ANNEX 2

FIRST PLENARY SESSION

Program exposure, objectives and Activity workshop

Workshop Objectives
Dr. Heriberto Vera Hermosillo. *Assistant Director of Oral Health, Ministry of Health of Mexico*

General Objetives:

- Facilitate collaboration among experts in oral health both from the public and private sectors and identify solutions to increase Caries Free Communities in the Region of the Americas.
- Recommend actions to improve the oral health status of the most vulnerable groups in the Americas.

Specific Objetives:

- Identify vulnerable communities in each country.
- Identify sustainable solutions to improve the oral health at governmental, professional and academic level.
- Develop strategic interventions for identified vulnerable communities.
- Promote the initiative of caries free community by leadership.

Workshop Program

Javier de la Fuente, *President, Mexican Federation of Colleges and Schools of Dentistry*

Continuation of morning session and Thursday afternoon session: PLENARY

- Presentations of all countries

Moderators: George Weber, Fannye Thompson, Eugenio Beltrán

Friday morning session: Plenary

- Debate of the statements made in the previous plenary meeting.

Afternoon session: Group work

The delegates of the countries will meet to work in groups previously formed with the following objectives:

- Discuss individual proposals of each country and exchange information on intervention strategies to increase caries free communities.
- Discuss work projects for the final declaration.
- Develop at least one intervention proposal and select a target population to achieve a caries free community from the list provided by the coordinating group.

Methodology:

Select a facilitator, recorder and a reporter who will be responsible for submitting proposals or the intervention proposals for the CFCI at the next plenary session.

Saturday morning session:

PLENARY

- Submission of proposals by each CFCI group.
- Final statement of the workshop
- Workshop closure

Pan American Health Organization

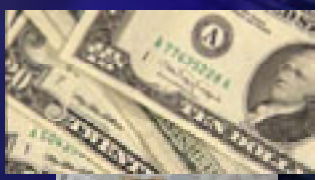
PAHO'S ACTION PLAN FOR ORAL HEALTH AND COMMUNITIES FREE OF CARIES
Mexico 23-25 April, 2009

Saskia Estupiñán-Day
Team Leader, Specialized Programs and Health of Vulnerable Populations
Senior Advisor for Oral Health
Pan American Health Organization

DRAMATIC CHANGES 2008-09

The World Economic Meltdown

- Outcome of the collapse of the US housing market
- Toxic debt on banks around the world
- World's leading investment banks have collapsed
- Most radical re-shaping of the global banking sector, as governments and private sector battle to shore up the world financial system
- Economic recession affects financial sector, job losses



IMPACT ON HEALTH

Challenges	Implications
Economic downturn will affect people	218 million people already uninsured, will increase further Limitations to health care
Economic recession on poorer communities	Less resources for development projects
Export goods produced in poor countries	Closing down Family incomes are shrinking
Family income decreases	Reduction of workforce in own countries Less resources for health care

IMPACT ON HEALTH

Challenges	Implications
Have not gotten rid of most common infectious diseases	Have to deal with problems of industrialized countries (obesity, diabetes, cancer, heart disease)
Fragmented health systems have a hard time adapting to complex transition	Health providers are not always where is most needed 100 million lack access due to geographic and economic constraints
Scientific evidence and technology to prevent diseases, but no money to implement where it is needed	Millions of people become impoverished every year because they have to pay out of pocket for services and medications Indigenous populations register lower access to care, including access to vaccines

PUBLIC HEALTH IN THE 21ST CENTURY

- Adaptability and alignment
- Scientifically based approaches to meet challenges
- Increase effectiveness and efficiency
- Strengthen the public health and health care workforces
- Improve accountability and decision making

Framework for PAHO's Oral Health Strategy

- Defines a 21st Century vision
- Establish a small number of measurable goals focused on critical challenges
- Best Practice Model
  "Best Buys"
- Partnerships and Downstream Investment
- Measurement of Progress

Priority countries: Tier 1

Bolivia, Haiti, Honduras, Guyana, Nicaragua
Ecuador, Guatemala, and Paraguay

Priority groups:

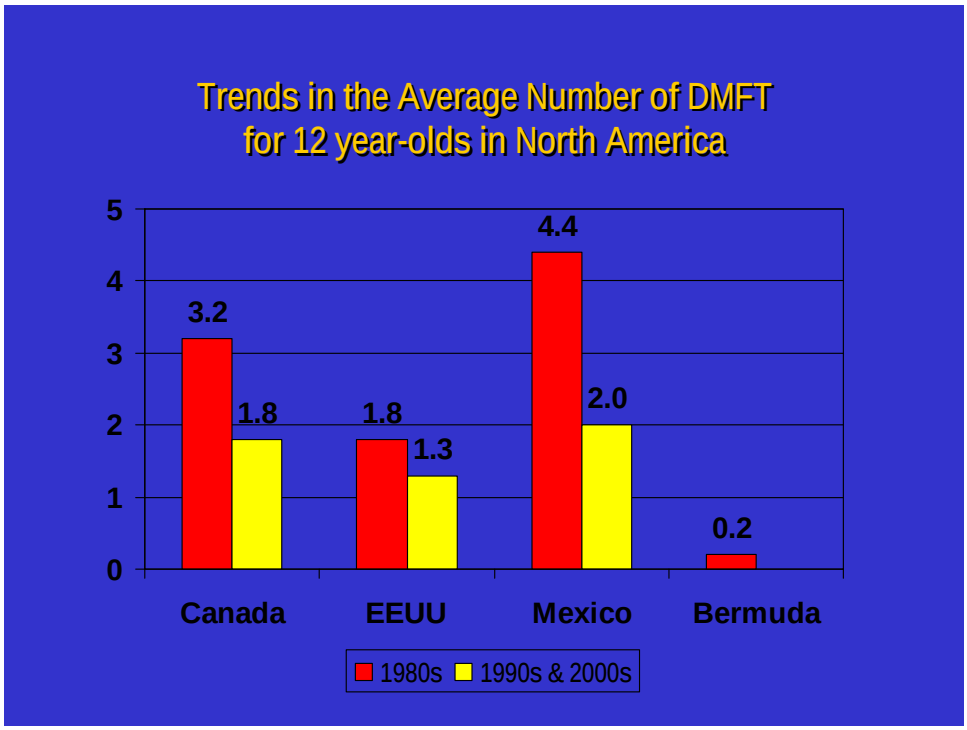
MCH, Children, Women in reproductive age groups, HIV/AIDS, Indigenous groups, Elderly

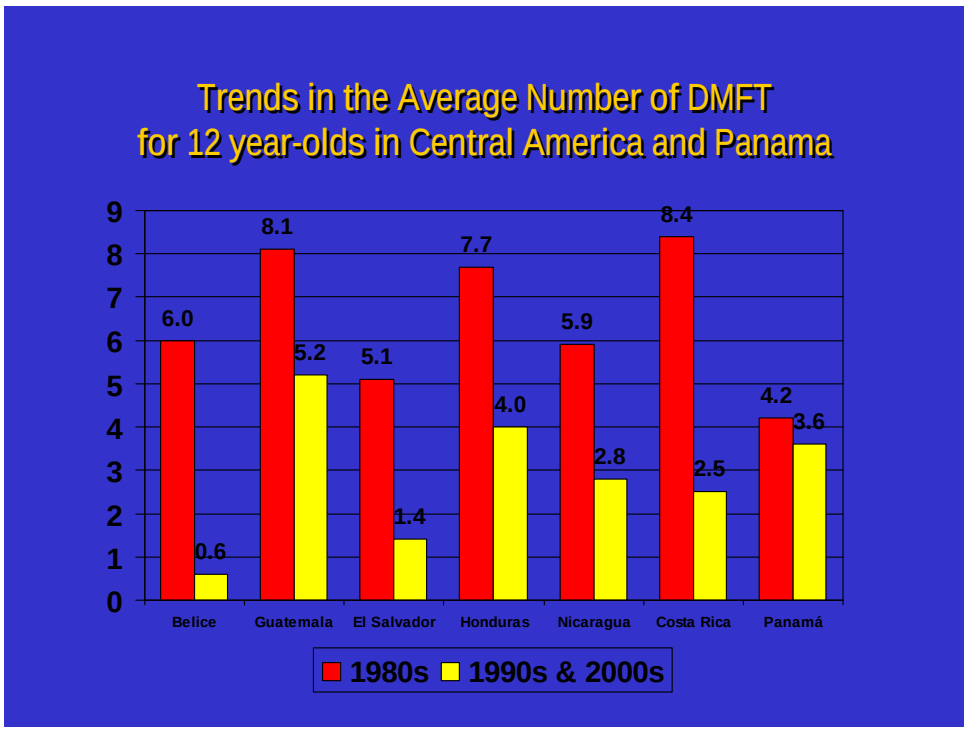
Where we are 1980-2009

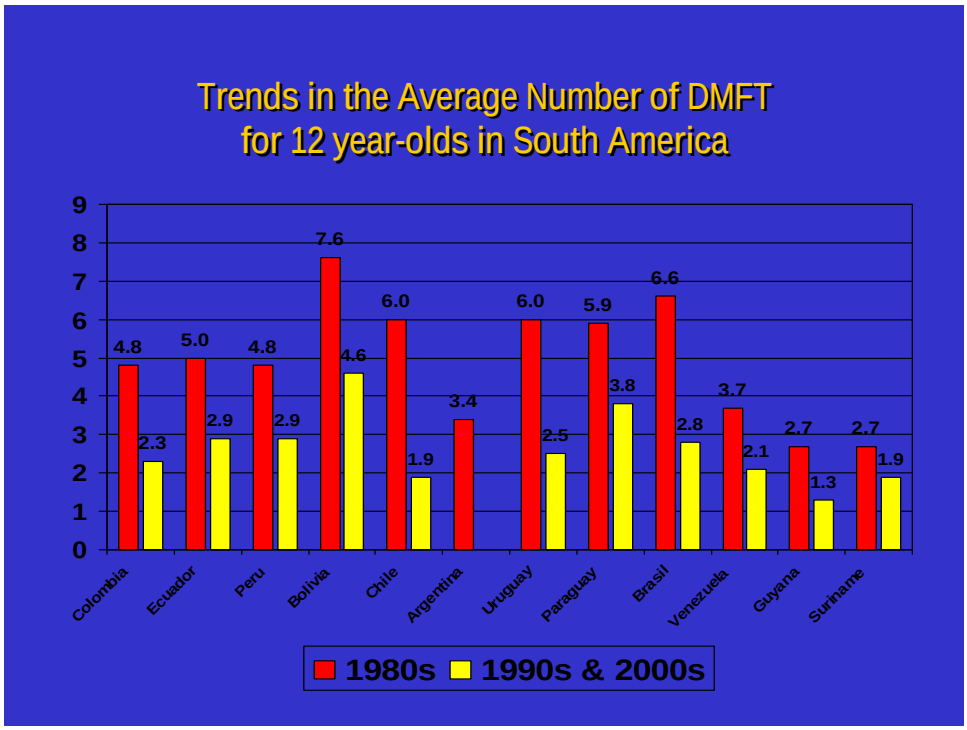
- Shift from emergency care to community programs
- Lack of equity seen as a health problem
- Better understanding of prevention and decentralization
- Surveys reported an average DMFT-12 score of 2.9 for the Region (34 countries <3 and 5 countries >3)

Typology Table in Oral Health

1990			2009		
EMERGENT DMFT > 5	GROWTH DMFT 3-5	CONSOLIDATION DMFT < 3	EMERGENT DMFT > 5	GROWTH DMFT 3-5	CONSOLIDATION DMFT < 3
Anguilla	Argentina	Antigua	Guatemala	Argentina	Anguilla
Belize	Canada	Bahamas	St. Lucia	Bolivia	Antigua
Bolivia	Cayman Islands	Bermuda		Dominican Republic	Aruba
Brazil	Colombia	Cuba		Honduras	Bahamas
Chile	Ecuador	Dominica		Panama	Barbados
Costa Rica	Haiti	Grenada		Paraguay	Belize
Dominican Republic	Mexico	Guyana		Puerto Rico	Bermuda
El Salvador	Panama	USA			Brazil
Guatemala	Peru				Canada
Haiti	Trinidad				Cayman Islands
Honduras	Venezuela				Chile
Jamaica					Colombia
Nicaragua					Costa Rica
Paraguay					Cuba
Uruguay					Curacao
					Dominica
					Ecuador
					El Salvador
					Grenada
					Guyana
					Haiti
					Jamaica
					Mexico
					Nicaragua
					Peru
					Suriname
					Trinidad
					Turks & Caicos
					Uruguay
					USA
					Venezuela


Trends in the Average Number of DMFT
for 12 year-olds in North America
5
4
3
2
1
0
3.2
1.8
1.8
1.3
4.4
2.0
0.2
Canada
EEUU
Mexico
Bermuda
1980s
1990s & 2000s


Trends in the Average Number of DMFT
for 12 year-olds in Central America and Panama
9
8
7
6
5
4
3
2
1
0
6.0
0.6
8.1
5.2
5.1
1.4
7.7
4.0
5.9
2.8
8.4
2.5
4.2
3.6
Belice
Guatemala
El Salvador
Honduras
Nicaragua
Costa Rica
Panamá
1980s
1990s & 2000s


Trends in the Average Number of DMFT
for 12 year-olds in South America
9
8
7
6
5
4
3
2
1
0
4.8
2.3
5.0
2.9
4.8
2.9
7.6
4.6
6.0
1.9
3.4
6.0
2.5
5.9
3.8
6.6
2.8
3.7
2.1
2.7
1.3
2.7
1.9
Colombia
Ecuador
Peru
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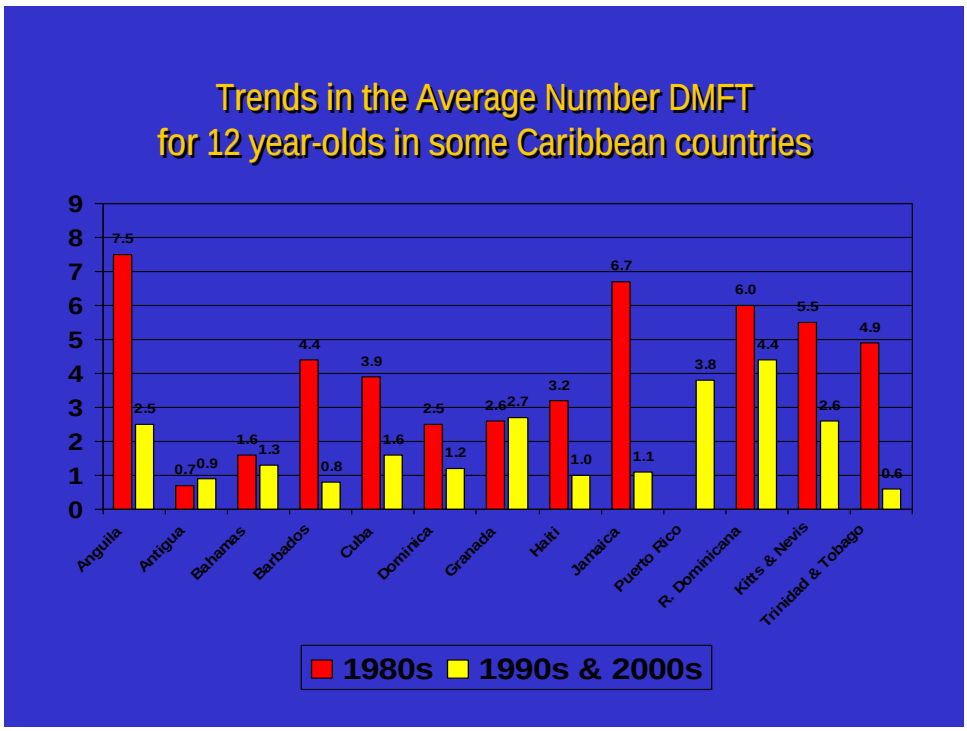
Chile
Argentina
Uruguay
Paraguay
Brasil
Venezuela
Guyana
Suriname
1980s
1990s & 2000s


Trends in the Average Number DMFT
for 12 year-olds in some Caribbean countries
9
8
7
6
5
4
3
2
1
0
7.5
2.5
0.7
0.9
1.6
1.3
4.4
0.8
3.9
1.6
2.5
1.2
2.6
2.7
3.2
1.0
6.7
1.1
3.8
6.0
4.4
5.5
2.6
4.9
0.6
Anguilla
Antigua
Bahamas
Barbados
Cuba
Dominica
Granada
Haiti
Jamaica
Puerto Rico
R. Dominicana
Kitts & Nevis
Trinidad & Tobago
1980s
1990s & 2000s

LESSONS LEARNED

- Forty four national oral health surveys indicate a marked decline between 35% to 85% in the prevalence of dental caries, attributed mostly to cost-effective salt and water fluoridation programs
- Burden of oral disease is severe and remains high in certain geographic areas and high risk populations
- Strong scientific evidence suggests the associations between oral infections, chronic diseases and adverse pregnancy outcomes
- Best Practice Models on prevention and delivery of oral care

Pan American Health Organization

WHERE WE ARE GOING

PAHO'S PRIORITIES

Unfinished agenda

8 MDGs developed in 2000 as a collective international responsibility to reduce poverty

Maternal health

Child health

HIV and other communicable disease

Facing new challenges

Mounting evidence linking oral and systemic health

Protect the achievements

HOW DO WE GET THERE?

The Road Map

- Goals
- Objectives
- Strategies
- Programs
- Marketing

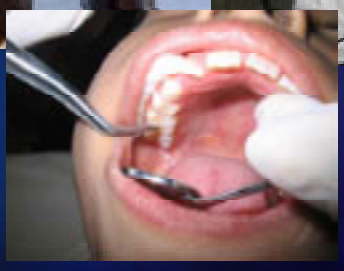
GOAL # 1:

A Minimum Level of Oral Health Care for All by Addressing Gaps in Care for the Most Vulnerable Groups

WHO ARE THE MOST VULNERABLE?

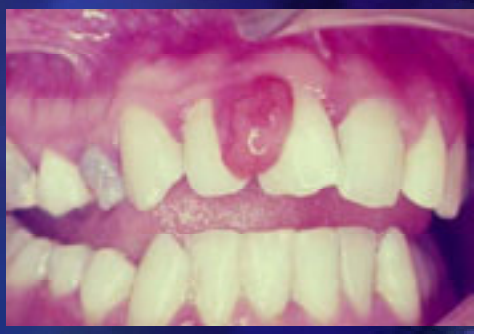
- ✓ Poor of all age groups
- ✓ Socially marginalized
- ✓ Geographically isolated
- ✓ Women and children
- ✓ HIV/AIDS

Objectives:
Reduction of Oral Infections
Increase Access to Oral Health Care



GOAL #2

The Integration of Oral Health into PHC Services



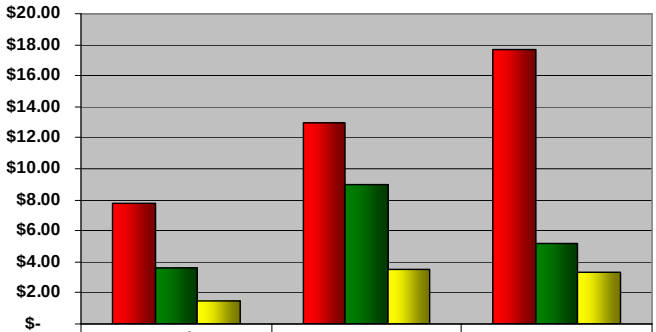
- ✓ Develop mechanism to integrate oral health within current PHC services
- ✓ Incorporate oral health component into prenatal programs
- ✓ Scale up best practice models

PAHO/IADB Clinical Trials in Ecuador, Panama and Uruguay

PRAT PROBABILITY OF SUCCESS AND FAILURE

	Success	Failure
• Dentist doing amalgam	0.943	0.057
• Dentist doing ART	0.960	0.040
• Auxiliary doing ART	0.942	0.058

Cost by Provider Modality
(US $)



	Ecuador	Panama	Uruguay
Amalgam	$7.77	$12.95	$17.65
PRAT by DDS	$3.64	$9.00	$5.19
PRAT by Auxiliary	$1.48	$3.48	$3.37

Source: Final Report Project PRAT 091024, OPS 2006

Scale Up Oral Health Coverage Using Cost-Effective and Simple Technologies, PRAT
$ 1.50 to treat/seal a tooth

Peru children treated with PRAT

Canelones priority PRAT Program

www.paho.org

"PRAT SYSTEM = Best Buy"

- PRAT provides the lowest cost service modality, produces acceptable outcomes
- PRAT as a best practice model provides a framework to implement at large scale oral health services and will reduce the inequities for access to care services
- A PRAT-based strategy for expanding coverage at reduced cost should become a cornerstone of policy at the regional and country levels
- This study has produced evidence to guide downstream investment to improve equity and efficiency and quality of life in the Americas

GOAL # 3

Scaling-Up of Proven Cost Effective Interventions

Salt Fluoridation

$ 0.06/person/year

DENTAL CARIES IN COUNTRIES WITH CONSOLIDATED NATIONAL SALT FLUORIDATION PROGRAMS

COUNTRY	BASELINE STUDIES		FOLLOW-UP STUDIES		CARIES
	YEAR	DMFT-12	YEAR	DMFT-12	REDUCTION(%)
Columbia	1980	4,8	1998	2,3	52,1
Costa Rica	1988	8,4	1999	2,5	70,6
Jamaica	1984	6,7	1995	1,1	83,9
México	1987	4,6	2001	2,0	45,7
Uruguay	1992	4,1	1999	2,5	40,6

Source: Health in the Americas, 2007 Volume 1

PROTECT YOUR ACHIEVEMENTS

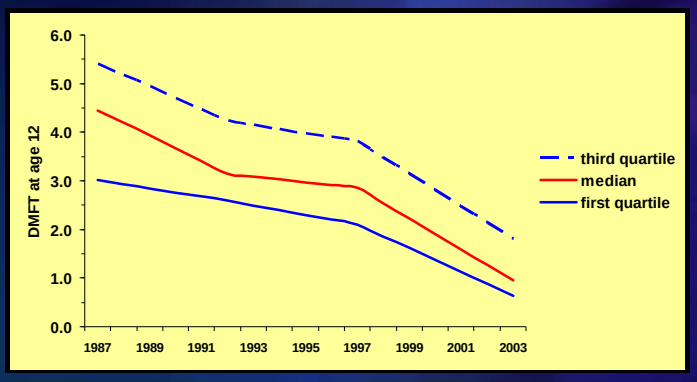
Because it works!

- ✓ Scale
- ✓ Importance
- ✓ Ability to prove and measure results
- ✓ Improved health impact
- ✓ Sustainable
- ✓ Cost effective
- ✓ Partnerships/multidisciplinary
- ✓ Information/marketing

HOW DO WE KNOW WE ARE MAKING PROGRESS

- Oral health policies and programs continue to incorporate current scientific knowledge and evidence-based practice
- There are sustainable interventions that worked
- Strengthening partnerships between *public* and *private* sectors is critical to protect the established progress, ensure sustainability
- Political considerations cannot be allowed to override scientific evidence in decision making

TRENDS OF DMFT-12 FOR THE REGION OF THE AMERICAS, 1987-2003



Source: Pan American Health Organization 2006

Trends in Dental Caries in Latin American and Caribbean 5-6 and 11-13 year-old children: A Systematic Review

- **Methods**
  - 599 databases searched
  - 438 extracted papers from 1970 to 2000
  - Meet inclusion criteria: 30 papers
  - Representing 50 study groups, across 16 countries in region
- **Conclusions**
  - Prevalence information was scanty in age grouping 5-6 years old
  - Variations in prevalence for 11-13 year olds were between 38 to 98%
  - Clear need for caries surveillance and international database system for monitoring changes in oral health

The agenda we need to finish!

- To implement comprehensive oral health care interventions that helps reduce drastically dental caries in vulnerable populations in each country

  -The downward trend does not mean that the disease is no longer a public health problem
  -The epidemiological profile may show a very different picture if it included the analysis of caries at an early age (the current prevalence is sub estimated)

- The oral health community makes efforts to identify sustainable solutions and ensure that vulnerable communities are free of dental caries

- Close the gap in oral health inequalities, through the CLC initiative, with a focus on priority countries and the most vulnerable communities in the Region

COMMUNITIES FREE OF CARIES

COMUNIDADES LIBRES DE CARIES

Implementation of CFC

Phase I

- Build consensus for CFC
- Identify communities
- Design and tailor oral health interventions/oral health packages

Phase II

- Implementation in Tier 1 selected countries
- From lessons learned design tailor interventions to Tier 2 countries
- Design and tailor oral health interventions/oral health packages

Phase III

- Empowering of HR and evaluation of interventions
- Measurement of progress
- Dissemination of results

Phase I Planning

Objectives	Actions	Performance Indicators
• Advocate oral care prevention to support CFC • Alignment across organizations is based on building trust • Develop initial country-specific interventions for CFC	• Advocacy from leaders from academia, governments, professional organizations • Advocate oral care prevention within network through regional consensus conference, experts' meetings, others • Sensitize public health institutions, academia, governments, professional organizations on current needs of effort to reduce caries among the young (less than 20 years old)	• Identification of key experts from public and private sectors for CFC. • Consensus reached on CFC to reduce caries in the region. • Developed jointly with country counterparts CFC in Tier 1 (priority) countries

Workshop on caries prevention for communities in the Region of the Americas

Taller de prevención de caries para comunidades en la Región de las Américas
Panama, 27-29 May 2009

Phase II
Implementation of CFC

Objectives	Actions	Performance Indicators
• Implement country-specific interventions for CFC on a rolling basis • Reduce dental caries by 80% in priority communities by 2014	• Work closely with MOH, Dental Schools, Dental associations to implement a joint CFC • Continually measure caries prevalence in target communities against baseline • Develop a set of "lessons learned" from the development of oral care packages for Tier 1 countries	• Oral health intervention implemented in Tier 1 (priority) countries • Oral health intervention developed in Tier 2 countries • Dissemination of results and outcomes

Phase III
Evaluation and dissemination

Objectives	Actions	Performance Indicators
• Empower oral health community in the development of sustainable oral health promotion and educational activities by year 2013 • Expand existing CFC network.	• Build on education / communications campaign from Phase I to generate awareness of available oral health programs and motivate access to them. • Develop and expand a "training of trainers" (TOT) program.	• Evaluation of impact. • Oral health interventions adopted by countries • Publication of success stories

En síntesis

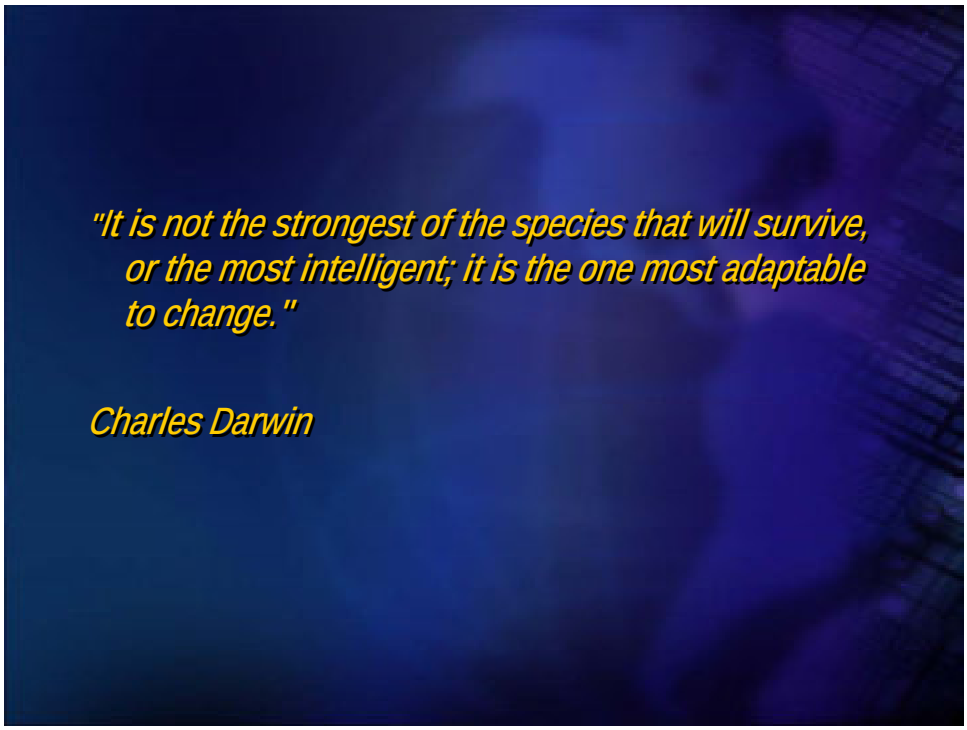
- La recesión económica mundial repercutirá sobre la salud
- Los servicios sociales destinados a los pobres son los primeros que corren peligro
- Llamamiento a la comunidad de salud oral con el fin de encontrar soluciones sostenibles para lograr CLC en las Américas
- Los modelos de mejores prácticas proporcionan un marco para ejecutar los programas a gran escala
- La ciencia detrás del compromiso y la evidencia de que ésta funciona
- La evidencia demuestra la factibilidad y costo efectividad
- La iniciativa CLC requiere liderazgo, compromiso y recursos para orientar la inversión hacia el futuro y mejorar la salud oral en las poblaciones vulnerables en la Región de las Américas

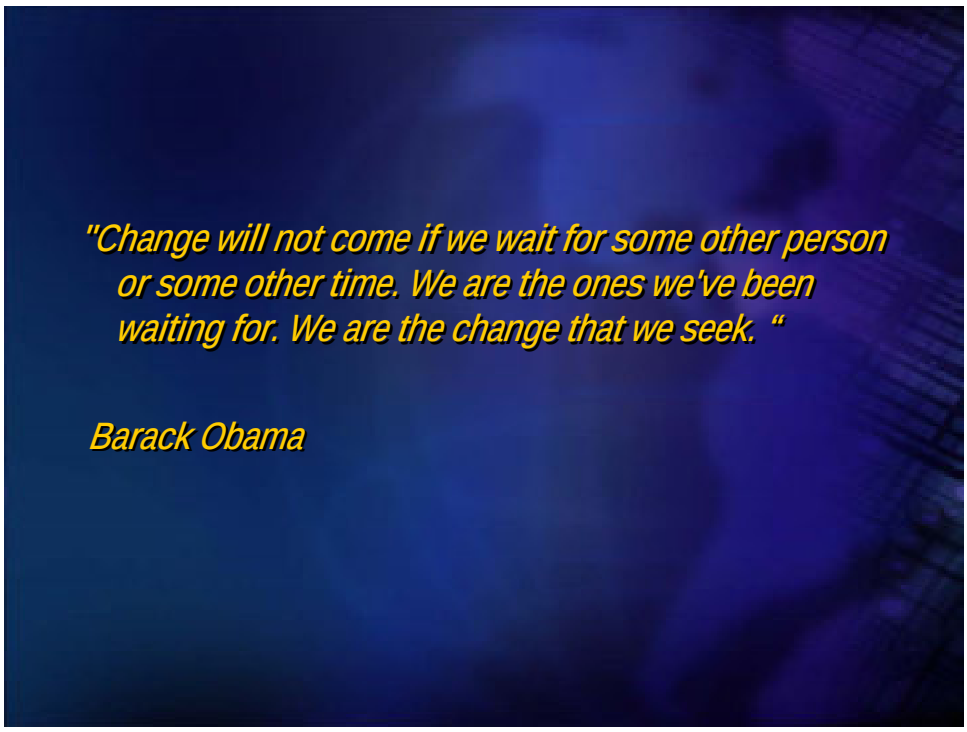
Organización Panamericana de la Salud

In Summary

- Global Economic recession will have impact on health
- Social Services for the poor are the first to be jeopardized
- Call on all stakeholders in the oral health community to join together to identify sustainable solutions to achieve CFC in the Americas
- Best practice model provides a framework to implement at large scale oral health programs
- The Science Behind the Commitment and the evidence and knowledge that it works
- Evidence demonstrates feasibility with extreme cost-benefit
- Implementation of CFC requires leadership, commitment, resources to guide downstream investment to improve oral health in vulnerable populations of the Region of the Americas

Pan American Health Organization


"It is not the strongest of the species that will survive, or the most intelligent; it is the one most adaptable to change."
Charles Darwin


"Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek. "
Barack Obama

SECOND PLENARY SESSION

PRESENTATIONS FROM ALL COUNTRIES

Methodology for Selecting the Order of the Presentation

Outline of activities during the team meeting of the groups:

- List all the countries that were participating in the workshop
- Place the name of the countries in a bag
- Remove the names from the bag and place them in alphabetical order so everyone can have equal time.

Participating countries

ANGUILA	**HAITI**
ANTIGUA	**HONDURAS**
ARGENTINA	**CAYMAN ISLANDS**
BAHAMAS	**VIRGIN ISLANDS**
BARBADOS	**JAMAICA**
BELIZE	**MEXICO**
BERMUDA	**MONTSERRAT**
BOLIVIA	**NICARAGUA**
BRAZIL	**PANAMA**
CANADA	**PARAGUAY**
CHILE	**PERU**
COLOMBIA	**PUERTO RICO**
COSTA RICA	**DOMINICAN REPUBLIC**
CUBA	**SAINT KITTS**
DOMINICA	**SAINT LUCIA**
ECUADOR	**SAINT VINCENT**
EL SALVADOR	**SURINAME**
UNITED STATES	**TRINIDAD/TOBAGO**
GRANADA	**URUGUAY**
GUATEMALA	**VENEZUELA**
GUYANA	

ANNEX 3

GROUP REPORTS

Proposals for Caries Free Communities Initiative (CFCI/ICLC)

During the workshop the participants worked in groups to exchange, discuss, analyze, and propose projects in target populations in order to implement the seed of the CFCI in selected countries. These actions were supported by over 100 experts at the workshop.

Participants gathered in groups to fulfill the following objectives:

- Discuss and exchange information on intervention strategies to spread the CFCI.
- Use the guide provided by the coordinating group to develop at least one intervention proposal in a target population to achieve CFC.
- Discuss projects for the final declaration.

The methodology applied in the group was:

- Selection of the moderator (leader of the group), recorder (all components of the debate and the proposal) and the reporter (to present the intervention proposals of CFCI)
- Development of the CFCI project to implement in the target population, according to the guidance provided by the group coordinator.
- Presentation in the plenary session of the FTC's proposals from each group.
- Review the presentations for the incorporation of the CFCI in the respective vulnerable groups already identified.

The objective of the group work was to propose interventions based on:

- Solving the problem of dental caries in the most vulnerable communities.
- Looking for solutions and interventions based on scientific evidence, considering the identification of needs, disease prevention, promotion, and health protection.
- Involving the active engagement of members (partners, stakeholders) of the public and private sectors of the target community.

- Identifying potential sources of funding.
- Creating a mechanism of evaluation.
- Achieving a sustainable plan.

In the process of group discussion, some preconditions were set for the development of CFCI:

1) To evaluate the target population, it is important to diagnose the community's health, then schedule a meeting with the community representatives and stakeholders, and finally, report results once a consensus has been reached with community leaders, neighborhood councils, school boards, religious groups, political clubs, parents, and others. Identifying target populations with the greatest need is prioritized using the following criteria:

   • Geographically isolated
   • Lifespan
   • Morbidity by dental caries
   • Socio-economic conditions
   • Access to services

2) It is necessary to implement interventions on young populations, especially on preschool age or early school children, so they establish communication with their mothers, guardians, or people who care for them. The interventions should be considered as an ongoing mother-child relationship.

3) It is important to consider the need for integration with other public policies, such as National-State or State-Local, so they can provide or limit the development of our intervention. Private, non-governmental, and religious groups may also be potential partners for project implementation.

Group Instructions

a) The four groups meet separately and decide to work by country or group. Each group appoints a registrar and a reporter, who reveal the group's name at the plenary meeting on Saturday.

b) The groups select a target population characterized by levels of dental caries, geographic (isolated and immigrant communities, ethnic minorities), age (1 to 7, 8 to 17, adults, seniors, etc.), and underlying conditions (co-morbidities, congenital, acquired, or chronic).

c) The groups develop a case study focused on dental caries as identified and explained as follows:

1) How to identify and follow-up the health needs related to dental caries in the target population.
2) Select interventions to address the health needs of this population including:
   • Health Promotion: desirable healthy behavior
   • Preventive interventions based on evidence.
   • Interventions to restore and maintain the oral health status
   • interventions to maintain an environment that promotes dental health.
3) Create a program to implement interventions detailed (1 and 2), include: stakeholders, government, private sector, and NGOs, among others.
   - Human and economic resources.
   - Plan for program evaluation.
   - Support plan.
4) Discuss the characteristics of the proposed intervention to extend or limit the outreach of the program within the country or other countries.

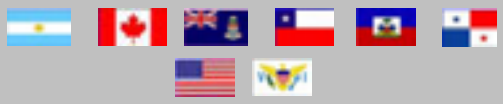
GROUP A

Caries Free Communities target young populations from 1 to 7 years who reside in isolated communities with high prevalence of dental caries and without access to dental health services.

GRUPO A		
Country	**Name**	**Group Funtion**
ARGENTINA	Norma Picaso	
	Jouglard Adrian	
	Santore Leonardo	
	Adolfo Domingo Torres	
	Cecotti Eduardo	
CANADA	Dr. Peter Cooney	Rapporteur
	Dr. Debbie Stymiest	
	Dr. Doug Brothwell	
CHILE	Olaya Fernandez	
	Maria Eugenia Valle	
UNITED STATES OF AMERICA	John S. Findley DDS	
	Dr. Christopher Halliday	
	Dr. Patrick J. Ferrillo	
FDI	Dr. George Weber	Moderator
HAITI	Jean Marius Lafond	
	Samuel Prophete	
CAYMAN ISLANDS	Dr. John Vitos	
VIRGIN ISLANDS	Dr. Nikki Rubaine	
PAHO	Dr. Saskia Estupiñán-Day	Coordinator
PANAMA	Aminta Galvez	Rapporteur

GROUP A

Argentina, Canada, Cayman Islands, Chile, Haiti, Panama, USA, Virgin Islands



Requirements for Diagnosis

The working group decided on three surveys:

- Quantitative survey: to determine the DMFT and dmft index.
- Qualitative Inquiry: (habits, attitudes) to learn hygiene, tooth brushing, number of toothbrushes per family, sugar consumption, schooling, family income, and if they ever received oral health care.
- Analysis of the system: health policy, infrastructure, human resources, and financial resources, among other services.

Group Dynamics

- Work as one group rather than as subgroups
- Select a reporter
- Make decisions through collective approach and consensus
- Share experiences among the countries
- Have valuable discussions

Determination of Vulnerable Populations

Criteria based on:

- Geographic isolation
- Lifespan
- Comorbidities

Initially we proposed to target children aged 1 to 7 years, but we decided that it would be better to perform a needs-based assessment first. Groups will be targeted according to the evidence and consensus with community leaders, including religious groups, political leaders, schools, and community councils.

Need assessment findings

Characteristics of the community:

- Environmental: No central water distribution system, primitive sanitation facilities
- No electricity
- High sugar consumption

Actions and Interventions

- **Interventions in the Community**
  - Systemic Fluoride (water / salt) since there is no fluoride, other community-level interventions will be provided
  - Promotion and Health Education (schools, health fairs, community centers, etc.). Development of appropriate educational materials according to the culture of the community
  - Education in environmental sanitation: chlorination of water, disposal of excreta

Survey results

- Quantitative: DMFT = 6, dmft = 7
- Qualitative: KAP- little knowledge of oral hygiene, brushing teeth, a brush for each family member, low reading level (low education), low household income, lack of dental care services and lack of knowledge of fluoride benefits.
- System Analysis: minimum level of health policies.
- Infrastructure: health post room without water provision.
- Human Resources: A health assistant or developer to visit the dentist every 3 months using only a minimum budget from the financial resources.

Actions and intervetions

- **Interventions to the members of the community:**
  - Topical fluorides:
  - Affordable quality toothpaste
  - School fluoride rinses
- **Interventions by the trained health personnel:**

-Diagnosis
-Fluoride Varnish
-Sealants
-PRAT/ART (dentists and dental assistants)
-Patient reference

Community Action

- Results of the needs assessment were presented to community leaders
- Offered intervention options to community leaders and recommended priority interventions
- Gained the support and advocacy of community leaders
- Informed community members and other stakeholders of the progress
- Transfered expertise to the community so they could deal with future problems

Communication and involvement

- Realize the importance of oral health in relation to general health, ensure community is fully aware of the need for political advocacy.
- Coordinate with environmental health team from nearest health facility to educate in the chlorination of water and disposal of excreta
- Advokate for the placement of solar panels in schools
- Leadership in health decisions and integration of actions within the oral health community

Partnerships

- Government including CDO engagement and commitment to oral health at national, provincial, and local level (policy, delivery of services, infrastructure)
- Oral health community (associations, dental schools, regulatory boards, private sector industries)
- Community empowerment and commitment including sustainability

Evaluation

- Evaluate the penetration and performance of the interventions
- Give feedback to the community on: presence of indicators such as brushing, fluoride varnishes, diet, oral health literacy, sealants, etc.
- Perform monitoring every 6 months
- Indicator for performance: DMFT and dmft
  Monitoring in 3-5 years
  Publication, dissemination of case-study results
- Scale-up intervention to the regional/national level

Target Population:

> *"Free Caries Community targets young populations from 1 to 7 years who reside in isolated communities with high prevalence of dental caries and without access to dental health services".*

To determine the target population, it is important to diagnose the community's health, then schedule a meeting with community representatives and stakeholders, report the results, and reach a consensus with its leaders, neighborhood councils, school boards, religious groups, political clubs, parents, and others to collectively identify which population to target based on the criteria for prioritization:

- Geographically isolated
- Lifespan
- Morbidity due to dental caries
- Socio-economic conditions
- Access to services

Identification and follow-up of health needs related to dental caries in the target population

To analyze the health situation, the following should be applied:

- Quantitative Surveys: to ascertain the DMFT and dmft index.
- Qualitative Inquiry: KAP (knowledge, attitudes, practices) to learn hygiene, toothbrushing, sugar consumption, reading level, whether ever has received oral health care.
- Analysis of the system: health policy, infrastructure, human resources, financial resources, services.

The results of these studies will show:

- Socio-economic conditions.
- Access to health services.
- Influence of knowledge from family and social environment mother, family, community).
- Lifestyle.
- Health status of the mother considering her social environment.
- Level of education and occupation of parents.
- Ethnic and cultural recognition.
- Risk characteristics (history of tooth decay, bottle use, poor nutrition, sweetened foods and beverages).
- Dental (ICDAS-DMFT-dmf).

Interventions to address health needs of the target population, including the following tasks:

When implementing interventions on mostly preschool and early school-aged children, it is necessary to involve the mother, guardian, or person in charge of caring for the child. The intervention should be considered as an ongoing mother-child relationship, like the integration of public policy such as state-national, state-local, or state-agency, so they can support or restrict the development of our project.

Interventions should be discussed and contributed to by community members.

Health Promotion: encourage desired healthy behaviors. To carry out the actions for health education and promotion, provide information and communication about the interventions to community members:

Interventions in the Community:

In:

- Schools
- Health Fairs
- Community Centers

Develop culturally appropriate teaching materials for the community.

Interventions for Community Members:

- Teach health interventions focused on methods and techniques of promotion, communication, and gathering information.
- Train members of the community as health promoters.
- Create educational programs with content specific to mothers and 1 to 7 year-old children.
- Build partnerships with the mother, link to breastfeeding, nutrition, and other health conditions that have an impact on oral health.
- Develop a partnership with the media.
- Conduct visual and written educational materials through billboards, continuous reinforcement in children's stories, theater skits, drawings, and education.
- Involve the family, particularly parents (mother and father), careers, and teachers.
- Develop skills, including teaching skills, to promote health.
- Urge hygiene and healthy lifestyles.
- Analyze education, awareness, and cultural competency.
- Search for self-management and training of community leaders.

Preventive interventions based on evidence. It should include both the community and individuals.

- **In the community:**
  Systemic Fluoride (water / salt). In the absence of fluoride, other interventions will be made at the community level.
- **To the members of the community:**
  Topical fluoride application, including fluoride mouth rinses for schoolchildren.
  Access to quality toothpaste quality at low cost.
- **Training of the health personnel for interventions**
  Includes training with:
  - Diagnostic
  - Fluoride varnish
  - Sealants
  - ART/PRAT (dentist and dental assistant)
  - Patients' reference

Interventions to restore and maintain the oral health status based on evidence.

Recovery:

In addition to children it will include mothers or people employed in child care to increase coverage according to the resources available to each country.

Treatment of non-cavitated lesions

- ICDAS treatment to prevent progression of injury (preventive).

Treatment of cavitated caries

- As one of the measures, the ART/PRAT technique can be applied with proper diagnosis according to the individual case. Each country will adopt the measure according to their own policies.
- Other restorative interventions regarding the diagnosis, patient needs, and resources of the country.

Maintenance:

Execution of all the actions described in order to maintain the oral health of children and their parent or guardian.

Come up with innovative interventions to maintain an environment that promotes dental health.

1. The results of health assessment must be presented to the community leaders.
2. Provide options for interventions to community leaders and recommend priority interventions.
3. Get support and advocacy.
4. Teach the community members and others to promote health.
5. Teach the community about dental caries and associated problems.

Program to implement the described interventions describe includes:

1. Stakeholders, government, private sector, NGOs, and others.

Government committed to the health of this community. This is at all levels: local, provincial, and national level (referring to policy, service providers, and infrastructure).

Dental Community: dental associations, dental schools, social security, dental companies, NGOs, private sector.

Community empowerment and engagement to achieve sustainability

2. Necessary human and financial resources.

It requires coordination among all stakeholders to ensure the participation and commitment of:

- Dentists, both public and private sectors, as well as colleges and dental schools.
- Guilds and associations.
- Dental students.
- Institutions promoting educational health.

Necessary Equipment:

- Set of mobile dental instruments for transport to isolated communities.
- Dental instruments.
- Materials for the treatment of dental caries by the determined method.

Financial Resources:

- Purchase of materials for health promotion and disease prevention.
- Acquisition of equipment, instruments, and others for program development.

- Salaries for personnel employed on the project.

3. Program Evaluation

Evaluation of effectiveness, performance, and feedback to the community.

- Effectiveness rates: Brushing, fluoride varnish, diet, oral health education, sealants, among others. Monitored every 6 months.
- Performance indicators: dmf and DMFT. Monitored 3 to 5 years.

Publication and dissemination of case studies at national and regional levels.

- Plan for sustaining the program
- Community: importance of oral health in the health of individuals. Ensure that the community has the knowledge to undertake policy advocacy in defense of their right to health. Awareness, empowerment.
- Dental Community: leadership in health decisions.
- Meetings to articulate skills.
- Re-educate the dental profession.
- Inclusion in the curriculum of universities
- Practical applications with specific characteristics and needs of the population. Multidisciplinary approach
- Creating effective partnerships.
- Political will.

Characteristics of the proposed intervention to facilitate or hinder their extension

Advantages:

a. Existence of scientific evidence showing the association between oral health and general health, and thus, the child's development.
b. Elimination or reduction of illiteracy, which increases understanding of the educational messages.
c. Partnerships between various players in dental and primary care, giving priority to pregnant women and children.

Difficulties:

a. Limitations of human recourses, materials, and finances.
b. Insufficient promotion and prevention content in curricula.

c. Misunderstanding about the importance of oral health form an early age, even before birth, by the community leaders, mothers, and others.
d. Current economic crisis.
e. Lack of political will to include dental care as a priority.

Group B

Caries Free Communities in schoolchildren from birth to 12 years of age, mothers, and pregnant women.

GROUP B		
Country	**Name**	**Group role**
BRAZIL	Gilberto Pucca Junior	Reporter
COLOMBIA	Marisol Tellez.	Moderador
COSTA RICA	William Brenes Gomez	
	Nora Chavez Quiroz	
ECUADOR	Ximena Raza	
UNITED STATES OF AMERICA	Lois Cohen.	Moderador
GRENADA	Crofton Stroud	
MEXICO	Heriberto Vera Hermosillo	Coordinator
MONTSERRAT	Coretta Fergus	
PERU	Jim Romero Llolla	
	Miguel Angel Saravia	
FOLA PRESIDENT	Dr. Adolfo Rodríguez	
DOMINICAN REPUBLIC	William Gilberto Portes	
VENEZUELA	Pablo Quintero	

GROUP B

Brazil, Colombia, Costa Rica, Ecuador, Grenada, Mexico, Montserrat, Peru, Dominican Republican, USA, Venezuela

Interventions on selected populations on health issues, including the following tasks:

- **Health Promotion: health desirable behavior**

–Focus on health education for mothers and fathers.
–Promote educational messages to the mass media
–Incorporate educational activities about chronic diseases in other programs
–Activities targeted towards preschool age children
–Information on how to improve oral health, the use of tooth brush and to have healthy lifestyle.

I. White Population

School children from 0 to 12 years of age, mothers and pregnant women.

- ***Identification of the health needs related to caries and its consequences in the selected population***

–To Determine DMFT/dmft
  –Knowing the population's social determinants, poverty indicators, service accessibility
  –Knowing the infrastructure
  –Effective access to health services
  –Qualitative assessment to determine the possibility of community participation
  –Institutional support articulation
  –Analyze previous epidemiological studies on the group of white population

- **Interventions to restore and maintain the oral health status based on evidence**

Recovery:
Early diagnosis of caries (white spots) in mothers and children.
PRAT/ART technique adapted to national conditions.
Other restorative interventions and strategies in line diagnosis, the patient's needs and resources of the country

Maintenance:
Implementation of all actions to maintain oral health, both on the children and on their mothers or responsible staff

•Innovative interventions to maintain an environment that promotes oral health

– Articulate communication and market leadership programs for the masses along with the sector entities and the media.

–Partnerships with professional associations, public institutions, opinion leaders, school systems and private foundations.

2. Necessary human and financial resources:

It requires working with the staff and oral health team with varied skills

Coordination between all stakeholders to ensure the participation and commitment to:

– Dentists, both public and private sectors as well as college and school of dentistry.
– Guilds and Associations.
– Dental students
– Health promoters from the community and scholarly institutions

•Program to implement the interventions would describe and include the following:

1. **Stakeholders, government, private sector and NGO's among others**

– Government (Ministry of Health, Ministry of Education, other sectors).
– Private sector (Universities, Associations, Unions, Schools, Companies)
– NGO's

Equipment needed:

– Mobile dental equipment that facilitates efficient transfer to isolated communities.

Instruments:

- Dental materials for caries treatment through the determined method.

Financial Resources for:

- Procurement of needs for health promotion and illness prevention
– Procurement of equipment, instruments and other miscellaneous materials for the development of the program
– Salaries for the non-volunteers in the staff

3. Program Evaluation

Through:
- Effectiveness
- Quality of intervention
- Expending coverage
- Equity compared to other groups.
- Indicators of perception sites established for monitoring
- Establishment of a global information system for the comparison of countries in terms of number of days lost due to dental causes

Facilitators and Difficulties in proposed intervention

Facilitators:
- Existence of scientific evidence demonstrating the association between oral health, general health, and child development
- Partnerships between various players in dentistry and primary care, giving priority to pregnant women and children.

Difficulties:
- Limited human, material, and financial resources
- Current economic crisis
- Lack of political will to recognize the importance of oral health by not including dental care as priority as evident in the absence of existing public policies.

4. Plan to support the program

- Request various entities from international agencies to contribute to the oral health budget.
- Ensure commitment of the state by its commitment to oral health.
- Create partnerships with the public sector, private sector, and other actors.
- Regulate the development of the program within the legal frameworks of the country.
- Ensure fair and legal recruitment of professionals.

Target Population*:*

Schoolchildren from birth to 12 years of age, mothers, and pregnant women.

Identification and follow-up of health needs related to dental caries in the target population

- Identify DMFT / dmft.
- Learn about the social determinants of population, poverty indicators, and accessibility to services.
- Know the infrastructure
- Effective access to health services.
- Qualitative assessments to identify opportunities for community participation.
- Articulation of institutional support.
- Analyze previous epidemiological studies on the target population.

Interventions to address health needs of the target population, including the following tasks:

Health promotion: desired healthy behaviors

- Focus on educating mothers and fathers about health.
- Promote educational messages in the media
- Educational activities in conjunction with other programs about chronic diseases.
- Activities targeting preschool children.
- Information on care for better oral health: the use of toothbrush and healthy lifestyles.

Preventive interventions based on scientific evidence

- Should be made based on the concept of transmission of dental caries.
- Education includes how to care for baby's health.
- The use of fluorides, especially systemic fluorides.

Prevention specific to mothers

- Intervention is based on the transmission of dental caries concept.
- Educate on how to take care of the baby's oral health.
- Use topical fluoride, varnishes, mouth rinses.

Prevention especially for children under 12 years.

- Analysis of risk factors.
- Use of topical fluoride, varnish, sealants of pits and fissures for children older than 6 years old, mass tooth brushing.

Interventions to restore and maintain the oral health status based on evidence.

Recovery:
- Early diagnosis of caries (white spots) in mothers and children.
- ART/PRAT technique adapted to national conditions.
- Other restorative interventions and strategies according to diagnosis, patient needs and resources of the country.

Maintenance:
- Implement actions to maintain the oral health of children and their mothers or guardians.

Have innovative interventions to maintain an environment that promotes dental health.
- Communication Programs for the greater community, including leadership, marketing, and the media.
- Partner with professional associations, public institutions, consultants, the school system, and private foundations.

Program to implement the described interventions, include:

1. Stakeholders, government, private sector, NGOs, among others:
   - Government (Ministry of Health, Ministry of Education, etc.)
   - Private sector (universities, associations, unions, schools, companies)
   - NGOs
2. Necessary human and financial resources:
   - It requires working with the staff and the team of oral health with its regulatory powers.
   - Dentists in the public and private sectors, as well as colleges and dental schools.
   - Coordination between all stakeholders to ensure the participation and commitment to:
     - Guilds and associations
     - Dental students
     - Promoting community and student health

Equipment needs:
- Dental instruments to be mobilized to isolated communities
- Instruments

- Materials for the treatment of dental caries by the determined method

Financial resources:
- Purchase materials for health promotion and disease prevention.
- Acquire equipment, and other instruments for program development.
- Salaries for the personnel employed on the project.

Program assessment through:
- Effectiveness.
- Quality of intervention.
- Expanded coverage.
- Equity compared to other groups.
- Indicators for monitoring.

Furthermore, it requires the establishment of a global information system to compare the number of work days lost due to dental-related reasons among the countries.

4. Plan for sustaining the program
- Require agencies and international entities to comply with oral health budget.
- Ensure they will honor their commitment to oral health.
- Make alliances with public, private, and other groups.
- Regulating the development of legal frameworks within the country.
- External evaluation by committees of international experts.
- Ensure a fair and legal recruitment of professionals.

Characteristics of the proposed intervention that may facilitate or hinder its success

Advantages:
1. Existence of scientific evidence demonstrating the association between oral health and general health, and thus the child's development.
2. Partnerships between various players in dental and primary care, with priority given to pregnant women and children.

Difficulties:
1. Limitations of human and financial resources
2. Current economic crisis.
3. Lack of political will to include dental care as a priority.

GROUP C

Caries-Free Community in target population: children from birth to 6 years of age

GROUP C		
Country	**Name**	**Group function**
ANTIGUA	Gregson Williams	
BELIZE	Raphael Samos Ozaeta	
BOLIVIA	Lidia Bustamante	
	Oscar Miguel Toco	
COLOMBIA	Sandra Tovar Valencia	Reporter
	Carlos Mario Uribe Soto	
EL SALVADOR	Cecilia Somoza De Diaz	
	Nuria Quinteros	
	Manuel De Jesus Joya	
UNITED STATES OF AMERICA	Dr. Ramón Báez	Moderator
GUATEMALA	Oscar Reyes	
HONDURAS	Pedro Cordova Zuñiga	
IADR	Dr. Ana María Acevedo	Moderador
MEXICO	Javier de la Fuente	Coordinator
	Maria Hirose	
	Elisa Luengas	
OFEDO PRESIDENT	Maria Clara Rangel	
SURINAME	Marcel Panday	
ST. KITTS	Trevor Christmas	

GROUP C

Antigua, Belize, Bolivia, Colombia, El Salvador, Honduras, Guatemala, Mexico, Surinam, St. Kitts

I. Target Population

- **Children under 6 years, preferably in rural areas and in cities with low GDP NBI**
- **Coverage should be fixed**

(*Several countries proposed that in addition to caries, the focus should also consider other types of diseases.)

Identifying Needs

- Analysis of social determinants
  - Socio-economic condition
  - Effective access to health services
  - Influence of knowledge of family and social environment (mother, family, community)
  - Analysis of lifestyles
  - Analysis of the health status of the mother (the social environment and nearby)
  - Educational level and occupation of parents
  - Ethnocultural recognition
  - Risk analysis approach (mother with caries, baby bottles, poor nutrition, food acids and sweetened beverages)
  - Identificatiuon of dental status (ICDAS-DMF-dmf)

Continuous interventions mother - child

Integration policies:

- State National
- Local State
- State institutional

Continuous Interventions mother - child

PROMOTION

PHASE 1

- Insertion into the community
- Involvement and empowerment of the dentist as part of the health care team (multidisciplilnary approach).
- Interrelation of professional oral care and overall health

PHASE 2

- Empowerment and ownership of the community

Continuous Intervention Mother-child

PROMOTION

PHASE 3

- Development of content specific to mothers, children under 1 year of age (before teeth start growing) and children from 1 to 6 years of age (growing teeth)
- Build alliances with mothers and pregnant women. Link breastfeeding, nutrition, and general health as conditions that have an impact on oral health.
- Partnering with the media

Continuous Intervention mother - child

PHASE 3 (con't)

- Educate with written and visual educational materials, posters, continous reinforcement of children's fairy tales, theater, drawing, and education.
- Family involvement, especially parents, caretakers, and teachers.
- New skills should be taught to improve teaching.
- Hygiene and healthy lifestyles.
- Educational diagnosis, awareness, and cultural competency.
- Encourage self management and training of community leaders.

Continuous Interventions mother - child

PREVENTION

Collective actions

- Fluoridation Programs

Individual Actions

- Risk approach to determining treatment needs:
  - Application of fluoride varnishes
  - Mass fluoride programs
    - Systemic route (water, salt, milk)
    - Topical route (enhanced toothpaste, varnishes)
  - Pit and fissure sealants applied according to the approach risk.
- Encourage staff to attend the first level

Continuous Interventions mother-child

RECUPERATION

CARIES LESION NON CAVITATED

- Treatment according to the International Caries Detection and Assessment System (ICDAS) to prevent the progress of a decay to a frank lesion. (Preventive activities)

CAVITATED CARIES

- TRA previous capacitation according to the case with proper diagnosis and seen on an individual basis.
- Other restorative interventions regarding patient's diagnosis, patient's needs, and resources of the country.

Continuous Interventions mother-child

INNOVATIONS

- Treatment plan based on risk approach (performed by trained personnel)
- Diagnosis and treatment according to ICDAS in early stage of dental caries (performed by trained personnel)
- Use of fluoride varnishes

Continuous Interventions mother-child

EVALUATION AND MONITORING

- Monitor children to keep them healthy.
- Frequency of clinical assessment: 2 times per year.
- Strengthening of recommendations for maintaining healthy lifestyles (breastfeeding, nutrition, hygiene etc).
- Monitor children who were previously sick to avoid other illnesses.

Program

Stakeholders

- Government (ministry of health, ministry of education and other sectors). Search for a state policy in each territory. Private sector (universities, associations, unions, schools, companies).
- NGO´s.
- WHO to facilitate the actions in each country in the region and mobilize resources from other organizations, notably UNICEF, UNFPA, among others).

Program

- Meetings with dentists to educate other allied health professionals.
- Inclusion in the curriculum of universities.
- Practical applications with specific characteristics and needs of the population.
- Multidisciplinary approach.
- Raising awareness, community empowerment.
- Development of effective strategic alliances.
- Political will.

Program

- Make a plan for sustaining the program
- Evaluation indicators (structure, process, and results)

Formal systems of operation:

- Establish a frequency of evaluation (monitoring)
- Improve plan according to the results
- Evaluation of the impact (feasible, viable, and cost effective)
- Strengthen actions
- Make a plan for sustaining the program that will be closely linked with commitment of all actors.

Target population:

Target children up to 6 years of age, preferably from rural areas and cities with low GDP and NBI affecting over 95% of the population.

Identification and follow-up of health needs related to dental caries in the target population

This requires an analysis of social determinants to consider:

- Socio-economic conditions.
- Effective access to health services.
- Influence of family knowledge and social environment (family, community).
- Influence of family on lifestyle.
- Health status of the mother (and her social environment).
- Educational attainment and occupation of parents.
- Recognition of ethnic and cultural differences.
- Focus on risk (mothers with caries, bottle habits, malnutrition, sweetened foods and beverages).
- Dental (ICDAS-DMFT-dmf).

Interventions addressing the health needs of the target population include the following tasks:

It is necessary to implement interventions on children (especially on preschool aged or early school). The activities of the parent, guardian, or person in charge of caring for the child need to be combined with the interventions as these are being considered as an ongoing mother-child relationship. This must be taken into account by integrating our intervention in public policy, such as in the national, state, or local policies, as they can assist or restrict the development of our goal.

Health Promotion: desirable health behaviors.
Execute actions that support health education and promotion, including implicit information and communication. Three Phases are considered:

PHASE 1

- Ties with the community.
- Involvement and empowerment of the dentist as part of the health care team (multidisciplinary approach).
- Professional relationship between oral care and overall health.

PHASE 2

- Empowerment of the community.

PHASE 3

- Development of educational programs with specific content for mothers with children younger than 1 year (before growing teeth) and between 1 and 6 year (while growing teeth).
- Build partnerships with mothers and pregnant women; link oral health to breastfeeding, nutrition and other health conditions.
- Partner with the media.
- Supply written and visual materials: billboards, children's stories, theater, drawings, education.
- Family involvement, particularly parents (mother and father), caretakers, and teachers.
- Develop skills, especially the teaching skills of health promoters.
- Hygienic and healthy lifestyles.
- Diagnosis of education, awareness, and cultural competency.
- Search for self-management and training of community leaders.

Preventive interventions based on evidence.
It should include both the collective and individuals.

Collective Actions
Mass fluoridation program:

- Systemic (water, salt, milk).
- Topical (toothpastes, varnishes).

Individual Actions
Risk approach to determine treatment needs:

- Application of fluoride varnishes
- Pit and fissure sealants: in line with the risk approach

Have staff promote top-level awareness.

Interventions to restore and maintain oral health based on scientific evidence

Recovery:
In addition to children it will include mothers or staff of infant care, to progressively increase their coverage according to the resources available to each country.

Treatment of non-cavitated lesions
Treatment ICDAS to prevent injury from progressing to frank lesions (preventive).

Treatment of cavitated caries:

- In one measure, the ART/PRAT technique can be applied after training according to the individual-based diagnosis. This technique will be adopted by each country according to their own policies.
- Other restorative interventions can be made based on the diagnosis, patient's need, and country resources.

Maintenance:

Execute the actions described in order to maintain the oral health of children and their mothers or guardians.

Come up with innovative interventions to maintain an environment that promotes dental health.

- Treatment plan based on risk (performed by trained personnel).
- Diagnosis and treatment according to ICDAS in early stage of dental caries (performed by trained personnel).
- Use of fluoride varnish.
- Monitor the health of children.
- Frequency of clinical assessment: 2 times per year.
- Strengthen recommendations for maintaining healthy lifestyles (breastfeeding, nutrition, hygiene, etc.).
- Monitor children who were previously sick to avoid other illnesses.

Program to implement the described interventions, including:

1. Stakeholders, government, private sector, NGOs, among others.
   - Government (ministry of health, ministry of education, and other sectors). Search for a state policy in each territory.
   - Private sector (universities, associations, unions, schools, companies).
   - NGOs.
   - WHO can facilitate the actions in each country in the region and mobilize resources from other organizations, notably UNICEF, UNFPA, and others).
2. Necessary human and financial resources:
   Coordination among all stakeholders is required to ensure the participation and commitment of:
   - Dentists, both public and private, and at colleges and dental schools.
   - Guilds and associations.
   - Dental students.
   - Community and school health promotion.

Necessary equipment:

- Moblie dental sets and instruments to reach isolated communities.
- Instruments.
- Materials for treatment of dental caries by the determined method.

Financial resources:

- Purchase materials for health promotion and disease prevention.
- Acquire equipment and instruments for program development.
- Salaries for the personnel employed on the project.

3. Program assessment

It requires the establishment and implementation of evaluation indicators.

a. Structure: Includes the use of equipment, media, instruments, medicines and materials, human resources.
b. Process: Takes into consideration the organization and operation of technical procedures for interventions.
c. Result: Coverage depends on actions taken (promotion, prevention, and treatment), indicators for residents of the community, cost of the actions, and the satisfaction of stakeholders and beneficiaries.
   - Formal operating system
   - Frequency of evaluation (monitoring) in accordance with the interests of each community and country, should be at least every 6 months.
   - Proposals for upgrading results (cost effective) as a response to feedback and analysis gathered at least every six months.
   - Impact assessment (practical, feasible, and cost effective) once per year.

4. Plan for sustaining the program
   - Meeting to explain skills
   - Rehabilitation of dental and other professionals.
   - Inclusion in the curriculum at universities.
   - Practical applications with specific characteristics that meet the needs of the population.
   - Multidisciplinary approach.
   - Raising awareness, community empowerment.
   - Development of effective strategic alliances.
   - Political will.

Characteristic of proposed intervention to facilitate or hinder their development

Advantages:

1. Scientific evidence demonstrates the association between oral health and general health, and thus the child's development.
2. The elimination or reduction of illiteracy will facilitate understanding educational messages.
3. Partnerships will form between various players in dental and primary care and will prioritize treating pregnant women and children.

Difficulties:

1. Limitations of human, material, and financial resources.
2. Insufficient inclusion of promotion and prevention in curriculum.
3. Community leaders and mothers may not realize the importance of oral health from an early age, even before birth.
4. Current economic crisis.
5. Lack of political will to include dental care as a priority.

GROUP D

Caries-Free Communities in populations with disabilities or special needs

GROUP D		
Country	**Name**	**Group Function**
BARBADOS	Fannye Thompson	
CUBA	Dr. Maritza Sosa Rosales	Facilitator
UNITED STATES OF AMERICA	Dr. Eugenio Beltrán	Facilitator
DOMINICA	Idalaine John	
GUYANA	Dr. Joanes Jean	
JAMAICA	Irving Mckenzie	
MEXICO	Víctor Guerrero	Coordinator
NICARAGUA	Yemira Sequeira	
PARAGUAY	Gloria Beatriz Medina	Reporter
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GROUP D

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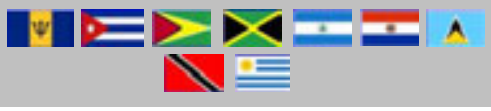


II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

1. Identify the needs of oral health-related to dental caries in populations with special needs.

1) Living conditions of the person with special needs. Where they live, with whom, and who is the legal representative of the person.
2) Evaluation of general health status, level of disability-co-morbidities, treatment, medications.
3) What does the Health System offer for the dental needs of the population? What elements are used by the person?

I. Vulnerable Population

"Populations with special needs identified as people of all ages who have limitations and special requirements due to their health and physical or mental limitations that impact their oral health status "

Note 1: The group agreed that the definition is broad and that the existing national and international definitions should be reviewed.
Note 2: The group identified the following two principles inherent to the development of the case study from all levels of involvement :
1. Activities that focus within the health team
2. Need to form coalitions

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

1. Identify the needs of oral health-related dental caries in populations with special needs

4) Understand risk factors for tooth decay and how do they differ with the population at large. For example- diet, fluoride use, among others.
5)Evaluation of the maxillo-facial needs of the individual.
6) The ability of individuals to carry out oral hygiene (personal or assisted)
7) Knowledge, attitudes and practices regarding oral health of an individual with special needs as well as the person who provides day care.

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

2. Identify interventions to address health problems related to dental caries in people with special needs

a) Oral Health Promotion
1. Existing measures of proven effectiveness and efficiency.
2. Emphasize the level of knowledge, attitudes, skills and behavior of the person in charge.
3. Coaching and training of oral health personnel to work with people with special needs on the characteristics of physical and mental limitations of the person, his ability to take care of themselves, and the clinical management of the individual
4. Develop skills in oral health for parents, guardians, or staff/volunteers who care for the oral health of people with special needs.
5. Using existing technology to improve oral health hygiene of the individual with special needs.

II. Identify what type of interventions is required to address the needs of dental health (tooth decay) of people with special needs.

2. Identify interventions to address health problems related to dental caries im people with special needs.

c). Interventions to maintain the oral health status of people with special needs
1. Determine the appropriate elements of oral health in modular packages that include interventions at different levels of care
1.1. In primary health care- Include medicine and dental surgery including PRAT/ART.
1.2. In secondary care- Attention to unconventional methods, such as treatment under sedation.
2. Maintain oral health levels acquired through systematic interventions for promotion and prevention and oral examinations at regular intervals to be established.

II. Identify what type of interventions is required to address the needs of dental health (tooth decay) of people with special needs.

2. Identify interventions to address health problems related to dental caries in people with special needs.

b) Preventive interventions
1. Identify the existence of national fluoridation in milk, water, salt. If necessary use supplements of supplement F.
2. Recommend appropriate and individualized oral hygiene and care.
3. Monitor the patient diet and medication.
4. Appropriate use of topical fluorides. Each country will choose the most suitable scheme depending on what the evidence establishes as the individual's need and capacity.
5. Use of pit and fissure sealants.
6. Timely care to prevent severe dental caries.

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

2. Identify interventions to address health problems related to dental caries in people with special needs.

d) Environmental innovative interventions to maintain gains.
1. Development of health policies that focus on the oral health care of people with special needs.
2. Establish a program that is specifically named and recognized by the community. Identify "champions".
3. Train human resources to meet the health needs of vulnerable populations

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

3. Develop a program to implement the actions described

a). Stakeholders

1. Parents, tutors and families
2. Public and Private Sectors
3. Academic Schools and Clinics (hospitals)
4. Education Sector
5. NGOs
6. Religious and secular groups
7. Groups focused on specific groups
8. Commercial sector

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

3. Develop a program to implement the actions described

a). Design and implement evaluations

1. Develop monitoring indicators
   - 1) Process
   - 2) Behaviors
   - 3) Expectations
   - 4) Interventions
   - 5) Flow of Information
2. Impact evaluation
   - 1) Changing attitudes, beliefs and customs
   - 2) Changes in levels of oral health status (% free of dental caries and % of untreated carious lesions)
   - 3) Satisfaction of the individuals, parents, guardians etc.

II. Identify what type of intervention is required to address the needs of dental health (tooth decay) of people with special needs.

3. Develop a program to implement the actions described

a). Identify human and material resources

1. Establish multiple levels and needed resources for the promotion of oral health
2. Establish levels and necessary resources for oral health care
3. Establish criteria prioritizing health care based on individual needs and availability of resources
4. Encourage, train, and include voluntary professionals programs
5. Encourage, train, and include preventive measures using promotional suitable staff. For example- nurses, assistants, faculty, and developers.
6. Identify sources of funding foundations and groups representing specific diseases.

Target Population:

> "*People with disabilities or special needs identified as people of all ages who have physical or mental limitations and special requirements due to their health that impact their oral health status"*

Note 1: The group agreed that the definition is vague and should review the existing national and international definitions.

Identification and follow-up of health needs related to dental caries in the target population

This requires an analysis of social determinants that considers:

a. Living conditions of the person with special needs: where the person lives, with whom, who is his legal representative.
b. Evaluation of general health status, level of disability, co-morbidities, treatment, and medications.
c. Determine what services the dental healthcare offers to this population. Also determine how the person is able to have effective access to health services.
d. Determine via a risk approach which risk factors are present, particularly those associated with tooth decay, and how they differ from the population as a whole. For example, diet, fluoride use, takes medication, limitations on oral hygiene, among others (including the impact of family and environment).
e. Oral maxillofacial assessment of the individual's dental needs, (ICDAS-DMFT-dmf).
f. Ability of the person to practice oral hygiene (personal or assisted).
g. Knowledge, attitudes, and practices regarding oral health of the person with special needs and the person who provides day care.
h. Influence of family and social environment with regard to educational and occupational level.
i. Lifestyle. Take into consideration ethnic and cultural background.

Interventions addressing the health needs of the target population, including the following tasks:

It is necessary to perform interventions on the population with disabilities or impairment that should be designed not only for the target population but also for the ones their caretakers, especially when the disability is due to a mental or motor skills impairment that limits nearly all ability to make independent decisions for their care.

It is also important to consider the need to integrate with other public policies, such as: national, state, local, or institutional, so they can facilitate or limit the development of our goal by seeking private,

religious, and nongovernmental organizations as potential partners for implementing the project.

Health Promotion: Desired healthy behavior.
To carry out health education and promotional activities, information and communication are necessary. The following measures should be developed:

- Identify existing effective and efficient measures in the population that can be included in the intervention.
- Emphasize the level of knowledge, attitudes, skills, and behavior to strengthen the positive behaviors and discourage the negative behaviors.
- Train oral health personnel on how to work with people with special needs by teaching them about the physical and mental limitations of the person, how they care for themselves, and the clinical management of the individual.
- Develop oral health skills of parents, guardians, staff, and volunteers who care for the oral health of people with special needs.
- Use existing technologies for better oral hygiene of people with special needs.
- Empower relatives, guardians, staff, and communities with the responsibility for providing general and oral health specifically for people with disabilities.
- Develop and disseminate educational materials for different special needs, socio and ethno cultures, and age groups.

Preventive interventions based on evidence

It should include both the collective and the individual.

1. Identify the national fluoridation programs (milk, water, salt) that can benefit the target population. If necessary, include the use of fluoride supplements in the intervention.
2. Appropriately use topical fluorides.
   Each country will opt for the most appropriate scheme, depending on what the scientific literature establishes and the individual's need and capacity.
3. Recommend appropriate oral hygiene and individualized care, reinforcing positive behaviors and methods, primarily from very early ages.
4. Determine the diet and medications used by the patient to determine the risk. Establish adequate preventive measures regarding their oral health status and disabilities. Form alliances with nutritionists and medical personnel who are involved in the project.

5. Indicate the use of pit and fissure sealants.
6. Provide timely care to prevent severe dental caries.

Interventions to restore and maintain the oral health status based on evidence.

1. Determine the appropriate elements of oral health for the community, according to the type of disability, the resources of each country, and the partnerships that are established, grouping them into modular packages which will include interventions at different levels of care.
2. In primary health care: the modules include prophylaxis, ART/PRAT, dental surgery, and extractions. These may be adjusted according to the ability of each country to achieve support for these actions.
3. In secondary care: the modules will include care with unconventional methods, such as treatment with sedation in order to treat all the patient's cavities at one time.

In short, it seeks to provide:

Treatment of non-cavitated lesions

- ICDAS treatment to prevent injury from progressing to frank lesions (preventive).

Treatment of cavitated caries

- One method is to use the ART/PRAT technique according to the individual's diagnosis case. This technique will be adopted by each country according to their own policies.
- Other restorative interventions regarding the diagnosis, patient needs, and country resources.

Maintenance:

Maintain oral health levels acquired through programs for promotion and prevention. Establish oral examinations at regular intervals.

Use innovative interventions to maintain an environment that promotes dental health.

1. Develop or adopt health policies directed to oral health of people with special needs.
2. Establish a program that is specifically named and recognized by the community.
3. Identify leaders and potential partnerships.

4. Use the media to report on achievements to attract volunteers and other stakeholders.
5. Train staff to meet the health needs of vulnerable populations.

Program to implement the interventions described include:

1. Stakeholders, government, private sector, NGOs, others:
   - Parents, guardians, families
   - Public and private sector
   - Academia and clinics (hospital)
   - Education sector
   - NGOs
   - Religious and secular groups
   - Groups focused on specific diseases
   - Commercial sector

2. Necessary human and financial resources
Coordination by all stakeholders is required to secure the participation and commitment of:
   - Dentists, both in public and private sectors, and at colleges and dental schools.
   - Guilds and associations.
   - Dental students.
   - Promoting community and school health.
   - Doctors, dietitians, nurses, and other professionals who treat these patients

Necessary Equipment:
   - Set of mobile dental instruments to transport to isolated communities.
   - Instruments.
   - Materials for the treatment of dental caries by the determined method.

Financial Resources:
   - Purchase materials for health promotion and disease prevention.
   - Acquire equipment and instruments for program development.
   - Salaries of personnel employed on the project.

3. Plan for program evaluation
It requires the establishment and implementation of evaluation indicators::
1. **Structure**: includes equipment, media, instruments, medicines and materials, human resources.

2. **Process**: takes into consideration the organization and operation of technical procedures for interventions. Use the flow of information to evaluate interventions.
3. **Result:** coverage reached according to the actions taken (promotion, prevention, and treatment), indicators for community residents, cost of activities, and the satisfaction of stakeholders and beneficiaries.

Emphasize the identification and monitoring of changing negative behaviors, attitudes, beliefs and customs, expectations of satisfaction, effectiveness of interventions. Changing levels of dental health (percentage of free dental caries and untreated carious lesions).

- Formal information systems.

- Frequency of evaluation (monitoring) determined by the interests of each community and country, should be at least every 6 months.

- Proposals for updating program (cost effective) based on feedback and analysis performed at least every six months.

- Impact assessment (practical, feasible, and cost effective) performed once per year.

4. Plan for sustaining the program

It requires:

a. Establishing multiple levels and resources needed for the promotion of oral health.
b. Establishing standards and requirements for oral health care.
c. Establishing criteria for priority health care based on individual needs and resource availability.
d. Encouraging, training, and including professional volunteers.
e. Encouraging and educating qualified personnel (nurses, ancillary staff, education promoters) about preventive actions.
f. Reeducating dental and other health professionals in the care of these population groups, including their treatment in the study plan in places where they are not yet available.
g. Multidisciplinary approach.
h. Identify sources of funding, such as foundations and groups that represent specific diseases.
i. Meetings to articulate skills.
j. Awareness and community empowerment.
k. Development of effective strategic alliances.
l. Political will.

Characteristics of proposed intervention that facilitate or hinder its development

Advantages:

a. Scientific evidence demonstrates the association between oral and general health, emphasizing people with disabilities (physically or mentally affected).
b. Elimination or reduction of illiteracy, which facilitates understanding educational messages.
c. Partnerships between various players in dentistry and primary care.

Difficulties:

a. Limitations of human, material, and financial resources.
b. Insufficient promotion and prevention content in curricula.
c. Misunderstanding by community leaders and families of persons with disabilities of the importance of oral health to overall health, especially in disabled people.
d. Discrimination against people with disabilities occurs in some ethnic and social groups.
e. Current economic crisis.
f. Lack of political will to include dental care as a priority.

ANNEX 4

DECLARATION

Declaration of the Workshop for the Americas on Oral Health held in Mexico City from April 23rd to 25th, 2009.

Oral health is a fundamental and integral component of general health; therefore, countries need to have national policies in which the government is responsible for enabling universal integrality, equity in participation, and a budget irrespective of social status, race, sexual orientation or religion. Epidemiological studies in the Region of the Americas show a close relationship between diseases of the oral cavity, especially tooth decay, and poverty levels as high prevalence is evident among populations with low socio-economic status. Also, scientific evidence shows that this association can be prevented through cost-effective interventions.

Despite improvements in oral health in the Region of the Americas, there is marked inequality, especially in vulnerable populations.

To meet the burden of existing disease and to achieve healthy communities free from dental caries, it is necessary to locate and mobilize resources. This is the time to unite the efforts of institutions and key persons for oral health, such as the heads of oral health programs, chief dental officers, the dental associations and federation, and deans of faculties and dental schools.

Based on the results of the workshop, participants agreed to:

1. Form strong coalitions and partnerships to promote oral health and to address the problem of dental caries in the most vulnerable populations in their countries.
2. Find solutions and evidence-based interventions.
3. Develop appropriate interventions based on needs analysis, promotion, oral disease prevention and health protection of the population.
4. Develop a variety of interventions including:

    a) Integration of stakeholders in the private and public sectors that are committed to aiding vulnerable communities
    b) Identification of human and economic resources

c) Development of an evaluation system and a sustainable intervention plan
d) Establishment of a vocational training program that works together and makes decisions regarding education, care, research and collaboration in the development of policies that seek health promotion and disease prevention.
e) Guarantee to develop a funding plan for the oral health care of vulnerable populations that are currently being provided services by national and international agencies. With the resurgence of the international financial crisis, it should be noted that vulnerable populations in America will grow in number and therefore require more resources for their sustainability.

All participants agreed that the CFC Initiative may be one of the most important and collaborative health interventions ever undertaken in the Region of the Americas.

ANNEX 5

Recommendations and Next Steps
Partnership for Caries-Free Communities (CFC)

Striving to reach disadvantaged populations with oral health care solutions – both preventive and remedial – remains one of PAHO's most formidable challenges. Building upon the success of its previous efforts working with national governments to reduce caries prevalence among children, PAHO has now called on all stakeholders in the oral health community to join together to identify sustainable solutions to achieve Caries-Free Communities in the Americas.

This eight-year plan, launched in Mexico City in April 2009, is a broad-based effort to tackle the burden of dental caries throughout the Americas by focusing in on priority countries and the most vulnerable communities. By pooling the resources of the entire oral health community, PAHO plans to lead this groundbreaking initiative – Partnership for Caries-Free Communities (CFC) – and create space for sustainable solutions for the region's most prominent oral health problem.

PAHO believes the public and private sectors can play a vital role in helping to achieve public sector goals, and so PAHO is building sustainable partnerships among and between stakeholders to implement health strategies and promote capacity-building to help achieve this goal. Stakeholders in this growing partnership include:

- Government agencies, including Ministries of Health
- Academic institutions, and dental schools in particular
- Dental Associations
- Commercial sector and other industry groups
- Parents, teachers, families
- Hospitals and clinics
- NGOs and CSOs
- Religious and lay groups
- Groups focused on specific illnesses
- Other public and private sector institutions
- Other special interest groups, depending on project type

The stakeholders are invited to participate in the initiative to achieve the broadest possible support and to contribute to the CFC by sharing successful

practices, profiling and scaling up existing programs and contribute to the creation and implementation of new programs under the initiative.

The Mexico Oral Health Workshop

In April 2009, PAHO sponsored – in cooperation with Mexico's Secretary of Health, the Federation of Mexican Dental Schools and the Mexican Dental Association – a three-day "Oral Health Workshop for the Region of the Americas" to launch the CFC. The Workshop aimed to facilitate collaboration between oral health leaders from the public and private sectors and to identify sustainable solutions to achieve Caries-Free Communities in the Region of the Americas. Additionally, participants in the Workshop recommended action steps for improving oral health status for the most vulnerable groups in the Americas.

The Workshop's specific objectives included: identifying vulnerable communities in each country; identifying sustainable solutions for improving oral health at governmental, professional and academic levels; designing strategic interventions for the identified vulnerable communities; and launching the CFC Initiative in the Americas by stakeholders.

Over 100 professionals participated, including chief dental officers, deans of dental schools, the FOLA, presidents of dental associations, the World Dental Federation, and International Association of Dental Research, the International Association of Dental Educators, OFEDO and representatives of the private sector.

Implementation of the CFC

Participants of the Mexico Oral Health Workshop began to lay out the actions necessary and outcomes desired for the CFC Initiative. The Initiative will have three separate but overlapping phases.

Phase I, the most developed of the three phases, will focus on vital research necessary for, as well as the development and implementation of, the CFC initiative. An integral part of this phase will be development of the public/private partnership that will support the initiative and ensure its sustainability. In addition:

- **Phase I** will seek out and evaluate opportunities to provide country-specific solutions to oral health care challenges. One example of such an effort would be the development of protocols to implement oral care packages in a school setting, where PAHO would provide technical support and private entities would provide funding to investigate methods for caries reduction among vulnerable groups. Other activities

under the **research component of** this initiative may include exploration of the dental report card initiative, modeled after the vaccine cards in each country; evaluation of the outcomes of Oral Health Month to validate initiatives already developed (such as oral cavity month); and mapping health systems in potential intervention countries to determine best approach (centralized versus decentralized). In addition, Phase I activities will include a well-developed education campaign to raise the profile of the initiative and pave the way for wider implementation in Phase II. PAHO suggests the following priority, or Tier 1, countries for initial intervention: Bolivia, Ecuador, Guatemala, Guyana, Haiti and Paraguay. Monitoring and evaluating progress will play an important role throughout each phase of the project.

- The focus of **Phase II** will be on implementation of oral health interventions to achieve Caries-Free Communities. During Phase I, oral care packages are developed for Tier 1 countries; during Phase II, those packages will begin to be implemented in Tier 1 countries. Concurrently, oral care packages will be developed for Tier 2 countries based upon the specific country context and upon "lessons learned" in the development phase for Tier 1 countries. These interventions will continue on a rolling basis. During the process of developing each oral care package, PAHO will work closely with MOHs and other stakeholders to design appropriate indicators that will measure progress toward achieving Caries-Free Communities. During Phase II, PAHO will work with the CFC to ensure that the interventions are effective in helping countries to meet the target of reducing dental caries by at least 80 percent in priority communities.

- **Phase III** will focus on empowering national and local health authorities and academia in the development of sustainable oral health promotion and educational activities. Activities in this phase will focus on increased and enhanced training for oral health professionals throughout the region, continued measurement of progress toward caries-free communities, and the promotion of success stories from both Tier 1 and 2 country interventions.

It is important to note that PAHO's priority countries are defined by considering individuals at the low end of socioeconomic status, in addition to low oral health indicators. These are the most vulnerable communities, and each intervention will be tailored to these most disadvantaged groups.

The Table below summarizes the Plan of Action resulting from the Mexico Oral Health Workshop, including objectives, strategies, actions and indicators for each phase of the CFC initiative.

Phase I: Research and Education for Caries-Free Communities (2009 – 2014)

Overall Objectives:

- Advocate oral care prevention to support caries-free communities.
- Develop public/private partnership for oral health community.
- Develop initial country-specific interventions for caries-free communities.

Underlying Strategies and Actions:

- Bring together key experts from academia, governments, the profession and related industries to research and support an oral care prevention program to greatly reduce dental caries in the region.
- Advocate oral care prevention within this new network through opportunities such as a regional consensus conference, Global Leadership Panel, roundtables and experts' meetings.
- Sensitize public health institutions, academia, governments and the profession on current needs of effort to reduce caries among the young (less than 20 years old).
- Ensure that caries prevention is integrated into the Primary Health Care agenda.
- Develop and execute an organized public awareness campaign, composed of information, communication and education elements, to enhance awareness of oral care prevention as well as to disseminate information about the CFC. Campaign may include multimedia materials, continuing education for dentists and auxiliary personnel, and protocols to establish fluoride use based on risk assessment. Additionally, the campaign will use mass media outlets to report on achievements of the program and to attract new CFC affiliates.
- Develop and support research opportunities directed toward caries intervention plans.
- In initial target countries (Bolivia, Ecuador, Guatemala, Guyana, Haiti and Paraguay), work closely with Ministries of Health and national dental associations to develop a joint oral care package, tailored to each initial target country's unique needs, that supports caries-free communities.
- Forge alliances with public and private sectors that to enhance support for the initiative and to further guarantee sustainability.
- Establish alliances with other strategic areas that have been developing in country, such as projects of mother/child health, elderly health, disability, among others, prioritized by non-governmental and governmental entities.
- Identify vulnerable communities and establish priorities for the implementation of the CFC in them.

- Determine best practice models and successful programs that are backed up by scientific evidence to provide solutions to problems specific to oral health for each priority community.
- Empower communities.
- Identify and mobilize, as possible, additional sources of program financing—including within the oral health community—with an eye toward sustaining funding beyond the period of the CFC.
- Design a solid monitoring and evaluation (M&E) system to assess progress in each one of the phases of the project, as well as project impact.
- Build capacity among existing human resources to attend to the health-related needs of vulnerable populations.
- Reinforce the existing programs and to contribute to the creation and implementation of new programs under this initiative of CLC.

Performance Indicators:

- Identification of key experts from public and private sectors to form PAHO's Partnership for Caries-Free Communities.
- M&E system developed.
- Consensus reached on oral care prevention package to reduce caries in the region.
- # of Key Experts' and Ministry of Health roundtables conducted.
- Oral care packages developed jointly with national governments and PAHO's CFC in Tier 1 (priority) countries.
- DMFT/DMFS (including non-cavitated lesions) and dental plaque index.
- Assessment of oral hygiene knowledge, attitudes and behavior.
- Proposals on caries interventions and impact evaluation.
- Number of publications (consensus documents from key experts' meetings).

Phase II: Implementation of Caries-Free Communities Initiative (2011 – 2015)

Overall Objectives:

- Implement country-specific interventions for caries-free communities on a rolling basis.
- Reduce dental caries by 80% in priority communities by 2014.

Underlying Strategies and Actions:

- Work closely with Ministries of Health, national dental associations and dental schools, to implement a joint oral care packages for Tier 2 countries that supports caries-free communities. This key effort should be based on lessons learned for Tier 1 countries and tailored to each country's unique

needs. Packages may include the provision of oral care packages and a cost-effectiveness validation of the oral care package.
- Continually measure caries prevalence in target communities against baseline.
- Develop a set of "lessons learned" from the development of oral care packages for Tier 1 countries.
- Strengthen alliances that support the CFC and help to guarantee its sustainability.
- Continue to apply best practice models as joint oral care packages are developed.
- Continue to identify vulnerable communities and extend to them opportunities to implement the CFC, in concert with the initiative's established priorities and available resources.
- Continue to strengthen community empowerment.
- Continue to execute and calibrate public awareness campaign initiated in Phase 1.
- Continue to build affiliated partners and funding sources for CFC.
- Implement the M&E system to assess progress toward objectives and overall impact, providing feedback to all stakeholders and working to correct any deviation from established indicators.
- Continue to develop the capacity building process in order to equip the existing human resources to attend to the health-related needs of vulnerable populations.
- Reinforce existing CFC initiatives and contribute to the creation and implementation of new programs under the CFC Initiative.

Performance Indicators:

- Oral care packages implemented in Tier 1 (priority) countries.
- Oral care packages developed jointly with national governments, dental schools and associations, and PAHO's CFC in Tier 2 countries.
- Publication of "lessons learned" from Tier 1 country interventions.
- Implementation of oral care packages for Tier 2 countries begun.

Phase III: Empowering the Oral Health Community (2012 – 2017)

Overall Objectives:

- Empower local and national health authorities, academia and other organizations in the development and preservation of sustainable oral health promotion and educational activities by year 2017.
- Strengthen the CFC in communities where it is being implemented.
- Expand existing CFC network, with an eye toward the most vulnerable

communities, so that, by the year 2012, all countries of the region will be capable of developing and implementing oral health plans in at least one extremely vulnerable community.

Underlying Strategies and Actions:

- Generate knowledge and skills to develop successful community programs.
- Build on education/communications campaign from Phase I to generate awareness of available oral health programs and motivate access to them.
- Conduct training on community-based participatory research methodologies.
- Continue to strengthen alliances that support the CFC and help to guarantee its sustainability.
- Expand the application of best practice models as joint oral care packages are developed.
- Continue to identify vulnerable communities and extend to them opportunities to implement the CFC, in concert with the initiative's established priorities and available resources.
- Continue to empower communities and national and local governments in the development of the CFC.
- Continue to execute and calibrate public awareness campaign initiated in Phase 1.
- Continue to implement joint oral health packages in Tier 1 and 2 countries, based on the specific context of each country and bearing in mind the "lessons learned" of previous phases, expanding the packages, as feasible.
- Continue to build affiliated partners and funding sources for CFC.
- Continue to implement the M&E system to assess progress toward objectives and overall impact, providing feedback to all stakeholders and working to correct any deviation from established indicators.
- Continue to develop the capacity building process in order to equip the existing human resources to attend to the health-related needs of vulnerable populations. Develop and expand a "training-of-trainers" (TOT) program that will help strengthen capacity.
- Reinforce existing CFC initiatives and contribute to the creation and implementation of new programs under the CFC Initiative.

Performance Indicators:

- Pre-post test surveys for evaluating training impact.
- Percentage of coverage among dental students, profession and community by trainings on community-based participatory research methodologies.
- Number of oral care programs adopted by MOHs.
- Publication of success stories from Tier 1 and 2 country interventions.

In addition to the phase-by-phase Plan of Action, Workshop participants considered other requirements for successful implementation of the CFC Initiative.

Required Human and Economic Resources

The CFC will require the participation and commitment of dental profession (public and private sector, including faculty of dental schools); Dental guilds and associations; dental students; community-based public health advocates, including those from academic institutions; and doctors, nurses and other health professionals. The CFC will also require specific equipment, including dental equipment (especially mobile equipment that is easily transferred to and used in remote communities); dental instruments; and dental materials for treating dental caries by the appropriate method. Finally, a respectable level of financial resources will be necessary for the purchase of resources for health promotion and prevention of illness; the purchase of equipment, instruments and other materials for program development; and for salaries of personnel that are not serving as project volunteers.

Requirements for Establishment and Implementation of a Monitoring and Evaluation Plan

Because the establishment and steady application of a Project M&E Plan is vital to ensuring successful interventions, participants agreed on the following minimum requirements for M&E:

I**ndicators:**

a. Structure: in terms of the utilization of equipment, methods, instruments, human resources, medicines and other materials
b. Process: in terms of the organization and operation of the intervention, as well as the execution of technical procedures. Free flow of information for evaluation of the interventions.
c. Results: coverage reached in accordance with project activities (promotion, prevention, cure rates), indicators by number of community inhabitants, cost of activity, satisfaction of interested parties and beneficiaries. Emphasize the identification and monitoring of change in negative behaviors, attitudes, beliefs and customs, satisfaction of expectations, intervention efficacy. Modification in levels of oral health (% caries-free and % with lesions of untreated caries).
    - Formal System of Information.
    - Frequency of Monitoring and Evaluation: M&E set according to the interests of each community and country, but should not exceed period of 6 months.

- Proposals for improvement in accordance with project results (Cost-Effective), such as intervals for feedback and analysis, not less than every six months.
- Evaluation of impact (feasibility, viability and cost-effectiveness) at least once a year.

Requirements for Program Sustainability.

Building sustainability throughout CFC implementation is a primary goal. To do so, Workshop participants recommended a series of steps to ensure program sustainability.

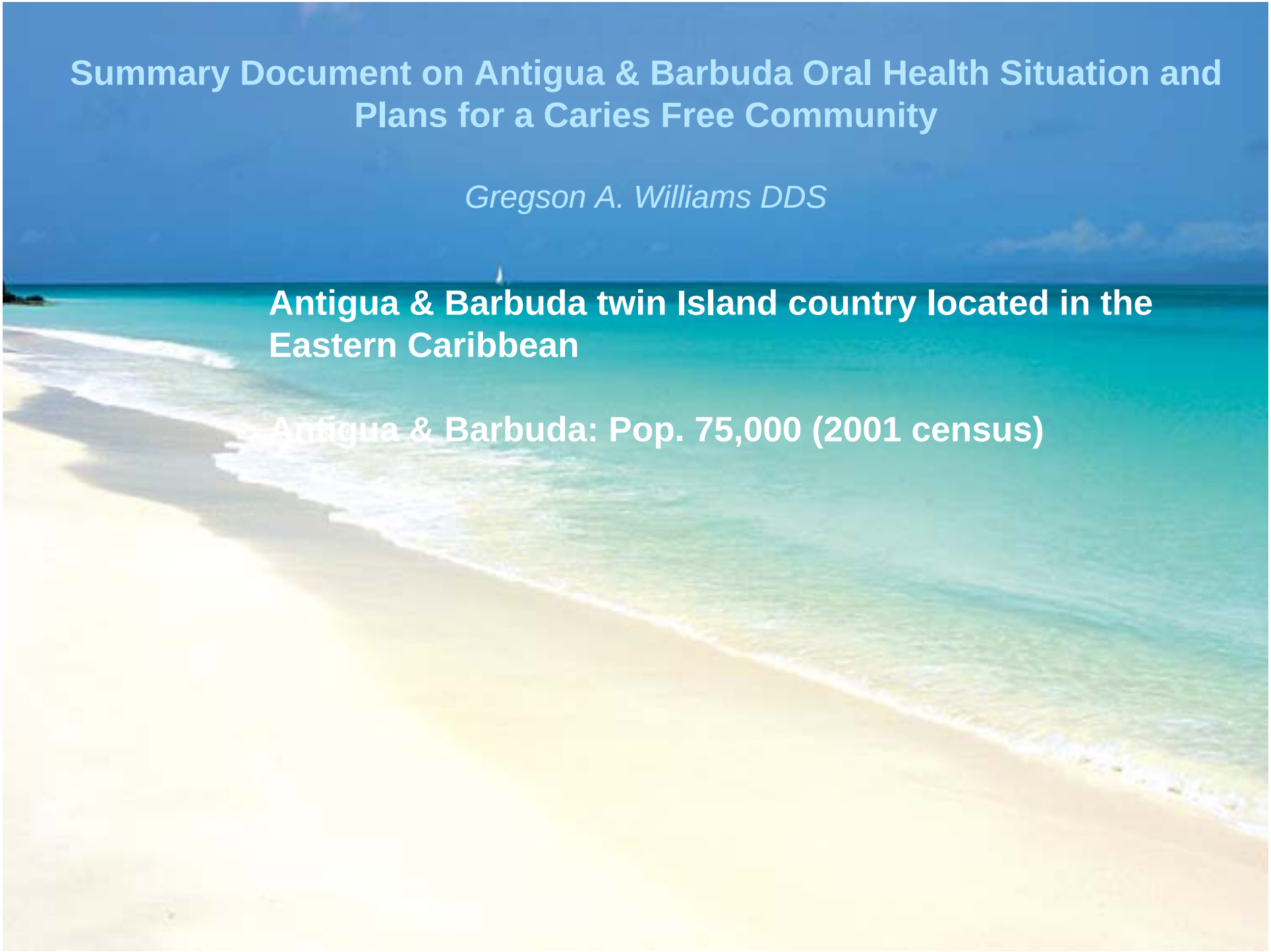
- Establish multiple levels of participation as well as the necessary resources for the promotion of oral health
- Establish criteria for prioritizing health care based on individual needs and availability of resources
- Offer training and foster the actions of voluntary health professionals
- Promote preventive health actions by utilizing suitable trained personnel, such as nurses, auxiliaries, educational personnel and health promoters.
- Maintain a multidisciplinary focus
- Identify sources of financing.
- Organize meetings to articulate competencies and share lessons learned.
- Promote sensitization and empower of communities.
- Promote the development of effective strategic alliances.
- Strive for political will.

ANNEX 6

COUNTRY PRESENTATIONS

Summary Document on Antigua & Barbuda Oral Health Situation and Plans for a Caries Free Community

Gregson A. Williams DDS



Antigua & Barbuda twin Island country located in the Eastern Caribbean

Antigua & Barbuda: Pop. 75,000 (2001 census)

Population Distribution according to age

Age	Female	Male	Year
Children 0-17	14,209	13,813	2001 Census
Adults 18-79	25,718	21,745	2001
Total	39,927	35,558	2001

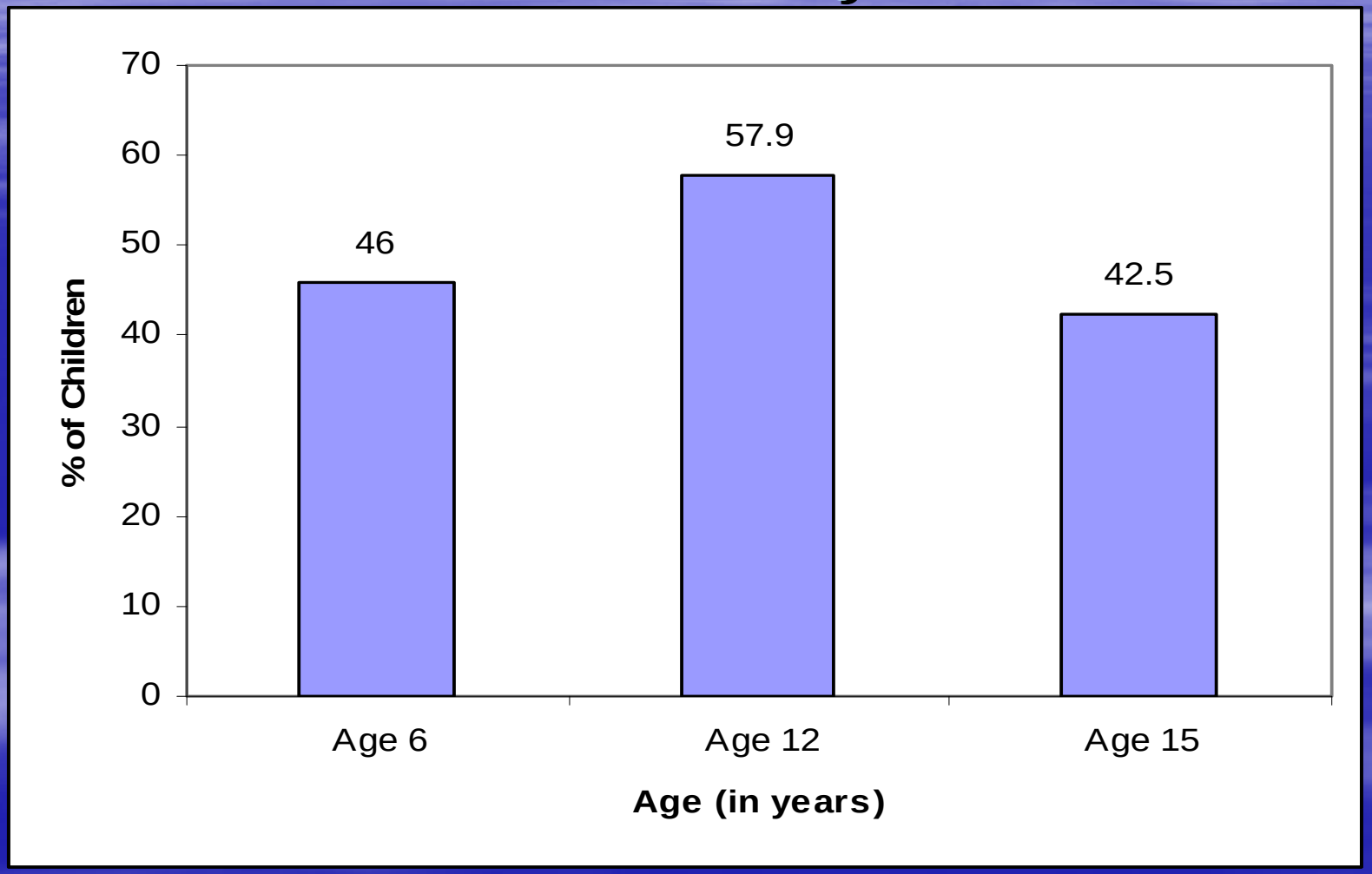
Data source 2001 Population Census

Population according to the 2006 Oral Health Survey (DMFT)

Population	6-yrs	12-yrs	15-yrs	Total
Boys	751	1028	357	2136
Girls	714	976	554	2281
Both Genders	1465	2004	911	4380
% of Pop Studied	33.4	45.8	20.8	100

Data source: Ministry of Health

% of Caries free Children by age 2006 survey



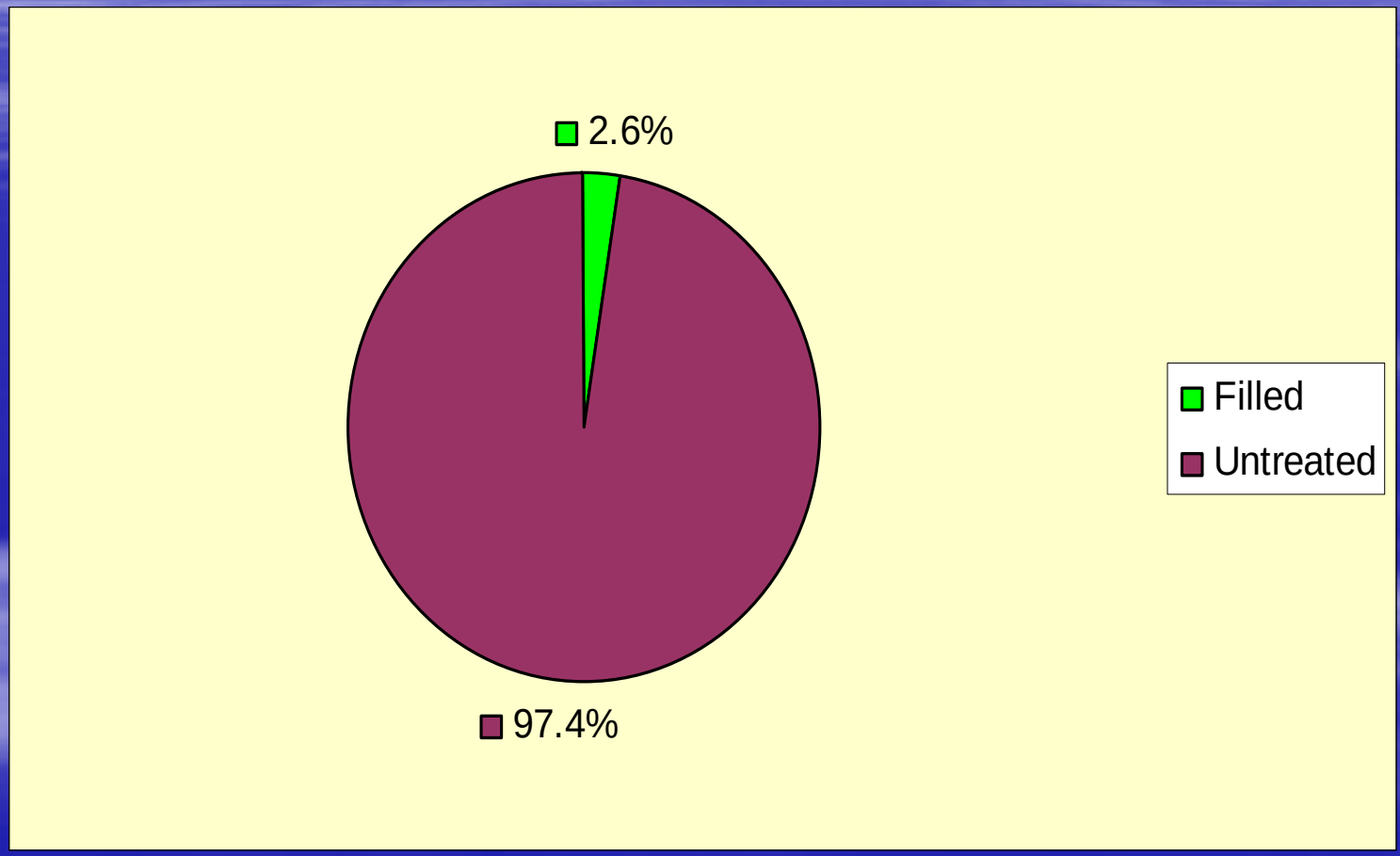
Date source Legall 2007 survey report

dmfs and DMFT scores by age 2006 OH survey

Age	6yrs olds	12 yrs olds	15 yrs olds
dmfs & DMFT scores	2.45	0.9	1.92

Data source Legall 2007 survey report

Treated vs. Untreated Decay 2006 OH Survey



Data source Legall 2007 survey report

Human Resources Available

Institution	Dentists	Hygienist	Dental Auxillaries
Ministry of Health	4 part time	1	4
Private	13 full time	0	20
Total	17	1	24

Infrastructure
Number of dental clinics

Institution	Comprehensive Care	Limited Treatments or Incomplete	Availability of Special Treatments (ex-sedation)
Ministry of Health	2	0	1
Private	11	0	11
Total	13	0	12

Proposed Interventions

- Oral Health Promotion targeting Pregnant Mothers, Nursing Mothers and Home Care givers (grandmothers & other family members)
- Use of Electronic & print Media highlighting noxious habit of prolonged bottle feeding and the deleterious effects of E.C.C

Interventions Cont'd

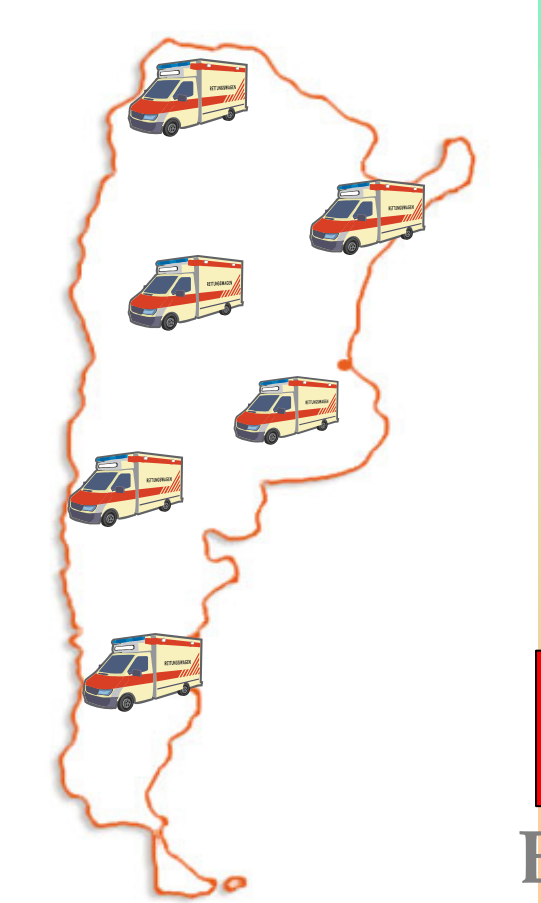
- Short Term: Set up F rinse programs in schools doing the necessary surveillance on a 2 or 3 yearly basis.
- Set up at least two roving mobile clinics in the school environment to address the issue of 97.4% of untreated decay found in the last OH survey

Thanks for Your Attention

Smiling Antigua/Barbuda school children

U. N. A. M. O. S.

Unidades Nacionales Móviles Sanitarias



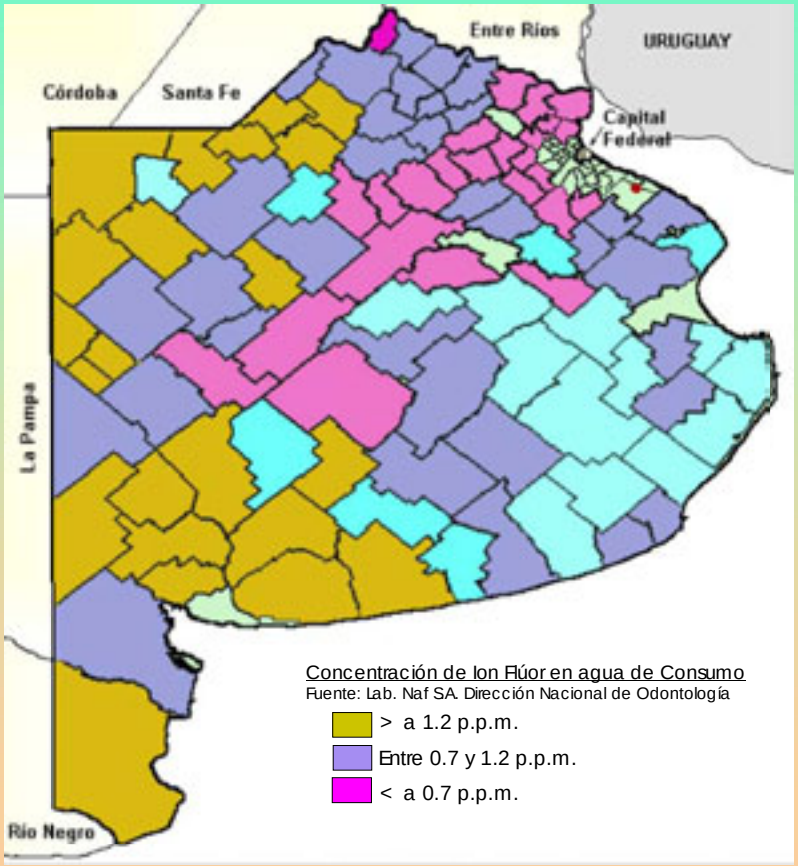
ProSanE

Al Gran Pueblo Argentino, Salud!

Programa de Salud Familiar y Comunitaria

El acceso a la Salud en Acción !

Concentración
de Ión Flúor en la Provincia de Bs. As



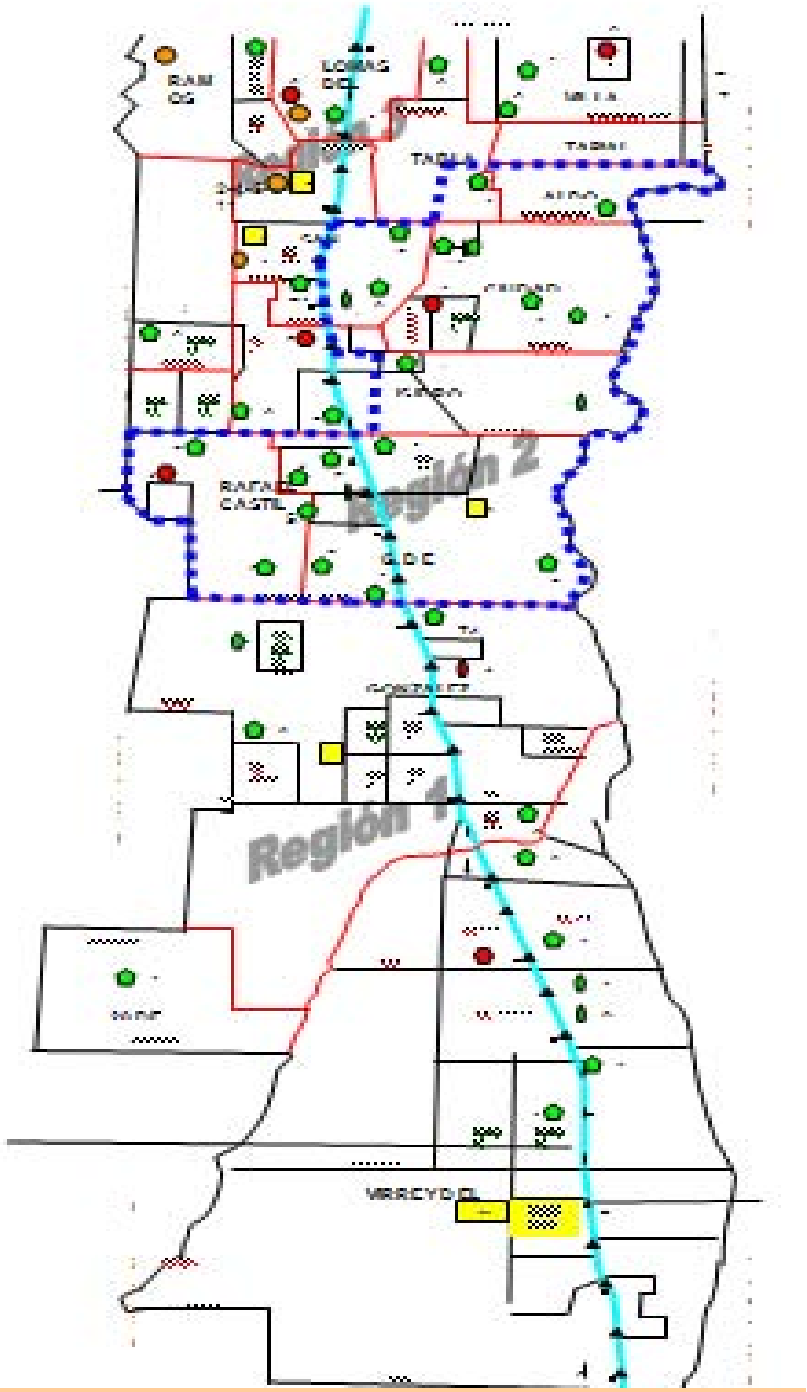
REPÚBLICA ARGENTINA

Población de 39.000.000 habitantes
Superficie de 2.780.400 Km.
45.000.000 Hab. Estimado a 2008
Fuente: INDEC

PARTIDO DE LA MATANZA

Ubicación:
En la provincia de Buenos Aires, en el sector el Gran Buenos Aires. Integrado por 15 localidades
Limita al Noreste con la Ciudad Autónoma de Buenos Aires, al Sudoeste con los Partidos de Cañuelas, Marcos Paz y Ezeiza, al Sudeste con los partidos de Lomas de Zamora y Esteban Echeverría y al Noroeste con Marcos Paz, Merlo, Morón y Tres de Febrero.

Superficie:
Es el municipio más extenso del conurbano, con una superficie total de 325,71km cuadrados.
El más poblado de la Provincia de Buenos Aires y el 2º más poblado de la Argentina, superándolo el de Córdoba. Según el INDEC a junio de 2008 la población del partido alcanzó los 1.365.244 habitantes.



DATOS DEMOGRÁFICOS

SOBRE LA COMUNIDAD

EDAD	FEMENINO	MASCULINO	AÑO
Niños	171.225	177.246	2005
Adultos	504.274	472.656	2005
Total	675.499	649.902	2005

Población de acuerdo a la encuesta sobre salud bucal más reciente CPOD- 12-4,66

Edad	Femenino	Masculino	Año
Niños de 6-9 años	784	866	2008
Niños de 12 años	763	705	2008
Niños de 15 años	26	36	2008
Adultos	-	-	
Total 3199	1592	1607	2008

Porcentaje de áreas con programa de fluoruración y otras intervenciones

Vehículo	% de población cubierta	Áreas fluoruradas	Áreas cubiertas por fluoruración	Mejores prácticas
Sal	-	-	-	-
Agua	%	%	%	
Leche	-	-	-	-
Otros vehículos PRAT/TRA selladores, etc.	15.000 10% Topicación de flúor en gel-ProSanE			TRA,selladores

Recursos Humanos

Recursos para la salud y salud bucal disponibles en la comunidad

Institución	Dentistas		Personal Auxiliar				
	Tiempo completo	Tiempo parcial	Auxiliar	Asistente	Higienista	Técnico	Enfermera
Seguridad Social	162			162			
Privado	162			162		22	
Otro							60 Municipio
Total							

Cobertura de salud bucal reportada para 2008

Año	% de cobertura						Tipo de atención					
	Estimada			Actual			Prevención		Curativa		Quirúrgica	
	MSP	SS	Priv	MSP	SS	Priv	MSP	SS	Priv	MSP	SS	Priv
0-5	48	48	4	48		4						
6-12	48	48	4	48		4	3199	1790	16.894 X mes	1470	2200	
13-19	59	36	5	48	36	5	10 %	10%	36 %	32	54	5
20-35	48	48	4	48		4						
36-60	48		6			6						
60 mas	11	83	6			6						
Total												

Infraestructura

Número de clínicas odontológicas

Institución	Atención Integral	Tratamiento limitado o incompleto	Disponibilidad de tratamientos especiales (ej. Sedación)
Ministerio	2 Nación ¿Provincia? 10 Municipal	Municipio: 50 Sillones Odontológicos	Dos (2)Nación Cuatro (4) Municipio
Servicio Social	162		Quince (15)
Privado	162		Quince (15)
Universidad	La Plata Buenos Aires		Dos (2) Dos (2)
Clínicas Móviles	Dos (2) Nación Una (1) Provincia		Dos (2) Una (1)
Clínicas Basadas en estudiantes		Facultad Odontología deLa Plata	
Otras (especificar)			
Total			

Costo de servicios *

Institución	Tipo de servicios		
	Prevención	Curativo	Quirúrgico
Ministerio	US 5,94	US 9,73	US 5,40
Seguridad Social	US 6,75	US 14,32	US 13,51
Privada	US 37	US 75	US 60
Universidad			
Clínicas móviles			
Clínica Universitaria			
Otra (especificar)			

* Usar cotización de US dólar más reciente

BARBADOS – CARIES FREE

Fannye V. Thompson, D.M.D., MSc. P.H.
Senior Dental Officer,
Ministry of Health

INTRODUCTION

- Estimated population of 295,000 (as of 2008)
- Highest population of elderly (life expectancy 75.8 years)
- High literacy rate & standard of living
- Most vulnerable – under 12 (1995 & 2001 surveys)
- 22% budget P.H.C.
- Dental Services - 2.5% of P. H. C. budget
- Polyclinic -P.H.C. service delivery
- 8 (9) Dental Clinics (11 Parishes) – up to 18
- Sealants, ART & Topical fluoride

DENTAL COVERAGE

- Well developed private sector

  - approx. 70 Dentists (Pedodontist, Orthodontists -4; Periodontists - ; O.M.F. Surgeons – 3)

- Government

  - Full and Part – time Dentists (7)
  - Auxiliary Dental Officers (Dental Nurse/ Therapist – 12)
  - Alleviation of pain (over 18 years – Polyclinics)
  - Inadequate Human Resource component

COMMUNITY DEMOGRAPHICS

AGE	FEMALE	MALE	YEAR
CHILDREN (0 – 19)	37,639	38,076	2007
ADULTS (20 – 84)	93,573	102,964	2007
TOTAL	131,212	141,040	-

Most Recent DMFT Population

AGE	FEMALE	MALE	YEAR
Children Ages 6	1,727	1,726	2001
Children Age 12	1,709	1,794	2001
Children Age 15	1,914	1,940	2001
Adults	N/A	N/A	-
Total	5,350	5,460	-

Percentage of areas with fluoridation programs and other interventions

Vehicle	% of population covered	Fluoridated Areas	Areas Covered by fluoridation	Best Practices
Salt	less than 1 %	-	Occasional wholesale outlet (1)	-
Water	less than 5 %	Negligible	-	-
Milk	-	-	-	-
Other vehicles: ART/Sealants, etc.	less than 10 %	-	-	No private sector info.

Human Resources
Health and oral health resources available in the community

INSTITUTION	DENTISTS		AUXILIARY PERSONNEL				
	Full Time	Part Time	Auxiliary	Assistant	Hygienist	Technician	Nurse*
Social Security	N/A		N/A	N/A	N/A	N/A	N/A
Private	65	5	N/A	70	8	12	N/A
Other (Govt.)	3	7	N/A	15	3	N/A	12
Total	68	12	0	85	11	12	12

*Referred to Auxiliary Dental Officers

Oral Health Coverage

Year	Coverage		Type of Attention					
2008	Actual		Prevention		Curative		Surgical	
	MOH	Priv. *	MOH	Priv.	MOH	Priv.	MOH	Priv.
0-5	676	450						
6-12	14,128	807						
13-18	19,747	1,449						
19-35	18,886	11,688						
36-60	1,802	28,859						
60+	1,253	2,010						
Total	**56,492**	**45,263**	**21,536**	**N/A**	**5,808**	**N/A**	**13,694**	**N/A**

* Responses received from 9/30 offices.

Infrastructure – Number of Dental Clinics

Institution	Comprehensive Care (up to 18 years)	Limited Treatment or Incomplete	Availability of Special Treatments (ex. Sedation)
Ministry	8	Ortho; O.M.F; Endo; Special Needs – S&P	G.A. (Extractions; Trauma,;Perio)
Social Service	N/A	N/A	N/A
Private	33	Perio – 2; Orthodontics – 6; Oral Surgeons - 3	G.A. (Extractions; Trauma; Perio) Implants; Prostho
University	N/A	N/A	N/A
Mobile Clinics	N/A	N/A	N/A
School-Based Clinics	N/A	N/A	N/A
Other (Specify)	N/A	N/A	N/A
Total	41	-	-

Cost of Services *

Institution	Type of Service		
	Prevention	**Curative**	**Surgical**
Ministry	$6.24 **		
Private	B.D.A. – no information collected		

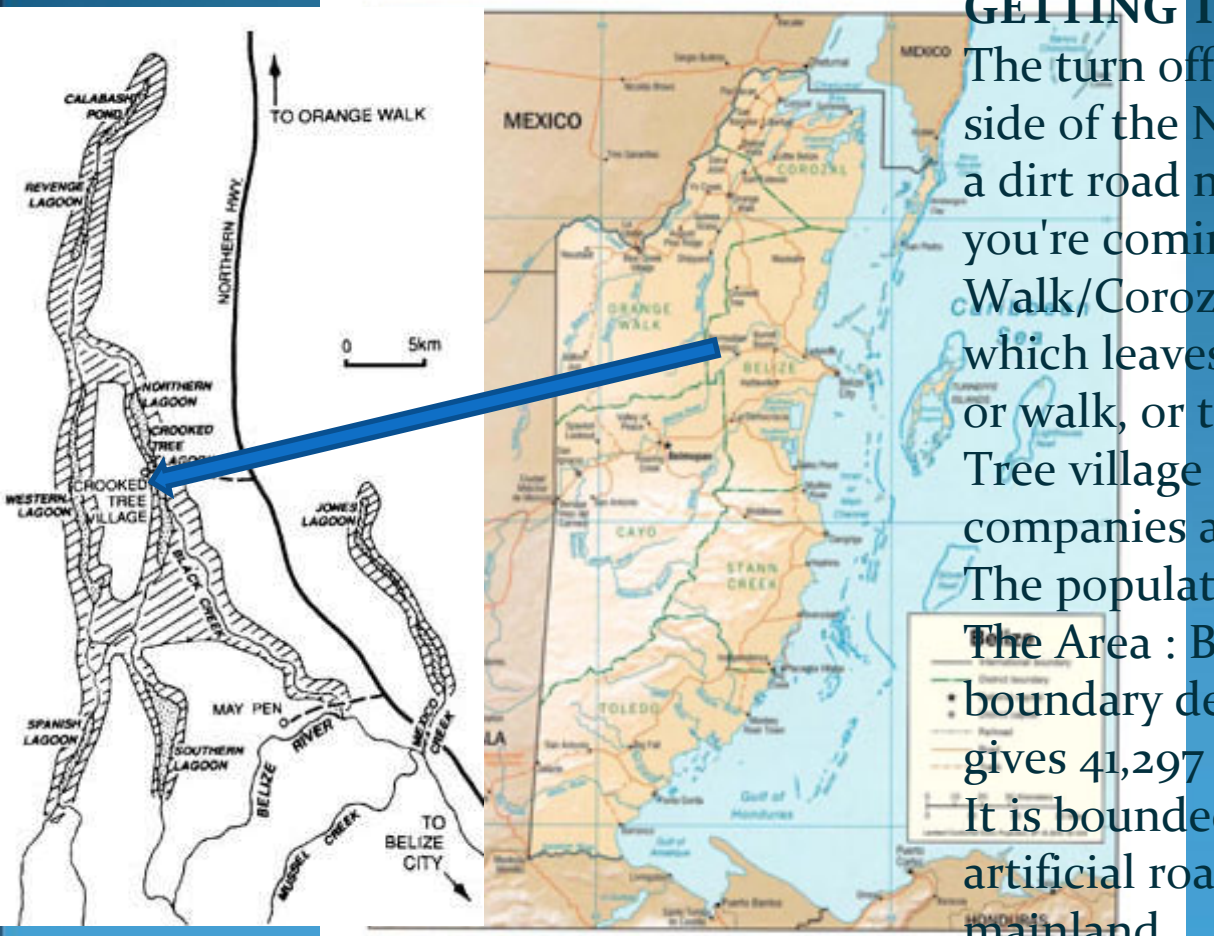
* Conversion – $2.04 Bds. = $1.00 U.S.

** Breakdown for each service not available.

Best Practices Model

- Oral Health information and examinations included as part of immunization record (P.H.C.)
- Rapid Assessment outreach for urban schools.
- Sealants, ART and Topical fluoride appplications as part of preventive treatment.
- Inter-sectoral collaboration with Nutrition Centre (childhood obesity, Fl enriched diets – planned)

Oral Health for the region of the Americas
23-25 April 2009



Introduction: The Village is Crooked Tree

GETTING THERE

The turn off to Crooked Tree is on the west side of the Northern Highway at Mile 33. It's a dirt road marked by a wooden signpost. If you're coming by a Belize City/Orange Walk/Corozal bus it will drop you off here, which leaves you a two mile stretch to hitch or walk, or there is a direct bus to Crooked Tree village from Belize City. Tour companies also run trips.

The population there is : 656

The Area : Based on its coordinates and boundary description the GIS calculation gives 41,297 acres.

It is bounded all around by lagoons. An artificial road joins the village to the mainland.

Demographic data on the Crooked Tree

Age	Female	Male	Year
Children			2004 BZE Rural
Adults			2004 BZE Rural
Total	8400 (2.71%)	8800(4.86%)	2004 BZE Rural
Children			2005 BZE Rural
Adults			2005 BZE Rural
Total	8700(2.62%)	9100(4.70%)	2005 BZE Rural
Children			2006 BZE Rural
Adults			2006 BZE Rural
Total	4500(5.06%)	4800(8.9%)	2006 BZE Rural
Children	222	207	2009 Crooked Tree
Adults	6	221	2009 Crooked Tree
Total	228	428	2009 Crooked Tree

Population according to the most recent oral health survey (DMFT)

AGE	FEMALE	MALE	YEAR
Children Ages 6- 9	20100	20875	2006
Children Ages 12	19835	20640	2006
Children Ages 15	16750	17215	2006
Adults	76225	72900	2006
Total	132940	131630	2006

Location AGE	Urban		Peri-uban		Rural		Total	
	Male	FEMALE	Male	FEMALE	Male	Female	Total	YEAR
Ages 6- 8	101	92	10	10	73	70	356	1999
Ages 12	101	113	7	10	63	59	361	1999
Ages 15	102	111	9	11	61	62	356	1999
Adults								1999
Total	312	316	26	31	197	197	191	1999

Percentage of areas with fluoridation programs and other interventions

Vehicle	% of population covered	Fluoridated Areas	Areas covered by fluoridation	Best Practices
Salt	1080			
Water				
Milk				
Other Vehicles: ART/Sealants, etc.Xylitol/Sorbitol	1277(0.6% in 1991)			

Orange Walk	104	Insufficient fluoride	79%
Corozal	96	Fluoride could Possible	7.9%
Belize	61	Optimal Fluoride	9.6%
Cayo	100	Above Optimal	3%
Stann Creek	95		
Toledo	52		
Total	508		

Human Resources
Health and oral Health resources available in the community Of Crooked Tree

Institution	Dentists		Auxiliary Personnel				
	Full Time	Part Time	Auxiliary	Assistant	Hygienist	Technician	Nurse
Social Security	0	0	0	0	0	0	0
Private	0	0	0	0	0	0	0
Other	1	0	0	0	0	0	1
Total	1	0	0	0	0	0	1

Oral Health Coverage reported up to 11th & 18th June 2008

Year	Coverage (%)						Type of Attention					
	Estimated			Actual			Prevention			Curative		Surgical
	MOH	SS	Priv	MOH	SS	Priv	MOH	SS	Priv	MOH	SS	Priv
0-5		0	0		0	0		0	0		0	0
6-12	27	0	0	108	0	0	108	0	0	3	0	0
13-19	15	0	0	21	0	0	21	0	0	0	0	0
20-35		0	0		0	0		0	0		0	0
36-60		0	0		0	0		0	0		0	0
60+		0	0		0	0		0	0		0	0
Total	42	0	0	129	0	0	129	0	0	3	0	0

Infrastructure
Number of Dental Clinics

Institution	Comprehensive Care	Limited Treatments or Incomplete	Availability of Special treatments (eg. Sedation)
Ministry	10	10	0
Social Service	0	0	0
Private	26	26	4
University	0	0	0
Mobile Clinics	10	10	0
School-Based Clinics	0	0	0
Other (Volunteers groups)	12	12	0
Total	58	58	4

Cost of services*

Institution	Type of Service		
	Prevention	Curative	Surgical
Ministry	US$5.00	US$5.00	US$200.00 (approx.)
Social Security	n/a	n/a	US$500.00
Private	n/a	n/a	n/a
University	n/a	n/a	n/a
Mobile Clinics	n/a	n/a	US$140.00
School Clinics	n/a	n/a	n/a
Other (Volunteer gps)	free	free	n/a

Exchange Rate = Bze $2.0175 = US$1.00

SALUD ORAL – BOLIVIA

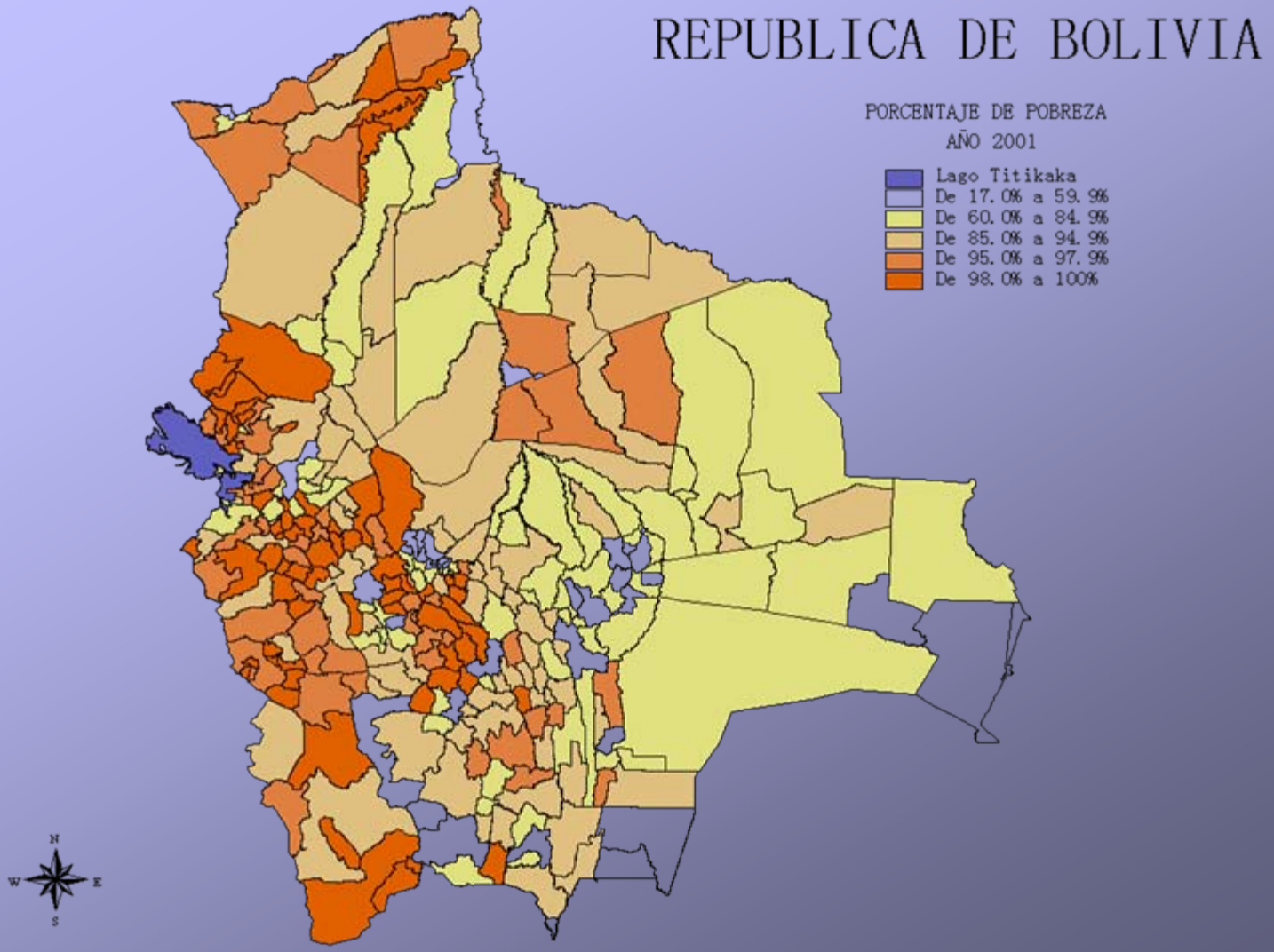
REPUBLICA DE BOLIVIA
MINISTERIO DE SALUD Y DEPORTES
PROGRAMA NACIONAL DE SALUD ORAL

TALLER DE SALUD ORAL PARA LAS AMERICAS

DEL 23 AL 25 DE ABRIL DEL 2009

MEXICO D F

SALUD ORAL – BOLIVIA



SALUD ORAL – BOLIVIA

GUBERNAMENTAL

Institución	Soluciones sostenibles
Ministerio de Salud	Intersectorialidad
Servicio departamental	Control, seguimiento y monitoreo
Municipal	Organización local eficiente y efectiva

SALUD ORAL – BOLIVIA

PROFESIONAL

Institución	Debilidades	Soluciones sostenibles
Públicos,	Profesionales del área rural no se mantienen en su fuente de trabajo (abandono)	Crear un sistema de promoción
Públicos, Cajas	Maltrato al paciente	Mejorar la calidad de atención (institucionalizar redes de servicios)

SALUD ORAL – BOLIVIA

ACADEMICO

Institución	Debilidades	Soluciones
Facultades de odontología Públicos y Privados	Poca formación en salud publica y Atención primaria, solo tiene formación asistencial	Ampliar hrs. Académicas de la materia Salud Publica, poniendo énfasis en atención primaria, intercultural en salud.
	No se realizan trabajos de investigación	Motivar los trabajos de investigación

SALUD ORAL – BOLIVIA

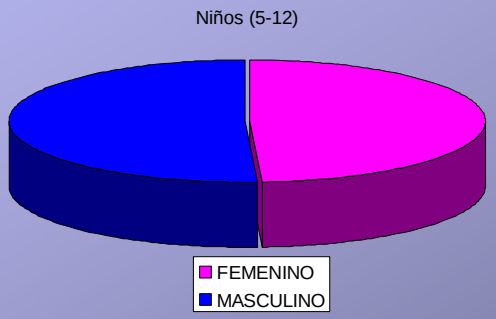
ESTRATEGIA PARA LAS COMUNIDADES MAS VULNERABLES

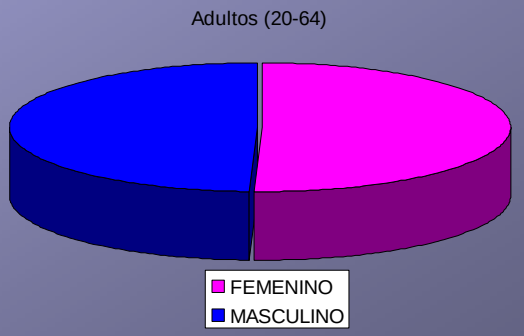
MARCO LÓGICO	LÓGICA DE INTERVENCIÓN	INDICADORES OBJETIVAMENTE VERIFICABLES
FIN	Contribuir a mejorar la calidad de vida de las y los bolivianos.	
PROPOSITO	Mejorar la salud oral de los municipios rurales desprovistos de atención odontológica en Cochabamba, Beni y Pando	10% de la población mejora su salud oral en los municipios seleccionados.
COMPONENTES (objetivo específico)	1. Promoción de la Salud Oral en la población en general de los municipios seleccionados.	50% de la población Motivada y sensibilizada en salud oral integral(163.770)
	2. Prevención primaria de enfermedades bucales (Equipos móviles)	10 % de reducción de enfermedades bucales primarias durante el primer periodo en los municipios seleccionados(32.754)
	3. Rehabilitación de edentulos totales o parciales.	50% de casos rehabilitados(10.200)

SALUD ORAL – BOLIVIA

DATOS DEMOGRAFICOS SOBRE LA COMUNIDAD

EDAD	FEMENINO	MASCULINO	AÑO
Niños (5-12)	948.180	985.673	2008*
Adultos (20-64)	2.448.429	2.383.883	2008*
Total	3.396.609	3.369.556	





Fuente: INE

SALUD ORAL – BOLIVIA

POBLACIÓN DE ACUERDO A LA ENCUESTA SOBRE SALUD BUCAL MAS RECIENTE (CPO- D)

EDAD	Femenino y masculino (CPO- D)	Prevalencia de Caries	AÑO
Niños de 12 años	6.68	84.6 %	1995

Fuente: SNIS

SALUD ORAL – BOLIVIA

PORCENTAJE DE AREAS CON PROGRAMAS DE FLUORURACION Y OTRAS INTERVENCIONES

Vehiculo	% de población cubierta	Áreas fluoradas	Áreas cubiertas por fluoruracion	Mejores practicas
Sal	Población de 6 a 15 años. (año 1997)	Deptos. Oruro La Paz Cochabamba		
Agua	Inaccesibilidad alcantarillados			
Leche	Costo			
Otros vehículos: PRAT-TRA selladores, etc.	36 % * chapare 68 %* 29 %* 96 %* 76 %* yungas 85 %* 88 %* 114% * 100% * 49 %*			

SALUD ORAL – BOLIVIA

RECURSOS HUMANOS
RECURSOS PARA LA SALUD BUCAL DISPONIBLES EN LA COMUNIDAD

Institución	Dentistas		Personal auxiliar				
	Tiempo completo	Tiempo parcial	Auxiliar	Asistente	Higienista	Técnico	Enfermera
Seguridad Social	115	319	434	---	---	---	---
Privado	27	23	---	---	---	---	---

SALUD ORAL – BOLIVIA

COBERTURA DE SALUD BUCAL REPORTADA PARA 2008

Año	% de Cobertura						Tipo de Atención*					
	Estimada			Actual			Prevención		Curativa		Quirúrgica	
	MPS	SS	PRIV	MPS	SS	PRIV	MPS	SS	MSP	PRIV	SS	PRIV
0-5 6-12 13-19 20-35 36-60		--			--		780.895	161.861	793.653	105.027	64.286	518

Fuente: SNIS- INASES

SALUD ORAL – BOLIVIA

INFRAESTRUCTURA
Numero de clínicas odontológica

	Atención Integral	Tratamiento limitado o incompleto	Disponibilidad de tratamientos especiales
Ministerio		491 Primer nivel de atención odontológica A.N.gubernamental	4 Tercer nivel de atención (cirugía maxilofacial)
Servicio Social		344	

Fuente: SNIS INASES

SALUD ORAL – BOLIVIA

COSTO DE SERVICIOS*

Institución	Tipo de servicio		
	Prevención por tratamiento promedio	**Curativo por tratamiento promedio**	**Quirúrgico por acción promedio (no incluye cirugías mayores)**
Ministerio	SUMI Gratuito (a cargo de municipio y MSyD) 1 US (va fondo municipal)	SUMI Gratuito (a cargo de Municipio y MSyD) 2 US (va fondo municipal)	SUMI Gratuito (a cargo de Municipio y MSyD) 1 US exodoncia (fondo municipal) 20 US otras (fondo de hospital)
Seguridad social	Cuotas mensuales de aporte patronal del 10%		
Privada	3 US	13 US	10 US
Clínicas móviles	0,50 US	3 US	3 US
Clínicas universitarias	0,50 US	3 US	3 US
Otras –ONG´s	Gratuito (aporte de al ONG)	No realizan	Solamente exodoncia gratuito

SALUD ORAL – BOLIVIA

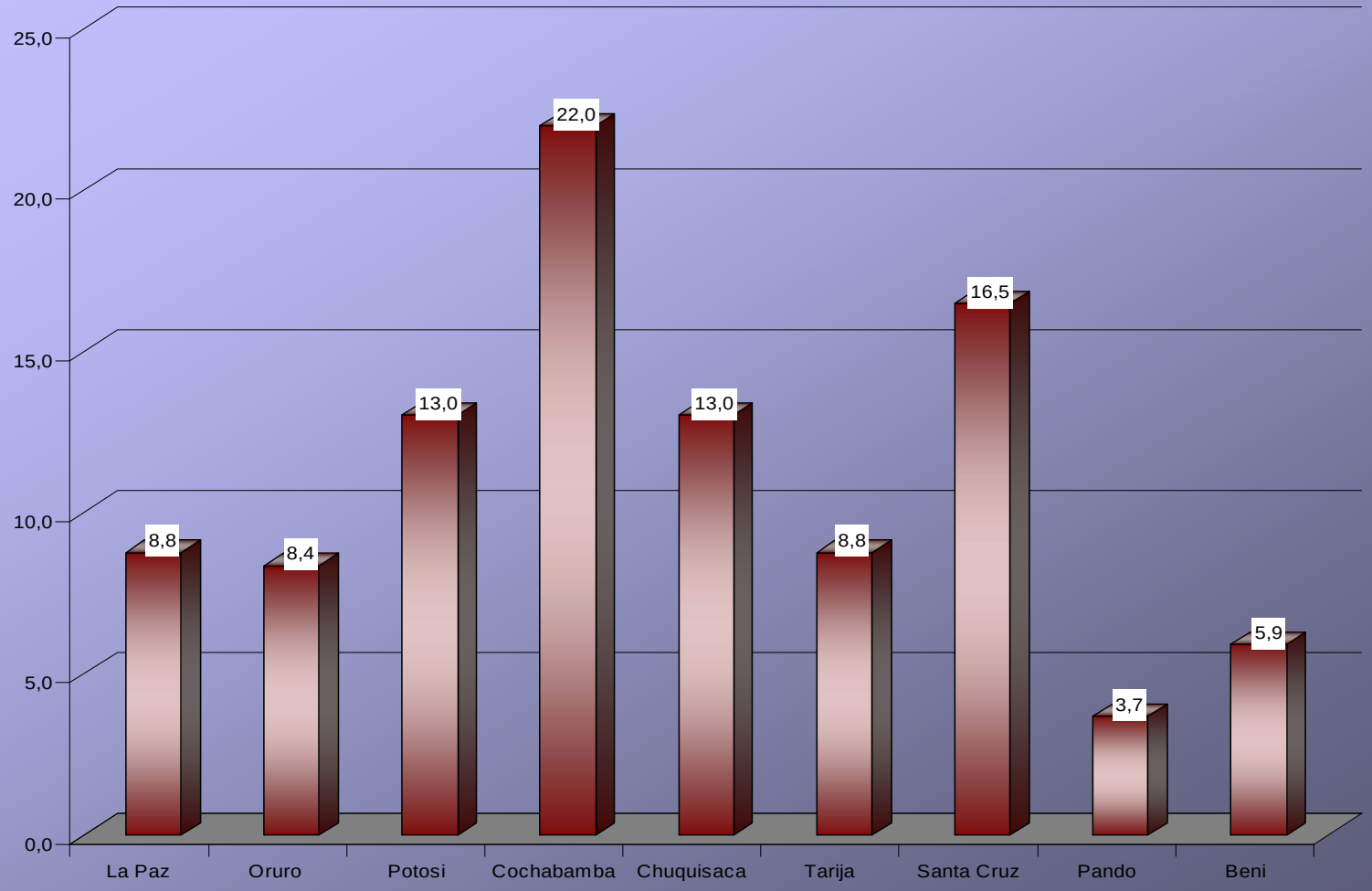
INFRAESTRUCTURA NUMERO CONSULTORIOS ODONTOLOGICOS (sector publico)

Departamento	MINISTERIO			
	Infraestructura*	Recursos Humanos		
		Tiempo completo	Medio tiempo	Total
La Paz	43	65	91	156
Oruro	41	24	22	46
Potosi	64	44	25	69
Cochabamba	108	94	39	133
Chuquisaca	64	39	39	78
Tarija	43	64	20	84
Santa Cruz	81	84	39	123
Pando	18	20	14	34
Beni	29	19	11	30
Total	**491**	**453**	**300**	**753**

Fuente: SEDES MSD

SALUD ORAL – BOLIVIA

PORCENTAJE DE CONSULTORIOS ODONTOLOGICOS



SALUD ORAL – BOLIVIA

MUNICIPIO LLALLAGUA NORTE POTOSI (POBLACION)

Descripcion	Censo 2001	Hombres	Mujeres
LLALLAGUA	**36.010**	**17433**	**18577**

SALUD ORAL – BOLIVIA

GRACIAS

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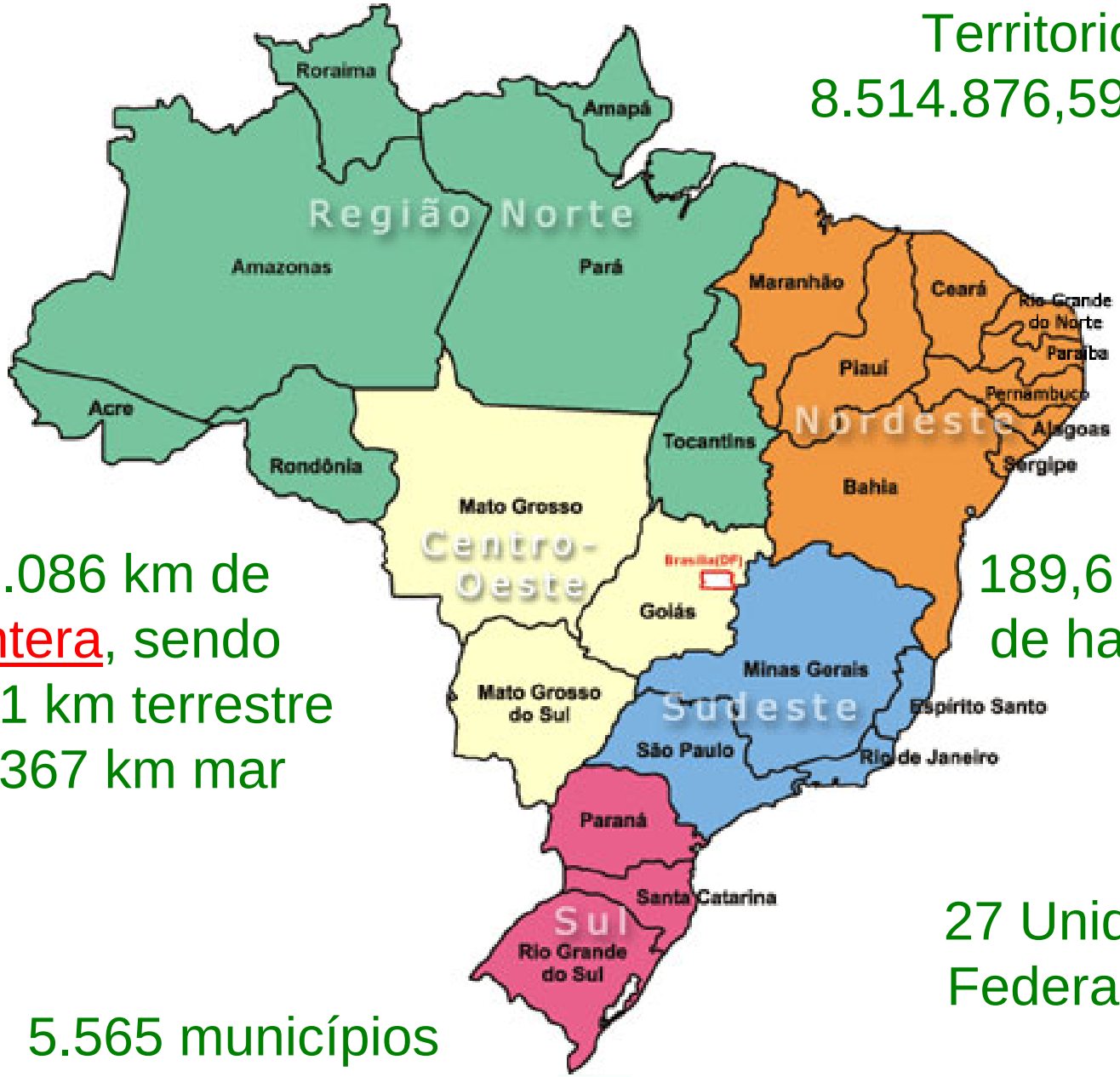
A SAÚDE BUCAL LEVADA A SÉRIO

Territorio:
8.514.876,599 km²



23.086 km de
frontera, sendo
15.791 km terrestre
y 7.367 km mar

189,6 millones
de habitantes

27 Unidades
Federativas

5.565 municípios

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Gerencia:
2003 a 2006

Gerencia:
2007 a 2010

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- **1986 - VIII. Conferencia Nacional de Salud consagró el derecho a la salud como un derecho de la ciudadanía universal, garantizada para el Estado, expresión de las luchas y conquistas sociales.**

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➢1986 I Conferencia Nacional de Salud Bucal

Ministério da Saúde

- **1988 - Nueva Constituición Federal – garantió la salud como un derecho de todos y un dever del Estado. Princípios: universalidad, integridad, equidad, descentralización de la asistencia y participación social.**

- **1990 -Ley 8.080 – Instituiyó el Sistema Único de la Salud (SUS), como comando único en cada "esfera" del govierno. Municípios como ejecutores de las acciones y servicios de la salud, con corporation técnica y financiera de los departamentos y de la Nación.**

Complejidad de Contexto

- **Dimensión geográfica del país**
- **Estructura socioeconômica heterogénea**
- **Conviniencias de enfermedades típicas del subdesarrollo, con demandas crecientes por servicios de alta complejidad**
- **Conformación del Sistema de Salud de Brasil: Universalidad X Equidad**

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A SAÚDE BUCAL LEVADA A SÉRIO

SUS 20 Anos
Sistema Único de Saúde

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A SAÚDE BUCAL LEVADA A SÉRIO

Coordinación Nacionale de Salud Bucal

Política de Salud Bucal de Brasil

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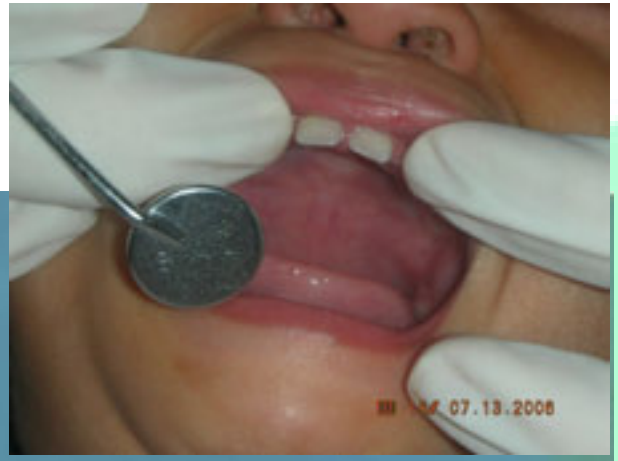


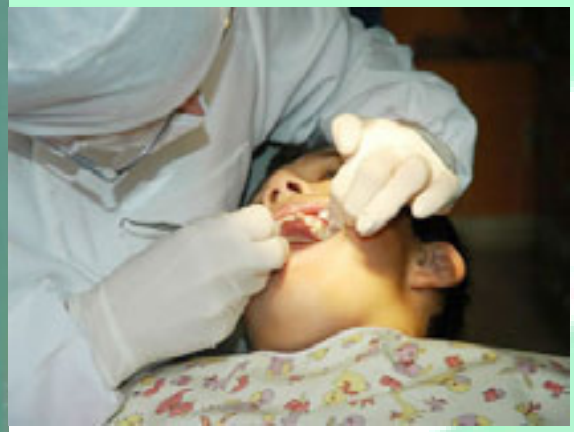
Projeto SB Brasil 2003

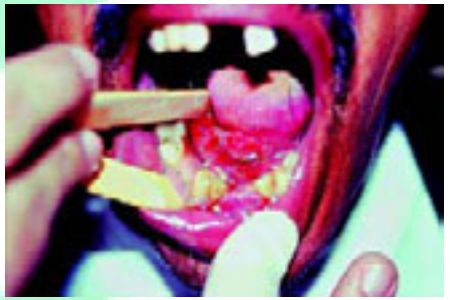
Condições de Saúde Bucal da População Brasileira

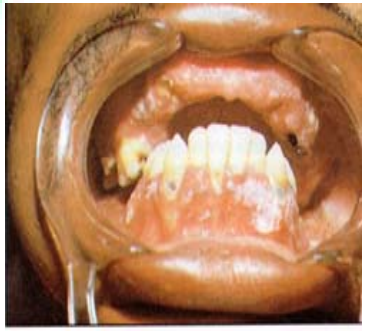
2002-2003

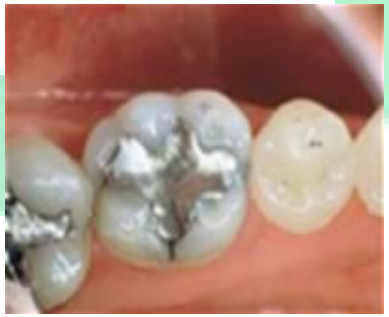
Resultados Principais

- ✓ Más de 2.000 profesionales trabajaron
- ✓250 municipios
- ✓108.921 personas examinadas









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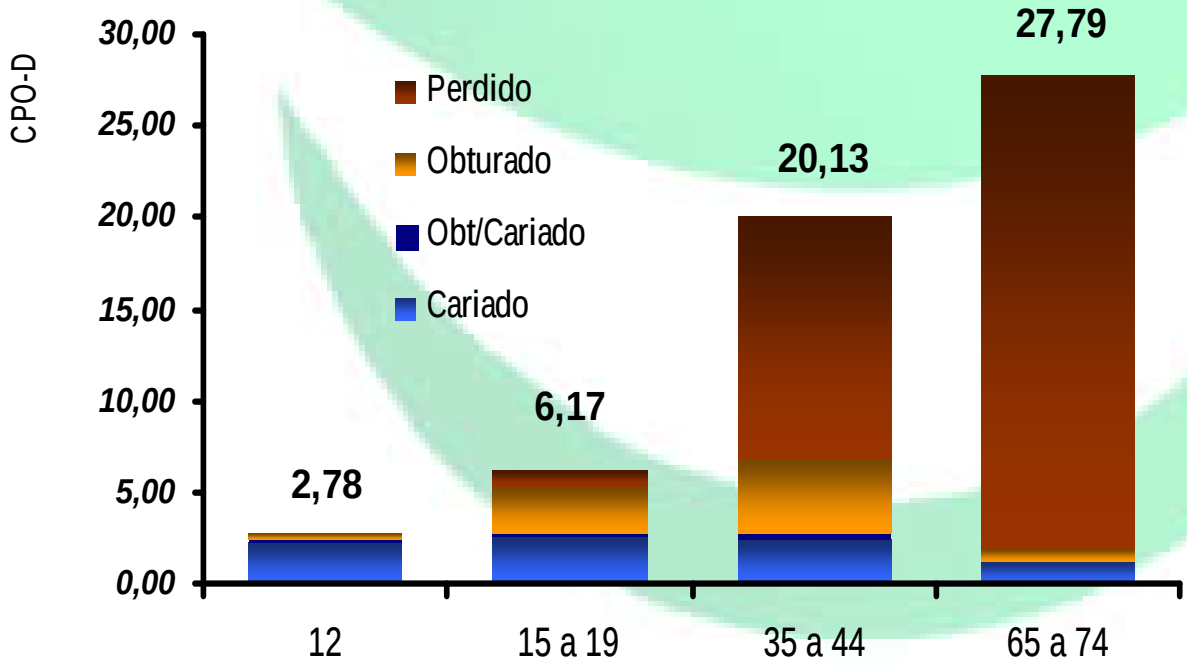
Situación de la Salud Oral

✓ **Medias de CPO-D y participación de los componentes conforme edad**

Carie Dental (SB – Brasil)



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Situación de Salud Oral

Pérdidas dentales

- ✓ Más de **28%** de la población adulta no tienen ningún diente funcional siquiera en una arcada (inferior o superior)
  - ✓ De esas personas, **15%** todavia no tienen prótesis total
- ✓ Três a cada cuatro ancianos **(75%)** no tienen ningún diente funcional
  - ✓ De esas personas, más de **36%** no tienen prótesis total

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Situación de la Salud Oral

Acceso a los Servicios Odontológicos en Brasil

- ✓ **28 milhões** de brasileños no fue nunca al dentista

Fonte: PNAD/IBGE (2003)

- ✓ **En media, 14% de los adolescentes brasileños no fue nunca al dentista. La región Nordeste ha presentado el mayor índice de personas que no fueron ninguna vez al dentista (22%), mientras que la región Sur presentó los mejores valores em relación al acceso (6%)**

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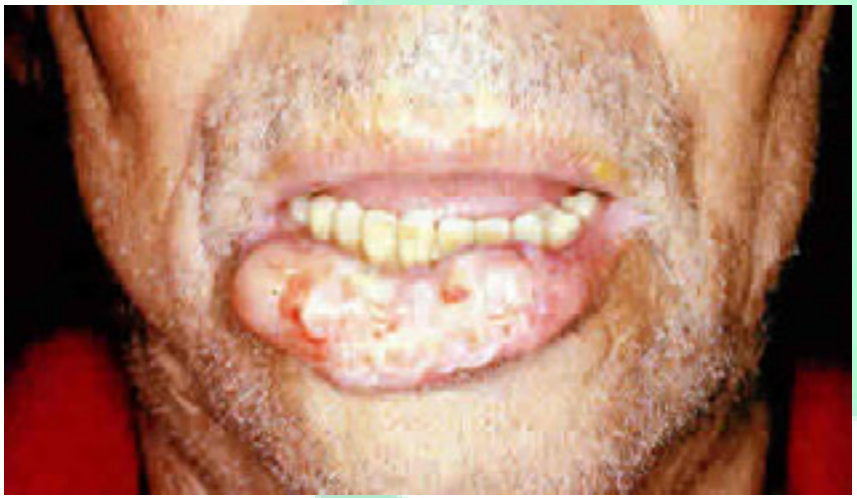
Cáncer Oral



- ✓ **4º lugar entre la mayoria de los tipos de cáncer incidentes en los hombres e 7º en mujeres**
- ✓ **La incidencia de 13,25 casos por cada 100 mil personas**

✓ **La tasa de mortalidad de 2,96 por cada 100 mil hombres (1998)**

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Lanzamiento de BRASIL SONRIENTE Marzo - 2004

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Fluoración del agua del abastecimiento publico

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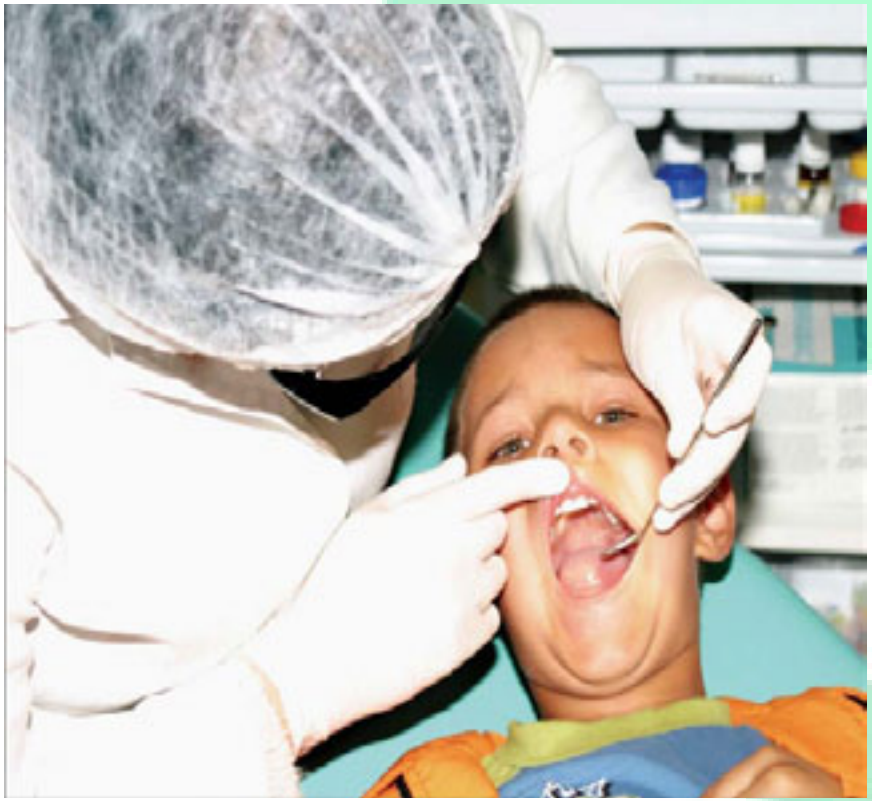
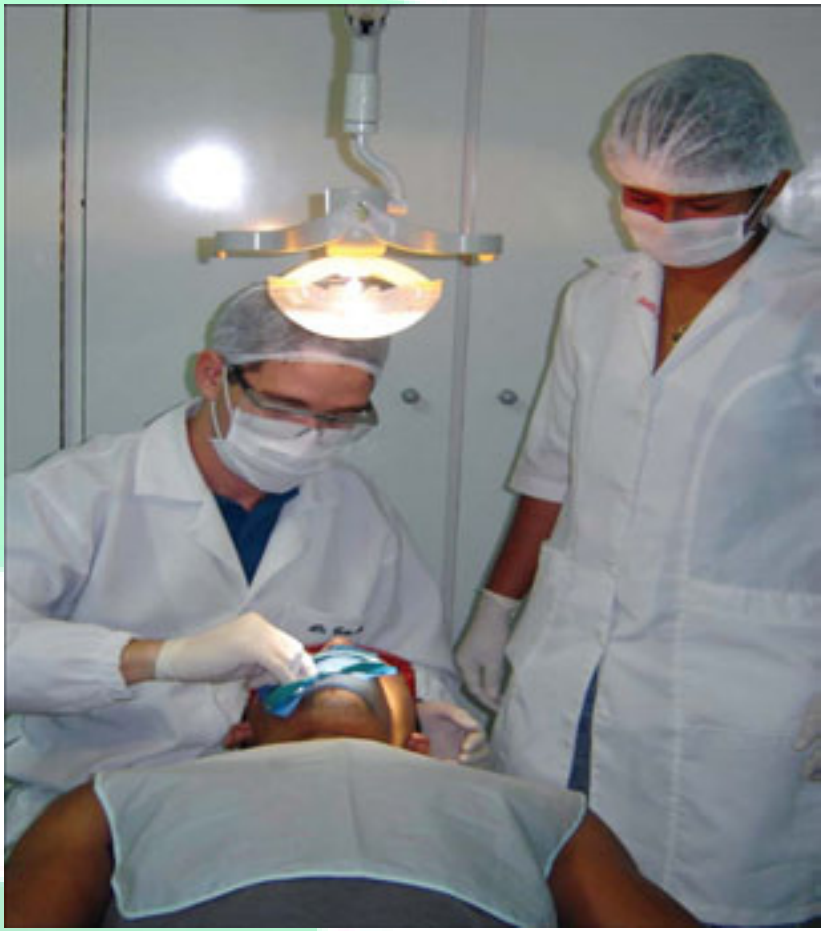
Estrategia de Salud Familiar





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BASES CONCEPTUALES

USF – UNIDAD DE SALUD DE LA FAMILIA:

COBERTURA :COBERTURA: cada ESF asiste de 600 a 1000 familias, con limite máximo de 4500 habitantes

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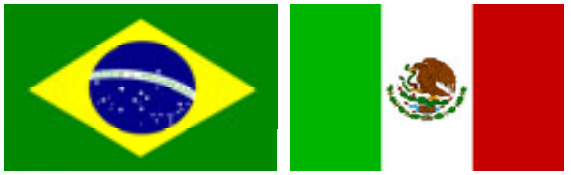
Estrategia de Salud Familiar



Acciones de los Equipos de Salud Bucal:

- Acciones de promoción y protección de salud
- Acciones de recuperación
- Prevención y control de cáncer bucal
- Incremento de la urgencia
- Inclusión de procedimientos más complejos em la Atención Básica
- Inclusión de la rehabilitación protética em la Atención Básica

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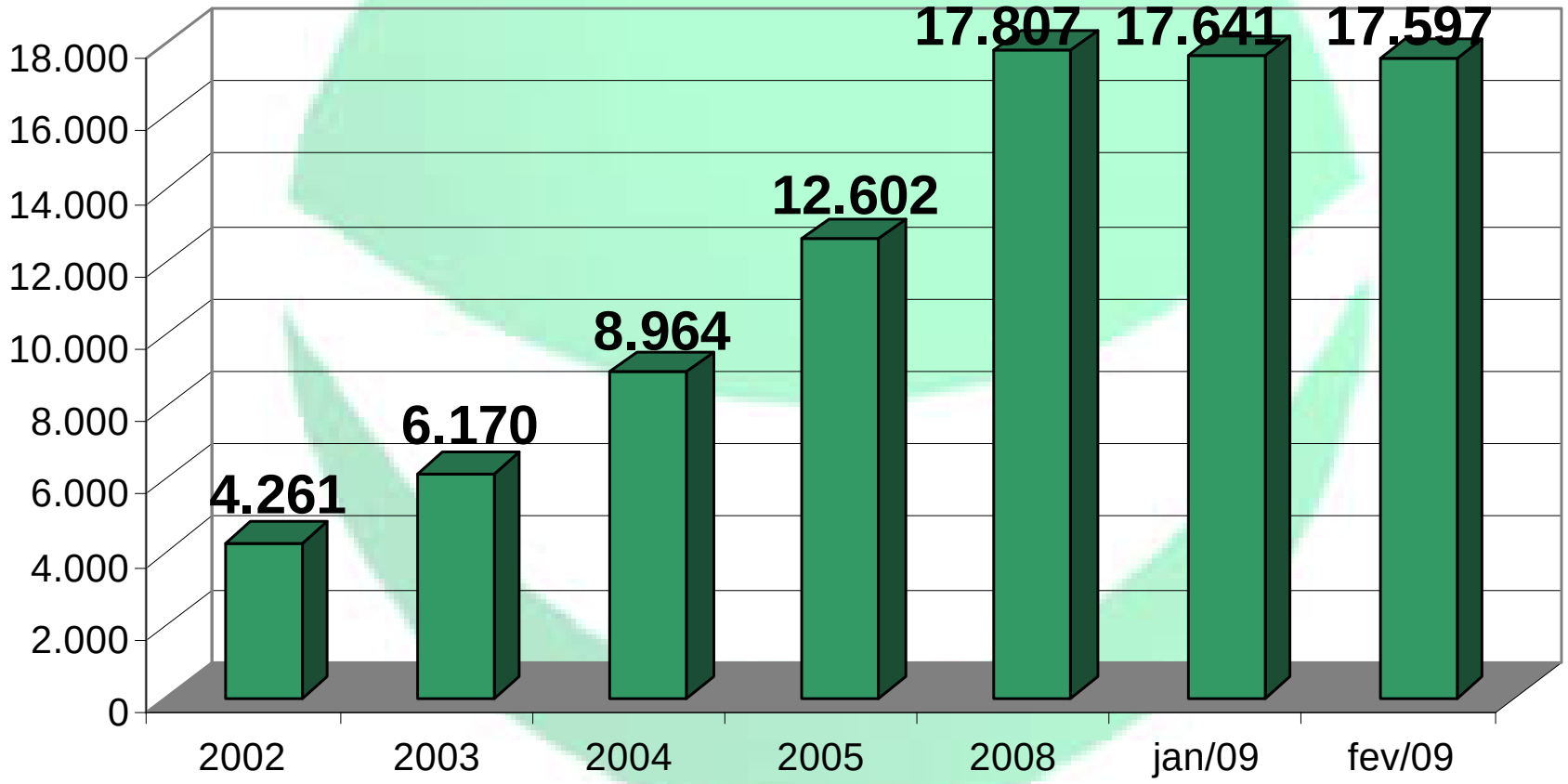
El crecimiento en el número de Equipos de Salud Bucal na estrategia de Salude de la Familia



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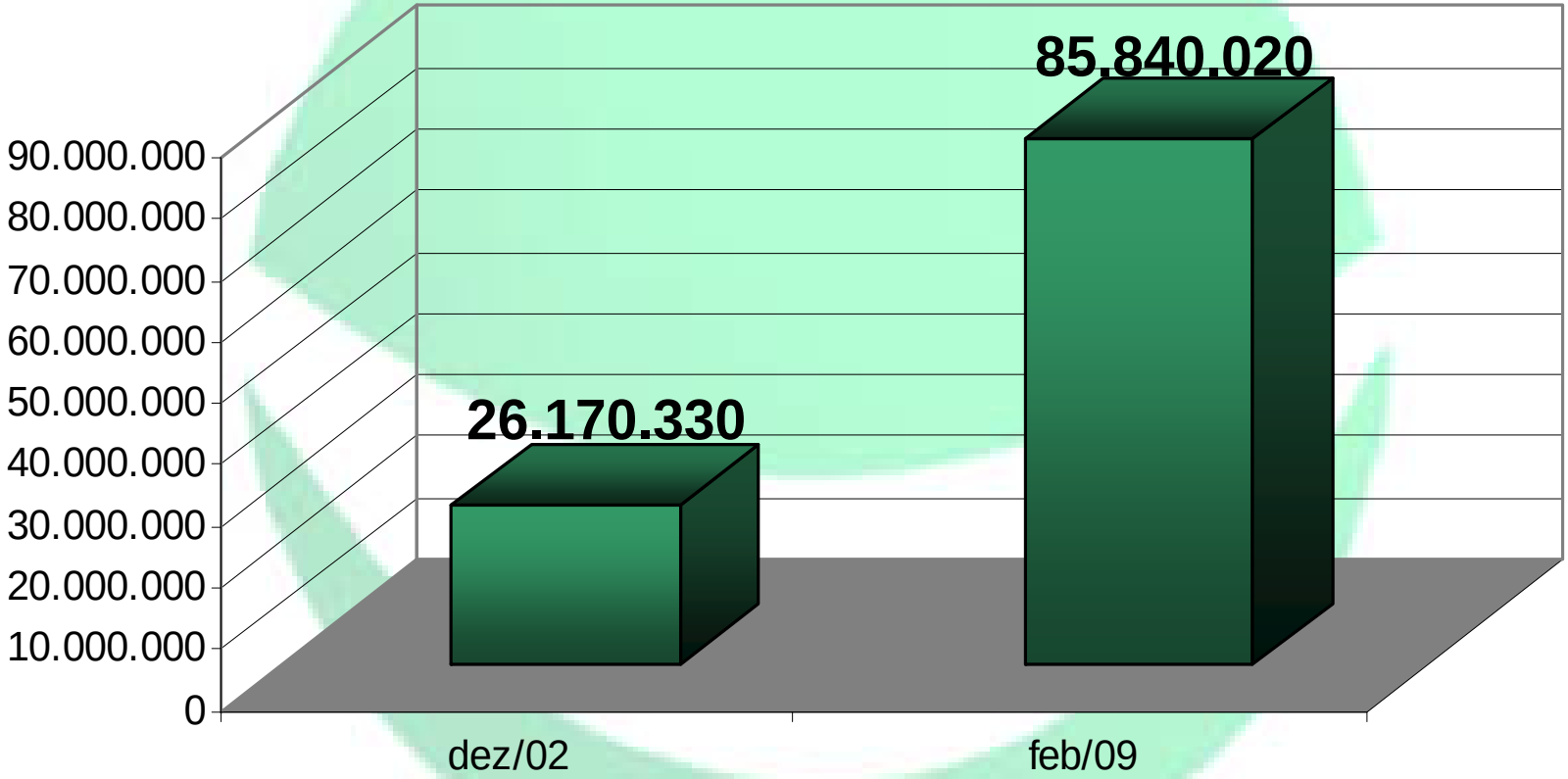
Cobertura Poblacional de los Equipos de Salud Bucal na estrategia de Salude de la Familia - Dez/02 e Feb/09



Crecimiento de 228%

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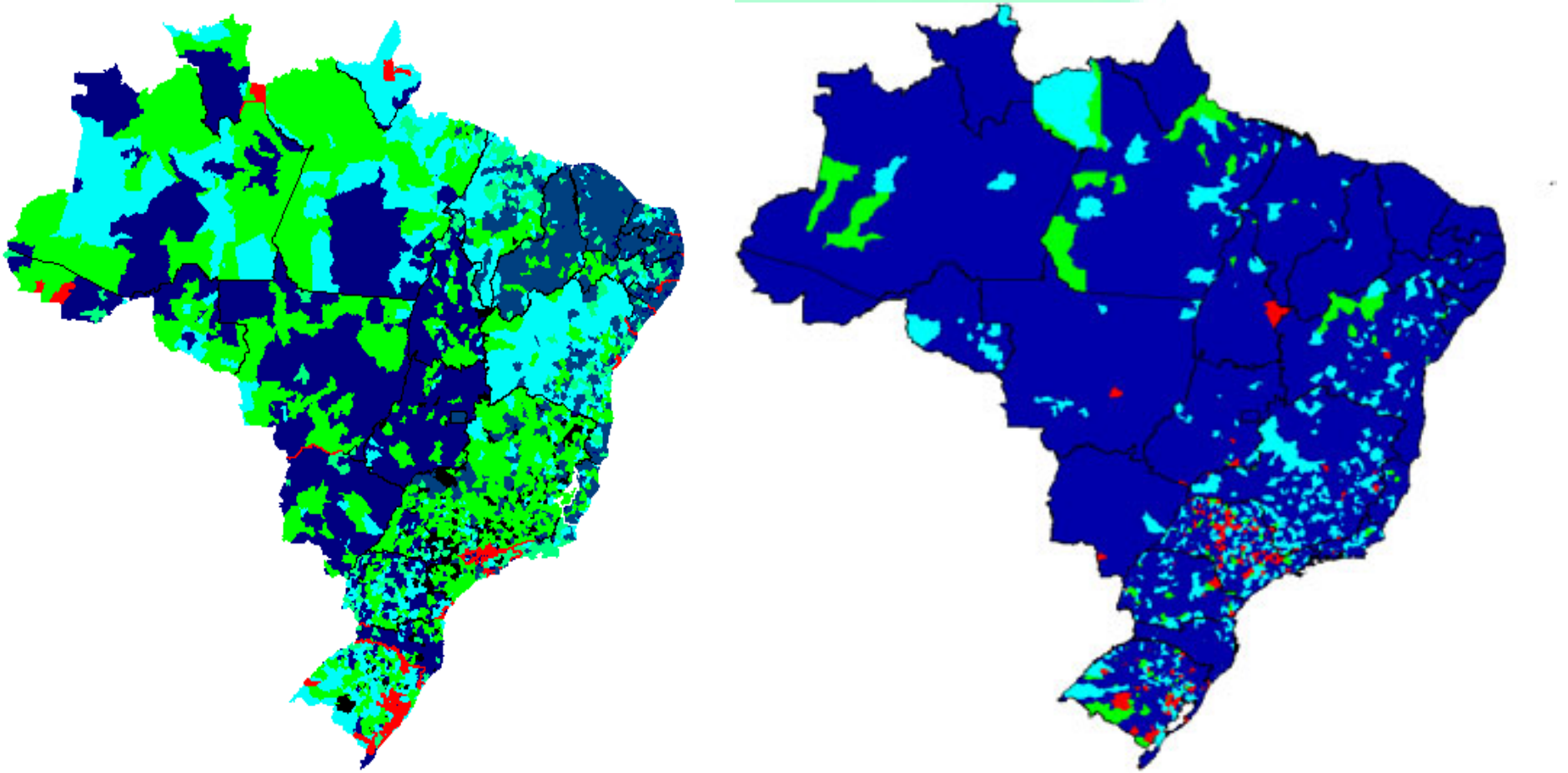
Estado de Aplicación de Equipos de Salud de la Familia, Equipos de Salud Bucal y Agentes Comunitarios de Salud
DICIEMBRE/2002 - SEPTIEMBRE/2008



ESF/ACS/SB

ESF/ACS

ACS

SEM ESF, ACS E ESB

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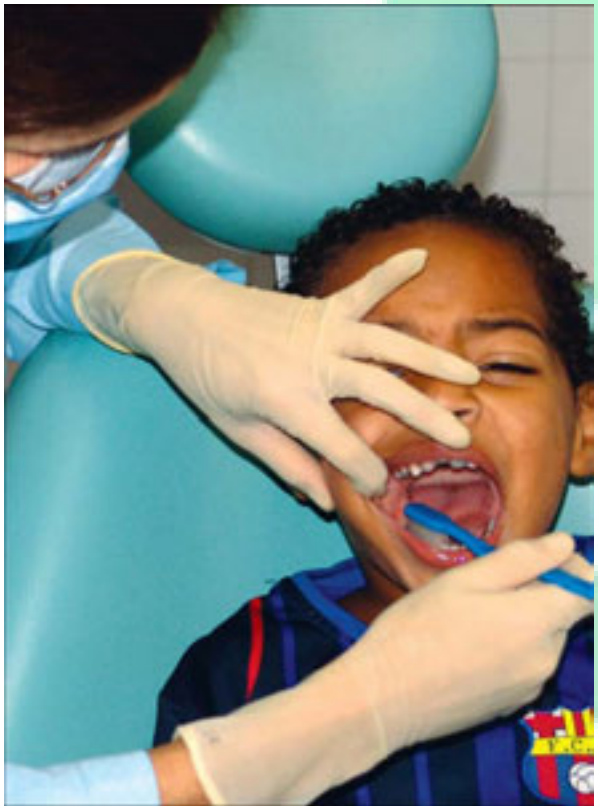
Kits de Odontología

✓**Total: 90 milones** de kits dentales para apoyar as acciones de promoción e prevención en Salud Oral.



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Centros de Especialidades Odontológicas

Ampliar la prestación de servicios especializados en odontología mediante la creación de Centros de Especialidades Odontológicas

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Centros de Especialidades Odontológicas

Especialidades mínimas ofertadas en los Centros de Especialidades Odontológicas

- ✓ **Cirugía Oral Menor**
- ✓ **La atención a pacientes con necesidades especiales**
- ✓ **Estomatología**
- ✓ **Periodoncia**
- ✓ **Endodoncia**

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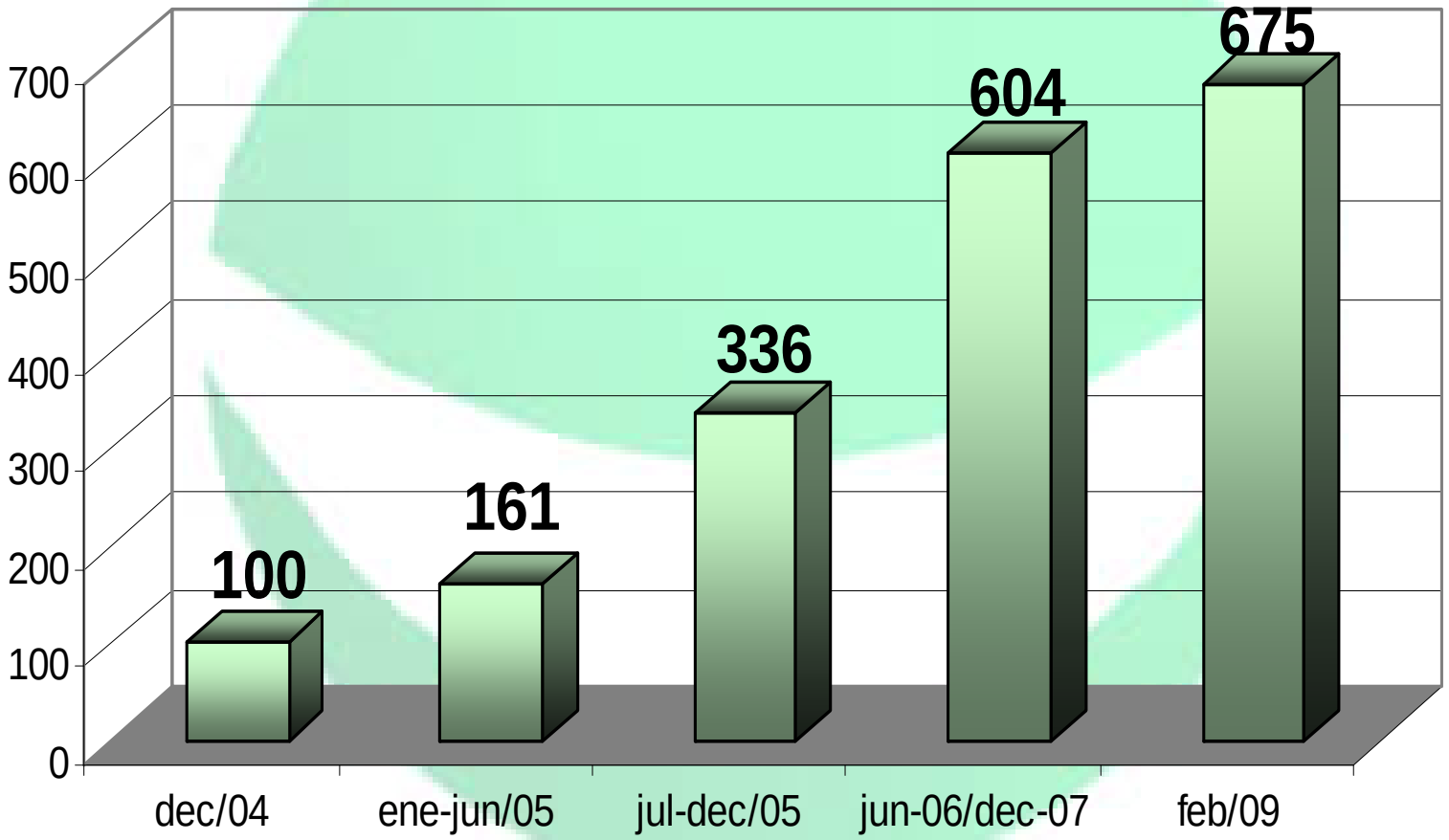
Centros de Especialidades Odontológicas



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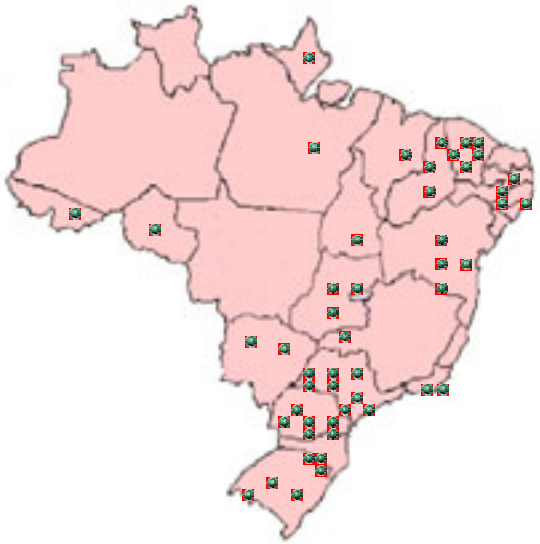
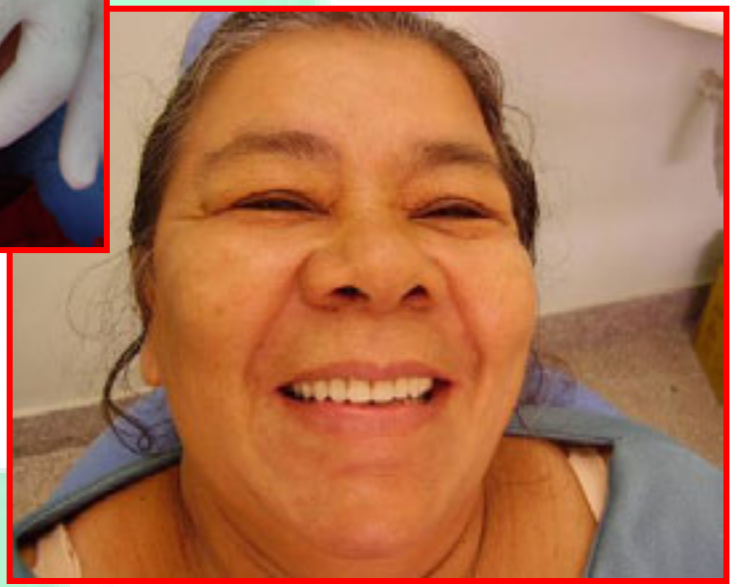
CEOs – Febrero/2009

CEOs – Dec/2004



Laboratorios Regionales de Prótesis Dental



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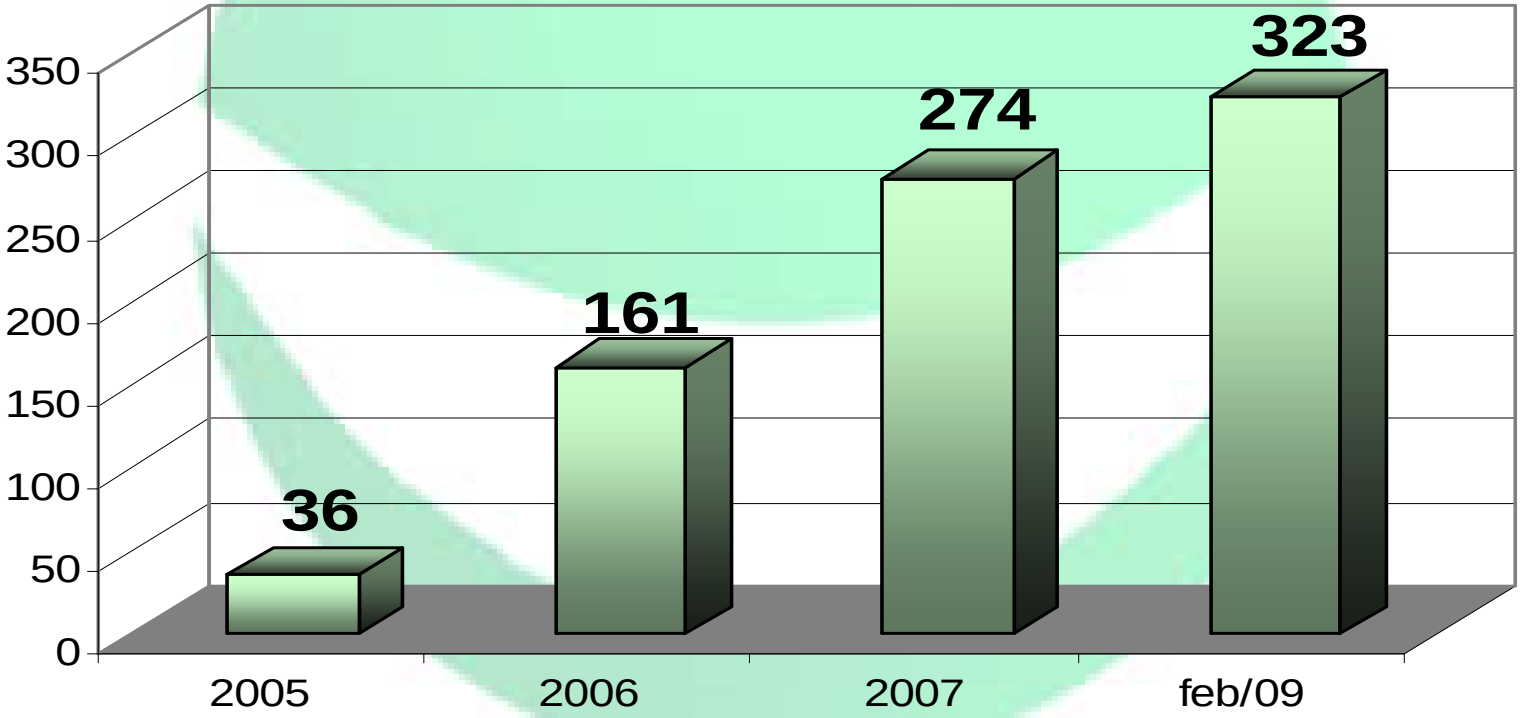
Laboratorios Regionales de Prótesis Dental

Implantación de LRPD
Febrero/2009



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LRPD – febrero/2009

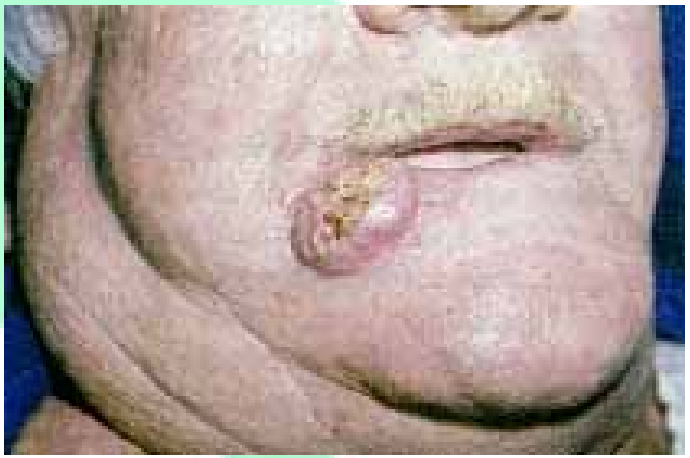
LRPDs – Dec/2004

TRATAMIENTO DE CÁNCER POR EL SUS

- ✓ **CACON** : Unidades de Hospital que tienen todo el apoyo necesario para el diagnóstico y el tratamiento de los tipos más frecuentes de cáncer. Han necesariamente unidad de radiación

- ✓ **UNACON**: Unidades de Hospital que tienen todo el apoyo necesario para el diagnóstico y el tratamiento de todos los tipos de cáncer. Puedem o no, tener unidad de radiación

- ✓ 215 Unidades en el país:
  - 41 CACON's
  - 174 UNACON's



Datos: junio 2008

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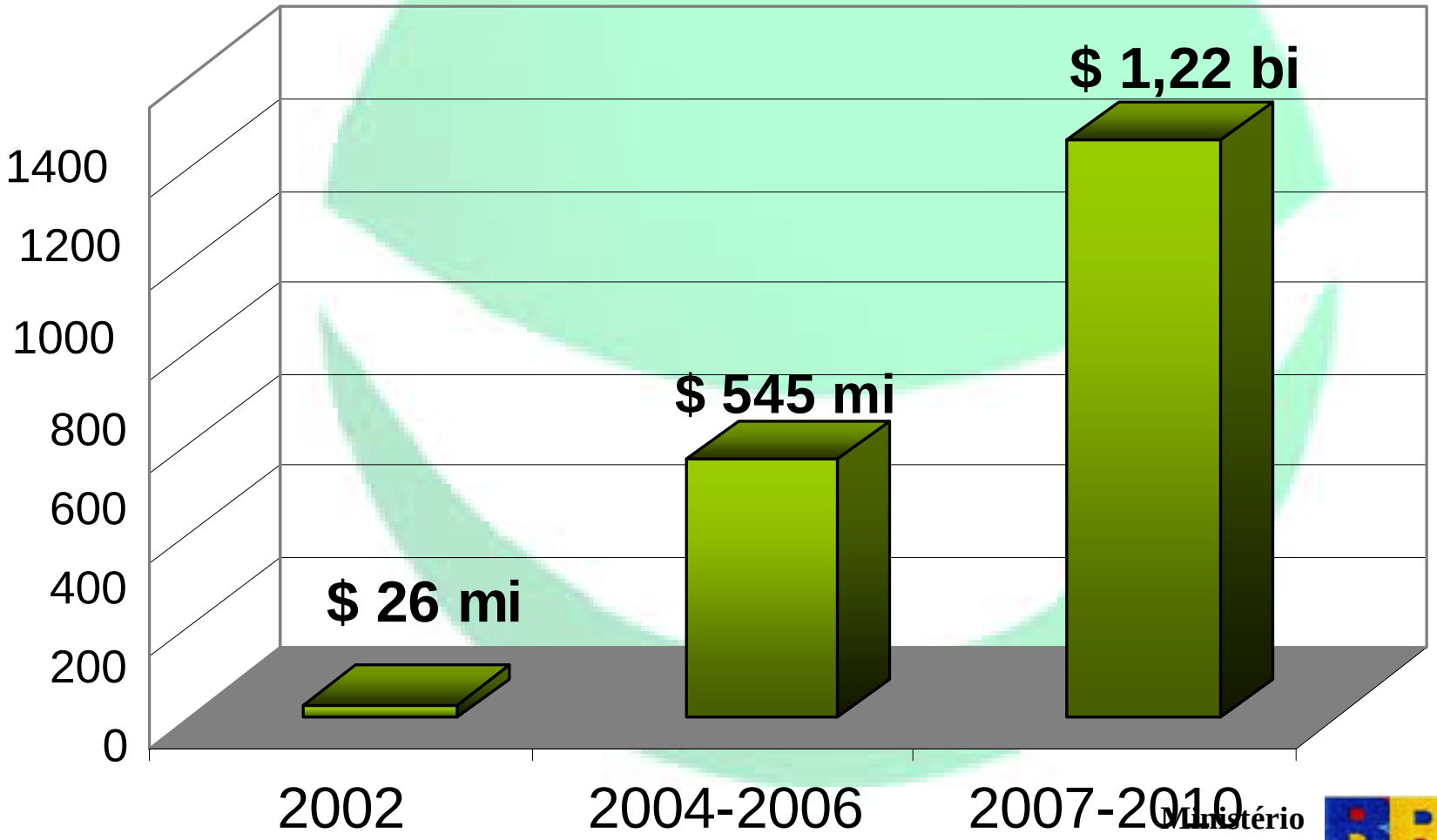
Brasil Sonriente

Ampliación Brasil Sonriente



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Brasil Sonriente

El impacto de las Acciones

Desde el año 2002 unos 2 millones de dientes ya no se extrajeron. Este es un importante indicador de la salude e demuestra la mejora de la calidad de atención a la salud bucal en el país.

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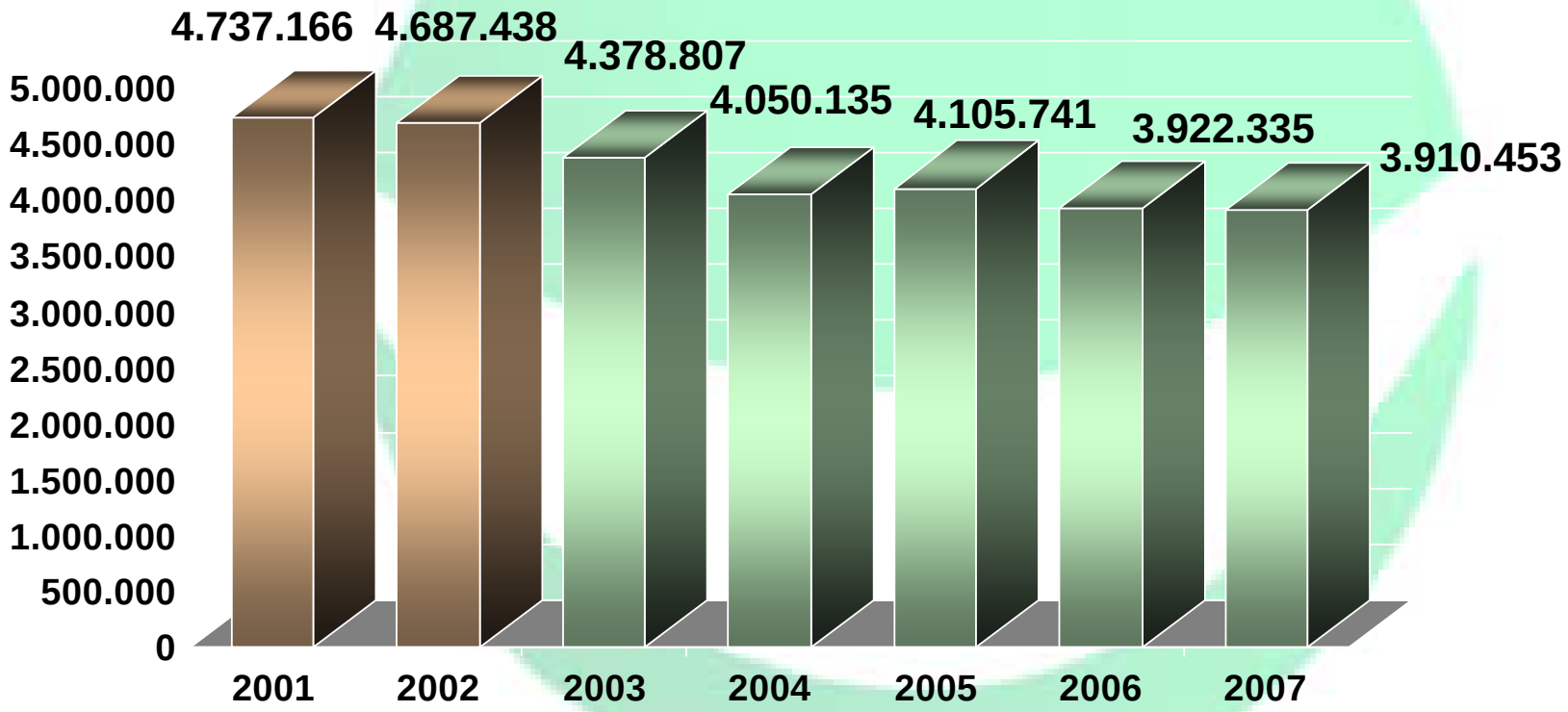
Impacto de la Política Nacional de Salud Bucal Brasil Sonriente

Número de Procedimientos de Exodontias de Dientes Decíduos



Fuente: MS – Sistema de Informações Ambulatorias do SUS / SIA/SUS

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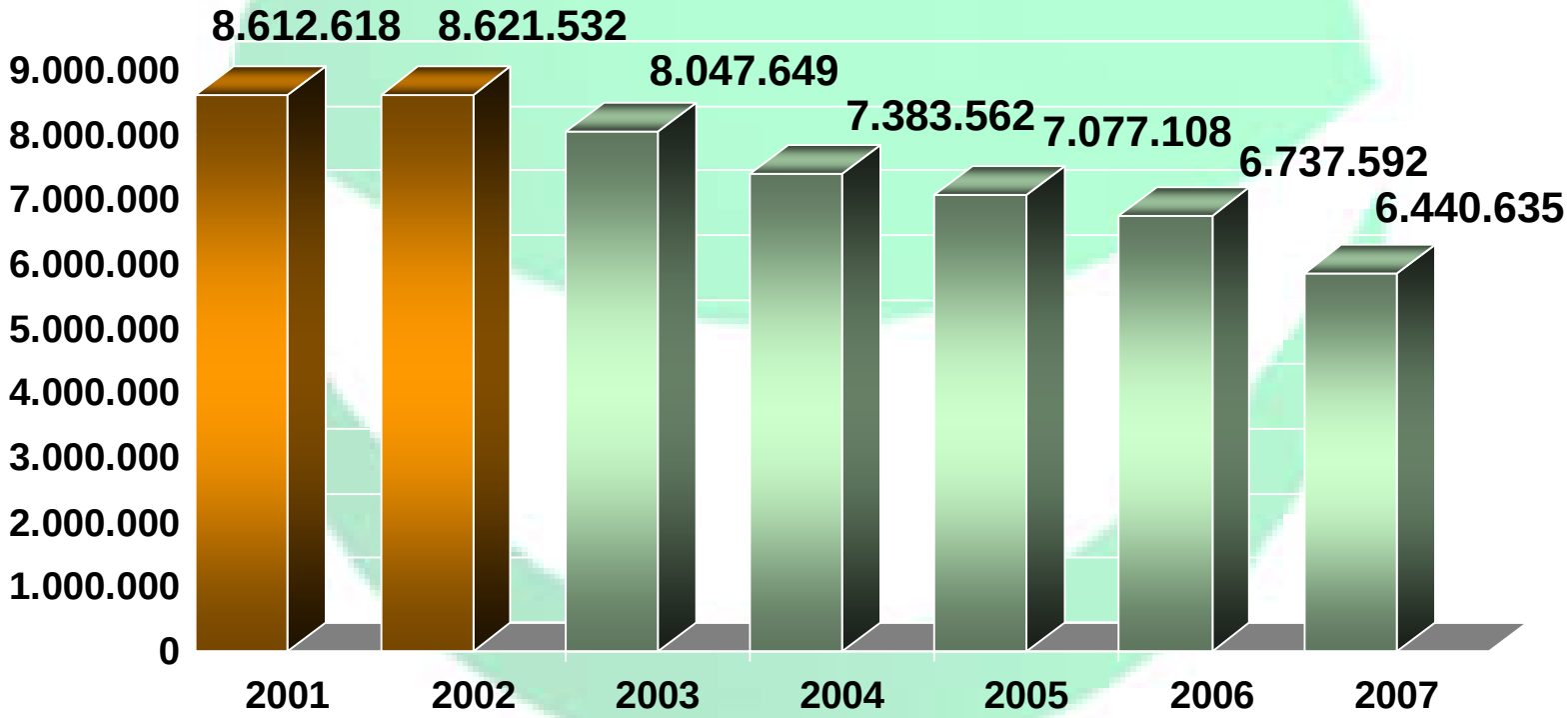
Impacto de la Política Nacional de Salud Bucal Brasil Sonriente

Número de Procedimientos de Exodontias de Dientes Permanentes



Fuente: MS – Sistema de Informações Ambulatorias do SUS / SIA/SUS

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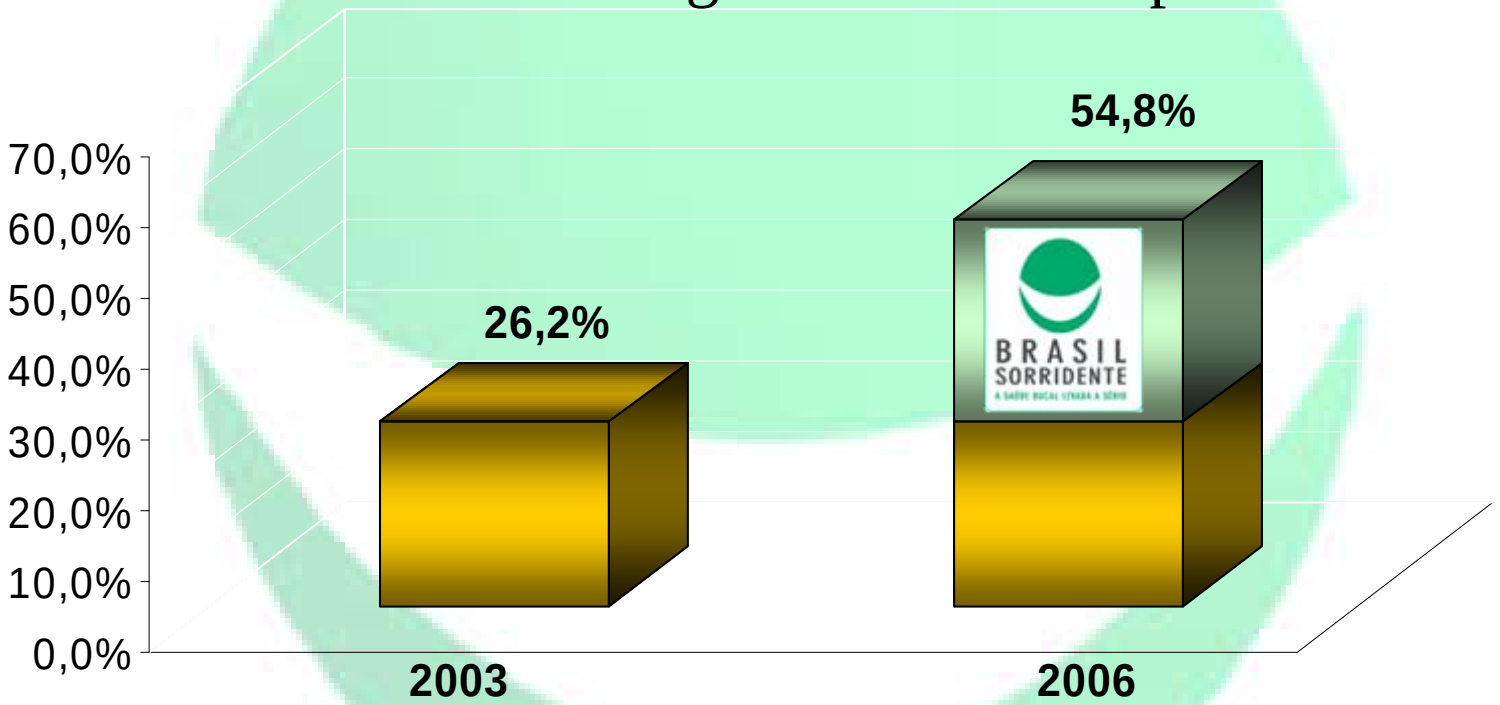
Brasil Sonriente

Metas - 2009

- **Alcanzar 850 Centros de Especialidades Odontológicas hasta final de 2009.**
- **Implantación de 500 nuevos sistemas fluoración del agua de abastecimiento público.**
- **Alcanzar 20.500 mil Equipos de Salud Bucal na estrategia Salud de la Familia implantadas hasta final de 2009.**

Brasil Sonriente – Generación de Empleos

Odontólogistas en sector público



Fuente: Site - Conselho Federal de Odontologia - CFO

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Brasil Sonriente – Generación de Empleos

Fueron generados, de deciembre de 2002 hasta junio de 2008, cabe 37 mil nuebos empleos para cirujano dentista (CD), asistente de consultorio dentario (ACD) y técnicos en higiene dental, allá de técnicos en prótesis dental (TPD) y personal de la área administrativa.

COORDENAÇÃO NACIONAL DE SAÚDE BUCAL

Ministério da Saúde
Esplanada dos Ministérios Bloco G Sala 650
BRASÍLIA/DF CEP: 70.058-900

Tel.: (61) 3315-2728 – 3315-2583
Correio eletrônico:
cosab@saude.gov.br
Site:
www.saude.gov.br/bucal

Ministério da Saúde

Canadian Oral Health Perspective

ORAL HEALTH WORKSHOP FOR THE AMERICAS

April 23 – 25, 2009

Mexico City

Dr. Peter Cooney
Chief Dental Officer
Health Canada

Health Canada Santé Canada

Population of Canada compared to other countries

CARIES IN CANADA

deft/DMFT
(decayed, extracted, filled teeth/Decayed, Missing, Filled Teeth)

Ontario (1996-Leake):	5 year olds deft:	1.22
First Nations (2004-Perressini):	7 year olds deft/DMFT:	6.20
Alberta (2006-Patterson):	7 year olds deft/DMFT:	2.0→6.0
	11 year olds DMFT: 1.0→2.0	
Quebec (1997 – Brodeur):	12 year olds DMFT: 2.1	

Caries Free Children

Toronto (2001-Leake):	Age 5 (70%); Age 7(60%); Age 13(70%)
Alberta (2006-Patterson):	Age 7 (50% → 8%)

[France Caries Free: 60%]

PROVINCIAL AND TERRITORIAL ESTIMATES FOR COMMUNITY WATER FLUORIDATION COVERAGE 2007

Province/Territory	Total Population	Population with fluoridated water	Population without fluoridated water	Percent with fluoridated water	Percent without fluoridated water
British Columbia	4,113,000	152,241	3,960,759	3.7%	96.3%
Alberta	3,290,350	2,457,406	832,944	74.7%	25.3%
Saskatchewan	968,157	356,096	612,061	36.8%	63.2%
Manitoba	1,148,401	803,116	345,285	69.9%	30.1%
Ontario	12,160,282	9,229,015	2931267	75.9%	24.1%
Quebec	7,546,131	489,420	7,067,711	6.4%	93.7%
New Brunswick	729,498	188,607	540,891	25.9%	74.2%
Nova Scotia	913,462	519,031	394,431	56.8%	43.2%
Prince Edward Island	135,851	32,174	103,677	23.7%	76.3%
Newfoundland/ Labrador	505,469	7,572	497,897	1.5%	98.5%
Nunavut	29,474	0	29,474	0.0%	100.0%
Northwest Territories	41,464	23,400	18,034	56.4%	43.6%
Yukon	30,372	0	30,372	0.0%	100.0%
Canada	31,611,911	14,258,078	17,364,803	45.1%	54.9%

NUMBER OF DENTAL SERVICE PROVIDERS IN CANADA:

Dentists:	**18,647[1]**
Dental Hygienists:	**20,928[1]**
Dental Technologists/Technicians:	**3,000[1]**
Dental Therapists:	**300[2]**
Denturists:	**2,075[3]**
Dental Assistants:	**25,000[3]**

[1]-Canadian Dental Association. http://www.cda-adc.ca/en/cda/news_events/statistics/default.asp

[2]-Health Human Resources in Canada. Locker D, Quinonez C et al. Community Dental Health Services Research Unit, University of Toronto, 2006.

[3]-Baldota K and Leake JL. A Macroeconomic Review of Dentistry in Canada in the 1990s. JCDA 2004; 70 (9): 604

HEALTH HUMAN RESOURCES IN CANADA
DENTAL PUBLIC HEALTH

Dentists	Dental Therapists	Dental Hygienists	Dental Assistants	Other
120[1(51)]	**158[2]**	**452[3]**	**242**	**148[4]**

[1] 51 Nationally / Provincially recognized or trained Dental Public Health dentists.

[2] 128 of these in Saskatchewan, Manitoba and Territories.

[3] 347 of these in Quebec and Ontario.

[4] Includes Dental Educators, Health Promoters, Licensed Practical Nurses, program coordinators, data entry personnel, secretaries, clerks, non-dental managers.

Health Human Resources in Canada:
Dental Public Health Specialists / Community Practice Dentists / Allied Dental Public Health Professional.
Locker D.,Quinonez C., Main P., Clarke M. Community Dental Health Services Research Unit, Faculty of Dentistry, University of Toronto.

CURRENT SITUATION

- Coverage
  - 52% of Canadians have private dental insurance.
  - 6 % of Canadians have public dental insurance.
  - 42% of Canadians pay as out of pocket expense.
- Utilization Rates:
  - 2/3 attend for oral health services each year.
  - 5/6 attend for oral health services every 5 years.
- Variations in Annual Attendance
  - British Columbia: 67%
  - Ontario: 70%
  - Newfoundland and Labrador: 46%
- Insurance
  - With insurance: 72%
  - Without insurance: 47%

Focus on:

- Getting a good information base with which we can make decisions.
- Dealing with primarily two diseases (dental decay and gum disease) which are virtually 100% preventable.
- Common risk factors.
- Established linkages between oral / systemic conditions.

PRIORITY #1 NEEDS ASSESSMENT
Canadian Health Measures Survey (CHMS) – Physical Measures

Anthropometry
- height, weight, waist circumference, sitting height
- 5 skinfolds

Cardiorespiratory Fitness
- blood pressure
- modified Canadian Aerobic Fitness Test (step test)
- spirometry

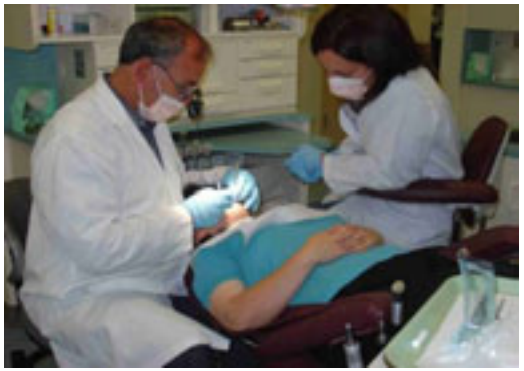
Musculoskeletal Fitness
- hand grip strength
- sit-and-reach flexibility
- curl-ups

Physical Activity
- accelerometry

Oral Health Exam

Biological Sample collection

(i.e; blood and urine)



EXAMPLE OF INTERVENTION

Children's Oral Health Initiative (COHI)

- COHI provides dental services to children from birth to age seven, and provides information to parents, caregivers and expectant parents.

- Early intervention and prevention will lead to overall better health throughout the child's life.

- Simple oral health preventive practices through COHI discourage serious dental disease which may lead to hospitalization.

Children's Oral Health Initiative (COHI)

COHI reaches out to children by providing:

- Oral health screening
- Fluoride varnish applications
- Oral health education and information
- Information/promotion of products containing xylitol
- Sealants to prevent cavities
- Filling - Alternative Restorative Treatment (ART); except for provinces of Ontario and Quebec.
- Referrals for treatment outside COHI's scope.

CONCLUSIONS

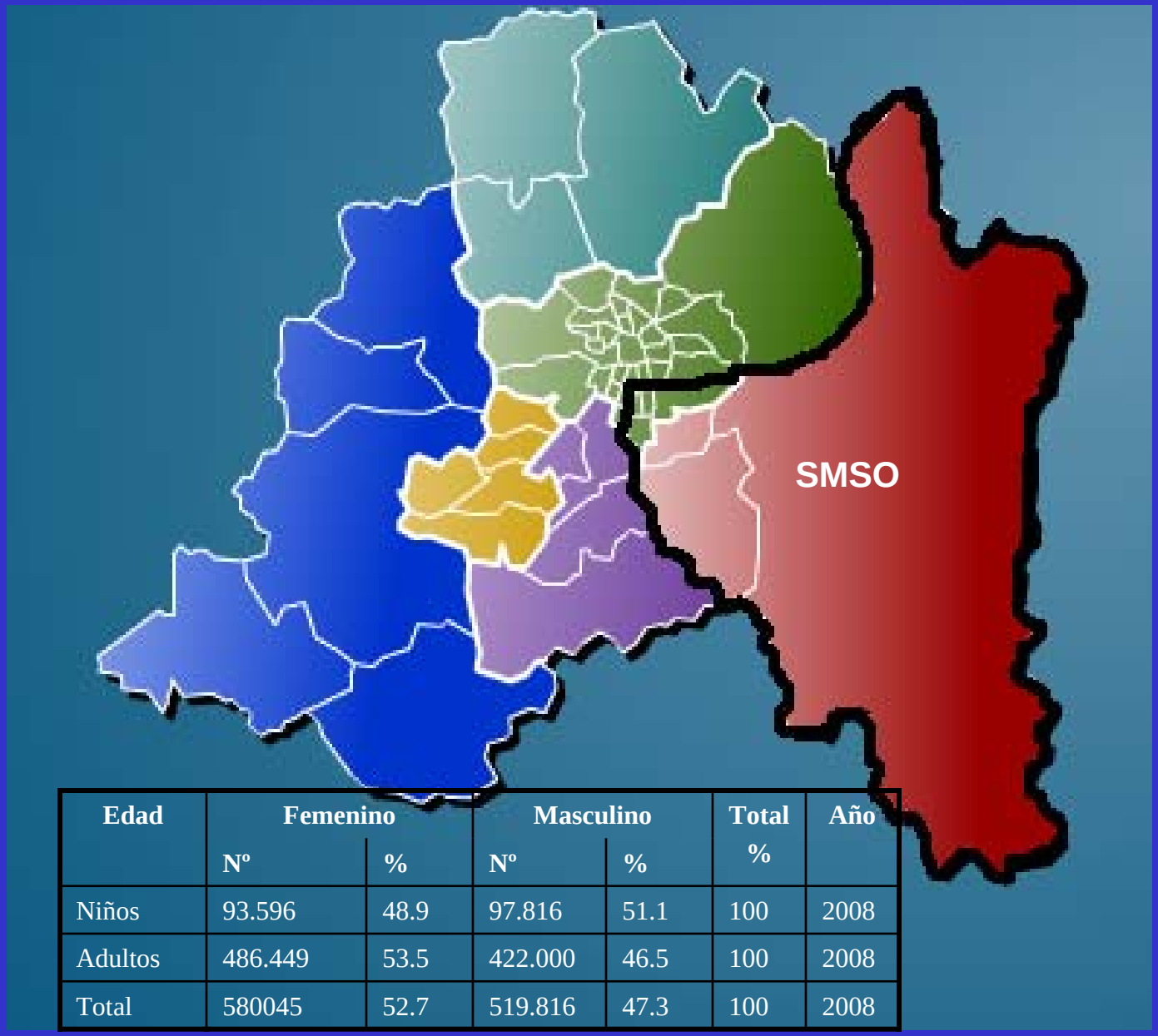
- **On-track for “Oral Health in Canada – 2010 Report”**
- **Focus on health promotion / disease prevention**
  - **Water fluoridation**
  - **Children’s Oral Health Initiative**
  - **Oral Cancer**
- **Working with partners and stakeholders regarding access for vulnerable groups**
  - **Ontario example**

CARACTERISTICAS DE CHILE

- 16.3 millones de habitantes (proyección censo 2005)
- Crecimiento demográfico anual: 1.2%
- Proporción pobl. menor de 15 años: 25,7%
- Proporción Pobl. 65> años: 7,4%
- Tasa Mortal Infantil 2004: 8,4 por 1000 NV
- Tasa Mortal General 2004: - 5,3 por 1000
- Pueblos originarios: 3.8%
- El 40% de la población reside en la R. M.: 87% población urbana.
- Índice de desarrollo humano: 0-854:lugar 37

- Expectativa de vida: 78 años
- Tasa de alfabetismo: 95,7% - Cobertura escolar: 90.0%
- Pobreza: 13.7%
- Población que vive con <US$1 día: 0
- Desigualdad ingreso, índice GINI: 57,1

REGION METROPOLITANA SANTIAGO DE CHILE



Edad	Femenino		Masculino		Total %	Año
	Nº	%	Nº	%		
Niños	93.596	48.9	97.816	51.1	100	2008
Adultos	486.449	53.5	422.000	46.5	100	2008
Total	580045	52.7	519.816	47.3	100	2008

Diapositiva 3
Población de acuerdo a la encuesta salud bucal más reciente (CPOD)
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

Edad	Femenino	Masculino	Año
Niños de 6 – 9 años	36.568	38.400	2006
Niños de 12 años	10.231	11.025	2006
Niños de 15 años	10.062	10.045	2006
Adultos	418.125	345.924	2006
Total	474.986	405.394	2006

Diapositiva 4
Población de áreas con problemas de fluoruración y otras intervenciones escolares
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

Vehículo	% de población cubierta	Áreas urbanas fluoruradas	Escolares rurales con F/leche	Mejores prácticas
Sal	-	-	-	-
Agua	98.2 %	1.306.041	-	-
Leche	100.0%	-	6.303	-
Sellante	88% (6-12años)	-	-	-
Flúor Tópico	70% (3-12 años)	-	-	-
ART	8-10% (zonas rurales)	-	-	-
Ortopedia interceptiva	2.1% (5-8 años)	-	-	-

Diapositiva 5
Recursos Humanos
Recurso para la salud y salud bucal disponibles en la comunidad
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

Institución	Dentistas		Personal Auxiliar				
	Tiempo Completo	Tiempo Parcial	NºAuxiliar Paramédico	Asistente	Higienista	Técnico labor	Enfermera Tiempo parcial
*S. de S. Público	209	62	237		2	2	34
Privado		148		100			
Total	209	210	237	100	2	2	34

* •1.9 Odont. /10.000 población beneficiaria
•1.15 hora auxiliar/ 1 hora odontológica.
} Sector público

Diapositiva 6
Cobertura de salud bucal reportada para 2008
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

AÑO	% de cobertura*		% Tipo de Atención					
	Actual		Prevención		Curativa		Quirúrgica	
	MSP	PRIV	MSP	PRIV	MSP	PRIV	MSP	PRIV
0-5	15.0	-	100.0	-	35	-	0.5	-
6-12	21.0	-	100.0	-	70	-	2.0	-
13-19	22.0	-	100.0	-	95	-	3.8	-
20-59	1.2	-	100.0	-	100	-	11.0	-
60 y más	3.2	-	100.0	-	100	-	25.0	-
Total	12.5	-	100.%	-	80%	-	8.5%	-

* % cobertura altas totales (educación + prevención + recuperación)

Diapositiva 7
Infraestructura
Número de clínicas odontológicas
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

Instituciones	Atención Integral	Tratamiento limitado o incompleto Ej. urgencias	Disponibilidad de tratamientos especiales (Ej. Sedación), otros especiales
Servicios Públicos	205	10	1 clínica para sedación
Privado	35	45	
Universidad	----	----	----
Clínicas móviles	1		
Otras (especificar)	----	----	----
Total	241	55	1 sedación

Diapositiva 8
Costo de servicios
Servicio de Salud Metropolitano Sur Oriente - Santiago de Chile

Instituciones	**Tipos de servicios**				
	Prevención (Sellantes flúor tópico, destartrajes) Nº %	**Curativo** (Obturaciòn) Nº %	**Quirúrgico** (exodoncia) Nº %	**Total** **%**	**U$**
Servicios Públicos	1.499.056 U$ (26.1%)	U$ 3.637.888 (63.1%)	U$ 619.156 (10.8%)	100.0	5.756.100
*Privado	-	-	-		
Universidad					
Total					

* Usar cotización de US dólar más reciente

República de Colombia

Taller De Salud Oral Para Las Américas

México D.F., Abril 23 a 25 de 2009

Dra. MARIA CLARA RANGEL
Decana Univ. El Bosque
Dra. MARISOL TELLEZ
Dr. CARLOS MARIO URIBE
Decano Univ. De Antioquia – ACFO
Dr. JAIME DONADO MANOTAS
Federación Odontológica Colombiana – FOC
Dr. JUAN VARELA BELTRAN
Subsecretario de Salud – Secretaria Distrital de Salud de Bogotá

Dra. SANDRA TOVAR VALENCIA
Ministerio de la Protección Social

Población por edad y sexo, Colombia. Proyección Censo DANE 2005

Edad		Femenino	Masculino	Año Proyección 2008 (a partir de censo 2005)
Niños	0 – 4 años	2.093.048	2.189.789	4.282.837
	5 a 14	4.333.422	4.524.841	8.858.263
	15 a 19	2.110.723	2.223.602	4.334.325
Adultos	20 - 34	5.349.567	5.221.373	10.570.940
	35 - 44	3.041.438	2.810.559	5.851.997
	> 45	5.579.865	4.972.033	10.551.898
Total		22.508.063	21.942.197	44.450.260

Fuente: Información estadística DANE. Proyecciones municipales de población 2005-2011 sexo y grupos de edad. Colombia

Comportamiento del Indicador ceo-d y COP-D en población Colombiana

Edad	Femenino	Masculino	Año
Niños de 5 años MPS	3.0	3.0	3.0 (ceo-d)
Niños de 6 – 9 años (6 años MPS)			0.2
Niños de 12 años	2.5	2.1	2.3
Niños de 15 años (15 a 19 años)			5.2
Adultos 35-44 años			15
Adultos 55y mas años			19.6
Total	11.0	9.6	10.3

Fuente: Ministerio de Salud, Tercer Estudio Nacional de Salud Bucal – ENSAB III, Colombia 1998.

Principales indicadores de salud bucal Estudios Nacionales. Colombia 1966, 1978-1980, 19998.

Condición	1966*	1978-1980*	1998**
Ceo 5 años	6.32	4.19	3.0
COP	15.4	12.7	10.3
Prevalencia caries en dentición permanente	95.5%	96.7%	65-3%
Prevalencia Enf Periodontal	88.7%	94.7%	El índice no es comparable con los años anteriores La prevalencia de marcadores periodontales por ICPNT es del 92.4%
Fluorosis	No Aplica	No Aplica	11.3% para edades de 6,7, 12 y 15 a 19 años

Fuente: * Ministerio de Salud, Instituto Nacional de Salud y Asociación Colombiana de Facultades de Medicina. Estudio Nacional de Salud – Morbilidad Oral. 1977-1980 y ** Ministerio de Salud - III Estudio Nacional de Salud Bucal 1998

Porcentaje de áreas con programas de fluoruración y otras intervenciones

Vehículo	% de población cubierta	Áreas fluoruradas
Sal	100%	Todo el territorio nacional
Agua	Sin dato cuantificado (fuentes naturales)	Sin dato cuantificado (fuentes naturales)

Fuente: Ministerio de la Protección Social – INVIMA

PRESTADORES HABILITADOS EN COLOMBIA POR NATURALEZA JURIDICA
SERVICIO DE ODONTOLOGIA GENERAL

ENTE TERRITORIAL	Mixta	Privada	Pública	Total general
Amazonas		16	5	21
Antioquia	2	1999	185	2186
Arauca		59	17	76
Atlántico		396	101	497
Bogotá D.C	1	4163	132	4296
Bolívar		320	148	468
Boyacá		424	165	589
Caldas		385	51	436
Caquetá		42	41	83
Casanare		115	25	140
Cauca	1	231	117	349
Cesar		179	51	230
Chocó		59	39	98
Córdoba		248	66	314
Cundinamarca	2	523	160	685
Guainía		5	1	6
Guaviare		22	8	30
Huila		204	49	253
La Guajira		88	38	126
Magdalena		141	120	261
Meta		240	41	281
Nariño		345	161	506
Norte de Santander	1	305	83	389
Putumayo		79	35	114
Quindío		210	36	246
Risaralda	1	299	26	326
San Andrés y Providencia		31	2	33
Santander		646	167	813
Sucre		132	59	191
Tolima	1	287	85	373
Valle del cauca		1317	265	1582
Vaupés		3	3	6
Vichada		13	8	21
Total general	**9**	**13526**	**2490**	**16025**

Ministerio de la Protección Social Registro Nacional de Prestadores
Octubre 31-2008

PRESTADORES HABILITADOS EN COLOMBIA DEL SERVICOS DE ODONTOLGIA GENRAL
POR TIPO DE PRESTADOR

Ente Territorial	Instituciones - IPS	Objeto Social Diferente a la Prestación de Servicios de Salud	Profesional Independiente	Transporte Especial de Pacientes	Total general
Amazonas	20		1		21
Antioquia	523	7	1656		2186
Arauca	43		33		76
Atlántico	297	6	194		497
Bogotá D.C	868	41	3386	1	4296
Bolívar	292	3	173		468
Boyacá	266	2	321		589
Caldas	126	9	301		436
Caquetá	63		20		83
Casanare	74	1	65		140
Cauca	190	7	152		349
Cesar	127		103		230
Chocó	65		33		98
Córdoba	149	4	161		314
Cundinamarca	303	2	380		685
Guainía	5		1		6
Guaviare	16	1	13		30
Huila	86	4	163		253
La Guajira	71	1	54		126
Magdalena	199	1	61		261
Meta	107	2	172		281
Nariño	242	7	257		506
Norte de Santander	149	2	238		389
Putumayo	74		40		114
Quindío	80	2	164		246
Risaralda	79	1	245	1	326
San Andrés y Providencia	8		25		33
Santander	372	3	438		813
Sucre	148		43		191
Tolima	138	2	233		373
Valle del cauca	593	8	979	2	1582
Vaupés	4		2		6
Vichada	11		10		21
Total general	**5788**	**116**	**10117**	**4**	**16025**

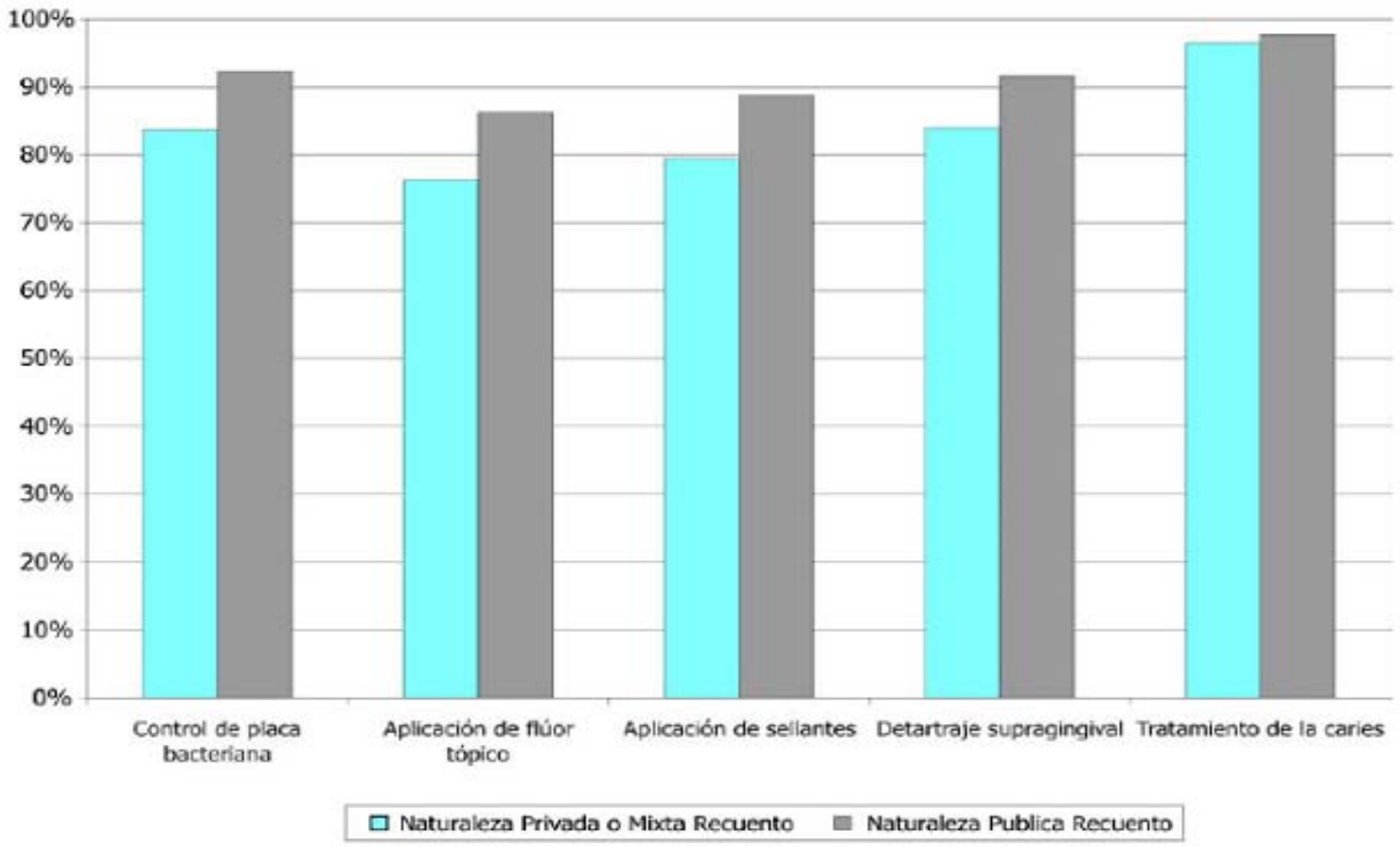
Ministerio de la Protección Social Registro Nacional de Prestadores
Octubre 31-2008

Stock mercado laboral por disciplinas. 1970-2006

Año	Medicina	Stock Total Odontología	Enfermería	Stock Total
1993	2043	1223	722	5926
1994	2260	1130	780	7125
1995	2327	1488	790	7698
1996	2168	1635	795	7416
1997	2329	1763	684	7842
1998	2538	1540	1267	8735
1999	2224	1487	1036	8277
2000	2403	1645	1363	9193
2001	1803	1326	1650	8637
2002	2342	1355	1586	8816
2003	2981	1787	2075	10725
2004	3140	1226	1919	9939
2005	3030	1004	2046	10096
2006	2447	892	2262	9917
TOTAL	**66702**	**35294**	**31862**	203900

Fuente: Ministerio de la Protección Social – Cendex, Los recursos Humanos en Salud en Colombia: Balance, Competencias y Prospectiva, 2008

Oferta de atenciones preventivas y curativas en salud bucal



Fuente: Ministerio de la Protección Social – Colciencias – Cendex – SEI.
Encuesta Nacional de Salud 2007.

Prestadores habilitados en Colombia por tipo y entidad territorial Odontología General

	Departamental	Distrital	Indigena	Municipal	Nacional	Privado Otros	Total
Total país	623	215	53	1489	72	13573	16025

Fuente: Ministerio de la Protección Social – Dirección General de Calidad, 2008

Valor estimado de la inversión en salud oral para la atención de la población colombiana como porcentaje de la UPC de 2008

Tipo de Afiliación	Población	Valor UPC*	% Salud Oral en la UPC	Valor en Pesos	Valor a Invertir en Servicios de Salud Oral por año
Régimen Contributivo	17.006.391	$ 430.488	3,7%	$ 15.928	$ 270.878.748.206
Régimen Subsidiado	21.606.812	$ 242.370	6,6%	$ 15.996	$ 345.631.639.613
Población sin Afiliación**	5.837.057			15966	$ 93.194.452.062
Poblacion Estimada a 2008 Censo DANE	**44.450.260**				**$ 709.704.839.881**

* Acuerdo 379 de 2008
Calculos del autor

Fuente: Ternera P. Jario H. El financiamiento de la salud oral en el sistema de aseguramiento, análisis y perspectivas

GRACIAS

Epidemiología bucal, respuesta social y desafíos para el desarrollo de comunidades libres de caries:

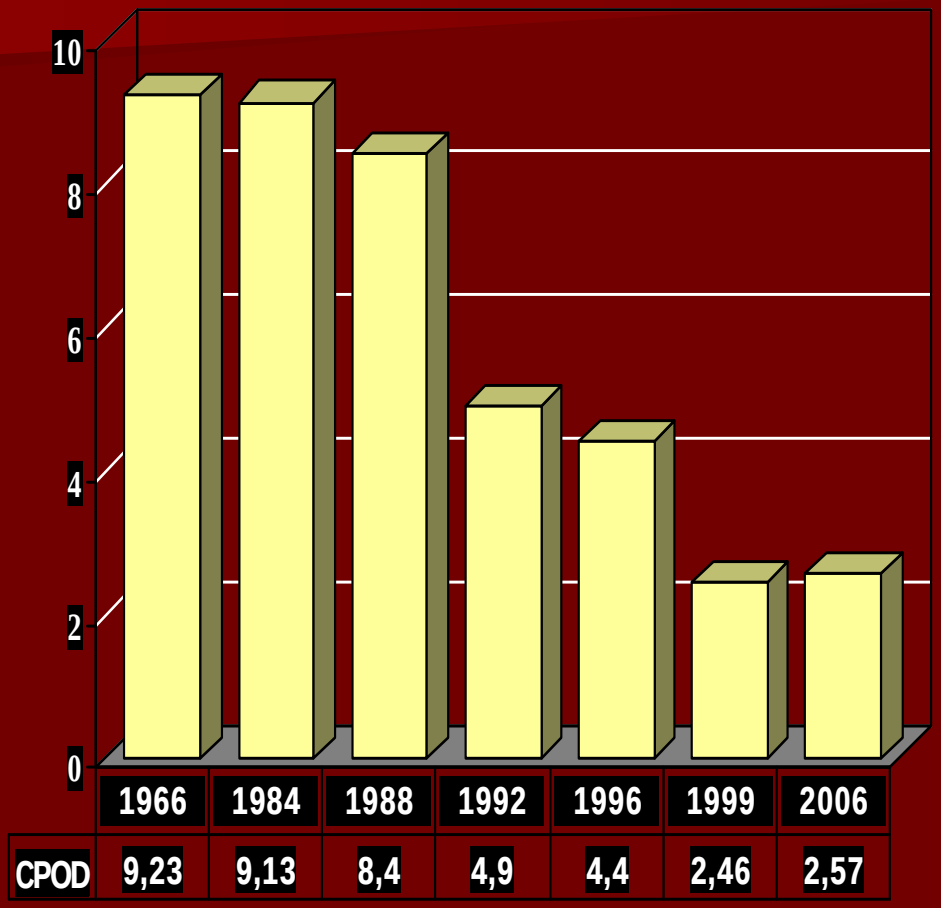
El caso de Costa Rica:

Propuesta presentada por el
Colegio de Cirujanos Dentistas de Costa Rica

La prevalencia de la caries dental en escolares costarricenses a la edad de 12 años en el 2006:

- 85% de los menores estudiados presentaban historia de la enfermedad.
- El índice CPOD se cuantificó en 2,57
  - El 55% al componente obturado,
  - el 39% al componente de caries activa y
  - 5,4% a piezas dentales perdidas por caries dental.

El comportamiento epidemiológico de la caries dental en Costa Rica (CPOD-12)



- Dos momentos históricos
  - 1966 a 1999 Acelerada reducción de la caries.
  - 1999 a 2006

    Estancamiento en la incidencia de la caries dental

Período de una franca reducción de la incidencia de la caries dental

(CPOD-12 en 1966 de y en 2006 de 2,57)

- Posterior a la década de los años cuarenta, se empezaban a producir transformaciones en el país.
  - En el campo de la salud, se gestaban fuertes reivindicaciones como el seguro social, además del salario mínimo y la jornada máxima.
- Programas exitosos en odontología:
  - Amplia cobertura en escolares por el MS.
  - Fluoruración de la sal.
  - Educación para la salud
  - Programas de formación de recursos humanos con fuerte desarrollo en docencia servicio.

Posibles explicaciones
Estancamiento de la incidencia en la caries (CPOD-12 en 1999 de 2,46 y en 2006 de 2,57)

- Los cambios en las estrategias de atención provocadas por la reforma del sector salud en los años noventa.
  - atención odontológica se realiza por demanda y no de forma sistemática.
- Ministerio de Salud cambia su función
  - de proveedor de servicios de salud,
  - al de ejercer la rectoría de la salud en Costa Rica.
- La responsabilidad de la prestación de los servicios de salud a toda la población, recae entonces en la Caja Costarricense de Seguro Social.
- Persiste una visión curativa de los problemas de salud,
  - resultado en la anterior separación de funciones
    - preventivas en el Ministerio de Salud y
    - curativas en la Caja Costarricense del Seguro Social.

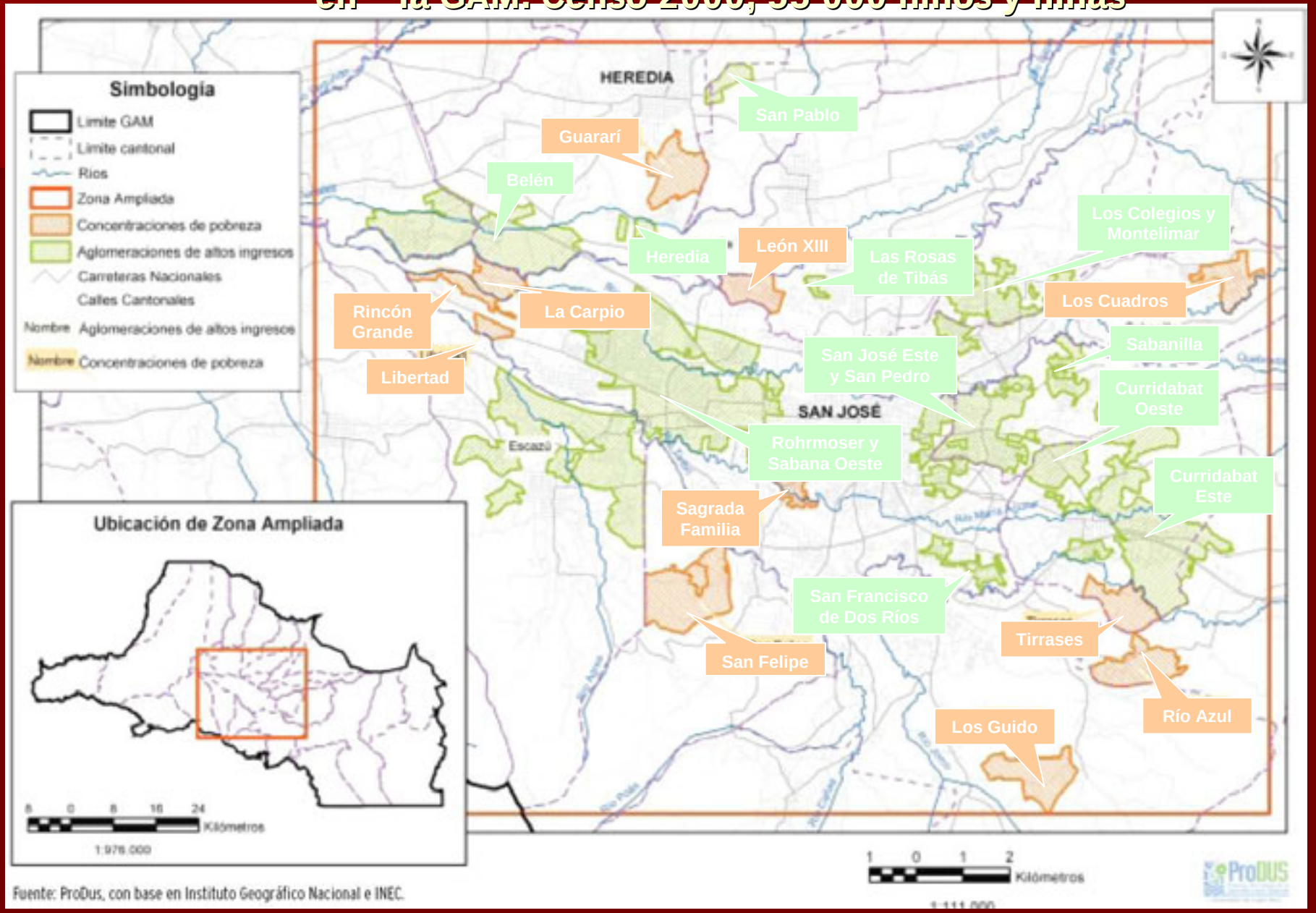
Equidad en el estado de salud bucal

- Escolares de 12 años de edad en una escuela pública en Costa Rica, presenta 3 veces el riesgo de tener historia natural de caries dental comparado con un niño o niña escolar promedio de 12 años de edad que asista a una escuela privada. (OR 2,96 IC 95% 1,8 - 4,5).
- Región Huetar Norte, una de las regiones con menor índice de desarrollo humano del país, el índice alcanzó un valor 3,01 (DS ± 2,38).
- Por su parte, la baja escolaridad materna el riesgo de caries de los infantes entre 12 y 24 meses de edad se cuantificó en 6,07 veces el riesgo.

Equidad en el uso de los servicios de salud

- En la Región Chorotega 3 de cada 10 escolares, nunca había asistido a una consulta dental.
- En el distrito de Tacares los menores de 5 años cuando tienen un problema dental tienen cuatro veces menos posibilidad de ser atendidos que los mayores de 5 años.

Poblaciones vulonerables
Concentraciones de pobreza y aglomeraciones de altos ingresos en la GAM. Censo 2000, 55 000 niños y niñas



Fuente: ProDus, con base en Instituto Geográfico Nacional e INEC.

Propuesta para el desarrollo de un Plan Nacional de Promoción de la Salud Buco-dental.

- Proponer los lineamientos de promoción de la salud para le desarrollo de los Programas integrales de Salud Bucal en Costa Rica.
- Proponer los lineamientos basados en competencias académicas y profesionales para la formación y capacitación de recursos humanos en odontología en la promoción de la Salud Bucal.
- Proponer los lineamientos para la investigación y evaluación en la promoción de la Salud Bucal.

Programas exitosos:
Programa Odontología Comunitaria de Palmares

30 años de desarrollo

- Participación Social
- Docencia servicio
- Investigación
- Reducción de caries CPOD-12 de 2.39
- Egresan de la escuela sin caries activa.

La Estomatología en Cuba

Dra. Maritza Sosa Rosales
Dirección Nacional de Estomatología.
MINSAP, Cuba

SISTEMA DE SALUD CUBANO

GRATUITO

UNIVERSAL

ACCESIBLE

REGIONALIZADO

INTEGRAL

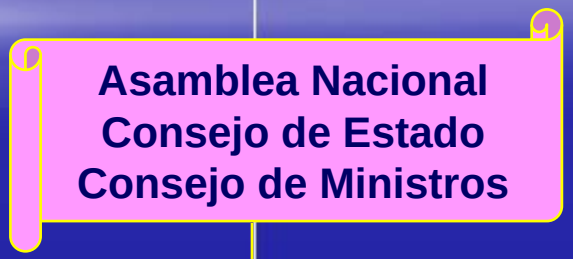
Al alcance de todos los ciudadanos:

- En el campo y en la ciudad
- De cualquier raza
- De cualquier sexo
- Religioso o ateo

Con participación comunitaria e intersectorial

Con una concepción Internacionalista

SISTEMA NACIONAL DE SALUD



MINISTERIO DE
SALUD PÚBLICA
REPÚBLICA DE CUBA

COMPONENTES DEL SISTEMA NACIONAL DE SALUD

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

ÁREA DE SALUD Y SU RED DE INSTITUCIONES

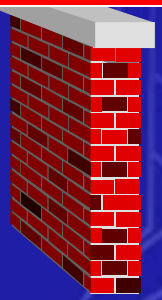
MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

Modelo de Medicina Familiar en la Comunidad

ANÁLISIS DE LA SITUACIÓN DE SALUD

- **ESTRATEGIA GLOBAL**
- **PRIMER NIVEL DE ATENCIÓN**

SISTEMA NACIONAL DE SALUD



ATENCIÓN PRIMARIA DE SALUD

Modelo de Estomatología General Integral

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

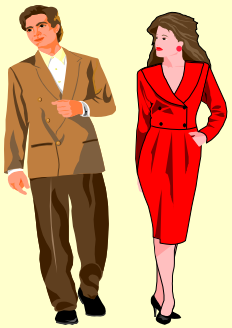
Salud Bucodental

Salud

SISTEMA DE SALUD

PARTICIPACION COMUNITARIA

OTROS SECTORES



ENFOQUE DE GENERO

Individuo

Familia

Comunidad

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

ESTOMATOLOGÍA GENERAL INTEGRAL

Un sistema de trabajo → Un concepto de trabajo

Acciones de Salud **Promoción**
Prevención
Curación
Rehabilitación

→ **En la Comunidad**
En las Instituciones

HOMBRE-FAMILIA-COMUNIDAD

Equipos de Salud =
Médico – Enfermera – Estomatólogo –**Tecnólogo** – TAE

NUEVO MODELO DE ATENCIÓN

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

PROMOCIÓN

PREVENCIÓN

Base del Sistema de Salud

ATENCIÓN PRIMARIA

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

PROGRAMA NACIONAL DE ATENCIÓN ESTOMATOLÓGICA INTEGRAL A LA POBLACIÓN

PROPÓSITO

Incrementar y perfeccionar la atención estomatológica a través de acciones integrales de Promoción, Prevención, Curación y Rehabilitación, con la finalidad de mejorar el estado de salud bucal, elevar la calidad de la atención y la satisfacción de la población y los trabajadores.

La Salud Bucal ⟷ **La Salud General**

Limitaciones y daños
que conllevan las enfermedades bucales para la

- **nutrición**
- **fonación**
- **comunicación**
- **estética**

promoción de salud y prevención de enfermedades

Examen de la cavidad bucal ⟷ **Como parte del examen físico**

- **detectando tempranamente cualquier alteración y riesgos**
- **desarrollando estilos de vida adecuados para la salud**

Instituciones de Salud

Clínicas Estomatológicas	156
Servicios en Policlínicos	474
Servicios en Hospitales y otros	869
Laboratorios de prótesis	326 funcionando de 413 existentes.

4 Facultades de Estomatología y
11 Departamentos

Equipos: 6223 conjuntos dentales

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

RECURSOS HUMANOS

- Estomatólogos
- Tecnólogos de la Salud en los Perfiles de Atención Estomatológica y Prótesis.
- Técnicos de Atención Estomatológica
- Técnicos de Prótesis Dental

MINISTERIO DE SALUD PÚBLICA
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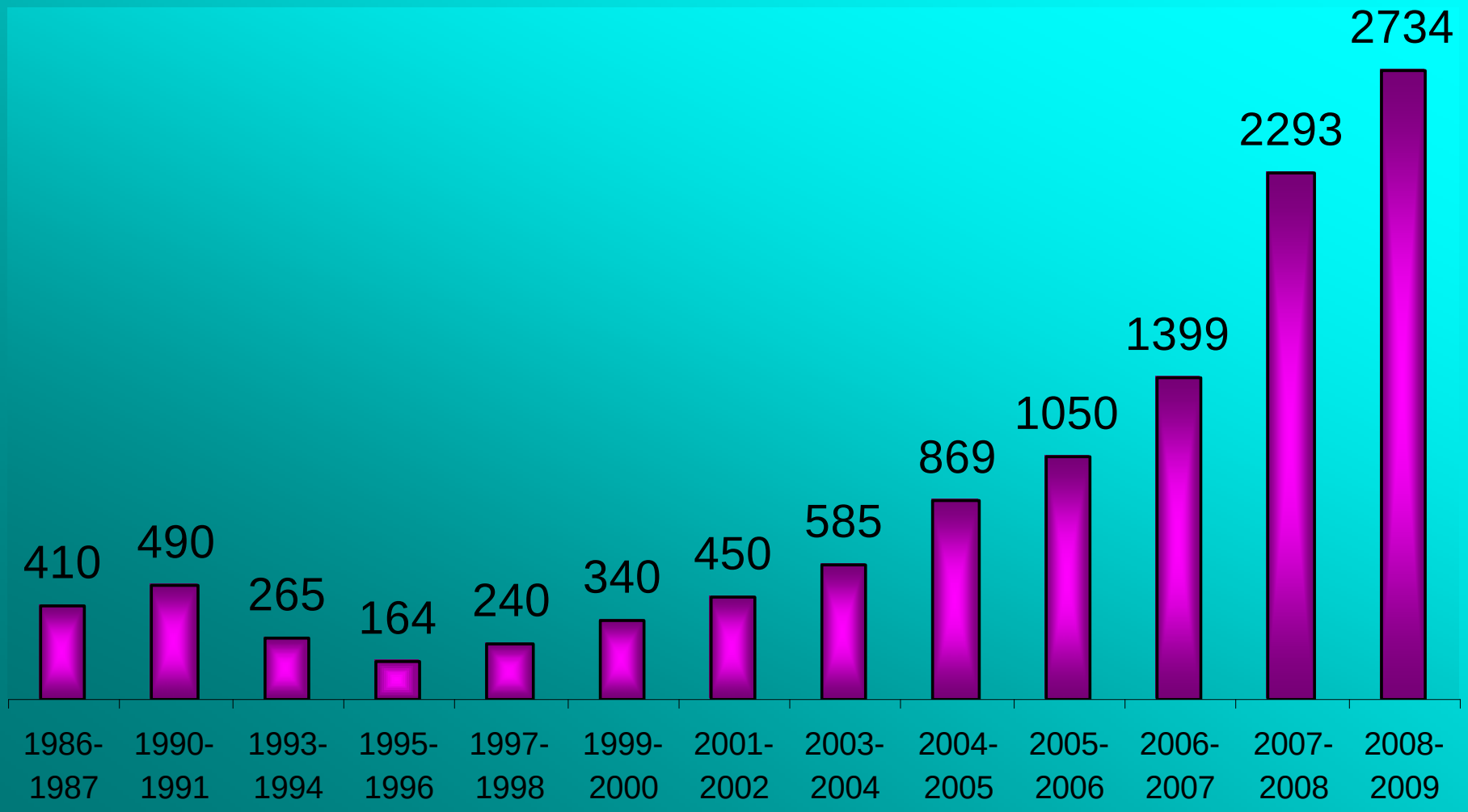
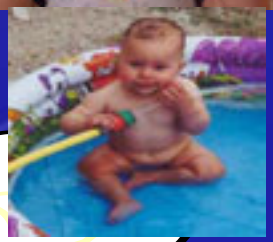
Comportamiento de la matrícula a Estomatología, Cuba, 1986 - 2008



EVOLUCIÓN DEL ESTADO DE SALUD BUCAL DE LA POBLACIÓN EN CUBA.



MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

Desarrollo de la Atención Estomatológica en Cuba

Década 60 - Surgimiento del Policlínico

Programas contra daños y enfermedades: Se crean las clínicas estomatológicas

Década 70 - Policlínico Comunitario

Programa de atención integral a las personas: Atención Estomatológica Comunitaria. Inicio de las Especialidades. Extensión de la Docencia. PROGRAMAS BASICOS DEL AREA DE SALUD

Década 80 - Incorporación del Médico de Familia

Programa de atención integral a la Familia. Modelo de Estomatología General Integral

Década 90 - Profundas afectaciones. Mantenimiento

2002 – REVOLUCIÓN EN LA SALUD: PROGRAMAS DE LA REVOLUCIÓN


Alegres con la REVOLUCIÓN

CUBA 2006

Indicador	Año 1998	Año 2006	Proyección 2010	Proyección 2015
% de Niños de 5 – 6 años Sanos	55.0%	68.0%	70.0	75.0
Índice de Cariados, Perdidos y Obturados a los 12 años	1.62	1.46	1.2	1.1
% que Conservan todos los dientes a los 18 años	75.8%	89.9%	93.0	95.0
Promedio de dientes perdidos en población de 35 a 44 años de edad	6.6	5.14	4.5	3.9
Promedio de dientes perdidos en población de 60 a 74 años de edad	20.6	16.38	15.5	14
% de población infantil sin maloclusiones	66.0%	**60.19%**	70.1%	74.8%
% de población sin afectación gingival y periodontal	48.0%	67.0%	70.0	75.0

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

Para alcanzar estos indicadores:

- ❖acciones de Promoción de Salud y Prevención de Enfermedades (por más de 25 años):
  - •con la población para crear hábitos correctos de higiene bucal e incrementar sus conocimientos.
  - •desde que el niño nace y sobre las embarazadas y madres
- ❖ aplicación de laca flúor en los niños de 2 a 5 años de edad en los Círculos Infantiles y en sus propios hogares, y en las edades de brote, desde 1968.
- ❖ejecución de los enjuagatorios de fluoruro al 0.2% quincenalmente a todos los niños mayores de 5 años en las escuelas primarias, extendiéndose posteriormente a la enseñanza secundaria y preuniversitaria.
- ❖fluoruración de la sal de consumo humano, medida preventiva que logra un costo beneficio de 27 a 1, estimando solo las edades menores de 15 años. (Se inició en el 2000).

- modificación de los planes de estudio, enfatizando en la Promoción de Salud y la integralidad de las acciones, capacitándose a profesionales y técnicos en técnicas educativas y afectivo – participativas que posibilitan el trabajo con la población.
- integración con otros sectores, fundamentalmente educación, capacitando a profesores y educadores y a los líderes formales e informales de las Comunidades en los temas de interés de ellos y del subsistema de atención estomatológica, de acuerdo a la problemática de cada territorio.
- conservación de los dientes, con el mejoramiento de la infraestructura y el equipamiento que posibilita el incremento de los tratamientos curativos, para evitar la extracción dentaria.

“... Somos un país pequeño, pero este país pequeño ha podido demostrar cuánto se puede cuando se quiere, cuánto se puede si los recursos humanos de cualquier país pueden ser bien utilizados..”

Fidel Castro Ruz.

MUCHAS GRACIAS

MINISTERIO DE SALUD PÚBLICA
REPÚBLICA DE CUBA

CARIES-FREE DOMINICA

DR.IDALINE JOHN

Health Care in Dominica

- Primary Health Care
  - Seven Health Districts
    - Type Three Serves as Administrative headquarters to the hospital
    - 4-7 Type One Health Centre
    - One Type Three Health Centre
    - Two District Hospitals
- Social Health Care
  - Social Welfare Division
  - Dominica Social Security

Health Care in Dominica

- Government Laboratory
  - Clinical and Health Testing
- Individual Care Service Clinics
- Princess Margaret Hospital
  - Provides Secondary Health Care
- Tertiary Services are provided by visiting consultants.
- Health Supplies

Services Provided by Dental Department

- Children or School Dental Program
  - Staffed by Dental Therapist
  - Children 2 ½ - 18 years
- Adult Dental Program
- Staff
  - Four Dental Surgeons
  - Four Dental Assistants
  - Four Dental Therapists
- Preventative and Curative Services
- Nurses, Policemen, firemen, persons on welfare and APU patients receive free services


Dominica
Portsmouth Health District
One Private Clinic
Marigot Health District
Castle Bruce Health District
St. Joseph Health District
Children Dental Clinic
Roseau Health District
Six Private Clinics
La Plaine Health District
Grand Bay Health District
Dental Clinics
Private Clinic
No Dental Therapist
Portsmouth
Indian River
Fort Shirley
Parish of Saint John
Melville Hall Airport
Parish of Saint Peter
Northern Forest Reserve
Salybia
Gaulette
Castle Bruce
Salisbury
Saint Joseph
Layou
Rachiel's Retreat
Central Forest Reserve
Macoucherie Rum Factory
Layou River
Roseau
Dominica Coconut Products
Canefield Airport
Old Mill Cultural Centre
Morne Trois Pitons
Boeri Lake
Freshwater Lake
Trafalgar Falls
Boiling Lake
Wotton Waven Sulphur springs
Victoria Falls
Parish of Saint Patrick
Pte Michel
Soufriere
Fort Cashacrou

Vulnerable Populations in Dominica

- Dominica's 3,000 Kalinago (also known as Caribs) live in eight villages scattered in a 3,700-acre area along the country's east coast. The community's economic activity has centred on subsistence farming and boat building. Although Caribs represent only 4% of the total population, they account for 7% of the population living in poverty. Their access to health services has been less than that of the general population.
- The Elderly
- Adolescence
- Children (0-5)

Survey Results

Population according to District

District	Frequency	Percent
District 1	195	15.0
District 2	124	9.5
District 3	600	46.3
District 4	143	11.0
District 5	115	8.9
District 6	19	1.5
District 7	102	7.9
Total	**1298**	**100.00**

Demographic Data on Community

Sex	Frequency	Percent	Year
Male	634	48.8	2006
Female	664	51.2	2006
Total	**1298**	**100.0**	

Survey Results

Population According to Most Recent Oral Health Survey (DMFT)

Age	Number of Children	Percent	Year
6	426	32.8	2006
12	451	34.7	2006
15	421	32.5	2006
Total	1298	100%	2006

In the age distribution of sample there was no cross tabulation indicating number of boys verses girls.

Health and Oral Resources available in the community

Institution	Dentists		Auxiliary Personnel			
	Full Time	Part Time	Auxiliary	Assistant	Hygienist	Technician
Government	4		4	4		
Private	5	2		14	1	1
Other						
Total	9	2	4	18	1	1

Health and Oral Resources available in the community

Positions	Number	Type of Coverage
Specialist Medical Officer	14	All Levels
Matron	1	Secondary
Medical Officers	27	All Levels
Physiotherapist	2	Secondary
Senior Pharmacist	9	Secondary
Nurse Practitioner /Anaesthetist	2	Secondary
Nurse Practitioner	1	All Levels
Departmental Nurse	5	Secondary
Clinical Nurse Practitioner	1	Secondary
Ward Sister	13	Secondary
Ophthalmic Technologist	1	Secondary
Radiographer	3	Primary /Secondary
Staff Nurse	137	All Levels
X-Ray Assistant	2	Secondary
Nursing Assistant	60	All Levels
Orderly	19	Secondary
Ward Aide	48	Secondary
Environmental Health Services	19	Primary

Dental Health Services Statistic for 2008

Districts	Adults	Children	Total of Patients seen per District	Preventive		Curative		Surgical	
				Adults	Children	Adults	Children	Adults	Children
Roseau	3,738	1,750	5,488	1,158	1,664	1,031	605	2,560	1182
Portsmouth	399	937	1,336	90	400	178	651	241	283
Marigot	285	339	624	89	60	232	69	265	28
La Plaine	147	380	455		412		93		175
St. Joseph	240	343	583		697		238		231
Castle Bruce	78	346	424		316		167		208
Grand Bay	140	1320	1460		2,073		434		341
Grand Total	**5,027**	**5343**	**10,370**	**6,472**		**3,417**		**4,389**	

Oral Health Coverage Reported up to 2008

	Coverage (%)						Type of Attention					
	Estimate			Actual			Prevention		Curative		Surgical	
	MOH	SS	PRIV	MOH	SS	PRIV	MOH	SS	PRIV	MOH	SS	PRIV
0-5						15						
6-12				5,343		269						
13-19						483						
20-35				5,027		3,074						
36-60						2131						
60 T						670						
TOTAL			16,000	10,370		6,634	6,472			3,417	4,389	

Infrastructure (Number of Dental Clinics)

Institution	Comprehensive Care	Limited Treatments for Incomplete	Availability of Special Treatment (ex. Sedation)
Ministry	0	8 (limited)	General Hospital
Private	2 (Maxcillo facial Orthodontist)	5 (incomplete)	
Other (Periodically dental Therapist provide treatment in schools)			
Total	2	14	

Cost of Services

institution	Type of Service		
	Prevention	Curative	Surgical
Government	6	10	3
Private	30	35 – 55	35 - 55
		221 - 332	
Other			
Orthodontics		2600	
Denture		268 – 443	
Crown		442	

Program Developed as a result of Survey

- Launching of Teen Program in all Secondary Schools on the island

Strengths and Weaknesses of Dental Service

Strength

- Committed Staff
- Positive response from client and parents
- Ministry of Health

Weakness

- Shortage of staff
- Migration
- Ageing equipment
- Transportation
- Lack of data
- Lack of policy

CONCLUSION

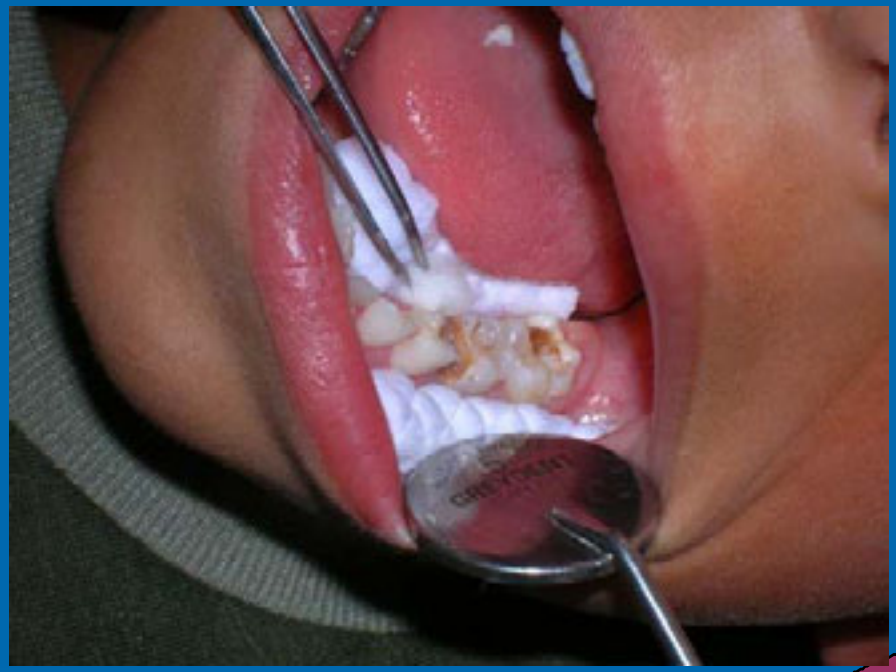
Despite all the odds, the Dental Unit of the Ministry of Health is providing excellent oral health care to the population. There is need for improvement. The department will be conducting a survey in the future to get accurate information, as recommended by PAHO.

MINISTERIO DE SALUD PÚBLICA DEL ECUADOR

Dra. Ximena Raza

Salud Bucal

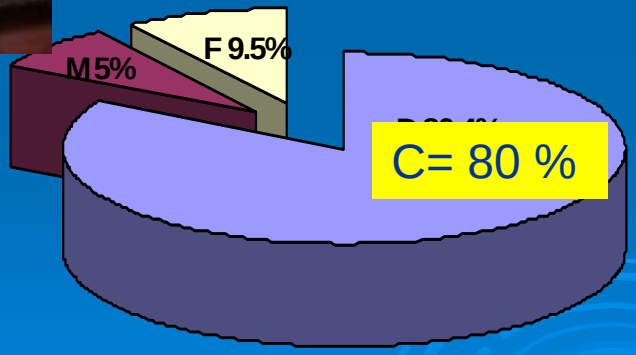
Alta prevalencia de caries no tratada



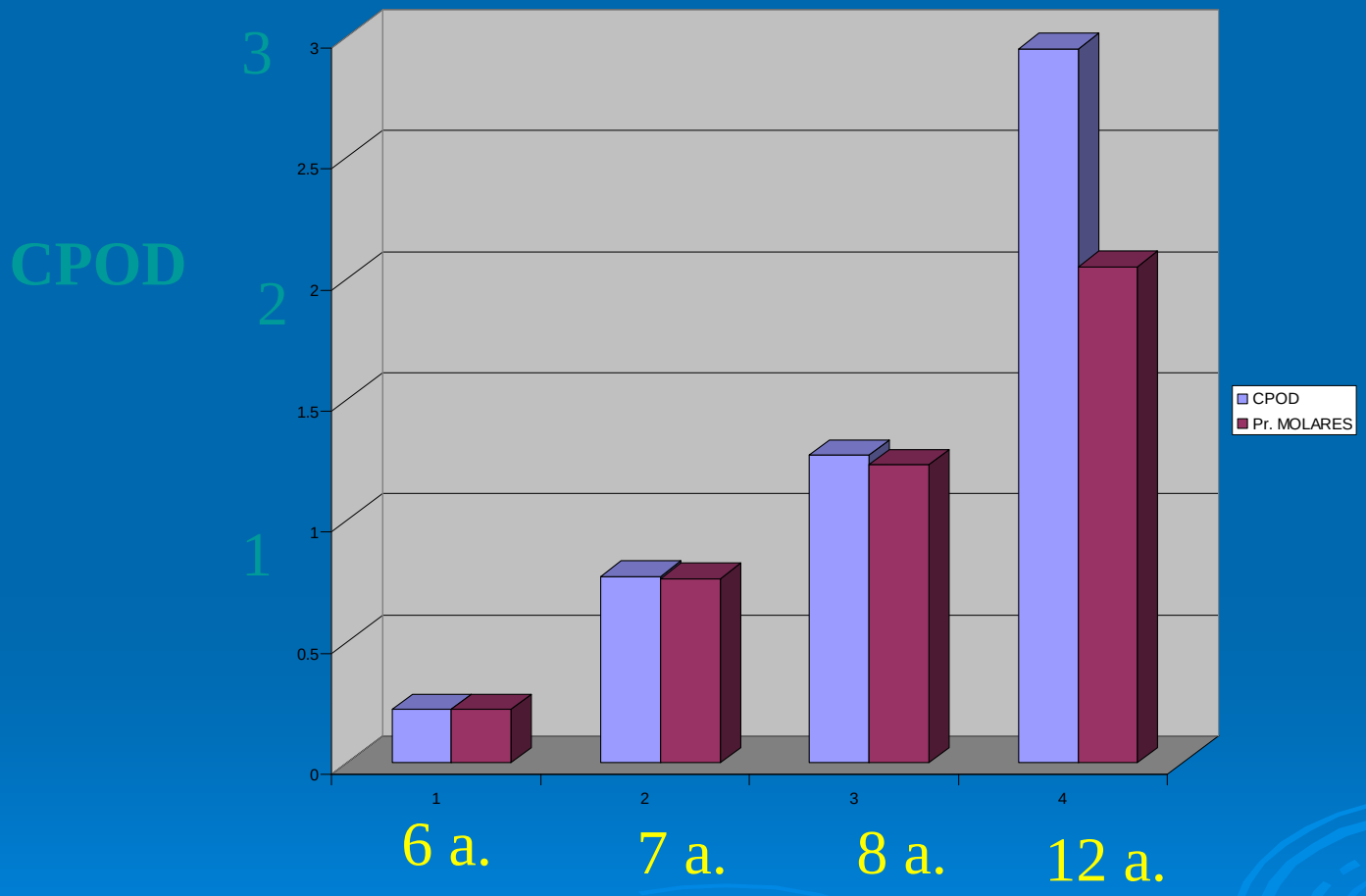
Ecuador

CPOD: 2,95

(1996)



CPOD Total y en Primeros Molares. Ecuador - 1996



DATOS DEMOGRÁFICOS SOBRE LA COMUNIDAD

EDAD	FEMENINO	MASCULINO	AÑO
Niños	2148528	2157140	2009
Adultos	4840191	4859590	2009
Total	**6988719**	**7016730**	**14005449**

Fuente: INEC 2009

Elaborado: Equipo Salud Oral

PORCENTAJE DE ÁREAS CON PROGRAMAS DE FLUORURACIÓN Y OTRAS INTERVENCIONES

Vehículo	% de población cubierta	Áreas fluoradas	Áreas cubiertas por fluoruración	Mejores prácticas
Sal	90%	-----	46,5%	*
Agua (natural)	10%	-----	87%	
Leche	-----	-----	------	-----
Otros vehículos PRAT/TRA selladores, etc	15,30%			*

Fuente: MSP

Elaborado: Equipo Salud Oral

RECURSOS HUMANOS
RECURSOS PARA LA SALUD BUCAL DISPONIBLES EN LA COMUNIDAD

Institución	Dentistas		Personal Auxiliar			
	Tiempo Completo	Tiempo Parcial	Auxiliar	Higienista	Técnico	Enfermera
Ministerios	1042	908	500	0	0	3388
Seguridad Social	0	357	320	0	0	1780
Privado	1759	4106	100	0	0	0
Otro						
Total	2801	5371	920	0	0	5168

Fuente: MSP

Elaborado: Equipo Salud Oral

COBERTURA DE SALUD BUCAL REPORTADA PARA 2008

AÑO	% DE COBERTURA						TIPO DE ATENCIÓN					
	ESTIMADA			ACTUAL			PREVENCIÓN		CURATIVA		QUIRÚRGICA	
	MSP	SS	Privado	MSP	SS	Privado	MSP	SS	Privado	MSP	SS	Privada
0-4 AÑOS	18,4			22,4			12,6			6,8		
5-9 AÑOS	25,2			28,2			19,9			9,6		
10-14 AÑOS	14,6			17,5			11,1			5,8		
15-19 AÑOS	2,6			5,8			3,1	O		4,9		
20 a más años	1,4			2,9			9,08			19,3		
EMBARAZADAS	35,1			36,4			5,5			5,2		
TOTAL	22,1			26,8			68,2			61,7		

Fuente: MSP

Elaborado: Equipo Salud Oral

INFRAESTRUCTURA
Número de Clínicas Odontológicas MSP

Institución	Atención Integral	Tratamiento limitado o incompleto	Disponibilidad de tratamientos especiales(EJ. Sedacción
Ministerio	127	1448	42
total	127	1448	42

Fuente: MSP

COSTO DE LOS SERVICIOS

Institución	Tipo de servicios		
	Prevención	Curativo	Quirúrgico
Ministerio	Gratuito	Gratuito	20
Seguridad social	0.4%		
Privada Popular	10	15	120
Privada	30	50	300
Universidad	5	10	48
Clínicas Móviles	5	10	
Clínica Universitaria	5	10	48
Otra (especificar)			

*Usar cotización de US dólar más reciente

* De lo que aporta cada afiliado, para salud es el 0.4%.

COMUNIDADES LIBRES DE CARIES

- **OBJETIVO:**
- Mejorar las condiciones de salud bucal de los escolares de 5 a 12 años de edad de escasos recursos económicos a través de acciones de promoción, educación y prevención de la salud oral para lograr **Comunidades Libres de Caries.**

COMUNIDADES LIBRES DE CARIES

- Comunidades urbanos marginales
- Comunidades indígenas
- Comunidades afroecuatorianas

COMUNIDADES LIBRES DE CARIES

- Educación
- Promoción
- Habito del cepillado dental
- Colocación de ART en niños de 6 a 9 años
- Fortalecimiento del Programa de Fluoruración de la Sal de Consumo Humano

GRACIAS

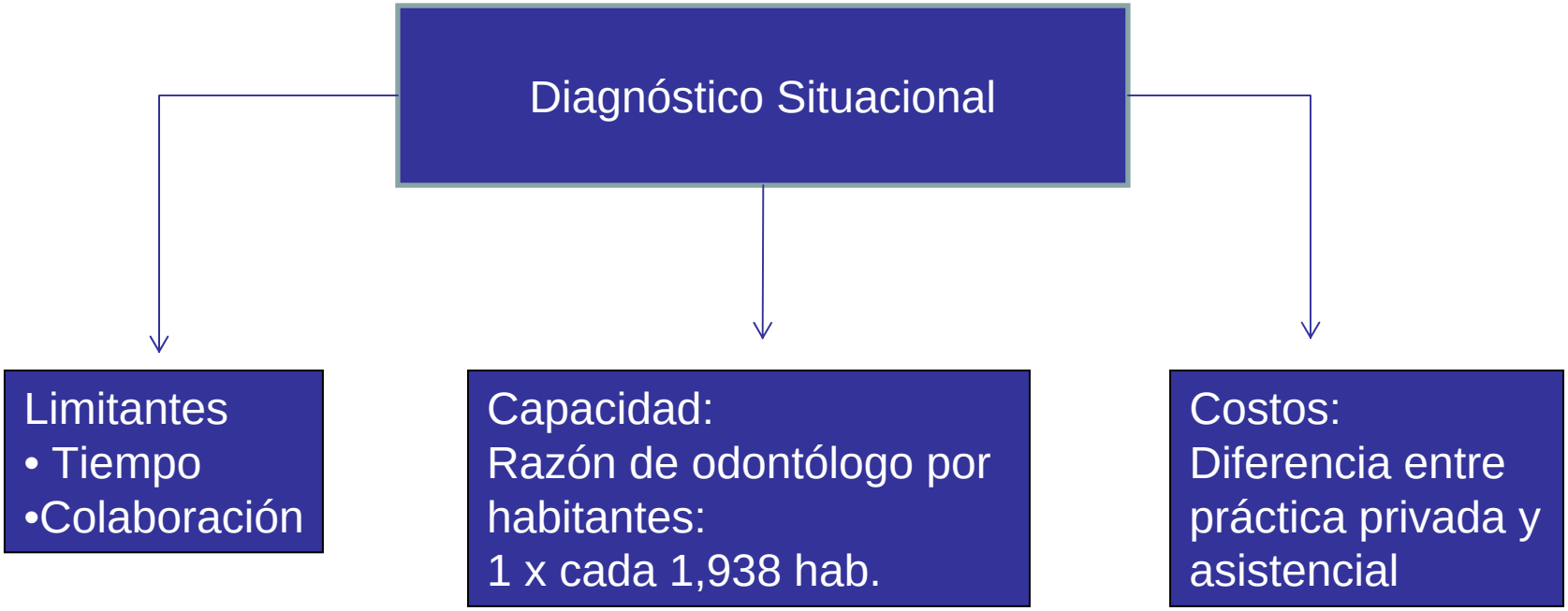
TALLER DE SALUD ORAL PARA LA REGION DE LAS AMERICAS

DELEGACION DE EL SALVADOR

DR. MANUEL JOYA
DRA. NURIA QUINTEROS
DRA. CECILIA DE DIAZ

MEXICO, 2009

INTRODUCCION



Datos Demográficos sobre la comunidad

Edad	Femenino	Masculino	Año
Niños	1,315,917	1,363,782	2009
Adultos	1,593,616	1,278,717	2009
Total	2,909,533	2,642,499	2009

Población de acuerdo a la encuesta sobre salud bucal más reciente (CPOD)

Edad	**Femenino**	**Masculino**	**Año**
Niños de 6-9 años	264,033	276,003	2009
Niños de 12 años	74,628	78,140	2009
Niños de 15 años	71,192	72,605	2009
Adultos	1,570,555	1,265,067	2009
Total	1,980,408	1,691,815	2009

Porcentaje de áreas con programas de fluoración y otras intervenciones

Vehículo	% de población cubierta	Áreas fluoradas	Áreas cubiertas por fluoración	Mejores prácticas
Sal	-	-	-	-
Agua	-	-	-	-
Leche	-	-	-	-
Otros vehículos: PRAT/TRA, selladores, etc	5%	-	-	•Implementación de Estrategia “Sonriendo desde el Vientre Materno” “Atención Odontológica al menor de 5 años” Aplicación Barniz Fluorado Atención a personas con capacidades especiales

Recursos Humanos
Recursos para la salud y salud bucal disponibles en la comunidad

Institución	Dentistas		Personal Auxiliar				
	Tiempo Completo	Tiempo Parcial	Auxiliar	Asistente	Higienista	Técnico	Enfermera
Seguridad Social	20	164	-	78	76	-	-
Privado	2,500	729	-	150	-	187	10
Otro	365	247	-	12	-	-	-
Total	**2,865**	**1,160**		**90**	**76**	187	10

Cobertura de salud bucal reportada para 2008

Año	% de cobertura						Tipo de atención					
	Estimada			Actual			Prevención		Curativa		Quirúrgica	
	MSP	SS	Priv	MSP	SS	Priv	MSP	SS	Priv	MSP	SS	Priv
0-5	20%	1%	0.2%	6.68%	DND*	DND *	5.09 %		*	1.53%		*
6-12	35%	1%	1%	30.20 %	DND*	DND*	21.33 %		*	12.24 %		*
13-19	15%	-	0.6%	30.10 %	DND*	DND*	18.57 %		*	13.12 %		*
20-35	7%	3%	0.7%	14%	DND*	DND*	3.0%		*	12%		*
36-60	6%	2%	0.3%	13.78 %	DND*	DND*	2.28 %		*	9.18%		*
60 más	5%	2%	0.2%	5.24%	DND*	DND*	0.42 %		*	1.24%		*
Total	88%	9%	3%	100%	DND*	DND*	50.69 %	47%	95%	49.31 %	50%	2%

*Datos no disponibles

Infraestructura
Número de Clínicas Odontológicas

Institución	Atención Integral	Tratamiento limitado o incompleto	Disponibilidad de tratamientos especiales (Ej. Sedación)
Ministerio	-	198	5
Servicio Social	129	-	-
Privado	2,360	140	25
Universidad	300	-	16
Clínicas Móviles	17	-	-
Clínicas basadas en estudiantes	-	-	-
Otras (especificar)	623	-	-
Total	3,429	462	46

Costo de Servicios

Institución	Tipo de Servicios		
	Prevención	**Curativo**	**Quirúrgico**
Ministerio	Gratuito *	Gratuito *	Gratuito *
Servicio Social	Cotización de empleados	Cotización de empleados	Cotización de empleados
Privado	$25.00	$100.00	$70.00
Universidad	$1.71 – $2.50	$4.00 - $35	$4.00 - $15.00
Clínicas Móviles	Gratuito *	Gratuito *	Gratuito *
Clínicas basadas en estudiantes	No Aplica	$30.00	$35.00
Otras (especificar)	$12.00	$15.00	$20.00
Total	-		

* CUOTA VOLUNTARIA

PROPUESTA

- Atención odontológica de primer nivel a niños y niñas 0 a 9 años de la comunidad Roble Viroleño del municipio de San Juan Nonualco, departamento de La Paz

ORAL HEALTH WORKSHOP FOR THE REGION OF THE AMERICAS

By Dr. Crofton O. Stroud

Picture of St. George's - the Capital of Grenada

DEMOGRAPHIC DATA ON COMMUNITY

AGE	FEMALE	MALE	YEAR
Children	15,439	15,915	2008
Adults	35.150	34,079	2008
Total	50,589	49,994	

POPULATION ACCORDING TO THE MOST RECENT ORAL HEALTH SURVEY (DMFT) 2000

AGE	FEMALE	MALE	YEAR
Children Ages (6-9)	5,749	5,798	2000
Children Age 12	6,709	6,837	2000
Children Age 15	5,834	6,077	2000
Adults	27,696	26,190	2000
Total	45,988	44,902	___

% OF AREAS WITH FLUORIDATION PROGRAMS AND OTHER INTERVENTIONS

Vehicle	% of population covered	Fluoridated Areas	Areas covered by fluoridation	Best Practices
Salt	None	None	None	
Water	None	None	None	
Milk	None	None	None	
Other vehicles: ART/Sealants, etc.	<15%			

HUMAN RESOURCE

INSTITUTION	DENTISTS		AUXILIARY PERSONNEL				
	FULL TIME	PART TIME	AUXILIARY	ASSISTANT	HYGIENIST	TECHNICIAN	NURSE
SOCIAL SECURITY		8		6		1	4
PRIVATE	6	8		6			
OTHER							
TOTAL	6	16		12		1	4

ORAL HEALTH COVERAGE REPORTED UP TO 2008

Year	Coverage (%)						Type of Attention					
	Estimated			Actual			Prevention		Curative		Surgical	
	MOH	SS	Priv	MOH	SS	Pri	MOH	SS	Priv	MOH	SS	Priv
6-12	8	10			N/A							
13-19	10	11			N/A							
20-35	10	13			N/A							
36-60	5	13			N/A							
60+	5	8			N/A							
Total	40	60			N/A							

INFRASTRUCTURE – NUMBER OF DENTAL CLINICS

INSTITUTION	COMPREHENSIVE CARE	LIMITED TREATMENTS OR INCOMPLETE	AVAILABILITY OF SPECIAL TREATMENTS (EX. SEDATION)
Ministry	8		
Social Service			
Private	8		
University			
Mobile Clinics			
School-Based Clinics		2	
Other (specify)			
Total	16	2	

COST OF SERVICES

Institution	Type of Service		
	Prevention	Curative	Surgical
Ministry	$2.00	$2.00	$2.00
Social Security			
Private	$20.00 – 50.00	$20.00 – 50.00	$30.00 – 50.00
University			
Mobile Clinics			
School Clinics	0	0	0
Other (specify)			

PRESENTACIÓN DE GUATEMALA

TALLER DE SALUD BUCAL PARA LAS AMÉRICAS

México, D. F., 23 al 25 de abril de 2009

DATOS DE GUATEMALA

- Guatemala es un país centroamericano con una extensión de 108,889 Km^2, que cuenta con una población de 12,229,888 habitantes, de ellos el 51% son mujeres y el 49% son hombres. Es importante hacer notar que la población está étnicamente diferenciada en tres grupos: el indígena, el ladino y el garífuna.

GRUPOS PRIORIZADOS

- Según datos del Banco Mundial se estimaba que para 2006 el 50% de la población guatemalteca caía por debajo de la línea de pobreza. Sin embargo, con la generalización de la crisis económica, para 2008 la pobreza ha crecido hasta alcanzar el 56%. Es decir, una cantidad cercana a los 6,750,000 guatemaltecos son pobres.
  El Banco Mundial cataloga como pobres a las personas que viven con menos de US$ 2.00 al día. Quienes viven con menos de US$ 1.00 al día se estima que forman parte de la pobreza extrema.

EXCLUSIÓN SOCIAL

Estas personas pobres habitan en las áreas rurales del país y sufren de tres problemas que hacen difícil su acceso a los servicios de salud en general y de salud bucal en lo específico.

Estos problemas son:

a. Falta de acceso físico.
b. Falta de acceso económico.
c. Falta de acceso cultural.

GRUPOS PRIORIZADOS

- Es obvio que el Estado de Guatemala actualmente no puede dar respuesta a la demanda de la población. Por ello, la actual administración como una política oficial se ha propuesto atender prioritariamente a 130 de los 334 municipios del país.

GRUPOS PRIORIZADOS

- Programa Nacional de Salud Bucodental, del Ministerio de Salud Pública y Asistencia Social, ha priorizado la atención de salud bucal a la población escolar que asiste a los establecimientos públicos de educación primaria en los 130 mencionados municipios.
- Asimismo, mujeres embarazadas que asisten a los Servicios de Salud del MSPAS.

Clínicas dentales en servicios del MSPAS

- 916 PUESTO DE SALUD: 0 clínica dental
- 273 CENTRO DE SALUD: 56 clínicas dentales
- 44 HOSPITALES: 30 clínicas dentales

- 1233 servicios de salud: 86 clínicas dentales

Odontólogos empleados por el MSPAS

- Estos servicios de salud son cubiertos por 136 odontólogos que son empleados por el Ministerio de Salud Pública y Asistencia Social. 63 de ellos se encuentran en los Hospitales y 73 en los Centros de Salud.

Odontólogos fuera del MSPAS

- A estos datos hay que agregar que 100 odontólogos están contratados por el Instituto Guatemalteco de Seguridad Social (IGSS), entidad estatal de carácter autónomo que brinda atención en salud a los trabajadores afiliados a su régimen.
- Actualmente existen alrededor de 3,400 profesionales de la odontología en el país. La mayor parte de ellos labora en los centros urbanos.

CPO en escolares de 12 y 15 años Guatemala, 2002

- **CPOD-12 = 5.18**
- **CPOD-15 = 6.88**
- **CPOD hombres = 5.47**
- **CPOD mujeres = 5.93**
- **CPOT = 5.68**

PRESUPUESTO ASIGNADO A SALUD BUCAL, EN EL AÑO 2005

ÁREA DE SALUD	PRESUPUESTO EJECUTADO (US$)	PRESUPUESTO PARA SALUD BUCAL (US$)	PORCENTAJE
Alta Verapaz	3,131,662.70	5,275.15	0.17%
Escuintla	1,693,843.80	1,365.00	0.08%
Guatemala	2,610,167.80	12,803.44	0.49%
Jalapa	963,038.80	2,272.50	0.24%
Sacatepéquez	552,981.25	2,495.75	0.45%
Santa Rosa	1,391,752.70	2,498.75	0.18%
Sololá	985,224.50	193.00	0.02%
Petén Sur Oriental	2,792,569.70	2,194.50	0.08%
Suchitepéquez	1,122,413.50	2,722.86	0.24%