Guest Editorial

The Berlin Declaration on Oral Health and Oral Health Services

A. Sheiham*

Although there are sufficient dentists in the world today, the majority of people do not have access to adequate, affordable, and acceptable oral health services. Discussions about the effectiveness of dental procedures and dental care in general are dominated by the concerns of dentists in industrialized countries. Are lasers useful in periodontal treatment? Which glass-ionomer cement should be used? Such questions are academic to the millions of people living in deprived communities and countries. Their needs are ignored despite the prevalence of dental diseases. The oral health of children in many developing countries is worse than that of children in developed countries, and the former cannot afford the appropriate resources to deal with the diseases. In all countries, the dental profession and government place more emphasis on the curative and technological aspects of dentistry than on promoting prevention and community programs for oral health, which are more effective and would have greater impact on the oral health of dentally deprived communities.

* Head, Department of Epidemiology and Public Health, University College London, Medical School, 66–72 Gower Street, London WC1E 6EA, England.

Editor's note: The purpose of the Guest Editorial is to allow authors to present their opinions on controversial issues. The views expressed by the author do not necessarily reflect the views of *Quintessence International* or its editors.

Copies of the Berlin Oral Health Declaration are obtainable from Dr W. Mautsch, Oral Health Alliance, Department of Dental Prosthetics, University of Aachen, Pauwelstrasse 30, D-52074 Aachen, Germany.

Because of the contradictions that exist but are generally ignored by policy makers and dental professionals, The Oral Health Alliance, in collaboration with the German Foundation for International Development, formulated the Berlin Oral Health Declaration and recommended strategies based on the principles in the declaration directed at reducing inequities in oral health status and availability of services. The strategies outlined in the Berlin Oral Health Declaration should help redress the imbalance in oral health between deprived and privileged citizens. Equity in health implies that ideally everyone should have a fair opportunity to attain her or his full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential. Despite efforts in the past decade to make health systems more equitable, in the poorer countries and communities people's health and access to health care are declining.

Oral health has not been given the attention it deserves. As a result, people who are poor and living in difficult circumstances, whether in developing or industrialized countries, continue to be dentally neglected, a situation that has every likelihood of worsening as the global debt crisis and privatization of health services occur. Although oral diseases are not life threatening, they are important public health problems because of their high prevalence and their impact on individuals and society in terms of pain, discomfort, and social and functional limitations. In addition, the financial impact on the individual and community is very high.

An important feature of oral diseases is that effective, inexpensive preventive methods are available, but in many cases these methods are not appropriately applied. The development of dental programs that incorporate effective, simple, and inexpensive preventive methods and involve local people have a better chance of ultimately improving both services and community oral health. These community-based pro-

grams are more likely to lead to self-reliance and self-management of oral health programs.

The recognition that many communities are dentally deprived has unfortunately produced a number of inappropriate responses. The worst mistake is that programs developed in one setting have been transferred without adaptation to a completely different locale. Most present programs concentrate their efforts on the provision of curative services and give little attention to health promotion.

To redress some of those inappropriate approaches, policies should be directed toward enabling people to adopt healthier lifestyles. Cheap and nutritious food should be distributed, advertising of health-damaging products should be controlled, clear information should be provided, and leisure and exercise facilities should be accessible. Health care should be based on the principle of making high-quality health care accessible to all. Oral health development is not achieved through the unmodified transfer of skills, programs, personnel, or equipment to deprived communities. Adaptation rather than uncritical adoption should be the rule.

Epidemiology is a fundamental tool in the development and evaluation of health plans and programs. It is necessary to develop indicators, different from those normally used, that measure social, economic, and health impacts. Sociodental indicators are more relevant measures of needs and should reflect pain, discomfort, function, and esthetics, as well as clinical indicators of dental health, such as caries, bleeding gingiva, pocketing, and number and position of teeth. Other impact measures include loss of sleep, loss of work, and opportunity costs.

Priorities should not be developed solely on the basis of the demand for treatment. Health promotion can alter a community's perception of the problems and hence priorities. Priorities should be established through a partnership between the community and the professional advocates for oral health. The community should be involved in setting goals that are stated in terms of oral health, oral disease, health promotion, equity, training, and personnel and health service.

Oral health promotion should have the highest priority and follow the principles as defined in the Ottawa Charter for Health Promotion (1986). Health promotion means building healthy public policy, creating supportive environments, strengthening community action, developing coping skills, and reorienting dental services. Health promotion policy must take into consideration the uneven distribution of health and disease; the uneven distribution of health hazards in the physical and social environment and of personal behavioral risk factors; and the uneven distribution and quality of health care. Oral health strategies should be integrated with general preventive approaches within an overall context of health, which leads to improvements in the quality of life. The preventive measures should be simple and effective and not contradict each other or confuse the community. Services and oral health promotion strategies should be modified on the basis of scientific knowledge regarding the effectiveness, efficiency, and cost-benefit of common interventions. This implies a constant review of the scientific basis for health education methods and messages, training and education of health workers, life history of oral diseases, oral pathology, preventive and treatment strategies, infection control, research and research methods, social science in oral health, and community-based programs.

Two principles of the primary health care approach have to be considered in almost all programs if lasting solutions to problems are to be found. These are community participation and multisectoral cooperation and integration. An important element in achieving equity in oral health and oral health services is the success of the multisectoral approach in securing community development. Health should be viewed as interrelated with the problems of unemployment, high prices, and inadequate housing. Prevention should be based on the principles of health promotion: reorienting oral health services, creating a supportive environment, building healthy public policy, supporting community action, and developing coping skills. Integration and a common risk-factor approach should be the cornerstones of health promotional activities. The fundamental concepts are tackling causes common to a number of chronic diseases, including oral hygiene education as part of general hygiene, and developing population rather than high-risk strategies. The approach can be developed because of risk factors common to a number of chronic diseases. Diets that lead to caries also contribute to obesity, coronary heart disease, and diabetes. Periodontal diseases and oral cancer are related to smoking, which causes other types of cancer and respiratory diseases. Integrated teaching or preventive activities with groups concerned about those chronic diseases should be more effective than disease-specific teaching activities.

In planning oral health services, all possible resources should be considered, including the role of

independent practitioners, which should be complementary to that of government service staff. The "six *A*s" should always be considered to improve health services: availability, accessibility, accountability, affordability, accommodation, and acceptability. The problem of unequal distribution of oral health personnel exists in nearly all countries. There have been several approaches to motivate dentists to work in rural and deprived areas. All have failed although training, salary, and conditions were favorable. Greater success has occurred with auxiliary personnel. Training more auxiliary personnel may be an important way of increasing coverage, but this should not be allowed to lead to the creation of a two-tiered service. The important role that such auxiliary personnel can play therefore must be supported strongly by governments and professional bodies.

Planning of training and education of personnel in oral health should be a part of comprehensive planning for improving oral health. It is important that all health personnel receive additional training, particularly to support the concept of primary oral health care and assume critical advocacy roles with respect to public health policy. To provide the skills necessary for health promotion action and for working in an integrated manner, the education of oral health personnel requires a fundamental reorientation to make it more relevant to the needs of the population. Training of oral health personnel should be based on a holistic approach and not only on the care of the teeth. There is a need for preparatory courses in education theory and practice, particularly in the development of communication skills.

Finally, every effort should be made to assist developing countries to become independent of imported oral materials and equipment. The knowledge and expertise of various people working on appropriate technologies, including the education and administration fields, must be shared.