SOUTH AFRICAN NATIONAL ORAL HEALTH STRATEGY

PREAMBLE

Most oral diseases are not life-threatening but affect almost every individual during his and her life time, resulting in pain and discomfort, expenditure on treatment, loss of school days, productivity and work hours, and some degree of social stigma. Oral conditions are important public health concerns because of their high prevalence, their severity, or public demand for services because of their impact on individuals and society.

Oral disease levels appear to be increasing in major sectors of the South African population, especially the underserved, disadvantaged and urbanising communities.

Basic health and social services are a human right and oral health is a significant component thereof. Individual oral health treatment options are not available to most people, with few oral health promotive and preventive activities. State dependent people should have access to basic oral health treatment services. Oral diseases are largely preventable and therefore oral health promotion and primary prevention are a top priority.

Although national goals are be of some value it is recognised that communities and the circumstances in which they live are extremely diverse. This strategy also provides guidelines to oral health care workers at district level to make the best decisions on what oral health strategies to implement. It allows for the most effective oral health interventions to the specific needs, infrastructure and resources available to each community.

AIM

The aim is to improve the oral health of the South African population by promoting oral health and to prevent, appropriately treat, monitor and evaluate oral diseases.

NATIONAL, PROVINCIAL AND DISTRICT FUNCTIONS

These functions are in the National Health Bill, 2002.

Specific oral health functions of importance at each level are as follows:

National

- National oral health strategy process (formulation, implementation and review)
- National water fluoridation programme and alternative fluoride measures (formulation, implementation, monitoring and evaluation in collaboration with the National Fluoridation Committee)
- National norms and standard for oral health service delivery. Refer to the following documents:
    - A Comprehensive Primary Health Care Service Package for South Africa
    - The Primary Health Care Package for South Africa – A set of norms and standards.

- National Norms, Standards and Practice Guidelines for Primary Oral Health Care

- Essential national oral health research (support executing such research)

- National oral health data set:

  For monitoring and evaluation, specific data has to be collected from the District Health Authorities via the Provinces to the national Department of Health (Appendix 5)

- National and international oral health matters liaison

  Liaise with health related national associations, statutory councils, training institutions, media and public as well as internationally with the World Health Organization, International World Federation, US Centers for Disease Prevention and Control etc.

- Integration of oral health into other health programmes

  e.g. HIV/AIDS, Maternal and Women's Health, Child and Adolescent Health, Nutrition, Chronic Diseases, Disabilities and Geriatrics.

Provincial

- Provincial oral health operational strategy (formulation, implementation and review)

- Prevention of oral diseases and promotion of oral health as priority:

  - Involved with the implementation of water fluoridation and alternative fluoride programmes

  - Identify and develop collaborative approaches to initiatives that address oral disease common risk factors such as tobacco, sugar, alcohol, unsafe sex, chronic medication, violence and vehicle accidents.

  - Raising the awareness of oral disease risk factors and appropriate means of oral self care.

  - Integrate oral health strategy elements and strategies into programmes and policies of all sectors that have an impact on community health like maternal and women's health, child and adolescent health, nutrition, chronic diseases, disabilities and geriatrics.

- Co-ordination of the oral health care system in the province
- Planning, supporting and evaluating district oral health services
- Collection of data from districts for own and national use
- Implement national norms and standards for oral health service delivery

District

The communities and the circumstances in which they live are diverse. Prepare a customised set of intervention strategies and targets selected according to the specific needs, determinants and other circumstances for each community. Match oral diseases with the best intervention strategies and available resources.

- As a minimum ensure:
  - ❖ the provision of appropriate disease prevention and health promotion measures,
  - ❖ the provision of basic treatment services,
    - an examination
    - bitewing radiographs
    - scaling and polishing
    - simple (1-3 surface) fillings
    - emergency relief of pain and sepsis, including dental extractions
  - ❖ the implementation of cost–effective and evidence–based strategies

- The following steps must be taken to ensure that an appropriate oral health plan is devised for each health setting:
  1. Assess the oral health condition of the community (Appendix 1)
  2. Prioritise the problems identified according to their prevalence, severity and social impact (Appendix 2)
  3. Identify the resources available (Appendix 3)
  4. Select the most appropriate interventions (Appendix 4)
  5. Implement, monitor and evaluate the selected strategies.

- Collect appropriate data for Provinces and the national Department of Health.

- An adequate referral system should be established for advanced and specialised oral health services

NATIONAL GOALS FOR 2010

- Increase PHC-facilities, through the provinces, delivering oral health care services by ensuring that these services are being (made) available in the following order of priority:
    - District Hospitals
    - Community Health Centres, and
    - Clinics or Mobile Dental Units or Portable Dental Units
- Increase the percentage of children at age 6 who are caries free to 50% (in line with WHO 2010 goals).
- Reduce the mean number of Decayed, Missing and Filled Teeth (DMFT) at age 12, to 1.0 (in line with WHO 2010 goals).
- That 60% of the population on piped water systems receive optimally fluoridated water.
- That 100% of clinics offer the primary oral health care package.

RESOURCES

Human Resources

Oral health human resources will form part of an integrated health human resource plan.

Financial Resources

The national Directorate: Oral Health has its own budget.

Oral health at provincial level should have cost centres for budgeting purposes. They have to, according to the MTEF, budget for oral health service delivery. Financial management must comply with the PFMA.

For the upgrading and refurbishing of oral health facilities and equipment, provinces have to budget through the MTEF, according to the needs determined by the provincial oral health programme managers in each of the provinces.

The provinces will be responsible for the capital expenditure and appropriate equipping of dental facilities in health facilities.

Oral health patients will be charged for services rendered according to the Uniform Patient Fee Schedule.

Physical Facilities

In the building of clinics and upgrading programme, oral health programme managers must be consulted at the planning stage. All accommodation plans and needs for public oral health services will be dealt with in accordance with the health facilities planning directives.

Transport

Appropriate transport should be made available where necessary for oral health service delivery.

LINKS BETWEEN NATIONAL AND PROVINCIAL HEALTH AUTHORITIES

In order to facilitate better communication between the national and provincial health authorities it is important for:

- The national Directorate: Oral Health to meet with the Oral Health Programme Managers of the provinces at national office at least three times annually.
- The national Directorate: Oral Health to visit the provinces to assist and guide provincial oral health services.

STRATEGY REVIEW AND DEVELOPMENT

The national Department of Health is required to convene a strategy review panel annually, to assess the implementation and outcomes of this strategy, and make recommendations accordingly. It is also responsible for collating the information provided by provincial health authorities and the regular dissemination of summary data and reports on the review process.

Appendices

Appendix One: Assessing The Oral Health Of A Community

Data for oral health programme management must be gathered at the level where programme implementation and decision-making takes place. They provide a basis for planning, monitoring and evaluation.

Appendices One and Two contain some examples of questions and formats to assist you in selecting questions and relevant information for a local oral health appraisal process. Adapt or restructure similar data sheets to suit your local circumstances.

When all such local data are aggregated then they also provide justification for the allocation of financial and other resources to the oral health sector. To be useful for this purpose such data must reflect community priorities in oral health. For this purpose, *the 12-year-old DMFT,* is *rarely adequate alone.* Of far greater relevance, is the number of people suffering from toothache at any one time, or the number of days of school or employment lost because of oral ill-health. These types of data show constituents' concerns, are measurable and are understandable by those whose support for specific policies is essential.

Sample questions to assess the local impact of oral diseases

1. Age ☐
2. Gender ☐ *Male* ☐ *Female*
3. Do you have anything wrong with your mouth at this moment or have you experienced any problems with your mouth in the past month? ☐ *Yes* ☐ *No*
4. If yes, which of the following conditions best describes what you think was wrong?
   - ☐ *Toothache* ☐ *Difficulty with chewing* ☐ *Pain*
   - ☐ *An ulcer/sore* ☐ *Appearance of teeth* ☐ *Bad breath*
   - ☐ *Bleeding gums* ☐ *Difficulty opening/closing your mouth*
   - ☐ *Cold sore* ☐ *Difficulty in speaking* ☐ *Other……*
5. Have you been treated for anything wrong with your mouth in the past month? ☐ *Yes* ☐ *No*
6. Have you experienced any pain from your teeth or mouth within the past month? ☐ *Yes* ☐ *No*
7. If yes, for how long have you experienced this pain? ☐ *Days* ☐ *Weeks* ☐ *Months*
8. How bad was the pain? ☐ *Mild* ☐ *Moderate* ☐ *Severe*
9. The impact of the pain: The pain stopped me from
   1. ☐ *eating. drinking or chewing*
   2. ☐ *sleeping*
   3. ☐ *going to school or work*
   4. ☐ *doing my normal daily activities*
10. What did you do to stop or control the pain?
    1. ☐ *Nothing*
    2. ☐ *Took pain pills or medicine*
    3. ☐ *Visited the doctor/dentist or clinic*
11. What did the health worker/clinic do?
    1. ☐ *Nothing*
    2. ☐ *Gave me medication*
    3. ☐ *Extracted a tooth*
    4. ☐ *Other……*
12. Estimated DMFT

D	*M*	*F*	*Total*

Etc…

Few if any accurate data exist for regions in South Africa on the impact of oral diseases on peoples' daily lives (pain, appearance, comfort, eating restrictions, bad breath etc). It is recommended that as part of the general data gathering process simple community based surveys to determine the frequency of oral health problems should be carried out. These data should be gathered using a rapid appraisal approach such as the questionnaire shown in the box above.

Appendix Two: Priority Oral Conditions And Determinants

Most oral health programme managers have a rough idea of the oral health conditions prevalent in their local communities. National and province-wide surveys are complex, expensive and take a very long time for the results to return to local level, so a simpler and quicker form of assessment is required to verify the manager's rough estimate.

Step One

Interview a number of reliable community informants such as clinic staff, general practitioners and others, on their perception of how common (the prevalence) and how serious (social impact) the community views the conditions listed below. The accepted morbidity and mortality of each condition is given.

Indicate your assessment of Social Impact and Prevalence as High, Medium, Low or None in the blocks provided.

The prevalence and severity of oral conditions

Oral condition	Social Impact	Prevalence	Morbidity	Mortality
Bad breath			Low	None
Benign oral tumours			Medium	Low
Bleeding gums			Medium	None
Congenital abnormalities			Medium	Medium
Early childhood caries			High	Low
Fluorosis			Low	None
Harmful practises			Medium	Medium
Loose teeth			Low	Low
Mouth sores			Medium	Medium
Noma			High	High
Oral cancer			High	High
Oral HIV			High	High
Oro-facial trauma			Medium	Medium
Pain			High	Low
Tooth decay			Medium	Low
Tooth loss			Medium	Low
Other..				

Note: This is only an example. You might add other conditions or delete some of these in your own list.

Step Two

Rank the listed conditions depending on how many times they score a High or Medium rating in their row of the table. Those conditions you move to the top of list on this basis will represent the priority oral health conditions in your particular community.

Step Three

This same group of community informants can assist you to identify the most prominent determinants or risk factors for oral disease present in their community.

Factors known to affect the risk of oral disease	How widespread is this?
Tobacco use	
Sugar consumption > 10kg/year	
Use of fluoride toothpaste	
Access to fluoridated water	
Other e.g. areca or betel nut chewing, disability etc.	

Indicate the responses as High, Medium, Low or None.

Appendix Three: Oral Health Resource Assessment

An absence or limitation on resources does not need to mean non-delivery of services but simply means alternative strategies that are less resource or technology-intensive must be provided. For this reason a series of decision table illustrating an approach to matching resources and interventions, is presented in Appendix Four.

However before proceeding to that stage of the process, it is first necessary to determine the level of resources available to implement the interventions you are considering. The following questions are designed to assist you in making this assessment.

		Yes	No	Don't Know
Finance				
1.	Is there an oral health budget?			
2.	Are there sufficient capital funds for equipment & instrumentation?			
3.	Are there sufficient recurrent funds for salaries and materials?			
Personnel				
4.	Are there sufficient, appropriately trained personnel?			
5.	Are there sufficient personnel to manage, monitor and evaluate the intervention?			
Equipment and Instrumentation				
6.	Is the equipment available appropriate?			
Infrastructure				
7.	Has a needs assessment been carried out in sufficient detail to select the intervention?			
8.	Are there clear lines of communication to the community?			
9.	Are there clear lines of communication for the acquisition of resources?			
10.	Are there clear lines of communication for reporting?			
11.	If yes, are they functional?			
12.	When some form of transport is necessary, (for people or goods), can you rely on the transport system to provide it?			

Interpreting the responses you get

Number of questions answered YES	Availability of resources
If there are less than six	LOW
If there are between six and nine questions	MODERATE
If there are more than nine questions	HIGH

Appendix Four: Decision Tables To Match Oral Diseases With Best Interventions And Available Resources.

After determining local oral disease priorities, each separate condition must be assessed in terms of the intervention options available and the resources or infrastructure necessary to deliver them. Based on this a selection of the best locally viable strategy (S) can be made and implemented. The outcome of each strategy may be measured using selected indicators such as the suggested targets included below each oral disease table**.**

The Oral Health Targets suggested for each of the listed oral disease or health conditions, are intended to provide a framework for health strategy makers at different levels – national, provincial, and local. They are not intended to be prescriptive. It is hoped these Targets will be mixed and matched according to prevailing local circumstances.

The tables are not provided for every conceivable condition and others will need to be constructed as they become necessary. Future tables might include malocclusion, and orthodontic treatment, occupational hazards such as erosion or abrasion, and others.

Always ask: Is the intervention based on best practice, i.e. is it evidence-based? (Refer to Appendix 6 for some examples).

Pain	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1= Provide pain relief with analgesics and/or antibiotics (See Essential Drugs List: EDL); extraction S2 = emergency endodontics of anteriors where indicated S3 = emergency endodontics of posteriors where indicated; pulpotomy
Adults	S1	S2	S3	
Children <6 years	S1	S2	S3	

Suggested indicator	**Your target**
A reduction in episodes of pain of oral and craniofacial origin of	**%**
A reduction in the numbers of days absent from school, employment and work resulting from pain of oral and craniofacial origin of	**%**
A reduction in the numbers of days of difficulty in eating, and speaking/ communicating resulting from pain or discomfort of oral and craniofacial origin of	**%**
A reduction in the numbers of days of difficulty in participating in social and cultural activities resulting from pain or discomfort of oral and craniofacial origin of	**%**

Oral HIV	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Advocacy and support for the health system's response to the HIV pandemic; Universal Infection Control; Prevent oral lesions amongst HIV^{+} people with chlorhexidine; Development of a local protocol for all oral health workers. S2 =S1 + specific treatment of oral mucosal lesions (See current treatment protocols and EDL).
Existence of HIV	S1	S2	S2	

Suggested indicator	**Your target**
To reduce the incidence of opportunistic oro-facial infections by	**%**
To increase the numbers of health providers who are competent to diagnose and manage the oral manifestations of HIV infection by	**%**
To increase the numbers of strategy makers who are aware of the oral implications of HIV infection by	**%**

Dental Caries	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Oral hygiene education, provide analgesics (See EDL), tooth extraction for patients with pulpitis
Severe	S2	S3	S3	S2 = S1 + Assessment of level of fluoride in water supplies and level of fluoride toothpaste use. Advocate for implementation of water fluoridation or distribute subsidised fluoride toothpaste.
Moderate	S2	S2	S3	S3 = S2 + Fissure sealants, Atraumatic Restorative Technique, Preventive Resin Restorations, Simple endodontic therapy for patients with pulpitis of anterior teeth and extraction of posterior teeth with pulpitis, Use of rotary instruments to place restorations if viable.
Mild	S1	S1	S3	

Suggested indicator	Your target
To increase the proportion of caries-free 6-year-olds by	%
To reduce the proportion of children with severe dental caries at age 12 years, with special attention to high-risk groups within populations, by	%
To reduce tooth loss due to dental caries at ages 18 years by	%
To reduce tooth loss due to dental caries at ages 35-44 years by	%
To reduce tooth loss due to dental caries at ages 65-74 years by	%

Fluorosis	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Identify alternative water source; Advocacy and social mobilisation for de-fluoridation using appropriate technology.
High prevalence of fluorosis	S1	S1	S3	S2 = No intervention
Moderate or low prevalence	S2	S2	S2	S3 = Clinical intervention for selected severe cases.

Suggested indicator	Your target
To reduce the prevalence of disfiguring fluorosis with special reference to the fluoride content of food, water and inappropriate supplementation by	%

Chronic periodontal disease	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = self-care and education; Occupational health and safety measures.
High priority Attachment Loss or pockets >5mm	S2	S2	S3	S2 = S1 + identify those at risk; Advocacy to reduce risk factors like poor nutrition, smoking, immuno-suppression; Extraction of teeth with pain and mobility; Treatment of critical teeth to retain at least 5 posterior occluding pairs; Scaling when necessary.
Low/moderate Attachment Loss or pockets <5mm	S1	S1	S1	S3 = S1 + S2 More complex evidence-based treatment to treatment to delay/slow progress, where appropriate.

Suggested indicator	Your target
To reduce tooth loss due to periodontal diseases at ages 18 years with special reference to smoking, poor oral hygiene, stress and inter-current systemic diseases by	%
To reduce tooth loss due to periodontal diseases at ages 35-44 years by	%
To reduce tooth loss due to periodontal diseases at ages 65-74 years by	%
To reduce the incidence of necrotizing forms of periodontal diseases by reducing exposure to risk factors such as poor nutrition, stress and immuno-suppression by	%
To reduce the incidence of active periodontal infection in all ages by	%

Noma	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	***S1 = immunisation, nutrition, education, feeding schemes (short-term), oral cleaning, chlorhexidine, mouthwash during acute infectious diseases, develop a local protocol for the acute phase of noma.*** S2 = S1 + reconstructive surgery.
Existence of noma	S1	S1	S2	

Suggested indicator	**Your target**
To increase reliable data on noma from populations at risk by	**%**
To increase early detection and rapid referral by ….. and …….. respectively	**% and %**
To reduce exposure to risk factors with special reference to immunization coverage for measles, improved nutrition and sanitation by	**%**
To increase the number of affected individuals receiving multidisciplinary specialist care by	**%**

Oral Cancer	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Train Primary Health Care (PHC) Workers in the detection of oral pre-cancer and cancer; Early diagnosis by PHC workers for oral pre-cancer and cancer; Advocate for a functional referral system if none exists; Train general pathologists in oral cytology and classification of oral cancers; Measures to limit occupational risk factors; Advocate for registration of all oral cancers in a national register; Adopt and use standardised treatment protocols.
Existence of Oral Cancer	S1	S1	S1	

Suggested indicator	**Your target**
To reduce the incidence of oro-pharyngeal cancer by	**%**
To improve the survival of treated cases by	**%**
To increase early detection and rapid referral by …… and …… respectively	**% and %**
To reduce exposure to risk factors with special reference to tobacco, alcohol and improved nutrition by	**%**
To increase the number of affected individuals receiving multidisciplinary specialist care by	**%**

Benign Tumours	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Training PHC workers in the detection of oral pre-cancer and cancer; Early diagnosis by PHC workers for oral pre-cancer and cancer; Adopt and use standardised treatment protocols based on the availability of resources
Existence of Benign Tumours	S1	S1	S1	

Suggested indicator	**Your target**
To increase the numbers of health care providers who are competent to diagnose and provide emergency care by	**%**
To increase early detection and rapid referral by ……. and …….. respectively	**% and %**

Cleft Lip &/or Palate	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Counselling, Ante-natal care; Surgical treatment of condition; Train PHC workers in early recognition and referral for speech therapy etc. S2 = S1 + orthodontic and prosthetic treatment based on the availability of resources
Occurrence of Cleft Lip & Palate	S1	S2	S2	

Suggested indicator	**Your target**
To increase the number of affected individuals receiving multidisciplinary specialist care by	**%**

Oro-facial Trauma	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Advocacy and support for programmes that: a) enhance social development; b) decrease alcohol and drug abuse; c) improve infra-structural development and d) create legislation for occupational health and safety and road safety; Adopt and use standardised treatment protocols based on the availability of resources.
Existence of Oro-facial Trauma	S1	S1	S1	

Suggested indicator	**Your target**
To increase early detection and rapid referral by …… and …… respectively	**% and %**
To increase the numbers of health care providers who are competent to diagnose and provide emergency care by……. to ……..	**% to %**
To increase the number of affected individuals receiving multidisciplinary specialist care where necessary by	**%**

Tooth loss	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Health Promotion and education; Advocacy and support for programmes that enhance social development S2 = S1 + Denture construction, based on the availability of resources and according to current protocols.
Partial edentulism	S1	S2	S2	
Complete edentulism	S2	S2	S2	

Suggested indicator	**Your target**
To increase the number of natural teeth present at ages 18 years by	**%**
To increase the number of natural teeth present at ages 35-44 years by	**%**
To increase the number of natural teeth present at ages 65-74 years by	**%**

Harmful practises	RESOURCES			INTERVENTION STRATEGIES
	Low	Medium	High	S1 = Health Promotion and education; Advocacy and support for programmes that enhance social development; Education and training of health workers; Treatment of severe complications S2 = S1 + Education and training of existing health workers to recognise and advocate for the eradication of harmful practises; Education and training of existing oral health personnel to use only evidence-based interventions.
High	S1	S2	S2	
Low	S1	S2	S2	

Suggested indicator	**Your target**
A reduction in the numbers of individuals experiencing difficulties in chewing, swallowing and speaking/communicating arising from a variety of harmful practises of	**%**

Appendix Five: National Monitoring And Evaluation

The following information needs to be submitted annually by the provincial health authorities to the national Department of Health.

1. National oral health programmes in place

1.1 Is there a provincial oral health operational strategy? Yes | No

If no, why not? _____

_____

When is it expected to have such a strategy finalised? _____

Attach a list of all health Districts, indicating (i) whether an oral health plan has been prepared or the stage of the planning process that has been reached, and (ii) the extent to which each plan has been implemented.

1.3 National water fluoridation programme.

Number of water providers in province	
Number of water providers fluoridating water supplies	
Number of water providers exempted from fluoridation	

Attach a list of all water supply agencies/municipalities in the Province, indicating (i) the stage of the fluoridation planning process that has been reached, (ii) the extent to which fluoridation has been implemented, and (iii) the number of people receiving fluoridated water.

2. Population strategies carried out

2.1 Are there oral health education and promotion programmes? Yes | No

If no, why not? _____

_____

Attach a list of all programmes of this kind that have been implemented, indicating (i) the nature of the programme, (ii) where they have been implemented, and (iii) the beneficiaries of the programme..

2.2 Are oral health strategies integrated with other health programme e.g. HIV/AIDS, health promotion, maternal and women's health, child and adolescent health, and nutrition.

Yes | No

If no, why not? _____

_____

3. Oral health strategies prepared and interventions implemented

List of oral health conditions	Estimated prevalence	Priority ranking	Number of LHA'S with intervention strategies in place for these conditions

Total number of Local Health Authorities (LHA's) in province ☐

Attach copies of this table for each of the health districts in your Province.

4. Community oral health assessment data

Has community oral health assessment data per LHA been collected? ☐ Yes ☐ No

If no, why not? _____

_____

Attach the data set for each health district in your Province for which this has been collected.

5. Resource assessment

Attach a completed copy of the form in Appendix Three for the province.

Appendix 6: Some Evidence-Based Practices for Dentistry

The table below contains some examples from published systematic reviews that have assessed the evidence for the listed oral health interventions. The national Department of Health is tasked with disseminating current research information, such as that illustrated below, to all Provinces. More oral health conditions will subsequently be added to this list along with the interventions proven to be affective ways to address them.

Oral Health Strategy	Evidence
Oral Health Promotion	There is clear evidence that oral health education/promotion can be effective in bringing about changes in people's knowledge. This process must be ongoing for maximum effect.
Water Fluoridation	Very effective at preventing caries
Mass Media Programmes for Oral Health	There is no evidence that mass media programmes significantly alter any oral health related outcome
School based health education programmes aimed at improving oral hygiene	There is no convincing evidence that these programmes had any effect on plaque levels in the participants mouths, even when daily brushing was done. School based programmes run by dental professionals, teachers, older pupils, etc have **not** been demonstrated to affect oral hygiene.
Toothbrushing	Good evidence to recommend brushing twice daily with fluoride toothpaste for caries prevention and gingivitis
Dental Flossing	Good evidence to recommend flossing as an adjunct to toothbrushing for control of gingivitis in adults Not effective in preventing gingivitis in children
Scaling	Good evidence to recommend against subgingival scaling in sites with no signs of disease. Good evidence to recommend scaling for initial therapy in patients with active periodontitis when combined with maintenance therapy.
Root planing	No evidence regarding additional benefits of root planing in periodontal therapy. There is a lack of scientific evidence regarding the effects of root planing beyond the effects that can be achieved with sub-gingival scaling alone.
Polishing	Good evidence to recommend against polishing prior to topical fluoride application Good evidence to recommend against polishing for control of gingivitis
Recall	No evidence that 6 monthly recall is optimal frequency
Prophylactic removal of impacted third molars	There is little justification for the removal of pathology free impacted third molars
Fissure Sealants	Effective in preventing dental caries. Effectiveness decreases with time-so periodic reapplication is advisable Self-curing sealants more effective than light cured sealants. Water fluoridation appears to increase effectiveness.

Some References (including websites for evidence based dentistry)

1. Brothwell DJ, Jutai DKG, Hawkins RJ. An Update Of Mechanical Oral Hygiene Practices: Evidence-Based Recommendations for Disease Prevention. J Can Dent Assoc 1998; 64(4): 295-304.
2. McDonagh MS, et al. Systematic review of water fluoridation. BMJ 2000; 321: 855-859. Also available on http://www.bmj.com
3. Locker D, Kay E. A systematic review of the effectiveness of health promotion aimed at improving oral health. Comm Dent Health 1998; 15: 132-144.
4. Song F, Landes DP, Glenny AM, Sheldon TA. Prophylactic removal of impacted third molars: an assessment of published reviews. BDJ 1997; 182: 339-346.
5. Netting the Evidence: http://www.shef.ac.uk/~scharr/ir/netting/
6. Centre for Evidence-Based Medicine http://cebm.jr2.ox.ac.uk/docs/adminpage.html
7. Cochrane Collaboration http://www.cochrane.org/cochrane/general.htm