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| **Title of Symposium: Closing the tap and not mopping the floor: Promoting oral health and reducing oral health inequalities** |
| **General Objective**  Globally, untreated tooth decay is the most prevalent non-communicable disease. Collectively, six oral health conditions affect half of the global population. This public health burden is shared disproportionally by socially disadvantaged individuals and societies. Unhealthy diet (high sugar consumption), tobacco use, symptomatic and irregular dental attendance, poor oral hygiene and alcohol use are key behavioural determinants of oral health. Social and commercial determinants of health play key role in determining population levels of health behaviours, and when ignored, have limited capacity in addressing public health challenges posed by poor oral health.  In this symposium, we will highlight research on the role of social conditions in oral health behaviours from three countries (Australia, India and New Zealand) using diverse and innovative methodological approaches (mixed methods, evidence synthesis, camera and GPS tracking, and multilevel modelling). We discuss implications of our findings for informing population-level prevention strategies and oral health promotion programs for preventing oral diseases and reducing social inequalities in oral health.  **5 minutes: Introduction**: Dr. Ankur Singh (Early career researcher, University of Melbourne, Australia)  **10 minutes: Sugar consumption in Australia – Applying mixed methodology to identify appropriate prevention strategies**: Dr. Adyya Gupta (Ph.D. Candidate, University of Wollongong, Australia)  **10 minutes: Promoting oral health in New Zealand: Tackling commercial determinants of oral health among children** Dr. Moira Smith (Deputy Director  HePPRU: Health Promotion and Policy Research Unit, University of Otago, New Zealand)  **10 minutes: Video presentations on oral health promotion practices**  **10 minutes: Quantifying role of contexts in different types of tobacco use in India: Benefits of multilevel modelling**: Dr. Ankur Singh (Early career researcher, University of Melbourne, Australia)  **45 minutes: Panel discussion – Policy and community action to reduce oral health inequalities**  **Proposed format of the session:** Individual oral presentations and panel discussion for audience participation  **Conference theme and/or subthemes addressed**  Ensure health equity throughout the life course, within and among countries, making each member of the global society an empowered lifelong learner. |

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| **Sugar consumption in Australia – Applying mixed methodology to identify appropriate prevention strategies** |
| **General Objective**  Background: Understanding social determinants of sugar consumption is the first and most critical step towards identifying potential prevention strategies to tackle this problem. Thus, the aim of this study was to provide a comprehensive understanding on the factors influencing high sugar intake among Australian adults using mixed methods.  Methods: Evidence from a systematic review, a quantitative study, and a qualitative study was collated to prepare a policy statement on responses to reduce free sugar intake at the population level. Systematic review examined factors influencing knowledge and attitudes towards sugar intake and, assessed the extent to which knowledge and attitude influences sugar intake. Quantitative investigation identified characteristics of Australian adults exceeding the World Health Organization’s free sugar (FS) intake recommendations of <10% and compared the sources of FS among those exceeding (high FS consumers) and complying (low FS consumers). The qualitative study designed to explore how Australian adults conceptualise and negotiate with their sugar intake.  Results: We discuss five key actions to reduce population levels of free sugar intake tailored to the Australian context. These are prioritising health in trade agreements and policy; introducing a healthy levy and promoting food reformulation; regulating advertising and improving labelling; strengthening the current dietary guidelines; and encouraging healthy choices. These strategies are informed by the global scientific evidence on the effectiveness of a range of policy responses to reduce high sugar intake at the population level.  Conclusions: Collectively, these studies suggest that the determinants of high sugar consumption are many and that high sugar is a population problem. Therefore, a range of strategies is needed across the spectrum of the social determinants to tackle the population levels of high sugar intake.  **Proposed format of the session:** Oral Presentation  **Conference theme and/or subthemes addressed**  Ensure health equity throughout the life course, within and among countries, making each member of the global society an empowered lifelong learner. |

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| **Promoting oral health in New Zealand: Tackling commercial determinants of oral health among children** |
| **General Objective**  Background: Oral diseases such as dental caries and periodontal diseases have high prevalence and occur more so among socially disadvantaged, despite being largely preventable. Health policies that create supportive environments can reduce population burden of oral diseases without stigmatizing and blaming individuals for poor oral health behaviours, a key drawback of individually-focussed interventions.  Methods: Using innovative data collection methods (wearable camera and GPS data), we studied the children’s exposure to sugar sweetened beverages (SSBs) and alcohol marketing among children.  Results: Findings showed that SSBs are typical feature of everyday environments of children. While schools and home presented with a higher availability of water and unflavoured milk, recreational venues and food retail outlets were dominated with SSBs. Similar results were identified for alcohol marketing.  Conclusions: Children are constantly exposed to health damaging environments and excessive marketing from alcohol and SSB industries. Urgent action is needed to alter environments through strict policy and regulations preventing children’s exposure to SSB and alcohol promoting environments.  **Proposed format of the session**  Oral presentation  **Conference theme and/or subthemes addressed**   1. Ensure health equity throughout the life course, within and among countries, making each member of the global society an empowered lifelong learner. 2. Make all urban and other habitats inclusive, safe, resilient and sustainable and conducive to health and wellbeing |

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| **Quantifying role of contexts in different types of tobacco use in India: Benefits of multilevel modelling** |
| **General Objective**  **Introduction:** Tobacco kills about a million Indians every year and is a key behavioural determinant for oral cancer and periodontal disease. Due to the widespread use of smokeless tobacco, different patterns of tobacco use appear in Indian context. Individual-level behavioural risk factors are largely shaped by socio-environmental factors unique to contexts. This study aimed to quantify the share of individual variation of different types of tobacco use that exists at village and city ward level.  **Methods:** Data on 69,030 adults from the Global Adult Tobacco Survey 2009-2010 was analyzed. Multilevel multivariable logistic regression models were fitted to quantify the share of variance for different types of tobacco use (cigarette smoking, bidi smoking, smokeless tobacco use and dual use (smoking and smokeless tobacco use). Unadjusted and adjusted measures of median odds ratio (MOR) and intra-class coefficients (ICC) were estimated from models to estimate the share of variance at the village and city ward level. Individual-level covariates included in the models were age, sex, individual wealth, educational attainment, and employment status. Area of residence (urban/rural) and region were also included as covariates in the models.  **Results:** After adjusting for all individual covariates, the MOR for any tobacco use at city ward/village level was 2.01 (95% CI: 1.95, 2.08). For different patterns of tobacco use, MOR ranged from 2.23 (95% CI: 2.15, 2.32) for SLT use to 2.84 (95% CI: 2.64, 3.03) for bidi smoking. The ICC at the same geographic level for any tobacco use was 14.1%. For different patterns of tobacco use, the ICC ranged from 17.8% for smokeless tobacco use to 26.6% for bidi use.  **Conclusion:** There is a considerable share of inter-individual variation in tobacco use at the city ward and village level in India after accounting for compositional characteristics at the individual level. Local areas can serve as an important point of intervention for tobacco control policies.  **Proposed format of the session**  Oral Presentation  **Conference theme and/or subthemes addressed**   1. Ensure health equity throughout the life course, within and among countries, making each member of the global society an empowered lifelong learner. 2. Make all urban and other habitats inclusive, safe, resilient and sustainable and conducive to health and wellbeing |