Initially it may not be necessary to have a detailed inventory of all resources available, a simple analysis like the completion of the questionnaire in Annexure B will give a quick guide as to the level of resources available to you. This, combined with a prioritised list of the oral health problems of the community or population you are planning for, will help you identify those types of interventions that are likely to be most appropriate and sustainable under the prevailing circumstances.

Background

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. However, for a significant proportion of the world's population, they remained only a remote aspiration. Nonetheless, the Oral Health Goals had stimulated awareness of the importance of oral health amongst national and local governments and acted as a catalyst for securing resources for oral health in general. Therefore, even though not all countries had achieved the goals, they provided a key focus for the effort.

Recently, the FDI, WHO and IADR have embarked on the activity of preparing goals for the new millennium, for the year 2020, and these are presented here. They were developed by a Working Group including representatives of the FDI, WHO and IADR from different regions of the world (see Annexure A for the Group's membership).

The drafts of this document were circulated to all National Dental Association members (NDAs) of the FDI and placed on the global Dental Public Health list

server for comment. All WHO Collaborating Centres in Oral Health (WHOCC) and the IADR were also consulted. Responses received from NDAs, IADR, WHOCC as well as from individuals have subsequently been incorporated in this document.

Aims

This document, which contains proposals for new Global Oral Health Goals, Objectives and Targets of increasing detail and complexity, aims to provide a framework for health policy makers at different levels – regional, national and local. The goals and targets are not intended to be prescriptive. By being focused broadly on the global level, it is hoped that it will encourage local action in the spirit of the United Nations Development Programme's report: '*Think globally act locally*'. Thus, the document will provide an instrument for local and national health care planners to specify realistic goals and standards for oral health to be achieved by the year 2020.

The process of formulating a regional, national or local oral health strategy necessitates many stages. This document provides the first step in that process by guiding health planners to evaluate the current situation of oral health and

set oral health goals, objectives and targets. The present Goals differ significantly from those of 1981 in a number of ways. First, they are more general. Their purpose is to facilitate regional, national and local oral health policy development and activities, leading to more detailed and locally relevant goals. The previous Goals, in their detail, are similar in scope to the present targets. Second, no absolute values are given, as these have to be established on the basis of local circumstances such as the adequacy of the information base, local priorities and oral health systems, as well as disease prevalence and severity and socio-environmental conditions.

Each situation will be different not only in so far as the epidemiology of oral diseases, but also with regard to the political, socio-economic, cultural and legislative context. It will require detailed knowledge of the prevailing circumstances and the significant determinants of oral health. This knowledge is crucial to the development of policies, which address not only the immediate known risk factors but also help create a social, legislative and economic environment that is conducive to good oral health.

The following goals, objectives and targets are proposed based on current classifications of diseases and established criteria for their diagnosis. After careful consideration of alternative ways of presenting them, it was decided to set them out in the familiar way in relation to different groups of diseases.

Goals, Objectives and Targets

Goals

1. To minimise the impact of diseases of oral and craniofacial origin on health and psychosocial development, giving emphasis to promoting oral health and reducing oral disease amongst populations with the greatest burden of such conditions and diseases.

2. To minimise the impact of oral and craniofacial manifestations of systemic diseases on individuals and society, and to use these manifestations for early diagnosis, prevention and effective management of systemic diseases.

Objectives

1. To reduce mortality from oral and craniofacial diseases
2. To reduce morbidity from oral and craniofacial diseases and thereby increase the quality of life
3. 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)
4. To develop accessible cost-effective oral health systems for the prevention and control of oral and craniofacial diseases
5. To integrate oral health promotion and care with other sectors that influence health, using the common risk factor approach
6. To develop oral health programmes that will empower people to control determinants of health
7. To strengthen systems and methods for oral health surveillance, both processes and outcomes
8. To promote social responsibility and ethical practices of care givers
9. To reduce disparities in oral health between different socio-economic groups within a country and inequalities in oral health across countries
10. To increase the number of health care providers who are trained in accurate epidemiological surveillance of oral diseases and disorders.

Targets

By the year 2020 the following will have been achieved over baseline:
1. Pain:
   - A reduction of X% in epi-

sodes of pain of oral and craniofacial origin
   - A reduction of X% in the number of days absent from school, employment and work resulting from pain of oral and craniofacial origin
   - A reduction of X% in the number of people affected by functional limitations (this covers a number of measurable factors such as pain and impairments, missing teeth, traumatised incisors and congenital dental and facial anomalies
   - A reduction of X% in the prevalence of moderate and severe social impacts on daily activities resulting from pain, impairments and aesthetics (this includes missing teeth, dental anomalies, enamel defects such as fluorosis, traumatised incisors, severe gingival recession and oral malodour.
2. Functional disorders
   - A reduction of X% in the numbers of individuals experiencing difficulties in chewing, swallowing and speaking/communicating. This covers a large number of measurable factors related to tooth loss and congenital and acquired facial/dental deformities.
3. Infectious diseases
   - To increase by X% the numbers of health care providers competent to recognise and minimise the risks of transmission of infectious diseases in the oral health care environment.
4. Oro-pharyngeal cancer
   - To reduce by X% the prevalence of oro-pharyngeal cancer
   - To improve by X% the survival (5-year survival rate) of treated cases
   - To increase early detection by X%
   - To increase rapid referral by X%

- To reduce exposure to risk factors by X% with special reference to tobacco, alcohol and improved nutrition
- To increase by X% the number of affected individuals receiving multidisciplinary specialist care.

5. Oral manifestations of HIV infection
   - To reduce by X% the prevalence of opportunistic orofacial infections
   - To increase by X% the number of health providers who are competent to diagnose and manage the oral manifestations of HIV infection
   - To increase by X% the numbers of policy makers who are aware of the oral implications of HIV infection.

6. Noma
   - To increase by X% data on Noma from populations at risk
   - To increase early detection by X%
   - To increase rapid referral by X%
   - To reduce exposure to risk factors by X% with special reference to immunisation coverage or measles, improved nutrition and sanitation
   - To increase by X% the number of affected individuals receiving multidisciplinary specialist care.

7. Trauma
   - To increase early detection by X%
   - To increase rapid referral by X%
   - To increase the number of health care providers who are competent to diagnose and provide emergency care by/to X/Y%
   - To increase by X% the number of affected individuals receiving multidisciplinary specialist care where necessary.

8. Craniofacial anomalies
   - To reduce exposure to risk factors by X% with special reference to tobacco, alcohol, teratogenic agents and improved nutrition
   - To increase access to genetic screening and counselling by X%
   - To increase early detection by X%
   - To increase rapid referral by X%
   - To increase by X% the number of affected individuals receiving multidisciplinary specialist care
   - To increase early detection of seriously handicapping malocclusions and their referral by X%.

9. Dental caries
   - To increase the proportion of caries free 6-year-olds by X%
   - To reduce the DMFT particularly the D component at age 12 years by X%, with special attention to high-risk groups within populations, utilising both distributions and means
   - To reduce the number of teeth extracted due to dental caries at ages 18, 35–44 and 65–74 years by X%.

10. Developmental anomalies of teeth
    - To reduce the prevalence of disfiguring dental fluorosis by X% as measured by culturally sensitive measures and with special reference to the fluoride content of food, water and inappropriate supplementation
    - To reduce the prevalence of acquired developmental anomalies of teeth by X%, with special reference to infectious diseases and inappropriate medications
    - To increase early detection by X% for both hereditary and acquired anomalies
    - To increase referral by X%

for both hereditary and acquired anomalies.

11. Periodontal diseases
    - To reduce the number of teeth lost due to periodontal diseases by X% at ages 18, 35–44 and 65–74 years with special reference to smoking, poor oral hygiene, stress and inter-current systemic diseases
    - To reduce the prevalence of necrotising forms of periodontal diseases by X% by reducing exposure to risk factors such as poor nutrition, stress and immuno-suppression
    - To reduce the prevalence of active periodontal infection (with or without loss of attachment) in all ages by X%
    - To increase the proportion of people in all ages with healthy periodontium (gums and supporting bone structure) by X%

12. Oral mucosal diseases
    - To increase the number of health care providers who are competent to diagnose and provide emergency care by X%
    - To increase early detection by X%
    - To increase rapid referral by X%.

13. Salivary gland disorders
    - To increase the numbers of health care providers who are competent to diagnose and provide emergency care by X%
    - To increase early detection by X%
    - To increase rapid referral by X%.

14. Tooth loss
    - To reduce the number of edentulous persons by X% at ages 35–44 and 65–74 years
    - To increase the number of natural teeth present by X%

at ages 18, 35–44 and 65–74 years
- To increase the number of individuals with functional dentitions (21 or more natural teeth) by X% at ages 35–44 and 65–74 years.

15. Health care services
- To establish evidence-based

plans to create human resources that can provide care that are appropriate to the cultural, social, economic and morbidity profiles of all groups within the population
- To increase the proportion of the population with access to adequate oral health

care by/to X/Y%.

16. Health care information systems:
- To increase the proportion of the population covered by satisfactory information systems by/to X/Y%.

Annexure A

Membership of the Working Group

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Annexure B

Resource Assessment Questionnaire

Before planning any specific intervention try to answer the following questions:

Questions	Yes	No	Don't Know
Finance			
1. Is there a central public health budget for oral health?	❏	❏	❏
2. Are there sufficient capital funds for the equipment and instrumentation?	❏	❏	❏
3. Are there sufficient recurrent funds for salaries and materials?	❏	❏	❏
4. Are sufficient funds allocated for prevention and oral health promotion?	❏	❏	❏
Personnel			
5. Are there sufficient appropriately trained personnel?	❏	❏	❏
6. Are there sufficient personnel to manage, monitor and evaluate the intervention?	❏	❏	❏
Equipment and Instrumentation			
7. Is the equipment available, appropriate?	❏	❏	❏
Infrastructure			
8. Has a needs assessment been carried out in sufficient detail to select the intervention?	❏	❏	❏
9. Are there clear lines of communication to the community?	❏	❏	❏
10. Are there clear lines of communication for the acquisition of resources?	❏	❏	❏
11. Are there functional lines of communication for reporting?	❏	❏	❏
12. If it is necessary to make use of transportation (e.g. for people and goods), is it available and functioning?	❏	❏	❏

If there are less than six questions answered yes = low availability of resources.
If there are between five and ten questions answered yes = moderate availability of resources.
If there are more than nine questions answered yes = high availability of resources.