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The Proceedings of the European Association of Dental Public Health and Council of European Chief Dental Officers Workshop in Montpellier on the Morning of Thursday, 8th September 2022. The WHO Action Plan for Oral Health – How Can the EADPH & CECDO Contribute?

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Aim and Objectives

The aim of the workshop was to explore how the members of the European Association of Dental Public Health (EADPH) and Council of European Chief Dental Officers (CECDO) can contribute to the success of the WHO Action Plan for Oral Health. Within this overall aim, the objectives for the workshop were to remind attendees of the aims of the WHO Action Plan for Oral Health and to consider how national actions in response to COVID-19, in particular interprofessional working, may help to facilitate the Action Plan.

Learning Outcomes

These were that attendees would have a clear understanding of the aims of the WHO Action Plan for Oral Health and its policy implications, together with an appreciation of how the experience of interprofessional working gained from the COVID-19 pandemic may help in the implementation of the Action Plan. They would also have an understanding of how EADPH can support the Action Plan and contribute to its implementation.

Workshop Programme

The workshop was chaired by Huda Yusuf who welcomed the 98 participants who attended in person plus a further 31 who attended online. She explained that the aim of the workshop was to explore how the members of EADPH and CECDO can contribute to the WHO Oral Health Action Plan, to remind attendees of the aims of the WHO Action Plan for Oral Health and to consider how national actions in response to COVID-19, in particular interprofessional working, may help to facilitate the action plan. She thanked Colgate for sponsoring the workshop and then outlined the programme. This consisted of a brief overview given by Paula Vassallo and Kenneth Eaton, followed by two guest speakers, Dr Paul Boom and Professor Habib Benzian, both of whom had been involved in drafting the Action Plan. This was followed by five presentations on national actions in response to COVID -19. These were given by :

Huda Yusuf	- United Kingdom
Paula Vassallo	- Malta
Dympna Kavanagh	- Ireland
Roxana Oancea	- Romania
Aristomenis Syngelakis	- Greece

The five presentations were followed by a short briefing after which the participants divided into four working groups which considered;

- Implementation and translation of the strategy into government policy, chaired by Dympna Kavanagh
- Universal health care coverage, chaired by Gabriele Sax
- Indicators and monitoring, chaired by George Tsakos
- Integration, inter-general health care and the impact of educating the future workforce, chaired by Stèphanie Tubert

The four working groups then reported back during a plenary and the workshop concluded with a summary by Paula Vassallo and closing remarks by Irina Chivu-Garip of Colgate, who sponsored the workshop.

Welcome and Introduction to the workshop

Paula Vassallo: welcome to Montpellier. It is a city of innovation so I think we need to link to the concept of this city. This is a landmark opportunity. Finally our dream has come true and we have the opportunity of putting oral health on the agenda. We're putting the mouth back into the body. So, I think we have a real opportunity. We need to focus this workshop on seeing what are the challenges? What are the opportunities? What have we learned from COVID, from the pandemic, which we can actually take forward and learn to give us an opportunity to achieve Oral Health Strategy in the WHO Action Plan. It is going to be a really exciting time for all of us, but we can only do it if we all collaborate and work together. We really need to persevere because it is a challenge and some countries will see it as such. However, I just think of one character, I've mentioned it to a few members who were here yesterday. We should think of J.K. Rowling and her persistence. How many publishers turned her away before she finally found one who said yes we will publish your book. Now J.K. Rowling and her books are known to all of us. She overcame rejection by 20 publishers but look where she is today. I look at all the years we've been insisting that oral health is on the WHO agenda. We have now achieved this. Let us work together to achieve the global strategy and see how we can implement it in our countries. So, this is why we are here today, so welcome everybody. And now I'd like to give the floor to Ken Eaton.

Ken Eaton: I am just talking about the nuts and bolts of this workshop. You've seen the programme. Essentially you have a lot of information provided in the first half of the workshop, and then you start working in small groups and come up with ideas which we can follow and use. So, this is really important. We'll have four small working groups and the key suggestions will be presented in a plenary. Very importantly, we are audio-recording this session, as we have in previous workshops, and the proceedings will then be published in Community Dental Health. Is there anybody who objects to being audio recorded? I'm very glad, I'm very relieved, we'd have a huge problem otherwise. I'm going to stop talking now. So, thank you very much. Have a fabulous congress and pre-congress workshop. Thank you.

OVERVIEW OF THE WHO ACTION PLAN OF ORAL HEALTH
DR PAUL BOOM

Huda Yusuf then invited Paul Boom to give his presentation. Good morning, my name is Paul Boom. I'm the WHO liaison officer for the Council of European Chief Dental Officers and a former Chief Dental Officer for the Netherlands. I would like to pick up on one sentence that Paula said in her introduction, that we should be very happy and joyful to have oral health finally on the agenda. I can only completely agree with that. But at the same time, as a former diplomat I know putting something on the agenda is one thing, but to keep it on the agenda is something completely different. I think now we are heading for this very crucial moment to keep the support for the oral health alive and to use all our efforts and creativity for this.

Now without further ado, this workshop is on the WHO Global Action Plan on Oral Health. Well, not to go into much detail of the history of the Global Action Plan because you know, the key document on this clearly is the resolution on oral health which was adopted in Geneva almost two years ago. On the basis of this, WHO, in consultation with the member states, developed a strategy on oral health addressing the most important elements of the resolution. Now the resolution has not completely fallen from the blue sky. It goes back, it has it's, you may say legal background. There have been earlier declarations which were issued in New York, both of them on the two pillars of the resolution, which are on non-communicable diseases, acknowledging that oral health is not simply a small domain for dentists but it is part of the wider range of non-communicable diseases. As you know oral diseases are the most common, the most prevalent non-communicable diseases. So it's a little bit surprising that it took so long to have them embedded into the NCDs. At the same time, it's very important that oral health is not only restricted to the well-to-do people in this world but it is for everybody and therefore universal health coverage is important, so that there is access to essential oral health available for all.

Now what are the global targets for the action plan? Like I said, enabling, ensuring oral universal health coverage and the target for this is that by 2030, which is the time limit of the action plan, three quarters of the world's population have access to essential oral health care. There is already a discussion on What is essential oral health. It has been suggested to reduce the oral disease burden by 10%. So, these are the guiding principles for the action plan and it is based on the global strategy, as adopted last year. It, covers six areas that should be addressed. They are governance, promotion, oral health workforce, health care itself, information systems and research agenda.

The target for governance is that 80% of countries should have an operational national policy on oral health which should be embedded into their primary health policies. So, oral health governance is not a separate domain anymore, but it must be embedded. WHO, again in consultation with the member states, will include different topics within governance. One of them is the Minamata Convention which aims at reducing Mercury in the environment and of course dental amalgam is a very important aspect of it, must be 90% phased out by 2030. As far as Europe is concerned, the EU, has regulations on this which require that amalgam must be phased out in 2023.

As for prevention, quite controversially there is sugar tax. In order to promote prevention, 70% of the countries must have sugar taxation on beverages. I've been asking WHO why it's such a very concrete and precise thing because you can imagine that there are other ways to have a sugar reduction, for instance by advertisements, campaigns by limiting sugar content. However, WHO, they say we must have a very clear indicator that is for everybody to see and maybe also for some extent to entice dentists and dental officers to look beyond the borders. It is not only about dentistry as a care facility, but you must also see that it has to do with legal measures, with taxation, with completely different domains. The action plan is due to be endorsed early in 2023 by the WHO Executive Board who will almost certainly discuss these issues. Another target is that 50% of countries must have a national guideline on fluoride delivery and then it's up to the countries how they achieve this either by drinking water fluoridisation or by using gels or fluoride in toothpastes or other means.

As far as oral health workforce planning is concerned, probably for most of you in this room, understand that this does not involve only the dentists and it does not only involve the oral hygienists or dental technicians but includes community health workers and people from all sorts of different fields in primary health care. The resolution is beyond the European domain, it also involves African countries. During my work at WHO in Geneva it was quite surprising and interesting to see that African countries were advocating for having traditional healers, we would say Witch Doctors, but I would not use this term, to have an understanding of oral health care because these people are very important intermediaries to the local population. Eighty percent of the countries have oral health services available in primary care facilities so oral health care must be part of primary health care. Personally, I know full well that not all countries have primary care facilities. There are different countries where dentists and oral hygienists have their own dental practices, but these should be linked up very carefully to primary health care networks.

A more technical thing is the WHO's essential dental medicines list. It includes only 50 medicines which WHO stipulate should be available to all the population in all countries. I do not know exactly what kind of dental medicines should be included but we should try to ensure that some are and at least this is mentioned in the resolution.

The next area in the Action Plan is information systems. We do have information systems in the European region, but not all of them are very stable. There are the Organisation for Economic Cooperation and Development (OECD) and Eurostat databases. However, they include little, if any data on oral health. This is something we have to work on because having an action plan is one thing but if you cannot measure how you perform, it is almost useless.

Research is the sixth area in the Action Plan. At least 20% of countries should have their own research agendas and I think this is fairly self-explanatory.

So all in all and I come to finalise my talk this morning, as you can see it's a very detailed plan, some people say it's a little bit too detailed. However, if you do not go into detail, then, a resolution is one thing but to keep it focused and have a very concrete plan is another thing. Clearly there will be some debate on it and the action plan has a very elaborate framework, a monitoring framework which is in the annex of the action plan with very clear indicators. There are 11 core indicators, most of them based on the topics that I've just been mentioning so these indicators are, you may say mandatory. They are important to monitoring progress and then there are a further 33 additional indicators.

So the plans are becoming more concrete quite necessarily because otherwise you know, it remains too vague to get to grips with. Nevertheless there will be debate and some controversy. So, I think that the oral health community, CECDO, but also EADPH, which is a scientific network, but at the same time having a lot of political sensitivity, should have an important role to play. We must balance the political sensitivity and the expertise that we have. In my opinion, expertise nowadays is taken more seriously by policymakers. We have been facing COVID and whatever your political stance is, there is a virus and it's there and we have to do something about it. Yesterday we had a tremendous storm I have never experienced before in my life. I think climate change is there to go and you can have political debates on what to do with it that's for sure, but we do have climate change. And that is the same for oral health. If we have half of the population suffering from poor oral health you are the experts and you can say, 'Look politicians, we have to work on this.

IMPLICATIONS FOR THE HEALTH CARE POLICY MAKERS AND PLANNERS PROFESSOR HABIB BENZIAN

Paula Vassallo introduced Professor Habib Benzian, who thanked EADPH for the opportunity to speak. He started his presentation by thanking the organizers, participants and online listeners for their interest; and Paul Boom for nicely seting the scene. He went on saying:

My name is Habib Benzian, I am Director of the WHO Collaborating Centre for Quality Improvement and Evidence-based Dentistry at the College of Dentistry at New York University. I live in Germany, and I work in New York and Geneva. In my presentation I would like to remind all of us why we need the WHO Global Oral Health Action Plan. From a European perspective we may feel comfortable about the status of oral health, or not, depending on whether one considers the glass is half empty or half full, but there are other parts of the world where the situation is very, very different. I will speak about the global action plan and its key features; and will highlight what is new and innovative with it and why this time we may have a chance, like Dr Vassallo said, to really make a difference. I will close with a few reflections related to the purpose of the workshop,which is how can we as dental public health professionals and decision makers contribute. I believe that it is time to rethink some of our fundamentals in dental public health, and to strengthen the interface between science and policy to make it stronger and more effective.

So, let's start with the status of oral health. This is a sentence from a report that will be published later this year by the WHO, the Global Oral Health Status Report: 'The status of global oral health is alarming and requires urgent action'. This is a sentence that seems simple and you have heard it many times and you will hear it probably throughout this conference even more. It was almost similar in The Lancet series, but what does it mean and why do we need this?

We have 3.5 billion people affected by oral diseases and that's almost half of the world's population. So, one in two persons are affected and this is unprecedented. There is no other disease group on the planet that affects as many people as this. From the global burden of disease studies, we know that there has been no change in prevalence between 1990 and 2019, so over 30 years there has been no significant change in prevalence. But at the same time, we see a massive increase in cases because the population is growing but also because the disease burden is growing. We have one billion additional cases and three out of four affected people live in middle-income countries, so the main burden really is in the middle-income countries. It doesn't mean that in high-income countries we are off the hook, not at all, I'll get to this a bit later. This is another graph to show where the burden sits in low-middle income countries and in upper-middle-income countries and the green and the blue parts represent caries which is the main part; two and a half billion cases of caries in deciduous and permanent teeth. These are staggering numbers. We may know this, but the community of public health and global health practitioners outside of this room will not know. For them this is news and maybe they might believe it or may not believe it but it's up to us to tell them and to convince them and to show them where we are with oral health.

Oral health globally is massive, this shows it has massive inequalities. Here (pointing to a slide) you have inequalities in expenditure, high-income countries spend 800 times more than low-income countries and 80% of that only benefits 20% of the world's population so we have massive imbalances here. This is not to blame anyone, it's just a matter of fact and is the reality. Another dimension of the reality is that we saw the inequalities in expenditure but here are also the inequalities in terms of health system capacities, shown in terms of the number of dentists per population.

You all probably know the consensus statement from the IADR's Behavioural and Science Group which calls for a broader range of research methodologies. The plea for more behavioural and social science research related to oral health has been going on for decades but now it is really time to make this a reality. It also means that funding institutions, who are funding oral health research, need to look at their priorities and the resources that they make available, the funding lines, the grant lines. The funds for research need to reflect these changing needs and priorities. In terms of data, I think we are in a time of transition. We all know DMFT and CPI and all the other indicators that we have been living with for a long time and have been used in many studies, but there's a shift now towards the global burden of disease system of estimations, which of course also needs surveillance and solid population data. But in places where a national oral health survey is a luxury and is really unaffordable, or not possible because of lack of resources or capacities, an estimation is better than having no data and these estimations are getting better. They are not ideal, they have many issues, and we can spend the whole day debating the validity and quality of global burden of disease data, but it's the best we have at the moment for most places. We need to look at quality dimensions and we need to look at health system indicators and that's where this full list of indicators that Paul has mentioned from the global action plan comes in because it covers all of those areas and gives examples of indicators that can be used to measure system performance, quality of care etc. Another area where I think we need to be really careful in the future is in the quality of research. There have been several papers in the recent past that have shown that there's a lot of garbage science out there and we have sometimes been part of that garbage science. But we need to be careful that our research is useful and matches priorities. The global action plan therefore also has a proposed action for defining national oral health research priorities for each country, and the target is that 20% of countries are supposed to have those plans. We are also all struggling to find research funding for the work that we want to do and that we need to do. At the same time we need to be cautious about conflicts of interests, particularly when it comes to research that is industry sponsored; and I'm not talking about the oral health care industry in the first place, I'm talking about the food and beverage industries and all other industries that produce health damaging commodities. As organisations we need strong policies related to conflicts of interest and how to manage those conflicts, and these policies need to be transparent and relations with industry need to be disclosed, otherwise we are risking our credibility being undermined in the long run.

I know it's complicated when you want to work with corporate partners. Our world is globalised, and you have a single name of a company that produces stuff and products that are unhealthy, but this company also produces one product that is healthy like a toothpaste or a sugar-free chewing gum. How do we deal with this? We try to limit our view on the department of that company, the branch that works in favour of oral health and we try to blend out all those other aspects. It's very complicated, I don't have a solution for this. We just need to have this discussion in a very transparent way.

In summary, I think an epidemiology of consequence, looking at implementation research, embracing the new data science that is evolving and looking at our priorities when it comes to oral health and dental public health research as well as the scientific independent studies that are so important for us.

Let me, lastly, talk a bit about the interface between policy and science. We have all seen during COVID how difficult this relation can be and has been in many countries, and for many of us even. Are the science and political decisions in public health compatible when you look at those examples? Probably very challenging. A former Centre for Disease Control director, William Roper, said that sometimes there is the idea on the part of scientists that politics is dirty, and politicians like to think that scientists are idealists, and they have no idea about how to put science into practice because it's just not possible in the right way. So, we have really two polarised opinions in this statement. Of course, in reality there's everything in between and we have seen everything in between during COVID. Sometimes there was political interference and data interpretation, and the communication of science was difficult for scientists because they're not used to talking to the public or even talking to politicians in a way that a politician can relate to. We have no training in this. We had political interests interfering with scientific integrity in many countries. All these debates about masks, about vaccinations, about public mitigation measures, we're going to talk about this later. So, the spotlight is really on this. Our naïve thinking oftentimes in science is we have the good evidence and then the change will happen, and the politicians will listen. This is not the case. This is not true. This is too simplistic. In reality, we have rarely evidenced-based decisions. At best we have evidence-informed decisions where many other things are taken into account when it comes to a political decision, and science and evidence is one element of these items to consider for decision making. As scientists, we need to understand this and be humble also in the way we can improve and integrate our science into political decisions. So, it's a process and I think the COVID pandemic is definitely a wake-up call in this context. A quote from Trish Greenhalgh, some of you may know her, she's one of the most eminent implementation scientists that we have, she has worked a lot on concepts of implementation research. She thinks that there's a deep mismatch between the science that we produce and the needs of politicians, of clinicians, of patients. So, we really need to work on this and listen more and understand better how we can improve our science.

In conclusion, I think the status of oral health as we have seen, gives best reasons for accelerated action. The action plan is a great opportunity, probably a once in a lifetime opportunity, at least for us who are beyond 50 or 60 years old. The concept of essential oral health care is something that we need to work on, take seriously and think through in all its implications. We need to look at and embrace the new indicators and metrics and not forget about the DMFT, but there's a world beyond the DMFT that we need to live in and be comfortable with. Dental public

health should focus more on implementation research and take the needs and priorities into account, and we need a very strong and effective coalition between dental public health science and policy. Sir Richard Horton, editor of The Lancet, put all of this in a very succinct statement at the launch of The Lancet series in London, 2019. 'Everyone who cares about global health should advocate to end the neglect of oral health' and I think this is why we're here.

Huda Yusuf: Thank you very much Professor Benzian. Are there any questions?

First Question: Thank you for this interesting presentation. My question is about the use of evidence, oral health evidence because we don't have a lot of strong research about the type of design we would use. How do you find the balance between the clinical research and evidence and public health evidence?

Habib Benzian: Thank you. Shall we collect a few questions and then try to answer them?

Second question: I would just like to add on the previous comment that we have a severe lack of qualitative studies you know and I feel like we're trained not enough to perform qualitative studies We do not include them in our undergraduate dental studies at all and only start to consider them in Master's and PhD programmes. I think we maybe need to think a little bit about that as well.

Third question: I'm quite interested in what you said in terms of evidence-based policy and making change, and what you seem to be saying is linking science to policy in terms of dental public health, but I feel the reality of the situation on the ground is that some of the perceptions about what is evidence-based policy amongst the profession in general, not just in the dental public health fraternity, are flawed. The evidence does not appear to influence the policy makers. So I wondered if you had any thoughts on this and perhaps it is more complicated making a change through evidence-based policy.

Fourth question: Thank you very much for your presentations. My name is Aristomenis Syngelakis. I am the Chief Dental Officer of Greece. I would like to say that of course I agree that it is a different story to do something with people's oral health, and most importantly for vulnerable people's oral health but I' m really anxious and I would like your answer. Are you afraid of the consequences of the war in Ukraine and the implications of rising prices in stopping WHO projects and more importantly, how can we react to that? We realise already that governments are trying to decrease their health budgets and I am afraid that oral health is the first victim of this massacre. Thank you.

Habib Benzian: That's a nice set of questions already.

Paul Boom: As for the last question, I leave it for Habib to speak about the scientific aspects. The current situation clearly affects all domains of society, including oral health. Undoubtedly, at present, governments have many other things on their minds. However, in these challenging times it is even more important to keep oral health on their agendas.

Aristomenis Syngelakis: I think that we need to be sensitive of the political situation that we live in nowadays. I mean the economic crisis and the energy crisis. The war in Ukraine and other political developments may certainly have an effect on oral health in the scope of the policymakers in two ways clearly. Firstly, there will be a change in budgets, you are right, so there is a challenge here how not reduce oral health funding - on the contrary, we need increased oral health funding. Even more serious is that politicians, many of them, have other things on their minds than oral health, so funding and political priorities can shift to other areas. Although there is a risk that the dental community may seem like a kind of sect to some, it is our duty to continue to say how important oral health is and we all need to work harder to make it a health system priority. Indeed, the fact is that oral health is a fundamental human right that must be guaranteed for everyone. These meetings help us to join our forces in this direction.

Habib Benzian: If I may add to this, we have seen in other situations that health budgets were the first to be slashed when it comes to austerity measures, we saw this after the Euro crisis. We have now already seen that some countries are cutting their investments, their budgets on foreign development assistance, Germany, UK have reduced their budgets.

Aristomenis Syngelakis: Prevention measures are the first victims of austerity.

Habib Benzian: Of course, but as Paul says the only thing we can do is to keep, keep advocating and keep pushing to have visibility, and again, this global action plan, all the entire set of activities around oral health at global level are giving us the best of arguments and visibility in a new way that has not been the case before. We tried to slot ourselves in to the NCD movement to get on some train that is running, that has political attention, now we can stand on our own feet with a resolution, with a plan, with a global strategy, and all the other products that will be forthcoming, so that's definitely something else.

With regard to the other questions, on the balance between clinical research and evidence and public health evidence, that's clearly a big challenge and it's deeply rooted in our system of oral health education, how we train dentists, how we see the role of dentists and oral health professionals in society. Are we a group of professionals repairing damage or are we a group of people who are looking after the wellbeing of populations at a higher level and prevent disease from happening? When we see the investments that are made in clinical care versus the investments that are made in preventive care, and that's not only in dentistry, that's across all domains of health, the investment for preventive is always the smallest part

in everything. Of course, that is, when it comes to discussing or negotiating or, as one of the questions suggested, finding a compromise between science and policy. That is a very complicated process and it's rarely straightforward, and as you rightly said there are battles, fights or disagreements within the profession that we need to resolve.

We have seen this very prominently in COVID, you see one evening an interview with a scientist who says masks are saving us and the next day you see someone who says masks are rubbish, and the same for vaccines. If you are a politician and you have no scientific training, how do you judge the quality of science? It's very difficult. The same applies of course to a lot of research saying that within the profession we have on many issues, some of the QUAL issues even we don't have agreement, look at the fluoride content in children's fluoride toothpaste. Aubrey Sheiham and colleagues did a study showing that every country has different recommendations, and this is similar also in general health when you look at the guidelines for endocarditis prophylaxis, you have different guidelines in each country. For First Aid responders for a heart attack, you have different guidelines in every country. So, this is a role for regional and international organisations to foster consensus and to promote alignment and I think EADPH has a platform, it's certainly well positioned to support such processes. And then if the science is clearer and it's more aligned, it's easier then to convey a common standpoint when it comes to political discussions and discourses.

Huda Yusuf: One question was about training and somebody online is asking whether we should have dental public health training within generic specialist public health training. What your thoughts were on that?

Habib Benzian: I'm very clear on that. Dental public health is public health and if you have an MPH or a Master's in dental public health, the difference is minimal so if you do an MPH and you have a module or two or ten on the specifics of oral health, fine, but why have this separation? We have too few dental public health specialists in every country, so any way that we can boost our body of workforce in dental public health and in public health is welcome.

Huda Yusuf: Thank you.

Paula Vassallo: Now we're going to have a few very short presentations on the impact of COVID in different countries because this also has an impact on the implementation of the oral health resolution in our own countries. Huda you'll be giving us examples of what happened during COVID, how you supported the different groups.

CONSIDERATIONS IN THE LIGHT OF NATIONAL ACTIONS IN RESPONSE TO COVID-19 LONDON: HUDA YUSUF

Huda Yusuf: I'm not going to be giving you the view from England but giving you the view from London, where I work, so please forgive me. It's not just going to be dentally focused, but it's going to take us through a journey of childhood obesity and tackling health inequalities among looked-after children. I'll be looking at the impacts of COVID-19 on children and young people. We know it's had significant impacts on education. The majority struggled with home learning, especially those from deprived backgrounds. Children's wellbeing was really impacted, isolation from friends and educational settings. Concerns about family and friends getting sick and dying during the pandemic and anxiety was especially significant among older young people. So there was decreased psychological wellbeing among children with special educational needs or disability and in those from disadvantaged backgrounds this was really prominent. In terms of health behaviours, we know that children consumed more junk food and snacks during lockdown, and this was more prevalent again, among children from poorer backgrounds, highlighting health inequalities. Lockdown in London and in England in general has led to food insecurity. It's very likely that existing inequalities have actually increased during the pandemic. So, if we look at two major public health problems, tooth decay and obesity, they're both public health challenges in London and globally.

In London, one in four children aged 5 years have tooth decay and one in four children aged 4-5 years are overweight or obese. You will see again social gradients both in tooth decay and childhood obesity and therefore we do need to target the social determinants and shared risk factors. So, what did we do in London? One of the biggest issues we had was looked after children. In Europe, I think they're known as children in alternative care. So, children looked after may be at risk of poor oral health due to social determinants, which impact on health behaviours, such as prolonged use of infant feeding bottles and increased risk of unhealthy behaviours such as unhealthy diets. They are more likely to have a diet high in free sugars and not used to consistent meal patterns, poor oral hygiene and limited access to dental services. Which leads us to the point of safeguarding, how are we safeguarding these children? During the pandemic in London, access to dental services was compromised like everywhere else in Europe. Hence, annual oral health assessments which are part of general health assessments, which is a legal requirement by the local authority and the NHS, the National Health Service couldn't be conducted. So, what did we do? We launched a pilot on 15 November 2021 with the aim of providing oral health assessments and dental care during the pandemic to 10,000 children across London. We promoted the pilot through different children's networks and re-integrated oral health into general health. We didn't just go ahead and do the pilot, we co-produced the resources, the model, the clinical care pathway with looked after children's teams, nurses, doctors, and dentists and we sought their advice. We trained dental teams. We also trained looked after children and we obtained ethics approval to evaluate the programme.

The other passion of mine is childhood obesity. We have 'every child a healthy weight' ambition in London. It was my job to develop a London child obesity delivery plan with key partners, with the Greater London Authority, with the local region, with the NHS and different stakeholders. If you look at the ten ambitions that we have for childhood obesity, I think nine of them relate to oral health. End child poverty, supporting women to breastfeed, skilling up the early years' workforce, using a child measurement programme to support parents and engage with them. Healthy schools, healthy early years. Making free water available everywhere in London. Creating more active spaces, stopping unhealthy marketing of food, transforming fast food and looking at better ways of food marketing and delivery. So, one of the programmes that we are trying to implement in London and have piloted already is the school superzones. It's a programme that protects children's health to enable healthy behaviours. It's based on a 400-metre zone around each school to reduce harmful exposures, such as air pollution, gambling, unhealthy food, alcohol sales and increasing health-promoting ones such as access to parks and safe spaces. Part of that programme is also water only schools and the healthier food advertising policy. To make free London water available everywhere, we launched the water only primary schools tool kit during the pandemic with COVID guidance. During the pandemic we also had an undergraduate dental student undertaking an MSc in global health and she supported the development of the water only secondary schools tool kit, which was co-developed with young people in London. This tool kit was launched in February 2022.

What have I done in terms of local action, being based at a university? We have implemented sugar smart Tower Hamlets programme. The university's based in a very deprived area of London. So, sugar smart Tower Hamlets targeted primary schools. It was co-developed again with teachers and was piloted reaching 2,700 children aged 4-11 years. The programme is actually delivered, you will see in the pictures, by dental undergraduates under supervision, to promote healthy living. So going beyond oral health but also into general health. It has been endorsed by the Mayor of Tower Hamlets. The programme was paused during the pandemic, but we had the opportunity to evaluate the programme again with a dental student doing another Master's in public health. So, it has benefits to the local population and upskilling undergraduates in delivering health promotion. So, in summary, the COVID pandemic has highlighted health inequalities, it also brought opportunities for multi-sectorial working that enabled a swift and co-ordinated response from all of us, including dental public health. The next step is to continue to advocate for child oral health in the context of general health.

Thank you. You can now hear the view from Malta.

CONSIDERATIONS IN THE LIGHT OF NATIONAL ACTIONS IN RESPONSE TO COVID-19 MALTA: PAULA VASSALLO

Paula Vassallo: Thank you Huda. I'm going to take a different perspective. I'm just going to highlight what we did in Malta during the pandemic. The role of the oral health workforce, how we were instrumental in dealing with the pandemic. I will also look at the impact of COVID on health and on oral health at a global level. What are we seeing? There is no scientific evidence to date as yet, because we haven't yet had outcomes of any studies, but this is what is happening in reality from the clinical service delivery, from graduation of students, from health promotion, some public health, and also what is happening in Malta.

So, what did we do when the pandemic hit in March 2020? Previously we thought it's in China, is it coming to Malta? You think it's far away but with globalisation on 7 March 2020 we had our first COVID case. A covid 19 response team was set up and all public health specialists and trainees were called upon to form part of this team. Different teams were set up including a senior advisory team, a case management team, a contact tracing team, a swabbing team, a follow up team and a communications team. A public health helpline was set up and a drive through swabbing hubs were set up,. As the numbers started to increase, all health care professionals were called upon to support the public response team. I think it was the first time. Look at how many times in public health we talk of whole government but in COVID it was the first time we actually had a whole of government approach. During the pandemic there was multisectoral collaboration and this included collaboration with the Ministry for Tourism, Ministry for Education, Ministry for Agriculture, Ministry for Home Affairs and the Ministry of Transport, which provided drivers and cars for transporting symptomatic patients who did not have their own transport to swabbing hubs.

The multisectoral collaborations were instrumental in dealing with the pandemic in Malta.

We needed transport so the Ministry of Transport gave us cars. We needed drivers, people came from nowhere, I mean I still to date don't know where everything came from and we also adopted a just-in-time vaccination strategy, the vaccines arrived on a Sunday by Monday, we started vaccinating. Malta had a successful vaccination. Vaccination was prioritised and started in December 2020. We set up a good communication team because we knew we had people who were managing the pandemic. We know from COVID how everybody became a public health expert overnight with all the fake news that was out there, and we ensured there was transparency in reporting because we couldn't afford to lose the reputation of public health.

So, how were the oral health care professionals involved? They were the first people to come and support in setting up and actually carrying out swabbing, carrying out the tests, they were managing our swabbing centres, they supported in our Helpline, in case management, contact tracing, in guidance and were instrumental also in vaccination hubs. In any other COVID related duties we had our dental students, who were also helping in administering the covid vaccines, who were supporting, who were going out in the community using the mobile dental clinic, which belongs to the university, using it as a vaccination hub. The dental clinic in the hospital was also used as a vaccination hub. For them, PPE was an easy thing because we know our profession is second to none in this aspect and for us infection control is easy.

What did we think of the impact of COVID on the wellbeing of the European population? We knew there was anxiety and depression, nearly one in three of our youths were suffering, Malta was no different and the demand on our mental health care services, which was already being stretched prior to COVID and let alone now, has been enormous.

Globally, Covid had a huge impact on employment and job losses, leading to income instability and hardship. Malta is a small island which depends on tourism so when we closed our island, we banned travel and a lot of people had job insecurities. There was support from the government in giving monthly financial support in order to alleviate the impact and ensure future sustainability and quick recovery.

How did vulnerable groups manage? They were suffering, you could clearly see. How could they access any service, anything that was needed? There was also fear, as we have heard before, from previous speakers.

What about the health care systems? What was happening around the world? Were they able to cope with the impacts of the pandemic? What happened? A lot of non-essential services were shutdown, everything was set up to deal with the influx of COVID patients so this also had an impact on service delivery in dental care. What about the long COVID? We're still seeing the impact of long COVID in general. We clearly have seen the inequalities and how the system was not geared 100% to deal with such a pandemic. The pandemic has resulted in widening of health inequalities globally and it quickly became apparent that many health care systems were not apt in dealing with such a pandemic.

Alongside widening health inequalities, access to healthcare was compromised with increased waiting times, increasing costs in the private and public sectors which are translated into increasing cost for patients. So, how can affordability in terms of access be addressed? There was decreased access to dental routine services and delays in oral health referrals. This was aggravated by poor health-related behaviours including a higher consumption of both sugars and alcohol. We heard also from the London experience we've seen the increase in health-compromising behaviours. In Malta all You would see while driving are taxi drivers on scooters, and driving around even for a simple cappuccino. It reaches the extreme where all the unhealthy habits were manifested and there was a higher sugar consumption and higher alcohol consumption. I was discussing some questions with colleagues who have alcohol shops, and they said the pandemic was the best time ever for them, business boomed.

One important factor was and is the mental health and wellbeing of our workforce which is something we are living with today. We know that we're facing a lot of challenges in terms of the non-communicable diseases, in terms of delayed treatment, in terms of no secondary prevention, no primary intervention, with a very tired workforce. How can we try to face all the challenges?

What was the impact on oral health?

During the first wave of the pandemic, dental services in Malta were providing only emergency services and aerosol generating procedures were not being provided. As a result, delivery of dental care was compromised.

Covid also had an impact on education in Malta as clinic dental education was postponed during the pandemic and dental graduations were delayed, leading to a shortage in the workforce.

What happened at a European level? Where are we going? What are we expecting to see? The deterioration we're seeing in oral health, as we heard before when budgets are cut out, oral health is given the cold shoulder. There was cessation of the oral health prevention programmes, schools, everything, since nothing was happening, they weren't allowing children to go to schools. It was in part of the public health advice which to keep everybody in bubbles, so public health programmes had to cease.

What are the lessons learned? One is that we need to ensure that oral health is included in pandemic preparedness plans. Hopefully it won't be in my lifetime that I there is another pandemic. We need to ensure and this is something in fact that EADPH, with a lot of colleagues over here, have worked together to draft an oral health pandemic preparedness plan. We've put this all together and we will then be disseminating it in a few weeks, maybe a few months, maybe a bit more. It's something that we have worked on because for us it clearly came out how oral health was not considered. We need to ensure sustainability of our health care systems. We need to ensure we have a resilient workforce, because we have clearly seen the impact it has had on each and every one of us. We need to ensure that public health programmes are prioritised. We need to include resilience within our training programme. We need to, as we heard yesterday, for those of us who were present yesterday, the digitalisation of healthcare, how COVID has

changed our way of delivering the service, how we have used digital technology to move forward together. I think we also need to build on the multi-sectoral collaboration we have actually achieved during COVID. So, we need to continue working together as a public health body in the first place but also with all the other sectors because it is only, when you say, 'health is in our hands', it's 'oral health in our hands.' Actually we are responsible for a very small part of achieving good oral health and good health just within our sector. If we don't have funding, the political will from the whole of government, if we don't have other sectors involved, they need to support as there's very little we can achieve alone. So in conclusion success depends on all of us working together with a common goal and I think here we have the action plan in mind focusing on our commonalities and not on our differences but keeping in mind that public health programmes need to be prioritised.

CONSIDERATIONS IN THE LIGHT OF NATIONAL ACTIONS IN RESPONSE TO COVID-19 IRELAND: DYMPNA KAVANAGH

Good morning and I might be repeating many of the things that are said already. I have included quite a few statistics but it's not about the numbers, it's about the message that's behind these numbers. I'm from Ireland, we're bigger than Malta; there's over 5 million people in the Republic of Ireland so my presentation is in that context. We have a little bit more bureaucracy than Malta but also that sense of a hands-on approach..

First of all, where are we now in relation to COVID? I think like very many other European countries we are seeing it moving into the distance. We had 1.5 million cases. The vast majority of our cases and our deaths were in the over 75s. In Ireland it was one of the red-light areas with regard to older persons' deaths in residential homes. At the moment, we have 253 in hospital and eight in ICU as of yesterday. Eighty-six percent are fully vaccinated, but we're moving into the fourth wave and again, like many other countries we're seeing a decline in the uptake in vaccination. So there is less anxiety within the population but the concern is that we still have a public health issue. Finally, for our fourth vaccination, we're targeting it at the moment on the over 50s but moving fast down the age scale. What's very interesting is from the very beginning of COVID, we had a very large debate about the inclusion of dentists and other health care professionals providing vaccination that has now completely quietened down. Dentists are accepted as health care professionals and have a greater sense of confidence. But at the moment, the health care professionals are calm about dentists giving vaccinations. So, this a new normal in Ireland. Education has returned to normal, in-person, no social distancing but a heightened awareness of ventilation and of the use of masks and other personal protection.

What is a clear positive sign for us in the Irish population is the increase in numbers going through Dublin airport. So, for the first time since 2019, we're almost back to 80% of previous levels and we expect that by the end of the year we will have recommenced normal travelling. We're very eager travellers and it's a key barometer of success in the return to normality. Hybrid working moved from 23% in 2018 to 65% in November 2020 and it is intended to be offered to all of us public servants from September. We will have an option of working hybrid. The cost of living has increased in line with all other countries up to almost 10%. However, our unemployment has stayed much steadier than we expected post COVID at 5%.

What did we do? I won't dwell too much on this because I think we're all aware that we had very similar strategies through COVID. Survival for many of us. We provided oral health care throughout COVID in primary care dental practices, with a six week stoppage when only emergency care was provided. We supported general health care from the dental profession, both for public health tracing, in testing and tracing, but a key role that has emerged has been the role of dental students and dental hygienists in relation to vaccination. I want to dwell a little bit on why this is so important for us going forward. First of all, in Ireland, we took a very legislative approach. We changed our national legislation to allow dentists to work as medical practitioners throughout the pandemic so they could work under the direction or prescription of a medical doctor and take on general health issues that they were not allowed to do so before. This meant that there was protection for a dentist, who went even beyond the scope of what the regulation said, so that they would be protected if they were considered to have stepped outside their scope. What was very interesting is the medics and the nursing profession came in very quickly and wanted this freedom for dentists removed. It was extended for about three to six months on the request of our Taoiseach (Prime Minister), who was a doctor himself, and then it was dropped. But it was a shame that the profession themselves didn't realise that for about 18 months that they could actually perform as a medical practitioner. I think many of them were unaware of that fact that we had changed the legislation.

In other key areas, we changed our legislation in relation to vaccinations and we had two approaches we could use. We could allow dentists to vaccinate under the supervision of another health care professional and also dentists in their own right under the legislation. This means that as a registered dentist, a dental hygienist or as a student undertaking a dental course, you are regulated and legislated for in Ireland to be able to provide a COVID vaccination. The real strength in this for us is that our practice in dentistry in Ireland is determined by how we practice, so if we take on particular vaccination or administration tasks, that becomes an integral part of the practice of dentistry.

Having established this means that going forward dentists can give flu vaccines or other vaccinations. We don't need new legislation. This is a big advance for dentistry. For the first time, we've been allowed to go into general health.

So, what are our legacies? The key message is very similar to what others have highlighted. The rising inequalities in dentistry. We have divided our state services into three main components. The first group are the low income and older population which are known as medical card patients. About 30-40% of our population, those below a certain income threshold or above a certain age, or with a particular medical condition, are eligible to receive state care. What happened from 2019 to 2022 is that this group reduced in numbers from 43,000 down to 30,000 for the uptake of state services. Over 65s remained much more static because this group has a poor record of uptake. Another statistic is the decrease in the number of dentists that were providing state care to this group. It reduced from approximately 1,300 state dentists, to less than 1,000 who are providing state care at the moment.

Social insurance is a different scheme and is a really good barometer of what happens in private practice. Social insurance is for employed and people who are self-employed in Ireland. So, they are the wealthier, middle class part of the population and we see a contrasting picture here. During the Pandemic their claims per month rose from 57,000 to 81,000. Expenditure again rose through the pandemic and the number of dentists operating privately or within the social welfare system increased to 2,500. Remember there are about 3,200 dentists on the register and this number is rising sharply at the moment according to our Dental Council. The vast majority are taking part in private care.

In our salaried public dental service, which is mainly confined to children, redeployment had an impact because our public dental service was the key workforce which went out to provide testing and tracing in the public healthcare system. There was a resulting lack of oral health personnel and restricted access to oral health services in the public sector. So, the key message for us at government level was the impact on the most disadvantaged in society. The older, those with medical conditions, those who are the poorest in society and our children's services, have been the most impacted. Whereas it was quite the opposite in the private sector. What happened was that first of all there was lobbying to look at an expanded oral health examination for all patients and that included both for the social welfare, the wealthier group, but was also for our state lower-income patients. For the first time we included as a mandatory requirement that dentists would have to include risk factors and health determinants covering alcohol, tobacco and diet as a key part of their assessment. They also had to include advice and action on referrals and intervention. We also insisted that it became mandatory to record caries and periodontal diseases before the dentists are paid, as well as dental enamel defects and trauma etc. This seems to be just words, but what is really important is, for the first time it determines how dentists are paid. We increased the fee that they would receive to do this, but we also included into national surveys that this will be assessed from 2023 onwards, to see what the uptake is and how the population responds to dentists providing this extra risk and oral health assessment. So that is, how much the population said it was a dentist who advised about alcohol or tobacco compared to any other health care practitioner.

There was a 40% increase in fees for treatment. There was the lobbying from the profession wanting to have much higher fees for treatment services so you can see the challenge with trying to get a small part of prevention compared to treatment. What also came was minimum pricing on alcohol. We have tobacco-free workplaces and a national sugar tax in Ireland. The key other areas that we're considering at the moment are, the removal of tax on toothpaste and also the inclusion of silver diamine fluoride within state services.

One of the key issues for us is, going forward is a post COVID evaluation of what has happened. From the indicators we look at in Ireland, what we find the most effective politically are oral health quality of life impact factors. In fact, when I was first CDO, and spoke about dental caries or periodontal diseases, politicians were not interested. They're interested in the impact of oral health on the population and so three years ago we introduced a functional oral health impact into national surveys, to see how people responded to lack of, to how they felt about their oral health. Traditionally, we always looked at attendance at a dental practice in our national surveys in the last, in 12 months. We measure the proportion of smokers, who discussed quitting with a health professional, and we have expanded this to include alcohol and poor diet, and very specifically looking at a whole range of health care professionals, where dentists are in amongst them so we can tease out who best provides risk factor advice. The single most effective statistic that we've been looking at is the proportion rating oral health as good or very good. I suppose this is coming back to the value of DMFT indicators over others, it's really important to use impactful indicators going forward.

In summary, what should we do in the future? We introduced a whole government policy in 2019 and it did not progress through COVID, in fact, it didn't get support from the profession at large. It was very much a primary health care approach rooted in dental public health. So, we were moving from a very complicated treatment system into a primary health care approach; and life-course approach and looking at common risk factors. I won't go into the detail of the policy now but for the first time post COVID, because of the crisis, the politicians have said we cannot continue providing the services that we provided before because they could see with the treatment service, how it could very quickly collapse. Also, what was really influential for our policy, is that my colleagues in general public health came forward and said you cannot keep just putting money into treatment. They were really quite shocked that we were getting 40% increases in fees for treatments, and this was against all of the principles of public health. So, this is the advantage of having a general public health voice in government, along with a lone oral health voice. For the first time we've an opportunity to put in leadership in oral health right across the system. Prevention and promotion across all of the areas is important to have public health at a government level where we are striving to

expand our team but it's also important that the actions and those that are closer to the ground are enabled to bring oral health promotion programmes forward earlier. It's pointless having a policy voice if you don't have the feet on the ground to put the policy into action.

CONSIDERATIONS IN THE LIGHT OF NATIONAL ACTIONS IN RESPONSE TO COVID-19 ROMANIA: ROXANA OANCEA

Good morning, everybody, thank you for this opportunity to have a voice from Eastern Europe, and my country Romania. From my point of view, listening to all the presentations up until now, unfortunately we cannot have this kind of approach, these spectacular programmes that you implemented during COVID-19. So, my presentation will follow along the much more introspective view about how the pandemic actually occurred in six waves and also what were the most important measures that were implemented by the college of dentists, and also some problems that we encountered.

So, a bit of epidemiology. I know that everyone is sick and tired of hearing about COVID-19 but still, we have to agree that the huge number of cases confirmed on 31. August 2022 will remain as a point in history, and if we look at the number of deaths also, more than six million, it was quite a big challenge. COVID-!9 was very prevalent in Europe. In Romania, between 3 January 2020 and 31 August 2022, here were more than three million confirmed cases. When the COVID-19 outbreak began in Italy, the Romanian government announced a 14-day quarantine for citizens returning from the affected regions. Primary preventive measures included the designation of five major hospitals across the country as isolation centres for new cases. There was the purchase and placement of thermal scanners in international airports, and especially designated lanes for passengers coming from areas affected by COVID-19. The next step was a ban on public gatherings in the second week of March and the institution of a state of emergency. If we look back at the moment that the pandemic started, we could see that the state of emergency in Romania was triggered by only 101 people with COVID-19. So at the beginning there were very aggressive measures for such a low number of people affected. But the number of cases increased rapidly from 101 to 2,000. On 22 March 2020, the first deaths were recorded and the national lockdown was implemented and some areas in the northern part of the country were placed under quarantine. Between 4 April and 14 May, further measures were introduced.

I want to highlight that in Romania, all the measures were announced by military ordinance, so it was quite like a state of war. For all intents and purposes the Government was in effect the Ministry of Internal Affairs. Between 15 May and 13 September, there was a state of alert with more relaxed measures. Probably this was because a holiday was coming, and maybe the people thought that come on, let's take a break from this COVID. We did not know what to expect but still we had to give people a sense of the normality. In September, schools reopened and there were local elections, because politicians had not placed too much importance on health issues, and they had to be elected or re-elected.

Vaccination started on 27 December 2020. The first person to be vaccinated was a hospital nurse and medical personnel were given priority. On 15 January 2021, Romania entered the second phase of vaccination and a second reopening of schools resulting in the spread of the new variant and a third wave of cases between 9 and 25 March 2021. Because the number of cases was increasing, the government introduced restricted measures. A fourth wave of cases unfortunately occurred after the general population had access to vaccination and this wave was the most severe, because as well as the older people it also affected all ages of adults, and younger people. Romania is the European Union member state with the second lowest percentage of fully vaccinated people after Bulgaria. This situation could be explained because of distrust of state institutions. I think that misinformation campaigns contributed a lot. There is also poor rural infrastructure and weak vaccine education.

A fifth wave of cases started on 8th January 2022 and in the second week of June we had also the sixth wave. You may ask me how come we can still get to this number of infected cases when vaccination is available? On this slide you can see how many people were vaccinated during the pandemic. We have also a statistic related to the number of people vaccinated with each type of the vaccines.

From 22 March 2020 by military ordinance, the provision of dental services in Romania was temporarily suspended and dental offices (practices) were closed for two months. Later, under pressure from the Ministry of Health, due to the large number of patients, and the large number of patients who had oral problems, private practices were allowed to treat emergencies if they complied with the conditions imposed. So, at present, there is no public sector for delivering dental services in Romania. This has created a lot of pressure because oral health care has to be provided by the private dental practices and they were not ready to meet this challenge. These emergencies, were predominantly surgical. Measures that were adopted to limit the risk of COVID -19 transmission in dental offices. They included general measures such as the preparation of patient lists, scheduling of patients by time intervals, and a mandatory interval of at least 20 minutes between patients, informing patients about the new rules regarding the procedures and measures which were implemented. So we knew what to do, but the most important thing was how well we actually

were able to perform all the requested measures. If a dental office does not have the specific equipment to carry out aerosol-generating dental procedures, according to the recommendations of the National Centre for Surveillance and Control of Communicable Diseases, emergency dental assistance cannot be carried out. In Timisoara, where I work, there were severe and intense checks from the public authorities on the designated dental offices which had applied to deliver dental services during COVID. The moment that the inspectors entered a dental office, they would ask 'where is this and where is that?' So, it was quite challenging to fulfil all the requested measures at that time. So, these dental offices were organised near the emergency units in hospitals and some open clinics mentioned that in order to meet the strict measures such as the increased period of disinfection between patients, and so on, approximately only 10 patients could be treated per day which is, a very low number.

There is also a problem with access to oral care in some counties of Romania, especially in underprivileged, rural areas in the northern part of the country. However, even the south of the country did not have functional emergency rooms at that time.

So, hopefully COVID-19 is coming to an end, but we have to take a broader view. At the moment per capita health spending on health in Romania is the lowest in the European Union (EU) countries. Romania also spends far below the European Union average in all areas of care, hospital services, pharmaceutical products, ambulatory medical care, long-term care and prevention. As far as dental care is concerned, coverage by dental services remain far below he EU average. There is full coverage only for children and some specific groups of adults such as veterans, and some people with chronic conditions and only 5% of dental care is publicly funded. The EU average is 31%. The situation is reflected in the access indicators, approximately 5% of Romanians reported unmet needs for dental care due to costs, distance or waiting times. Hopefully I gave you an overview of what has happened in Romania during this pandemic. Thank you very much for your attention.

CONSIDERATIONS IN THE LIGHT OF NATIONAL ACTIONS IN RESPONSE TO COVID-19 GREECE: ARISTOMENIS SYNGELAKIS

Aristomenis Syngelakis: Hello. Good morning, my name is Aristomenis Syngelakis. I am the Chief Dental Officer of Greece and the President-Elect of the Council of European Chief Dental Officers. I will try in a comprehensive way to present the main points for the oral health policy in Greece and the work that has been done since May 2021 when we had the historic resolution of WHO on oral health. The impact of COVID-19 pandemic on Greece was more than substantial. Greece has seen one of the highest mortality rates per head of population in Europe. Also, as we know COVID-19 is not a socially neutral disease and we have seen that mortality and morbidity rates in Greece and Europe as well, have unequally affected populations and vulnerable people suffered the most. During the period of the pandemic, we had the operation of dental units both in private and public sectors stopped for some weeks. Unfortunately, in the public sector we had a serious decrease in the number of dental appointments for all this period, not only for the initial period. University dental schools were closed for some weeks but they recovered very fast. During the next phase of the pandemic, strict measures were imposed on dental practices. Unfortunately, the economic difficulties of patients, the reduced operation of public dental clinics, as well as the fear of transmission of the virus, reduced patient access to dental care, which was dramatically reduced. Oral health promotion programmes in communities and school settings were postponed for more than two years and no oral health promotion programmes in schools have taken place.

We hope that the schools will run smoothly in the new school year. However, the accumulated effect of all these constraints was a serious increase in oral health inequalities, but we need to have valid data, so the plan is to conduct epidemiological research in order to see what is happening. Some research that has already been published shows that the situation is very difficult. So, what is the answer to these problems? The answer is to fully implement the WHO resolution on oral health. Universal Oral Health Coverage is the number one target. This is for us very, very important. However, that means adequate funding for oral health. Moreover, integration of oral health into general health and social care policies is also a necessity. In addition, the materialization of effective oral health programs and the implementation of the Common Risk Factors Approach to the prevention and management of non-communicable and dental diseases are extremely important.

What have we done in Greece to promote these resolutions? First, our government suggested to the WHO that it is important for each country to establish dedicated oral health budgets. This means that a guaranteed minimum share of public health spending is directed exclusively to oral health and dental care. Fortunately, the WHO has recently (May 2022) adopted this proposal in the Global Oral Health Strategy. We estimate that oral health share should be about 5% of public health spending but we can define it after a wide consultation. Otherwise, the reality is that in times of hardship, such as during the pandemic and other economic problems, the first budgets to be cut are those for prevention programmes and dental care. Therefore, this is something we really support, and hope it can be implemented. In addition, the National Oral Health Committee has been re-established (after more than 10 years of non-operation) and will hopefully soon undertake the design of a comprehensive oral health strategy. Legislation for prevention and control of

infections in the Primary Health Care units has been introduced, as well as legislation for home dental care. Furthermore: a public debate in the Social Affairs Committee of the Hellenic Parliament took place one day after the 2022 World Oral Health Day (March 21). In this important debate, for more than two hours we presented the latest scientific arguments in favor of oral health and dental care before the Minister of Health and representatives of the political parties, who then spoke and made relevant commitments. A new campaign on oral health promotion that uses leaflets to promote sugar reduction, informed by the WHO recommendation for reducing sugars intake was launched. More importantly, there is a government commitment to enable the planning of EU co-funded projects on oral health. We have initial approval for 40,9 million euros. We hope it will materialise. What does it include? It includes a universal prevention program for all children and adolescents, the implementation of epidemiological and needs assessment surveys on a permanent basis, as well as the operation of mobile oral health units for refugees, remote areas and vulnerable populations. What I think is more important is that during COVID-19 pandemic, oral health inequalities substantially increased, the vulnerable population has practically stopped visiting a dentist and what we need to do in the light of the new world energy and economic crisis is to change the priorities of political leaders. To change the priorities in favour of oral health as there is valid evidence that oral health substantially affects general health and the quality of life as well as the national economy and social prosperity. That is for now; it is really tough to change peoples' minds. We try to do it and we hope that with our common efforts, at a European and world level the future can be better than the present. Thank you very much. I would also like to say that we sent some suggestions to WHO, I mean the National Dental Association to the FDI and then the Ministry of Health, and one suggestion I have not mentioned yet is to establish an observatory on oral health policy and inequalities. I can see my friend George Tsakos who is at University College London, where they have a great observatory and it could be the basis to establish national and European monitoring centres for oral health, otherwise what we say today will be neglected in the future.

Huda Yusuf: I'm sorry we're running a bit late but thank you to all the speakers. We're just going to brief the workshops and Ken is going to brief them.

Ken Eaton: Well, thank you very much. There are four working groups, and the first group is on indicators and monitoring, it will be led by and George Tsakos. The second group is going to be on universal coverage, including oral health care and that will be led by Gabriele Sax. The third group is on implementation and translation of the strategy into government policy and Dympna Kavanagh will be leading it and I hope that Aristomenis will join that group because clearly, they've done a lot in Greece. How have you managed to get your politicians to agree to all this? That's a key point. And the fourth group is on integration, inter-general health care and the impact on how we're going to educate our workforce in the future. It will be led by Stèphanie Tubert.

PLENARY WITH REPORTS FROM THE SMALL GROUPS

Dympna Kavanagh's Group: implementation and translation of the strategy into government policy. Rapporteur: Niall McGoldrick

Dympna Kavanagh: We were looking at translating into government policy. Our rapporteur will summarise the group's discussion and conclusions.

Niall McGoldrick: We focused on looking at translating policy into actions and we started off thinking about the challenges that we are finding. Some of the feedback that came across from the group was that there's so many different layers in the systems that we work in and often we'd think we would be talking to the person with power and influence but perhaps that person's actually included in another part of the systems that we work in. So, it's really important that we identify who those people are and how they work together and how we can help provide evidence to inform policy decisions. It's recognising the role of the CDO as well and how sometimes that may be restricted by their job description in their government role, so getting back to that power and influence where it lies and how to find it is important.

We had some other challenges that we identified as well. How dental provision is provided is different in our different countries and the influence over private dentistry in particular is one thing where there is limited influence. One of the key points that we identified was that we don't have a clear problem definition that resonates amongst our dental colleagues and the wider profession. But also, that would resonate with people who are not from dentistry, so thinking about how we demonstrate impact of poor oral health and again coming back to within the dental profession, the lack of alignment as to what the real problem is and if we can try and find that out for sure. Then we started to think more positively and thinking about some of our other opportunities and we thought we'd talk about some of the good practice that we have amongst the group and one of the key things that came out was how integration of oral health into general health provision. We had some examples about diabetic care pathways using the common risk factor approach and building alliances within dentistry but also with that inter-disciplinary alliances again demonstrating impact of oral health, good oral health and poor oral health and what that can mean and how that then can all feed into the system and into informing evidence which informs policy. We had some good practice shared from our colleagues in Belgium about integrating oral health indicators into general health indicators and surveys, starting small I think, maybe one or two questions and then building up to I think, how many questions in Ireland?

Dympna Kavanagh: About 23 next year.

Niall McGoldrick: Yes, 23 questions in their general health survey, so using those examples of colleagues within the group to build on that. One of the other key points that came out was that it would be really good to have alongside the WHO strategy documents, some guidance on which stakeholders should be involved in developing national policy, who should be around the table, so that we don't necessarily have an echo chamber of voices from one particular specialty or one group, who then can influence the discussions. So, on top of that, the really key thing was around patient and public involvement and the voice that they have and the influence that they can have. We've heard that sometimes politicians can make decisions based on their personal experiences, but if we are able to bring some of the experiences and provide a platform for patients and the public to share their experiences, perhaps that might be a way of influencing policy decisions. We need to find a way to do that because colleagues agreed that it can be a very powerful way to shape policy thinking. One practical point as well about whenever the WHO strategy goes live, could we have a, something like a press pack around that so that we, as a European association can say, 'Right this is out, we've got these resources to spread the news about that' and use mass media, social media, and all the different outlets that we have.

Dympna Kavanagh: Summing it all up, there was very much a focus on having a national policy in place and that it would be really helpful if we could develop criteria around what that policy should look like because in many countries the experience was that it might be over-influenced by primary care dentists or by other influences and not necessarily with a public health approach. So, that was an area that we could particularly work on developing criteria or what we think the development and shaping of an oral health policy, a national policy would look like, to define our problem.

Gabriele Sax's Group: Universal Health Care Coverage. Rapporteur: Natasa Pejcic

Hello, everyone. Our group was from many countries. We had people from Italy, Canada, North Macedonia, Serbia, Australia and Austria.

We considered what was essential for oral health care. Nowadays all of us know that aesthetics are key for some people. it's modern to surf Facebook, Instagram and other social media, they influence many young people and to them, appearance is most important. There are also a lot of girls who are having veneers fitted and bleaching and so on, but what is essential ? The main conclusion of our group was that essential dentistry is dentistry, which maintains a functional, pain-free dentition and which enables people to eat, speak and be competent to take care of their dental health and their health. We recognised the connection between oral and general health. We suggested that professional care should be a priority and functional dentistry, not the need for cosmetic dentistry, is essential and that dentists should think what is essential for each patient and provide them with adequate prevention and treatment. So, this was the main focus of our group.

We have also recognised that there were financial constraints and what essential dentistry might offer if there were no financial constraints. We concluded, if there were no financial constraints, essential dentistry was everything that is necessary so that people can live healthy lives, with a feeling of wellbeing and be part of the society. However, because there are financial constraints, we agreed that there would be variations and then there may be variations between age groups. There should be special packages for children, who should be offered a full range of prevention and treatment, including orthodontics, at no cost to their parents or guardians. Adults who can afford to pay towards their oral health costs should be required to do so. However, adults who were vulnerable because of health or social problems should not have to pay for essential oral healthcare and prevention.

George Tsakos' Group: Indicators and Monitoring. Rapporteur: Denise Faulks

The discussion in this group was around the indicators listed in the global health action plan. George asked if we were we actually aware of the indicators that have been suggested? They're in the Appendix, the long Appendix at the back of the document. In the group there were many that were unaware of these indicators. So, there's going to be a problem also with visibility of indicators and we're going to need to publicise them. When you look at the long list of indicators in the Appendix, they are actually very comprehensive. They include essential care, the notion of which we've just heard discussed, they include some clinical measures, they include some points of evidence and policy and issues such as the implementation of a sugar tax? But some of these indicators are ill defined and will be difficult for governments to put into place.

The next point was how difficult data collection was going to be. How difficult the implementation of all these indicators was going to be. We felt that maybe in itself, that wasn't so much the problem, in that all these indicators existed and would help to emphasise the importance of oral health and raise awareness. However, maybe they were more aspirational for some countries and in some areas. What we all felt was important was that within these indicators, the inequalities in oral health should appear more clearly. The inequalities of oral health should be integrated into the data collection at all levels. We also felt that there were missing indicators. Subjective indicators are important for the politicians. We've said all morning, that politicians and the policy makers don't necessarily understand clinical indicators, what they want is human stories, subjective feedback, and that seems to be a missing part in what's proposed within the action plan. There is also the other missing part which relates to what we've just heard about maintaining a functional dentition. We wanted to bring up these points with regards to the indicators.

In terms of goals, it was felt that if one of the goals is to reduce the oral disease burden, that might actually be something, although it may be aspirational, if we know we're not managing that, then perhaps it's not necessary for it to be in the document. We know we have an ageing population, reducing the burden of oral disease in the population is going to be too ambitious. There will need to be guidance on how to interpret the data that we do collect and possible questions about its quality. A point made about a certain number of indicators that might be missing in terms of process. So mid-stage process indicators such as how many oral health initiatives have you engaged in, may not be very scientific clinical indicators, but could be mid-stage indicators for policy makers.

The second, of our thoughts about what's in the document, and the second part of the discussion was how and who could possibly implement the collection of data, how to implement the data collection and how to use the oral health indictors. There was a consensus that there would need to be specific national oral health action plans, that each country would have to approach this slightly differently, that certain aspects would be more important than others in different countries. Partly because of the amount of resources that would be required if all of these indicators were to be collected and that there would need to be sharing strategies. There may be a way also of doing this within the European Union and then maybe there would be European guidance on how to do it within the European countries at least.

We also felt there was something missing there in terms of inclusion of all the stakeholders. So again, going back to what was said earlier by the first group, including population groups, including patients, including all the other stakeholders, other health care workers and not just having dentists around the table and just having dental indicators. So, we concluded that probably the long list of indicators is more aspirational and more in the hoped for direction of travel, rather than specific indicators that every country will be able to put in place.

Stèphanie Tubert -Jeannin's Group: integration, inter-general health care and the impact of educating the future workforce

Thank you very much. This particular group began with looking at the WHO Action Plan on education and research, and Stèphanie decided to ask the question what were important points according to that brief.

I think almost everybody in the group agreed that the most important point was integration between oral health and general health. It seemed to be important in terms of maintaining and developing education and research. We discussed what kind of interdisciplinary aspects can be the key aspects in education. One of the most important things that came up was training programmes in education. One consideration is that oral professionals, oral health professionals and general health professionals, need to be aligned at a certain level of education, which means that we should be aware of each other's educational curriculum or at least be incorporated in each other's curriculum. This means oral health professionals should know about general health and vice versa. Primary Care doctors should understand the aetiology of dental caries and periodontal diseases and be able to check the oral mucosa. One member of the group gave a nice example, which was that GMPs rarely if ever ask the question 'have you ever visited an oral health professional?' They may also prescribe sugary syrups for children without being aware that this increases the risk of dental caries. It should not be forgotten that there must also be integration and collaboration within the oral health team (dentists, dental specialists, dental hygienists and therapists, dental nurses and dental technicians).

The group also considered that it would be nice to include more public health in the curriculum for all oral health professionals. This might help them understanding people in more of a demographic and population-based approach rather than just always looking at the clinical picture

Then there is an aspect of public health which is called social welfare, so if you are from a vulnerable group this should be recognised in epidemiological surveys and dental health professionals, especially dental public health professionals should look at people as a group. Being able to identify vulnerable groups and being educated to be able to understand their needs was also a topic which should be included in the dental curriculum. We thought that oral health professionals should go into the community outside dental schools and meet vulnerable populations to learn together.

The second point that came out in the discussion was changes in research models. Researchers in this group pointed out that research needs to follow an inter-disciplinary approach and recognise patient involvement. For example the general and oral health of patients with mental health problems should be factors to be considered by those researching the care of these patients. The same principle applies to research into the care of vulnerable groups. This reminded us that we should be looking into various other aspects of social determinants in oral health disparities, looking at how behaviour and other kinds of attitudes can have an influence on the uptake of oral health care by the population and how their health affects their oral health in general.

Finally, we considered how to put our suggestions into practice?

- First of all, we needed to understand that there is a bias in integration, and it is an important problem that needs to be addressed when we talk about integration aspects. There is a lot of disparity in what people consider oral health disparities to be. So, how do you put it into practice?
- The importance of including dental public health specialists in any discussion about oral health disparities was made. There is a need to develop the specialty of dental public health in all countries.

- In addition, there needs to be participation at the international level. Somebody in the group pointed out that, every country does not have their own national dental public health association. It would be nice to have a global dental public health association where at least some approaches could be standardised.
- We could also see that it was important to address the questions in which general health personnel should be involved. So, what is it that we're looking for from them? What are the important pieces of information that we want them to know so that we can be integrated and be at the same platform, at the same level.
- We also thought that it would be nice to have partnerships. There should be interdisciplinary partnership between oral health professionals and general health professionals so that we can publish papers in journals which have a more global audience, so that the issues related to oral health are seen and read and more people are made aware of these issues.

There is also a need at the advocacy level for a macro level, which means that for example, that when we seek grants for our research projects, the policy makers can see that the proposed research is impact-related and have tangible benefits for the population. So maybe at that level, if we are more interdisciplinary or we are inter-professionally more involved with one another, not only with general health professionals but also with social sciences professionals. it might result in a more meaningful and more comprehensive research.

There needs to be change with more integrated (competency based approach), contemporaneous and quality assured curricula. Dental educational programmes should be based on best practices (educationally and scientifically evidence based) and consider the health needs of the local populations (social responsibility).

Closure of the Workshop

Paula Vassallo: Thank you very much to all of you. Just one more point as EADPH now we want to expand and create an International Association of Dental Public Health (IADPH). At a European level, there's an oral health section which of the European Public Health Association (EPHA). We are working with other disciplines at what is possible at the public health level to ensure that there is integration.

I would like to see if Paul and Habib have any comments before I invite Irina Chivu-Garip to close the workshop.

Habib Benzian: All of this was possible in 20 minutes?

Paul Boom: Well, there's an overarching theme for taking forward the WHO Action Plan. I think now we start to have discussions, which will take a couple of years, on how we should work together. Where do we absolutely need consensus and where can there be a variety of approaches? We don't need one size fits all for all the countries.

Paula Vassallo: What are the areas we need to have in common and where can we follow different approaches?

So, Irina I'm glad to invite you to close the workshop. Thank you very much for supporting it. Thank you all of you for the feedback and the contribution. And as somebody said this is just the beginning. So, come on, let's fight, let's do it together, we really can, it's an opportunity for all of us.

Irina Chivu-Garip: Thank you for your contributions today. I think if I were to summarise the conversation today. the word 'collaboration' would be the one that I would use and the need to develop it further. Linked to this I can only speak from the side of my, from the company that I represent today, and we are really keen to collaborate and it's a call to action for all of us to work together. I think as an industry in oral care we have much more in common with your goals and in the end, we ultimately work towards better health, and better oral health. So, let's work together as Paula said, and enjoy a great annual congress. I want to thank everyone who has contributed to this workshop, including those who have been online on Zoom. I hope you will try as much as possible to implement the WHO oral health plan, for the community to interact and exchange for the better. Thank you so much.

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