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# The 7th WHO Global Conference on Health Promotion - towards integration of oral health (Nairobi, Kenya 2009).

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Since the first World Health Organization (WHO) Global Conference on Health Promotion (GCHP) that produced the Ottawa Charter for Health Promotion, subsequent GCHPs were held in different continents. It was Africa's turn to host the 7th GCHP in Nairobi in October 2009, organised by WHO and Kenya Ministry of Health. The theme of the meeting was *Promoting Health and Development: Closing the Implementation gap.* It was the first time in the GCHP history that oral health received such a high profile and featured in one of the 12 special sub-plenary sessions. This report summarises the proceedings of the sub-plenary session on social determinants of oral health. Strategies for tackling social determinants of oral health and closing the implementation gap were considered, together with specific examples from developed and developing countries from different WHO regions. Oral health promotion implications were discussed based on public health experience and operational research. At the end of the session, input on oral health related issues was prepared for the Nairobi Call to Action adopted by the conference. In follow-up, the WHO Global Oral Health Programme contributes to the newly established WHO initiative *Mainstreaming Health Promotion*, which particularly seeks to build capacity in health promotion in low- and middle income countries. This work is carried out in support of the World Health Assembly Resolution (WHA60.17) on oral health.

**Key words:** *Capacity building, community empowerment, health policy, health promotion, social determinants, strategies for oral health*

## Introduction

In 1986, the Canadian city Ottawa hosted the first World Health Organization (WHO) Global Conference on Health Promotion (GCHP) that established *the Ottawa Charter for Heath Promotion* (WHO, 1986), building on the spirit of Alma Ata (WHO, 1978). The values and principles were consolidated in subsequent meetings on *Healthy Public Policy* in 1988 in Adelaide, Australia (WHO, 1988); *Supportive Environments for Health* in 1991 in Sundsvall, Sweden (WHO, 1991); *New Players for a New Era - Leading Health Promotion into the 21st Century* in 1997 in Jakarta, Indonesia (WHO, 1997); *Health Promotion: Bridging the Equity Gap* in 2000 in Mexico City, Mexico (WHO, 2000) and *Policy and Partnership for Action: Addressing the determinants of Health* in 2005 in Bangkok, Thailand (WHO, 2005a). These conferences contributed significantly to the development of concepts, approaches and strategies in health promotion and several countries have adopted health promotion principles as part of national health policies and programmes.

However, the need persists for strengthening of health promotion globally. Global health is facing unprecedented challenges. These include the threat of global pandemics as well as the inexorable growth of non-communicable conditions in lower and middle income countries (WHO, 2005b). The financial crisis threatens the viability of national economies in general and the financing of health systems in particular. These new challenges compound the problems many countries still have in the attainment of the internationally agreed development goals such as the United Nations Millennium Goals (WHO, 2005c). The burden of ill-health is increasingly recognized to be inequitably distributed, between and within countries, leading the Commission on Social Determinants of Health to conclude that "Social injustice is killing people on a grand scale" (WHO, 2008a). In the face of these new challenges, the attainment of health equity depends on an effective health promotion approach: on individual and community empowerment, on health system leadership and on intersectoral action to build healthy public policy. In this context, health promotion has never been timelier, or more needed. Over the period from the Ottawa Conference (1986) through to the sixth global conference in Bangkok (2005), health promotion has accumulated a large body of knowledge, evidence and experience as an integrative, cost-effective public health strategy and approach, and an essential component of health systems.

## The implementation gap

Global health urgently needs to apply the body of evidence based policies, strategies and approaches of health promotion developed over the past twenty years. Two global health promotion charters (Ottawa and Bangkok), conference declarations and WHO Regional Committees and World Health Assembly (WHA) resolutions endorse the importance of health promotion; yet the evidence for their implementation in countries is lacking. These along with a rich body of research and experience from around

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the world provide a resource for guidance and direction for the implementation of health promotion, which is essential in order to *achieve health for all* and to *tackle the issue of inequities in the distribution of health* by gender, social class, income level, ethnicity, education, occupation, and other categories. As emphasized in the World Health Report 2008, Primary Health Care (PHC) is essential element in health promotion (WHO, 2008b); the PHC approach was renewed by setting four broad policy directions: 1. dealing with inequalities by moving towards universal coverage; 2. putting people at the centre of service delivery; 3. multisectoral action and health in all policies; 4. inclusive leadership and effective governors for health. Furthermore, the World Health Assembly 2009, in its resolution on primary health care, including health systems (WHO, 2009a), urged Member States to tackle the health inequities within and across countries through political commitment on the main principles of "closing the gap in a generation" as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools. Meeting these challenges cannot be reduced to a technical problem, for example, of finding cases of a specific disease and treating them. These are also significant political challenges. How to ensure that development policies effectively promote health? How to ensure that the work of all sectors contributes to a healthy policy environment that improves the daily living conditions of disadvantaged populations? How can civil society itself help to hold governments and international agencies accountable for their impact on health? What is the role of communities and individuals? How can societies promote positive health and offer social protection? Where, in all this, is the role of the private sector?

## Challenges to oral health promotion

The rapidly changing development in the world, intensified by globalisation and urbanization, triggers urgent responses to rising public health challenges to oral health. Evidence-based oral health promotion policy and practice are essential to effectively tackle oral health problems, addressing the widening inequalities in oral health within and between countries (WHO, 2003; Kwan & Petersen, 2010; Petersen 2008, 2009). While action strategies have been identified in previous global health promotion meetings (Tang et al, 2006), critical implementation gaps remain, particularly in developing countries with limited infrastructure and financial resources. There are gaps in health promotion programmes where evidence is not effectively incorporated into public health practice. Evidence on the oral health impacts of social determinants is not adequately considered in public policies. Moreover, there is a lack of capacity in the health systems to promote oral health, particularly in developing countries and countries with economies in transition (Petersen, 2008, 2009).

### *7th Global Conference on Health Promotion 2009*

Against this background, the seventh GCHP *Promoting Health and Development – Closing the Implementation Gap* was convened in October 2009 in Nairobi, Kenya, the first ever global health promotion conference that took place in Africa. Over 600 delegates representing more than 100 countries attended the five-day meeting, together with a large number of virtual participants via a social networking site www.conneet2change.org. The programme - including workshops, case studies and keynotes and sub-plenary sessions - was organised in five tracks addressing major strategic areas of health promotion that promote healthy development (***Box 1***). For the first time in the history of GCHP, oral health promotion was given special attention with a dedicated sub-plenary session, one of the twelve sub-plenary sessions with special themes that cut across tracks and cover a range of application areas. This report summarises the proceedings of the Sub-Plenary Session on Social Determinants of Oral Health.

***Box 1.*** Five key tracks of the 7th Global Conference on Health Promotion

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| Track 1: Community empowerment |
| Track 2: Health literacy and health behaviour |
| Track 3: Strengthening health systems |
| Track 4: Partnership and intersectoral action |
| Track 5: Building capacity for health promotion |

## Social determinants in oral health: building capacity for oral health promotion

Oral health is 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. Significant numbers of people around the globe suffer from illness and pain related to the mouth. The disadvantaged and poor people suffer most and they often do not receive appropriate oral health care. In addition, disease prevention and oral health promotion are widely neglected area in public health. This is particularly the case in middle and low income countries. In the World Oral Health Report 2003 issued by the World Health Organization (WHO, 2003), and further in a series of WHO publications (WHO, 2005d; Petersen, 2008, 2009; Petersen and Kwan, 2004; Kwan and Petersen, 2010), policies and the necessary actions to the continuous improvement of oral health are formulated.

The global 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. Integration of the prevention of specific oral disease manifestations with the control of infectious diseases is particularly relevant in the case of HIV AIDS (Petersen, 2006). The new approaches form the basis for future development or adjustment of oral health programmes at country and community levels. The good news is that most oral

diseases are avoidable. Public health research has shown that a number of individual, professional and community preventive measures, and community oriented oral health promotion are effective in control of oral disease and promoting oral health. However, advances in oral health science have not yet benefited the poor and disadvantaged populations worldwide. Inequalities in oral health still exist. The major challenges of the future will be to translate knowledge and experiences in oral disease prevention and health promotion into action programmes.

Directions as regards to strengthening health promotion, incorporating oral health, and orientation of oral health services towards health are emphasized to countries and communities (Petersen 2008, 2009). Particular attention is given to the following assumptions:

Increasing the global awareness of the significance of oral health to general health and quality of life, and the importance of social determinants to oral health.

National capacity building in oral health promotion and integrated disease prevention is a major platform for public health.

Strengthening of primary health care is vital to closing the gap in oral health and general health between the rich and the poor within countries and across countries.

The sub-plenary session on Social Determinants of Oral Health focussed on the analysis of negative and positive factors in building programmes and developing strategies. The implementation gap in oral health promotion was discussed, taking into account lessons learnt from existing community and national oral health promotion projects and the experience gained by WHO Collaborating Centres (WHOCC) in oral health. In addition to the participation of WHOCCs, the session was attended by the two oral health Non-Governmental Organizations in official relation to WHO, i.e. the International Association for Dental Research (Professor David Williams) and the World Dental Federation FDI (Dr Roberto Vianna). Moreover, Aide Odontologique Internationale, a French non-governmental organization having extensive work relations with the WHO Global Oral Health Programme, took part in the conference.

Dr. Nanna Jürgensen of WHOCC University of Copenhagen, Denmark was appointed Chair for the session and Dr Jayanthi Stjernswärd of WHOCC Malmo, Sweden as reporter. Dr Petersen introduced on the background, the philosophy and the structure of this special WHO session on oral health; seven contributions were then presented with examples from different countries in different regions.

### *Contribution 1: Social determinants in oral health -strategies for oral health promotion*

S. Kwan and P.E. Petersen. WHO Collaborating Centre for Research and Development for Oral Health, Migration and Inequalities, Leeds, United Kingdom, and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

Good oral health enables people to speak, eat and socialize without active disease, discomfort or embarrassment. However, oral disease is a major burden to populations across countries of the world. According to the World Health Organization Global Oral Health data bank and the World Health Survey 2003, widening social disparities in oral health exist across low-, middle- and high income countries. The influence of education, economic circumstances, material possession, living and working conditions and the environment on health is significant. These social determinants are also responsible for inequities in access to and use of oral health services. The social determinants of health are largely universal, affecting a range of oral health outcomes and the exposure to risk factors. The social gradients appear to be persistent over time. Poor oral health is found among people living in poverty. Proximal risk factors such as unhealthy lifestyles in relation to diet and nutrition, tobacco and alcohol, and poor personal hygiene are related to living conditions as well. The good news is that oral disease conditions are preventable, and social inequality in oral health is avoidable. Oral diseases share the common risk factors of several chronic diseases. Interventions in relation to the socio-economic environment, settings for health, and risk factor approaches are important strategies for promotion of oral health of the whole population. Moreover, evidence exists on promotion of oral health and prevention of oral diseases through public health interventions. Country experiences worldwide show that community outreach primary health care is essential to improvement of oral health, however, a lack of health policy and limited national budgets for oral health are major barriers for implementation of integrated health promotion.

### *Contribution 2: Common risk factor strategies in oral health promotion for youth - Some experiences from Tanzania.*

F.K. Kahabuka and P.E. Petersen. WHO Collaborating Centre for Primary Oral Health Care, Planning and Research, Dar-es-Salaam, Tanzania and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

Risk factors to poor oral health include unhealthy diet and nutrition, inadequate personal hygiene and lack of regular oral hygiene practices, inadequate sanitation, and insufficient exposure to fluorides, growing tobacco and alcohol consumption, and limited availability and access to dental services. The planning of public health intervention directed towards modifiable risk factors shall be based on available evidence, which has been called upon by the Tanzania Ministry of Health. In a nation-wide school health survey of adolescents, it was shown that adolescents had frequent consumption of sweets, chewing gum with sugar, and sugar containing drinks. Significant proportions of young people performed cigarette smoking and consumed alcohol, and they seldom consulted a dentist for oral health care. On the other hand, most children and adolescents had good general hygiene practices and brushed their teeth daily with a plastic tooth brush utilizing a fluoride tooth paste. Risk behaviours relevant to non-communicable chronic disease are common to oral disease. Experiences from Tanzania show that oral health risk behaviours of children

and adolescents are modifiable. Sustainable behaviour modification is possible through oral health promotion for the young and should start early in life. Risk factors to chronic and oral disease are common and this may call for integrated approaches in general health promotion strategies. Nevertheless, there are several constraints in relation to public health priorities and consequently to implementation of oral health promotion which include: high priority towards prevalent infectious life threatening diseases; low priority by health authorities to oral health problems; low literacy level; poverty; poor infrastructure; incomplete sanitation and clean water; limited number of health personnel; oral health is conceived isolated and independent from general health. Against this, there are positive factors that may facilitate the implementation process, namely;

Existing school health programmes aimed to combat infectious diseases may provide a unique context for incorporation of oral health

The availability of primary health personnel

*Contribution 3: Oral health promotion for people living with HIV AIDS - the example of Burkina Faso.*

S. Ouattara and P.E. Petersen. Research Centre Muraz, Bobo-Dioualaso, Burkina Faso and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

HIV AIDS is a disease of poverty which significantly affects populations of Sub-Saharan Africa. Many people are currently living with HIV AIDS; they are likely to suffer from a double burden of disease as they are also often affected by non-communicable chronic disease. Prevention of HIV AIDS may be strengthened effectively through oral health. HIV/AIDS manifest in the oral cavity with several oral lesions such as oral ulcers, bacterial and fungal infections. Oral health promotion and prevention of oral disease however need to be integrated with primary health programmes. Oral health professionals and primary health workers play important roles in this process, particularly; they have great potential in early detection of conditions, provision of essential oral care, health education, and referral for special care. Primary health care (PHC) is an appropriate community platform for control of disease and promotion of oral health. Initiatives of strengthening community intervention against HIV AIDS and their oral manifestations currently take place in Burkina Faso and Tanzania. Community participation and empowerment of people are important and in relation to children/orphans the schools and schoolteachers are essential. The efforts for strengthening of health promotion are supported by public health research to be translated for action and capacity building. Practical experiences from implementing evidence-based community-oriented oral health promotion are given from Burkina Faso.

*Contribution 4: Oral health promotion through schools - global experiences.*

N. Jürgensen. WHO Collaborating Centre for Community Oral Health Prorammes and Research, University of Copenhagen, Denmark

One of the challenges of health promotion is to identify effective settings for implementation. Schools have globally proven to be ideal platforms. Although the school setting will not be able to reach all children the primary school setting still covers a considerable large and diverse part of many child populations. This provides a unique opportunity to level out the socio-economic and geographical gradients observed in morbidity as well as in modifiable risk factors important for oral health; risk factors such as oral health related knowledge, attitude and behaviour. The idea of health promotion through schools has also been introduced in a number of countries in Southeast Asia. However, developing schools into a health promoting setting often strongly depends on visionary individuals at local level or the support of external resources. This keeps the number of health promoting schools limited/low while the project approach makes them less sustainable. To address this implementation gap and support the scaling up of health promoting schools a number of suggestions should be considered:

As a strategy for healthy public policies health promotion should be integrated permanently into the structure of the educational system and mirrored in teachers training and educational material for all primary schools

Personnel at all levels should develop necessary skills and be responsible for supporting the implementation of activities

Parents and local communities should actively be involved in the creation of the school as a supportive setting for health thereby increasing local ownership and sustainability

The health sector should be involved to assure correct technical input and provision of preventive and basic services

*Contribution 5: Barriers and opportunities for community-based oral health promotion in developing countries - lessons learnt in Africa and Asia.*

B. Varenne and B. Decroix. Aide Odontologique Internationale, Paris, France.

In many low income countries, oral diseases contribute substantially to the burden of non-communicable diseases and injuries. Oral health remains a neglected public health issue. This is reflected in the lack of organization of oral health promotion, disease prevention and oral health services. Both in urban and rural areas, populations have only limited access to oral health care and the use of fluoride is not widespread. Apart from national budgets for general health and in particular for oral health being very limited, one significant barrier to implementation of community oral health promotion relates to the gap between training offered to oral health professionals and the perceived and real needs of people living in developing countries. A comprehensive project has been established in Burkina Faso and involves the French Non-Governmental Organization Aide Odontologique Internationale. The project is based on the integration of preventive and curative oral health components into health promotion and shows how difficult it is to go from theory to practice if socio economic and oral health manpower requirements are

not met. The opportunity for organization of oral health promotion programmes is illustrated from experiences with capacity building activities. Oral health promotion skills of oral health staff may be achieved through technical, university and institutional networks. Thus, a programme ongoing in Cambodia shows that one of the keys to success is the active role played by local oral health officers capable of implementing and following up innovative and integrated oral health promotion activities, i.e. school health education, primary oral health care and work for population use of affordable fluoridated toothpaste. Research and practical experiences in numerous countries have demonstrated that health promotion should be based on awareness of environmental factors and healthy lifestyles of people. The example of Laos shows how the implementation of salt fluoridation will become an intersectoral programme as planned and developed at community level. At the end, the experiences gained call for a better integration of oral health activities into global health promotion programmes.

*Contribution 6: Health Promotion and Oral Health – Japanese Experiences.*

H. Miyazaki. WHO Collaborating Centre for Translation of Oral Health Science. Department of Oral Health Science, Graduate School of Medical and Dental Sciences, Niigata University, Japan.

Because of the failure to tackle social and material determinants and incorporate oral health into general health promotion, millions of people still suffer intractable toothache and poor quality of life and end up with few teeth. Health policies should be reoriented to incorporate oral health using socio-dental approaches to assessing needs and to apply the common risk factor approach for health promotion. "Healthy Japan 21" is a 10-year (2000-2010) national campaign intended to promote healthy behaviours of the national population and to build healthy environments through actions of communities, worksites, health professionals and other related organizations. National objectives are established and shared by interested parties. Oral health is included objective to prolong length of healthy life and improve quality of life. Objectives are specified within nine areas for "Healthy Japan 21": 1) food and nutrition, 2) physical activities, 3) mental health, 4) tobacco, 5) alcohol, 6) oral health, 7) diabetes, 8) cancer and 9) cardiovascular diseases. Lessons learnt from the development process of programmes for oral health promotion in Japan are that the continuous sharing of local and national experiences is important factor in effective implementation. Information about the weakness and strengths in identification of health determinants and formulation of policies and action plans are instrumental to oral health intervention.

*Contribution 7: Disease prevention, an essential complement to health promotion.*

R. Baez. Former Head, WHO Collaborating Centre for Translation of Oral Health Sciences into Clinical and Public Health Practice, San Antonio, Texas, USA.

Health promotion contributes to maintenance of oral health but efforts must be complemented with prevention. In several countries dental caries is on the increase. Fluoride for caries prevention has been recognized as an effective agent and various methods are available for use in public health and private practice.

There are many reasons that these public health measures are not available to populations, particularly in developing countries:

Non-existent or inadequate oral health programmes
Lack of oral health policies on public health prevention
Cost or non-availability of fluoride compounds or equipment
Inadequate human resources
Lack of technical expertise
Absence of on-site training opportunities
Lack of community education and impact of anti-fluoridationists
Poor economy and cost

For example the introduction of water fluoridation requires that the country/community has a reasonably well established economy with a reliable public water supply system. Also availability of equipment and fluoride product is essential. Caries levels should be high enough to justify the cost of the programme and government/legislative support is essential. Similar issues arise if salt or milk fluoridation is contemplated. The cost of fluoride toothpastes can be a barrier to their use; being classified and taxed as cosmetics in some communities contribute to their cost. Gels and varnishes require trained personnel for their application. Finally, use of fluoride supplements and fluoride mouthrinses require considerable compliance. Capacity building in planning and administration of fluoride programmes is essential. Countries are encouraged to ascertain the most suitable strategy to incorporate use of fluoride in community prevention programmes with the ultimate goal of optimizing oral health in the most efficient manner with minimum risks.

## Summing up and conclusions

The essential points made by the contributors are presented according to the five conference tracks.

*Track 1: Health Literacy and Health Behaviour*

Experiences from Tanzania show that oral health risk behaviours of children and adolescents are modifiable. Sustainable behaviour modification is possible through oral health promotion for the young and should start early in life.

Risk factors to chronic and oral disease are common and this may call for integrated approaches in general health promotion strategies.

Constraints to implementation of oral health promotion include high priority given by public health administrators to prevalent infectious life threatening diseases, low priority for oral diseases, lower literacy, poverty, sanitation and clean water and limited health personnel.

Existing school health programmes and the availability of primary health personnel are positive factors in the implementation process of oral health promotion for children (Kwan *et al,* 2005).

*Track 2: Community Empowerment.*

Schools have globally proven to be ideal platforms for implementation of health promotion.

As a strategy for healthy public policies health promotion should be integrated permanently into the structure of the educational system and mirrored in teachers training and educational material for all primary schools.

Developing schools into a health promoting setting often strongly depends on visionary individuals at local level or the support of external resources.

In several low- and middle income countries dental caries is on the increase. Fluoride for caries prevention has been recognized as an effective agent and various methods are available for use in public health and clinical practice. Automatic fluoridation programmes shall be considered by countries where fluoride in drinking water is sub-optimal.

Initiatives of strengthening community intervention against HIV AIDS and their oral manifestations currently take place in certain countries of Africa. New approaches to improving quality of life of people affected by infection and orphans are developed.

Oral health promotion and prevention of oral disease for people living with HIV/AIDS need to be integrated with primary health care programmes.

*Track 3: Strengthening Health Systems.*

Apart from national budgets for general health and in particular for oral health being very limited, one significant barrier to implementation of community oral health promotion relates to the gap between training offered to oral health professionals and the perceived and real needs of people living in developing countries.

In the majority of developed countries oral health systems need reorientation towards prevention of disease and health promotion. In developing countries oral health programmes need to be established urgently and policies shall give priority to health promotion and oral disease prevention. Human and financial resources are required to meet the needs for oral health care of the population.

In agreement with the recommendations of the WHO Commission on Social Determinants (WHO, 2008a), oral health services need to be financially fair in order to ensure oral health of poor and disadvantaged people.

*Track 4: Partnership and Intersectoral Action.*

Oral health promotion skills of oral health staff may be achieved through technical, university and institutional networks. Thus, a programme ongoing in Cambodia shows that one of the keys to success is the active role played by local oral health officers capable of implementing and following up innovative and integrated oral health promotion activities, i.e. school health education, primary oral health care and work for population use of affordable fluoridated toothpaste.

The example of Laos shows how the implementation of salt fluoridation will become an intersectoral programme as planned and developed at community level.

*Track 5: Building Capacity for Health Promotion.*

Health policies should be reoriented to incorporate oral health using socio-dental approaches to assessing needs and to apply the common risk factor approach for health promotion.

"Healthy Japan 21" is a 10-year (2000-2010) national campaign which has shown effective to promoting healthy behaviour of the national population and to build healthy environments through actions of communities, worksites, health professionals and other related organizations.

Capacity building in health promotion is essential to oral health. Countries are encouraged to study the most suitable strategy to incorporate oral health into national public health programmes with the ultimate goal of optimizing oral health in the most efficient manner.

## The Nairobi Call to Action

The oral health presentations focussed different dimensions of community oral health: social determinants; modifiable risk factors; poverty and HIV/AIDS; empowerment of communities for oral health; strengthening of oral health systems; settings for oral health; integrated disease prevention and oral health promotion, and development of oral health promotion in the context of a national health programme. Following the seven presentations, ideas were exchanged and, after much deliberation and constructive discussion, three key oral health messages were drafted for input to the Nairobi Call to Action (***Box 2***). The Nairobi Call to Action, which was developed through expert- and web-based consultation before and during the conference, was officially adopted on the last day of the meeting. It is a strong political statement that urges WHO and United Nations partners, governments, non-governmental organisations, civil society, communities and individuals to consider the key strategies and commitments urgently required for closing the implementation gap in health and development through health promotion (WHO, 2009b).

Global commitments are that all countries – governments and stakeholders- are called urgently to use the untapped potential of health promotion, to make health promotion principles integral to the policy and development agenda, and to develop effective and sustainable delivery mechanisms. According to the call for action, countries are to build capacity in health promotion, to strengthen health systems, to ensure community empowerment, to develop partnerships and intersectoral actions relevant to addressing the determinants of health, and to help improvement of health literacy and healthy lifestyles. Further, the Nairobi Call to Action emphasizes the need for countries to specify the responsibilities for implementation of health promotion, such as strengthen leadership and workforces, mainstream health promotion, empower communities and individuals, enhance participatory processes, and build and apply knowledge. The call to global commitment is presented in ***Box 3.***

## WHO- the way forward for promoting oral health

In follow-up of the 7th GCHP, WHO has strengthened its work for country capacity building in health promotion with a focus on low and middle income countries and application to priority public health problems. This initiative includes oral health conditions as well. *Mainstreaming Health Promotion* is a new WHO activity to

***Box 2.*** The three key messages that were formulated in relation to preparation of the Nairobi Call to Action

1. Oral health is a human right and essential to general health and quality of life.
2. Promotion of oral health and prevention of oral diseases must be provided through Primary Health Care and general health promotion. Integrated approaches are the most cost-effective and realistic way to close the gap in implementation of sound interventions for oral health around the globe.
3. National and community capacity building for promoting oral health and integrated oral disease prevention requires policy and appropriate human and financial resources to reduce the gap between the poor and rich.

***Box 3.*** The 7th Global Conference on Health Promotion Call to Action by Governments and stakeholders

**GLOBAL COMMITMENT**

We, the participants of the 7th Global Conference on Health Promotion, recognising the changing context and acute challenges, call on all governments and stakeholders to respond urgently to this Call to Action and the strategies and actions that follow.

*TO USE THE UNTAPPED POTENTIAL OF HEALTH PROMOTION*

We pledge, as champions, to:

- Use the existing evidence to prove to policy-makers that health promotion is fundamental to managing national and global challenges such as population ageing, climate change, global pandemic threats, maternal mortality, migration, conflict and economic crises;
- Revitalise primary health care by fostering community participation, healthy public policy and putting people at the centre of care;
- Build on the resilience of communities by harnessing their resources to address the double burden of non-communicable and communicable diseases.

*TO MAKE HEALTH PROMOTION PRINCIPLES INTEGRAL TO THE POLICY AND DEVELOPMENT AGENDA*

We call on governments to exercise their responsibility for public health, including working across sectors and in partnership with citizens, in particular to:

- Promote social justice and equity in health by implementing the recommendations of the WHO Commission on the Social Determinants of Health;
- Accelerate the attainment of national and international development goals by building and redistributing resources to strengthen capacity and leadership for health promotion;
- Be accountable for improving people's quality of life and well being.

*TO DEVELOP EFFECTIVE AND SUSTAINABLE DELIVERY MECHANISMS*

We request Member States to mandate WHO to:

- Develop a Global Health Promotion Strategy and action plans, with regional follow-up that respond to the major health needs and incorporate cost-effective and equitable interventions;
- Strengthen its internal capacity for health promotion, and assist Member States to develop sustainably funded structures and set up accountable reporting mechanisms for investment in the promotion of health;
- Disseminate compelling evidence on the social, economic, health and other benefits of health promotion to key sectors.

support the development of an evidence-based, outcome oriented package of health promotion actions. In response to this initiative, the WHO Global Oral Health Programme has intensified its actions for assembling the evidence on community based oral health promotion and integrated disease prevention; the goal is to strengthen the mechanisms for translation of oral health science into country policies and action programmes for oral health.

Health promotion offers a comprehensive range of specific and proven actions. Health promotion actions seek to produce changes in individuals, communities, health services, and environments. Actions for promoting health take a series of forms, including:

Dissemination of information, education and communication to individuals, to change health related behaviour, knowledge, attitudes and beliefs.

Using advocacy, mass communication and social marketing to shift cultural norms.

Legislation and regulation, to reduce population exposure to health risks and encourage health behaviour.

Empowering and supporting communities to take action and control.

Orienting health systems towards universal access, prevention and early intervention, primary health care and optimal patient education, and with a people-centred focus.

Ensuring sustainable health promotion capacity, including financing, training, workforce and leadership, and monitoring the effectiveness of health promotion programmes.

Advocacy and development of healthy public policies, to create healthy physical and social environments.

Such actions are in fact the basis of the WHO global policies for promoting oral health as being emphasized recently by the WHO governing bodies. The World Health Assembly 2007 is a major event in the world history of oral health. At the annual meeting of the WHA, the WHO Member States agreed on a unique Resolution (WHA60.17): ***Oral health: Action plan for promotion and integrated disease prevention*** (Petersen, 2008; Petersen, 2009). Based on a thourogh analysis of the global oral health situation, new strategies and approaches are recommended for countries to adopt. The scope of the Resolution is most comprehensive as it encompasses the major oral health problems and risk factors relevant to public health. Principal actions are suggested for tackling the social determinants in oral health, intervention in relation to risk factors of oral health, disease prevention and effective control of oral diseases through establishment of appropriate national oral health systems.

More information about the work carried out by the WHO Global Oral Health Programme is available on www.who.int/oral_health

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