



SASKATCHEWAN

ORAL HEALTH
COALITION

Updated website by Objectified Software <http://www.saskohc.ca/>

SOHC Newsletter
April 2018

Through a unified voice, the Saskatchewan Oral Health Coalition works collaboratively with dedicated partners to improve the oral and overall health of Saskatchewan residents. As an inter-disciplinary group, we strive to identify and address the needs of vulnerable populations, and by using evidence based decision making, promote advocacy, education, prevention and standards.

Save the date for **SOHC Meeting, Monday May 14, 2018 Saskatoon**
Please see page 1 and page 15 for more information

In This Issue: Page

SOHC Presents: Dr. Sheelah McLean	1
April is Oral Health Month	2
Happy World Oral Health Day	2
New liquid treatment stops tooth decay	3
Fluoride study reviews	3
Thyroid functioning in Canadian population	4
Do you need antibiotics?	4
Connecting Oral health and food environments	5
CBC Report on Dental benefit and Indigenous Children	6
Microbiome associated with severe caries in Canadian First Nations children	7
Health Equity Report 2017	7
Restricting marketing of unhealthy food and beverages to children	8
Maclean's magazine articles on dental care	9
Issues of poverty and getting dental care: One man speaks out	10
Canadian Community Health Survey on tobacco smoke	11
Research article: Periodontitis and the effects of the liver	12
Behavioral impacts of school-based oral health education among children	12
Nutritional and Oral Health	13
Eating Right	14
Save the Date for SOHC Meeting	15
Becoming a member	15

SOHC Presents May 14, 2018

"Social Justice in our Everyday actions"
Dr. Sheelah McLean



Sheelah McLean has a PhD in Anti-Racist education from the University of Saskatchewan. She has worked as a high school teacher for the SPSD for 25 years and taught both graduate and undergraduate courses in the College of Education for 15 years. Sheelah is also an organizer with the Idle No More network. As an educator, scholar and community organizer, Sheelah's work has focused on research projects and actions that address inequality, particularly focusing on the legacy of oppression experienced by Indigenous Peoples within a white settler society. Sheelah has received many honors for her work in social justice including the University of Saskatchewan's Alumni of Influence Award (2013), the Council of Canadians Activist of the Year Award (2014) and the Carol Gellar Human Rights Award (2015).

SOHC Education Day and AGM

Monday, May 14, 2018
8:30am – 5:00 pm
Edelweiss Hall - German Cultural Centre
160 Cartwright Street East
S7T 1B1 Saskatoon, SK

Lunch will be provided.
Please RSVP by May 1, 2018 to sohcadmin@saskohc.ca

(This is required to plan lunch. Let us know if any specific dietary requirements are needed.)
"Please feel free to attend as travel permits"

This Meeting will be Live Streamed



If you are unable to attend in person, please log onto www.saskohc.ca under **SOHC Meeting Live** to join the meeting live streamed.

True compassion means not only feeling another's pain but also being moved to help relieve it" - Daniel Goldman

April 2018 is National Oral Health Month

Statement From: [Public Health Agency of Canada](#)

April is Oral Health Month, a chance for all Canadians to take extra care of our oral health and recognize its often understated impact on our overall well-being. As well, April 7 to 13 is National Dental Hygienists Week, a time to celebrate these dedicated professionals who help to keep our mouths healthy.

The year's theme is *Think Mouth, Think Health*. Ranging from tooth decay and gum disease to oral cancer, oral diseases are among the most common illnesses here in Canada and worldwide. Yet many of them are preventable – daily brushing and flossing as well as regular visits to an oral health professional help maintain a healthy mouth. The food we eat also plays a role: a healthy, balanced diet reduces the risk of oral health issues.

Although these steps may seem easy for some, making healthy choices can be difficult for many Canadians. Unhealthy, processed foods high in sugar are sometimes the only option for families with limited time or budgets.

Our government understands these pressures – that's why we've launched our [Healthy Eating Strategy](#) to help make the healthier choice the easier choice. I urge you all to take a moment to learn more about [oral health](#), including how to keep your mouth healthy and prevent disease. You can show appreciation for Canada's dental hygienists by using #NDHW18 on social media.

This April, *Think Mouth, Think Health!*

The Honourable Ginette Petitpas Taylor, P.C., M.P.
Minister of Health

<https://www.canada.ca/en/public-health/news/2018/04/national-oral-health-month--april-2018.html>

Be part of the Global Movement

It's almost time to 'Say Ahh' and tell the world to 'Think Mouth, Think Health'. Don't miss a chance to celebrate World Oral Health Day (WOHD) this 20 March.

Say Ahh: Think Mouth, Think Health

A healthy mouth and a healthy body go hand in hand. The 2018 WOHD campaign encourages people to make the connection between their oral health and their general health and well-being, and prompts them to recognize the impact that one has on the other

How to get involved?

- A range of multi-lingual resources are available to help you organize a successful WOHD campaign:
- Download and print the WOHD posters 'at home', 'at the dentist', 'for children':
- [Send the oral health professional advertisement to a local magazine](#)
- Can't decide on one poster? [Make your own with the poster web app](#)
- [Distribute copies of the WOHD brochure at your dental practice](#)
- [Use the advocacy guide to help you demand 'oral health in all policies'](#)
- [Share the social media assets and get social](#)
- Organizing an event? [Submit it to the global map and be eligible for a WOHD award](#)
- [Share the WOHD video](#)

**Changing lives
One mouth at a
time**



Happy World Oral Health Day was on March 20

- What you need to know
- With WOHD around the corner, here is a reminder of this year's key messages:
- Oral health is much more than a nice smile
- Oral health and general health have a close two-way relationship
- The mouth cannot be considered in isolation from the rest of the body
- Most oral diseases share the same social determinants and some common risk factors with other diseases
- Celebrate WOHD on 20 March and be part of the global movement
- Find out more about their meaning and how to promote them in the [WOHD Campaign Toolkit](#).

Video Link https://youtu.be/dXTgoVb_tIM

<https://www.fdiworlddental.org/news/20180306/happy-world-oral-health-day-celebrate-on-20-march-and-be-part-of-the-global-movement>

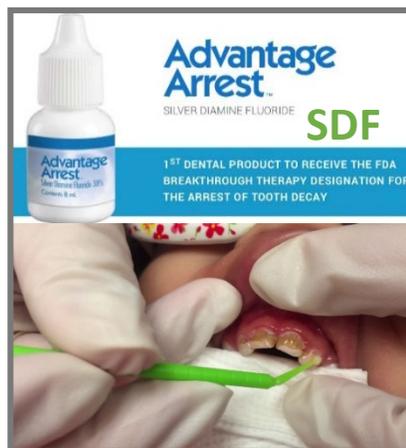
<https://www.youtube.com/watch?v=9zbRAbWyk9k>

Ellen DeGeneres debates flossing (funny video)

New Liquid Treatment Stops Tooth Decay Painlessly

Silver Diamine Fluoride (SDF) has been used for years in Japan, Australia and Argentina. Recently, it has been approved in Canada, under the product name Advantage Arrest. SDF can prevent, fight and protect against cavities.

Dr. Katherine Roche, the Edmonton dentist, has tried it on about a dozen patients so far. "You just paint it on like a little bit of varnish ... no freezing and drilling," said Roche. She believes it "really revolutionizes the care" for children, seniors and other patients who don't tolerate dental procedures well. SDF reduces the risk of developing new cavities throughout the mouth due to what's called the "zombie effect," she explained. "What happens is bacteria will take up the silver ions and they will go visit their other bacteria friends



and they spread that silver ion around ... and kill those bacteria as well." Additionally, it is less costly than traditional fillings. At her clinic, a SDF treatment is billed per unit of time. She can treat an entire mouth within 15 minutes, which would not cost above \$100 compared to a filling that cost almost \$200. A second treatment is recommended six months following the first. However, the main drawback of SDF is that it stains the tooth a dark brown/black. In addition,

It isn't the best option for advanced decay, Roche says. Still, Roche says SDF offers a better option for young children – who often can't tolerate extensive dental work – than giving them a general anesthetic for traditional fillings. Moreover, any staining that occurs in their baby teeth will not affect their adult teeth.

SDF "is the easiest, simplest way to stop dental decay that has already started," said Benoit Soucy, the Director of clinical and scientific affairs at the Canadian Dental Association. But, he added SDF is not for everyone – especially "anybody who is concerned about the appearance of their smile...It will definitely not replace fillings" Soucy said. "This is an additional tool that helps to treat certain, very specific situations that had no good options until now."

Read More [Here](#)

www.kidsteethandbraces.com for good videos on how to do.



About Fluoride Science

Fluoridescience.org is dedicated to balanced reviews of fluoride studies and communicating the qualities and summaries of the scientific evidence for professional communities that may engage in patient care and/or public health services. The primary goal is to provide them with the best information available regarding the use of fluoride by offering topic summaries, critical appraisals, commentaries that are developed and reviewed by a group of experts, and interview videos of prominent scientists in the field.

Fluoride Science has reviewed a few recently published articles and made the Critical Appraisals available at its Website www.fluoridescience.org

Prenatal Fluoride Exposure and Cognitive Outcomes in Children at 4 and 6-12 Years of Age in Mexico

The study found:

Significant correlation between GCI and IQ scores.

No significant correlation between prenatal creatinine-adjusted urinary fluoride and offspring's specific-gravity adjusted urinary fluoride levels at 6-12 years of age.

Prenatal creatinine-adjusted urinary fluoride level and GCI at 4 years of age showed mild linear relationship: 0.5mg/L increase in prenatal urinary fluoride was associated with 3.15-point drop in GCI scores ($p=0.01$, $N=287$).

Prenatal urinary fluoride level and IQ at 6-12 years of age showed mild curvilinear relationship: 1) no clear association between prenatal urinary fluoride and IQ scores below approximately 0.8mg/L urinary fluoride levels, and 2) a negative association above prenatal urinary fluoride 0.8mg/L. The authors found 0.5 mg/L increase in prenatal urinary fluoride was associated with -2.5 points in IQ scores ($p=0.01$, $N=211$).

Sensitivity analyses conducted for the subsets of data ($N<200$) indicated the following:

The negative associations between prenatal urinary fluoride and GCI or IQ persisted with further adjustment for other potential confounders (family possession, maternal bone lead and blood mercury levels). The effect estimates were attenuated when family possession (SES proxy) and maternal blood mercury values were adjusted in the models relative to unadjusted models, while all of the effect estimates were higher in the subset of subjects with available data of SES, maternal bone lead and blood mercury levels.

There was no clear, statistically significant, association between contemporaneous children's urinary fluoride and IQ at 6-12 years of age either unadjusted or adjusted for maternal urinary fluoride during pregnancy.

<http://fluoridescience.org/appraisals/prenatal-fluoride-exposure-cognitive-outcomes-children-4-6-12-years-age-mexico/>

Please email fluoridescience@gmail.com or hiida@rpcn.org if you have any question, comment, and or suggestion on Fluoride Science

Fluoride exposure and indicators of thyroid functioning in the Canadian population: implications for community water fluoridation

Both thyroid outcome and fluoride exposure were measured at individual level as follows:

Fluoride exposure measures

Fluoride level in spot urine sample

Fluoride concentration in primary drinking water (mg/L) + self-report on residential history (at least 3 years of consecutive residence)

Self-reported use of fluoride containing toothpaste and or mouthwash as well as history of fluoride treatment at dental office

Thyroid outcome measures

Self-reported diagnosis of thyroid condition (yes/no)

Serum thyroid stimulating hormone (TSH) level (low/normal/high)

No significant association was found between fluoride exposure measured in urine, and tap water samples and self-reported diagnosis of a thyroid condition or altered (low or high) TSH levels. Fluoride exposure, in a time and place where multiple sources of fluoride including community water fluoridation exist, is not associated with impaired thyroid functioning in a representative sample of the Canadian population.

Canada has fluoridation program guidelines that are similar to the US, and the findings are relevant to the US and other countries with similar populations and CWF schemes. <http://fluoridescience.org/appraisals/fluoride-exposure-indicators-thyroid-functioning-canadian-population-implications-community-water-fluoridation/>

University of Toronto <https://dentistry.library.utoronto.ca/content/cdhsru-reports>

Community Dental Health Services Research Unit (CDHSRU) Reports

The Community Dental Health Services Research Unit (CDHSRU) was funded by the Ontario Ministry of Health and Long-Term Care through its Health Systems Linked Research Unit program from 1991 to 2008. It was led by Dr. David Locker at the Faculty of Dentistry, University of Toronto, and worked in partnership with the Ministry and the dental divisions of a number of Ontario Public Health Units/Departments to undertake research concerning dental and oral diseases in the Ontario population, their outcomes in terms of their impact on systemic health and the quality of life, and access to appropriate and effective oral health services. It also conducted research to evaluate the school and community-based dental services offered by Public Health Units/Departments, supported other provincial and federal agencies in regards to various policy issues, and forged collaborative links with dental and other investigators across Canada, the United States, and United Kingdom.



Canadian Institute for Health Information

Better data. Better decisions. Healthier Canadians.

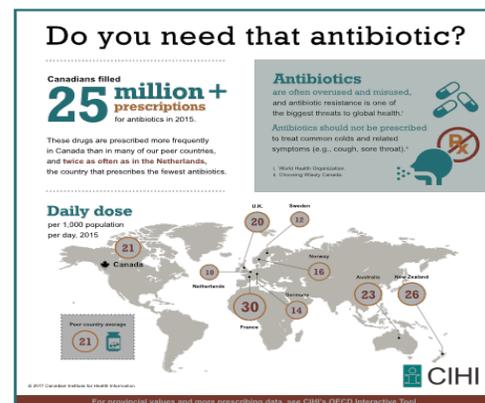
Measuring pan-Canadian access to Mental Health and addictions services, and to home community Health care.

<https://www.cihi.ca/en/national-health-expenditure-trends>

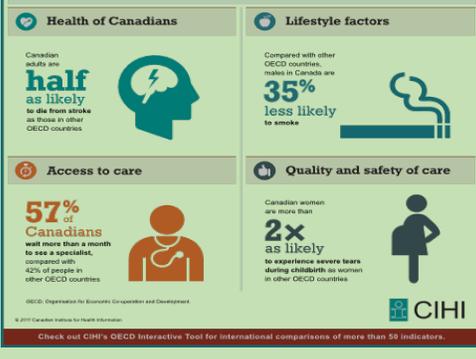
Do you need that antibiotic?

<https://www.cihi.ca/en/infograph-ic-do-you-need-that-antibiotic>

<https://www.cihi.ca/en/antibiotic-s-prescribed-more-often-in-canada-than-in-other-oecd-countries>



How does Canada compare internationally on health care?



Antibiotics prescribed more often in Canada than in other OECD countries **November 10, 2017** — In 2015, more than 25 million courses of antibiotics were prescribed in the country — the equivalent of almost 1 prescription for every Canadian age 20 to 69. According to new data from the Canadian Institute for Health Information (CIHI), antibiotics are prescribed more frequently in Canada than in other Organization for Economic Co-operation and Development (OECD) countries.

The data also reveals that

Every day, about 20 out of 1,000 Canadians take a dose of antibiotics.

Canadian clinicians prescribe 33% more antibiotics than clinicians in countries like the Netherlands, Sweden and Germany.

In all OECD countries, 3 out of 5 antibiotic prescriptions were for diagnoses considered inappropriate such as common colds and related symptoms (e.g., sore throat, cough).

Government of Canada

Commentary – What about the mouth? Connecting oral health and food environments

Commentary by the Office of the Chief Dental Officer of Canada

Oral health is a fundamental component of our overall health and well-being

Oral health includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex.

Tooth decay to gum disease to oral cancer are the most common spread diseases in Canada and worldwide.

Oral diseases share common risk factors and have causality or clinical exacerbation relationships with some of the leading chronic diseases: diabetes, cardiovascular diseases, chronic respiratory diseases and cancer. Some of the common risk factors are unhealthy diet (particularly those high in added sugars), smoking, alcohol abuse, and poor oral hygiene.

Considering that what we eat and drink goes through the mouth first, the dietary choices that we make—as influenced by food access and availability, food promotion and pricing and food labelling—can have direct implications on our oral health. As highlighted by Vanderlee and L'Abbé in the September issue of this journal,⁵ dietary choices go beyond the individuals.

Even though we can argue that we all have a certain degree of responsibility over the food choices we make, we need supporting food environments that contribute to make the healthy options—fresh, nutrient-dense foods—attractive, available and easily accessible, at reasonable prices.

Globally oral health has not improved in the last 25 years, and oral conditions still has remained a major public health challenge in 2015.

As part of Canada's Healthy Eating Strategy,⁶ Health Canada has the vision to “Make the healthier choice the easier choice for all Canadians.” The Office of the Chief Dental Officer (OCDO) of the Public Health Agency of Canada, along with the Federal-Provincial-Territorial Dental Directors Working Group (the individuals appointed as the senior government authority in oral health in each of Canada's provinces and territories) share that vision.



The most prevalent condition worldwide

A lot still needs to be accomplished to achieve that goal. Health Canada notes that many food environments make it difficult for Canadians to make healthy choices due to the following:⁷ • Widespread availability of inexpensive foods and beverages high in calories, fat, sodium and sugars; • Marketing of foods is very powerful and children are particularly vulnerable; • There is a constant flow of changing (and often conflicting) messages; • Canadians face challenges in understanding and using nutrition information; • Some sub-populations in Canada face challenges in accessing nutritious foods.

The sugary and/or fatty low-cost and nutrient-poor foods and beverages are still too often the tempting and readily available options in so many places.

Sugar consumption is the most obvious example when we talk about effects on oral health. We all know that sugar is not good for our teeth—the primary risk factor for dental caries (or tooth decay) is a diet high in added sugars.

In fact, there is a consistent association in scientific literature between tooth decay and higher sugar consumption. We have a clear understanding of the biological mechanism that causes tooth decay: sugar acts as a substrate for oral bacteria, leading to the production of demineralizing acids.^{8,9} Some research suggests that modifying our diet, and more specifically our sugar consumption, could potentially be more effective to minimize the risk of developing tooth decay than even fluoride application.

Soft drinks, sports and energy drinks often have large amounts of sugar and calories—a can of soft drink contains the equivalent of 10 teaspoons of sugar.¹⁰ Sugar-sweetened beverages (SSBs) are the largest contributor of sugars in Canadians' diet, especially among teenagers and young adults. Regular carbonated soft drinks make up the largest portion of SSBs consumed by these two groups.

Greater consumption of SSBs is associated with increased risk of obesity, type 2 diabetes, cardiovascular disease, kidney diseases, osteoporosis, some cancers, and tooth decay.

Tooth decay affects 57% of Canadian children aged 6 to 11 years and 96% of Canadian adults over their life time.² This prevalence increases to 94% in First Nations and 93% in Inuit children and > 99% of First Nations and Inuit adults.^{12,13} Consequences of untreated tooth decay—a fully preventable disease—may include pain, discomfort, infection, abscesses, reduced ability to speak, to socialize or eat, time lost from work and school, it can also lead to lower self-esteem and confidence and potential discrimination (based on dental appearance). It is an economic burden on the health care system (2nd largest health care expenditures after medications/drugs—oral health expenditures are greater than 13 billion annually). In Canada, dental procedures are the leading cause of day surgery for children aged 1 to 5. Each year over 19 000 day surgery operations—mostly due to tooth decay—are performed under general anesthesia, with disproportionate representation of Indigenous children.

Health Canada doesn't know if its dental programs benefit Indigenous Canadians: report

Inuit and First Nations people have nearly twice as much dental disease as other Canadians



The auditor general's audit sought to determine whether Health Canada had 'reasonable assurance' that its oral health programs for Indigenous people were having a positive effect on their oral health.

Nunavut program offers free dental checkups for kids



When the buzzer goes off, eight year old Haley Kennedy knows it's time to stop brushing. With help from her dad, Haley uses a two-minute timer when she brushes her teeth. She knows the consequences if she doesn't take care of them. "Your teeth are going to go black," she said.

The Grade 3 student was Ron Kelly's last patient of the day in a makeshift dental office inside Nakasuk Elementary School in Iqaluit, home to the Nunavut oral health project. Kennedy is missing a few teeth, placed in a pocket for the tooth fairy to pick up. She's looking at braces down the road but other than that, her teeth are in good shape. That's not the case for many of the patients Kelly sees.

"Oral health in Nunavut generally is not as good as in the general Canadian population," said Kelly, who is the territory's chief dental officer.

Feds spend \$1M to fly Inuit children south for dental surgery

120 children under 7 to head to Churchill hospital

The federal government is spending a million dollars to send five chartered plane loads of Nunavut children to the hospital in Churchill, Man., for dental surgery.

Their dental problems are so severe they need to be put under anesthetic before their teeth can be pulled or capped.

Three chartered flights for children under seven years of age, some as young as two, have already taken place from Nunavut's Baffin region and more are planned for the Kivalliq and Kitikmeot regions. In all, 120 children will go.

Each surgery costs about \$1,000, not counting the cost of travel and accommodation.

"Really none of those children are selected to go for general anesthetic unless they have five or six teeth that are severely affected, those are with abscesses and large decays and cavities that need to be addressed," said Monita O'Connor, assistant deputy minister of operations for Nunavut's Department of Health.

The government considered sending them to the hospital in Iqaluit but decided Churchill was better equipped to handle that many children.

Health Canada pays for dental care for Inuit through its Non-Insured Health Benefits program, but there are no dentists or dental hygienists in most Nunavut communities.

Iqaluit dentist Steve Partyka says the government should be spending its money on bringing more dentists to the territory.

"Every child should be seen by a dentist — not a pseudo-dental professional — a real dentist or hygienist twice a year," he said. "

Tooth decay surgery rates highest in Nunavut



A child with teeth showing signs of cavities and early white spots on other teeth that are the first visible signs of decay. (Courtesy Dr. Bob Schroth)

Severe tooth decay top reason for preschoolers' day surgery

19,000 Canadian preschoolers per year require day surgery under anesthesia to treat cavities and severe tooth decay, a new report finds.

Thursday's report from the Canadian Institute for Health Information looks at the treatment of preventable dental cavities in children under age six.

"Early childhood caries," the technical term for or rotting baby teeth, are generally preventable. If caught early, it's treatable with fillings or varnishes at a dentist's office. But the infectious disease can lead to poor growth, behavioral problems, poor learning and sleep loss.

About one in every 100 preschoolers needed day surgery for ECC during the two-year period 2010-11 to 2011-12, the report's authors said.

"A major finding of this report is that living in a rural or remote community, a neighborhood with a high proportion of Aboriginal residents or a neighborhood characterized by material deprivation is a strong risk factor for day surgery for ECC," the report's authors concluded.

Day surgery rates were:

8.6 times as high for children from neighborhoods with high Aboriginal populations compared with low Aboriginal populations.

3.9 times as high for children from least affluent neighborhoods compared with those living in the wealthiest areas.

3.1 times as high for children from rural neighborhoods versus urban neighborhoods.

Treating cavities was the leading indication for day surgery among preschoolers, making up 31 per cent of operations in that age group.

Inserting ear tubes was the second most common indication at 19 per cent.

On average, children were put under for 82 minutes to fill or treat cavities and extract teeth. The vast majority, 99 per cent, had general anesthesia for the operation.

Read More...

<http://www.cbc.ca/news/canada/north/health-canada-oral-health-inuit-1.4412961>

Microbiome Associated with Severe Caries in Canadian First Nations Children

Article: Dr. Bob Schroth Assistant Professor in the Department of Oral Biology at the University of Manitoba interview

Highlights

Young Indigenous children in North America suffer from a higher degree of severe early childhood caries (S-ECC) than the general population, leading to speculation that the etiology and characteristics of the disease may be distinct in this population. To address this knowledge gap, the authors conducted the first microbiome analysis of an Indigenous population using modern molecular techniques.

- The authors investigated the caries-associated microbiome among Canadian First Nations children with S-ECC. Thirty First Nations children <72 mo of age with S-ECC and 20 caries-free children were recruited in Winnipeg, Canada.
- Parents or caregivers completed a questionnaire on general and dental health, diet, and demographics. The plaque microbiome was investigated by sequencing the 16S rRNA gene. Sequences were clustered into operational taxonomic units and taxonomy assigned via the Human Oral Microbiome Database, then analyzed at the community level with alpha and beta diversity measures.
- Compared with those who were caries free, children with S-ECC came from households with lower income; they were more likely to live in First Nations communities and were more likely to be bottle-fed; and they were weaned from the bottle at a later age. The microbial communities of the S-ECC and caries-free groups did not differ in terms of species richness or phylogenetic diversity.
- Beta diversity analysis showed that the samples significantly clustered into groups based on caries status. Twenty-eight species-level operational taxonomic units were significantly different between the groups, including Veillonella HOT 780 and Porphyromonas HOT 284, which were 4.6- and 9-fold higher, respectively, in the S-ECC group, and Streptococcus gordonii and Streptococcus sanguinis, which were 5- and 2-fold higher, respectively, in the caries-free group. Extremely high levels of Streptococcus mutans were detected in the S-ECC group.
- Overall, First Nations children with S-ECC have a significantly different plaque microbiome than their caries-free counterparts, with the S-ECC group containing higher levels of known cariogenic organisms.

See full interview video at website link: <http://oasisdiscussions.ca/2018/01/22/msc/>

Health Equity Report 2017

<http://equity.bvsalud.org/2018/03/28/health-equity-report-2017/>

U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity Authors/Editors for the Full Report: Gopal K. Singh (Lead Author), Andrew "Drew" De Los Reyes, Michelle Allender, Christine Ramey, Gem Daus, Elijah Martin, Chris Perry, and Ivy Vedamuthu (all from OHE).

Published online: March, 2018

The Report presents analyses of various health equity trends affecting the nation's diverse, vulnerable, and socially disadvantaged populations. Trends in health disparities and improvements in health equity are presented for a number of program areas, including maternal and child health, primary health care access and quality, HIV/AIDS, mental and behavioral health, chronic disease prevention and health promotion, health workforce, and rural-urban and geographic disparities. Also addressed are patterns of disparities in three priority areas for the Department of Health and Human Services: mental health, opioid use, and childhood obesity. Health equity analyses are conducted using a variety of national and HRSA program databases, often stratified by important socioeconomic and demographic characteristics such as gender, race/ethnicity, family structure, education, income, employment status, rural-urban residence, and geographic area/location. On several health outcomes and performance measures, the HRSA programs outperform the national trends by providing greater access to preventive health services, social services, and needed medical care to the underserved and disadvantaged populations and communities in the United States. Although substantial progress has been made in improving the health and well-being of all Americans, health inequities between population groups and geographic areas have persisted and remain marked. Marked disparities are found in a number of health indicators, including infant mortality, life expectancy, cardiovascular disease, cancer, diabetes, chronic obstructive pulmonary disease (COPD), HIV/AIDS, health care access and utilization, health insurance, disability, mental health, preventive health services such as cervical, breast, and colorectal cancer screening, smoking, obesity, substance use, suicide, homicide, and unintentional injuries.

<http://equity.bvsalud.org/>

Pan American Health Organization, Regional Office of the World Health Organization for the Americas <http://www.paho.org>

Office of the Deputy Director. Area of Knowledge Management and Publications (KMP)

For additional information and to learn how to send contributions, please follow this link <http://equity.bvsalud.org/general-criteria/> or contact Eliane P. Santos - Advisor, Knowledge Management and Networks – KMP/DD/ PAHO - pereirae@paho.org

Health Canada: Consultation Report:

Restricting Marketing of Unhealthy Food and Beverages to Children in Canada

"The major role these new regulations will play is forming healthy habits for the future, if slightly unhealthy foods will still be allowed to be marketed to children, this will create bad habits going forward based on the TYPE of food being advertised and told to them it is okay to eat."

"It would be wise to limit restrictions to foods of poor or no nutritional value and for nutritious foods, such as dairy products, to be exempted. We should not be limited to categorizing foods according to a few "negative" nutrients, since this is very reductive and not indicative of the nutritional value of a food."(Translated)

"Although sugars, saturated fat and sodium are key nutrients of concern for Canadians, there is more nutritional value to a product than being low in negative nutrients."

Option 1 (~5% DV)

Foods allowed to be advertised

Foods not allowed to be advertised

FOUNDATIONAL FOODS

OTHER FOODS

- vegetables and fruit with no added fat, sugars or sodium
- whole grains, like barley, popcorn, quinoa, brown rice, and oats
- protein-rich foods, like beans, lentils, nuts, nut butters, and eggs
- milk
- plain yogurt

- club soda
- pasta

- plain "animal" cookie
- frosted wheat cereal
- graham cracker
- "fish" cheese-flavoured cracker
- granola bar
- potato chips
- french fries
- calorie-reduced cheese

- regular soda
- most cookies, cakes, pies and sweets
- pudding and ice cream
- chocolate and candies
- juice
- most sugar-sweetened cereals
- instant sugar-sweetened oatmeal
- cheese
- sugar-sweetened yogurt
- frozen waffles
- bagel

Option 2 (15% DV)

Foods allowed to be advertised

Foods not allowed to be advertised

FOUNDATIONAL FOODS

OTHER FOODS

- vegetables and fruit with no added fat, sugars or sodium
- whole grains, like barley, popcorn, quinoa, brown rice, and oats
- protein-rich foods, like beans, lentils, nuts, nut butters, and eggs
- milk
- plain yogurt

- club soda
- pasta

- plain "animal" cookie
- frosted wheat cereal
- graham cracker
- "fish" cheese-flavoured cracker
- granola bar
- potato chips
- french fries
- calorie-reduced cheese

- regular soda
- most cookies, cakes, pies and sweets
- pudding and ice cream
- chocolate and candies
- juice
- most sugar-sweetened cereals
- instant sugar-sweetened oatmeal
- cheese
- sugar-sweetened yogurt

Traditional Marketing Techniques

- packaging and labelling
- use of characters and celebrities (on packages, in ads, at events, etc.)
- sponsorship (of sports teams, events, school supplies)
- sales promotions/premiums (e.g., toy give-away, contests)
- branding (logo, symbol, word or images associated with a food product)
- advertisements (commercials, direct appeal)
- product design
- content (e.g., colours, voices, images)
- product placement

Digital Marketing Techniques

- advertisements (e.g., banner ads, popup ads)
- advergames (video game that advertises a branded product as part of the game)
- buzz marketing (peer-to-peer)
- word-of-mouth ("liking", sharing, tweeting)
- marketing "influencers" through
- blogging, vlogging (blogging with video), or social media
- neuromarketing (emotional analysis through sensors)
- behavioural advertising (informed by analytics use of shared personal data or tracking through cookies, device fingerprinting, geo-location)

Communication Channels

- television
- radio
- print media (e.g., youth magazines, comic books)
- billboards
- DVDs
- video games
- digital channels (e.g., websites, social media platforms, game platforms, apps)
- mobile devices (e.g., texting)

Read More of the report

<https://www.canada.ca/en/health-canada/services/publications/food-nutrition/restricting-marketing-to-kids-what-we-heard.html>

Food front of package Nutrition Consumer Consultation

<https://www.healthyeatingconsultations.ca/front-of-package>

Child deaths after dental anaesthesia

<http://pediatrics.aappublications.org/content/early/2017/11/03/peds.2017-2370>

Early childhood caries (ECC) is the single most common chronic childhood disease. In the treatment of ECC, children are often given moderate sedation or general anesthesia. An estimated 100 000 to 250 000 pediatric dental sedations are performed annually in the United States. The most common medications are benzodiazepines, opioids, local anesthetics, and nitrous oxide. All are associated with serious adverse events, including hypoxemia, respiratory depression, airway obstruction, and death. There is no mandated reporting of adverse events or deaths, so we don't know how often these occur. In this article, we present a case of a death after dental anesthesia and ask experts to speculate on how to improve the quality and safety of both the prevention and treatment of ECC.

Women need health and dental care to stay out of prison

<http://www.macleans.ca/society/women-need-health-and-dental-care-to-stay-out-of-prison/>

A new study reveals that basic health care, both in prison and on release, is essential to ensure successful reintegration into society

How Canadian dental tourism exploits Mexican workers

<http://www.macleans.ca/news/world/how-canadian-dental-tourism-exploits-mexican-workers/>

Poor working conditions and discriminatory practices in Mexican dental clinics suggest the need for global regulation of medical tourism, says Krystyna Adams

How bad teeth are at the root of income inequality in Canada

<http://www.macleans.ca/society/how-bad-teeth-are-at-the-root-of-income-inequality-in-canada/>

Anne Kingston: The glaring omission of dental care from Canadian health-care plans is both illogical and a public-health concern

Maclean's magazine

When Bernie Sanders took his well-publicized cook's tour of Canada's much-vaunted universal public health care system recently, he wouldn't have seen a cavity being filled or a root canal performed or a missing front tooth replaced. That's because most oral health care is exempt from provincial and territorial health-care plans (some dental services are covered by government dental programs, but working-class people lacking employer coverage are on their own).

It's a glaring omission that's both illogical and a public-health concern. We know that periodontal disease affects heart health; that an untreated tooth infection can be fatal; that mouth pain can lead to drug addiction and force people to stay home from work; that dentists and dental hygienists can spot precancerous or cancerous lesions, as well as diabetes and gastroesophageal reflux disease; and that hospital emergency rooms are flooded with people with untreated dental problems.

Poor oral health isn't only a physical risk, of course. It threatens education and job prospects, and thus, social mobility. It's a problem so dire that it's shocking a federal government elected on its promise to strengthen and expand the middle class—and one well aware of the power of a smiley selfie—hasn't championed equal access to oral health care.



So Why is he out of work?



In the Toronto Star there is a story about Jason Jones which picks up 10 years after he received dental care – and tells about the impact that it made on his life. Many of us will recall the 2007 front page story of Jason in the days before HSO (which wouldn't have helped Jason at the time or now).

A decade later, Jason Jones still smiling thanks to generosity of Star readers

His teeth rotted down to the bone, Jason Jones turned his life around when he got free dental work from a Markham dentist after his story appeared in the Star in 2007 as part of a series that examined issues of poverty and possible reforms. Yet a decade later, the fight for dental care for low-income adults rages on.



Jason Jones with his wife, Candice, and “army” of five blue-eyed, blond children who range in age from six months to 10 years. “(If he didn’t get help) I definitely don’t think that we would be anywhere close to where we are today, nor have the family that we have,” says Candice. (TARA WALTON FOR THE TORONTO STAR)

By [PAUL HUNTER](#) Feature reporter
Mon., Oct. 30, 2017

WELLAND, Ont.—The first thing you notice about Jason Jones are his teeth. They radiate. “I keep hearing, ‘You’ve got a gorgeous smile.’ Well, thank you, it’s totally fake, but thank you,” he says with a mischievous grin. “They’re all fake. All of them. Every single one.” The admission, says Jones, almost always leads to the inevitable question for a 36-year-old with fake choppers. What happened?

“Have you got 10 minutes? This will take a while.”

Toronto Star readers [first met Jones](#) in 2007 as part of a Star series that examined the issues surrounding poverty and possible reforms.

In a photo that dominated a Saturday front page, a smiling Jones stared out at the world, a bright-eyed, handsome man brimming with hope, except for one glaring, arresting detail.

He had no teeth.

Well, actually there were two decaying ones that stuck out hauntingly from his lower gums like a broken picket fence. He had the mouth of an old man. It was impossible not to stare back.

Accompanying the image, under the headline “He’s 25, Gregarious, Driven, Disciplined. So why is he out of work?” reporter Moira Welsh told the story of how Jones’s teeth had rotted down to the jawbone, largely because he was poor and could never afford to correct dental issues that plagued him since childhood.

Read Jason’s story <https://www.thestar.com/anniversary/2017/10/30/a-decade-later-jason-jones-still-smiling-thanks-to-generosity-of-star-readers.html>

To what can we attribute this decrease in smoking prevalence in Saskatchewan?

Canadian Community Health Survey (CCHS) released national and provincial results for 2016. CCHS has long been considered a superior survey partly due to the larger sample size.

CCHS results show Saskatchewan's smoking prevalence for those 12 years of age and older to be statistically significant with the rate having fallen from 21.8% to 18.1% for current smokers! (Note: Current smokers = daily smokers plus occasional smokers.)

Nationally, the survey shows a decrease from 17.7% to 16.9% in current smokers. Provincial prevalences are as follows:

(Note: Data for territories was not included in the 2016 results. Territories data is from 2014)

	Saskatchewan Smoking Prevalence: Current Smokers	Canada's smoking prevalence: Current Smokers
	2000/01 28	26% 2001
14.5% BC	2003 24	23% 2003
15% PEI	2005 24	22% 2005
16% ON	2007 26	22% 2007
18% MB	2008 25	21% 2008
18% QC	2009 22	20% 2009
18% SK	2010 23	21% 2010
18% AB	2011 24	20% 2011
19% NB	2012 20	20% 2012
19% NL	2013 23	19% 2013
20% NS	2014 20.5	18% 2014
26% YT (2014)	2015 22	18% 2015
33% NWT (2014)	2016 18	17% 2016
62% NU (2014)		

Detailed data can be retrieved through here: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050508>

Saskatchewan has been particular in choosing evidence-based cost effective tobacco reduction policies. Although there has been some delay in passing some policies, we have seen increases in tobacco tax over time, most recently in 2013 and 2017. (Tobacco taxation is the most effective tobacco reduction strategy although the tobacco industry is somewhat reducing its impact with lower cost tobacco products.) Smoke-free public and workplaces, a ban on retail tobacco displays as well as a number of other evidence-based strategies passed in Saskatchewan are the most effective at reducing tobacco use. This is because, unlike programming, which is more costly in the long run and only works when it continues to be funded, policies continue to be effective year after year after year.

Saskatchewan needs both provincial and federal governments to introduce more tobacco reduction strategies. We commend municipalities who have strengthened their smoking bylaws to include outdoor smoke-free spaces. Nationally some tobacco reduction steps are being taken. Stay tuned.

The Tobacco Free Saskatchewan Network is a network of over 200 health workers, citizens and others. It is sponsored by the Saskatchewan Coalition for Tobacco Reduction. The Network is available for anyone to use who has information on tobacco activities in Saskatchewan. Just email information or questions to the address below.

The Saskatchewan Coalition for Tobacco Reduction is a provincial coalition of 19 members. It is also a member of the Canadian Coalition for Action on Tobacco, the Canadian Council for Tobacco Control and the Framework Convention Alliance, an international organization of NGOs supporting the World Health Organization's international tobacco control treaty.

Periodontitis is associated with significant hepatic fibrosis in patients with non-alcoholic fatty liver disease

Non-alcoholic fatty liver disease (NAFLD) has a bidirectional association with metabolic syndrome. It affects up to 30% of the general population, 70% of individuals with diabetes and 90% with obesity. The main histological hallmark of progressive NAFLD is fibrosis. There is a bidirectional epidemiological link between periodontitis and metabolic syndrome. NAFLD, periodontitis and diabetes share common risk factors, are characterized by inflammation and associated with changes in commensal bacteria. Periodontal disease is more common in patients with liver biopsy-proven significant fibrosis. The data from the NHANES cohort demonstrate an epidemiological association between oral health, hepatic steatosis and elements of the metabolic syndrome. The data also suggest that patients with more advanced liver disease have more severe indicators of periodontal disease. To examine this further, we conducted a prospective study of 69 patients with NAFLD in our centre. Of these, 45 (65%) had a liver biopsy to stage the liver disease.

Read More <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0185902&type=printable>
<https://odha.on.ca/wp-content/uploads/2016/08/Gum-Disease-14-1-final.pdf>

Public Health Ontario:

Behavioral impacts of school-based oral health education among children

Key Messages School-based oral health education interventions can have positive impacts on behavioral outcomes among children. □ Repetition and reinforcement of oral health messages tends to significantly improve results in the short term. □ Experiential learning is more effective than conventional methods. Implementation considerations include intervention type, mode and frequency of delivery.

Issue and Research Question

Oral health plays an important role in maintaining general health and well-being of an individual. Despite advances in treatment, oral diseases continue to be prevalent, causing pain, discomfort, sleepless nights and days lost from work or school. In addition, the high cost of dental treatment has considerable economic impact on individuals, families and community. As such, prevention remains a more cost effective approach.

Conclusions

In conclusion, oral health education interventions in general, showed a positive impact on both behavioral outcomes such as oral health knowledge, tooth-brushing practices, diet, attitudes and clinical outcomes such as calculus and plaque levels, gingival health, and dental caries. The impact of education on schoolchildren can depend on a number of factors including the type of intervention, method of delivery, and the time of evaluation. In addition, it is important to conduct a comparative analysis of different education programs in terms of their reach, implementation feasibility, and sustainability.

Implications of Practice

Oral health education programs in schools can be integral to oral health promotion of school-aged children. Such interventions have potential for positive changes in behavioral outcomes. Oral health education programs based on a health behavior model can build capacity of young children in terms of their oral health knowledge, practices, and attitudes and in turn provide opportunities to maintain good oral health. However, implementation considerations are important in terms of the context for intervention, type of intervention, mode of delivery, frequency and repetition, and role of providers.

Read More...

http://www.publichealthontario.ca/en/eRepository/EB_Oral_Health_Education_Among_Children.pdf

Ontario Dental Hygienists Association Fact Sheets
<https://odha.on.ca/your-oral-health/oral-health-facts/>



Ontario Dental Hygienists' Association <https://odha.on.ca/>

Between-meal snacking may contribute to tooth decay. Choosing nutritious snacks that are low in sugar and do not promote tooth decay helps in the fight against cavities. Foods such as apples and raw carrots, and hard cheese have a natural cleansing action on teeth, making good snack food choices.

Acid production from bacterial plaque occurs most dramatically within 20 minutes of eating, contributing to tooth decay. That is why rinsing your mouth with water after eating is a good habit.

Effective brushing techniques clean only the most exposed tooth surfaces. Flossing is a good choice to clean the areas between your teeth and where your toothbrush can't reach.

Brushing and flossing with an ineffective technique may do more harm than good. Dental hygienists can teach you how to use your toothbrush, dental floss and other cleaning aids effectively without causing excessive wear or damage to the teeth and gums.

A vigorous rinse with water may help to dislodge food particles and dilute acid produced by plaque bacteria. Rinsing throughout the day supports daily brushing and flossing to maintain oral health.

Fluoride is an important tool in the fight against tooth decay and may be found in such sources as community water supplies, private wells and tooth paste.

Read more about the benefits of [fluoride](#) .

Sports injuries often involve damage to the teeth. When engaging in rugged and contact sports, a mouth guard should always be worn.

Keep your mouth happy video link: <https://www.youtube.com/watch?v=CruHJaTP20k>



Nutrition and Oral Health

A well-balanced diet is important for good oral health and general health. The food we eat supplies the nutrients that the body, bones, teeth and gums need to renew tissues and help fight infection and disease, including periodontal (gum) disease.

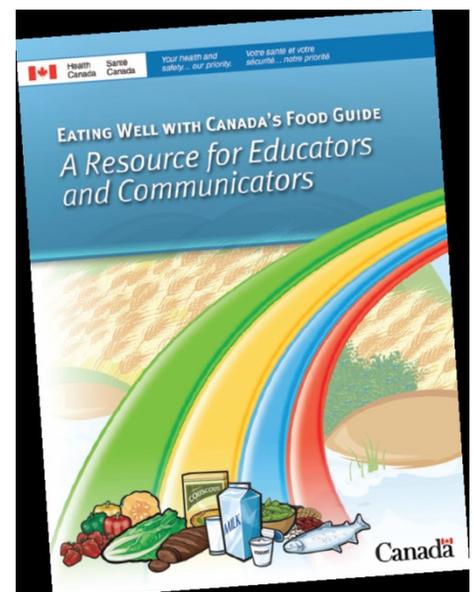
Hectic lifestyles, fast food, fad diets, large amounts of sugar and trendy supplements can have health repercussions. A poor diet can contribute to gum disease and tooth decay. Food high in sugars and starches increase the [production of acids that can erode and weaken the tooth's outer layer (enamel). Eventually these acids can cause tooth decay.

To this guide and read more... <https://odha.on.ca/wp-content/uploads/2016/08/Nutrition-14-1-final.pdf>

Choosing nutritious snacks that are low in sugar are good for teeth and gums and can help prevent #toothdecay. Talk to a dental hygienist to learn more about healthy snack choices.

Also visit ODHA's website <https://odha.on.ca/your-oral-health/oral-health-facts/>

Canada's Food Guide <https://www.canada.ca/en/health-canada/services/canada-food-guides.html>



HOW TO EAT RIGHT

Because the body cannot manufacture all the necessary nutrients for good health, individuals rely on food sources and supplements.

Getting the proper amount of vitamins, minerals, fats and protein is essential for the growth and regeneration of normal tissues, and for building the body's immune system.

For instance, carbohydrates, fat and protein supply the energy the body needs for tissue maintenance and repair, along with vitamins such as A, B, C, E, K and D, which are also essential for healing and quicker recovery time. Vitamin A, for example, significantly reduces the healing time for repairing inflamed tissue.

Canada's Food Guide (<http://hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php>) Maintain a well-balanced diet by following Canada's Food Guide. The Food Guide stresses the importance of reading nutrition facts on labels and choosing products that contain less fat, saturated fat, trans fat, sugar and sodium.

FOOD/BEVERAGES THAT CONTRIBUTE TO POOR ORAL HEALTH

The average Canadian eats the equivalent of 40 kilograms of sugar each year – one of the main causes of oral health problems. Some food choices are more harmful than others. Therefore, practice moderation when consuming the following:

- *Chewy, sticky foods* – Raisins, granola bars, jellybeans, caramel and honey stick to teeth.
- *Sugary snacks* – Candy, regular gum, cookies, cakes or other sweet treats contain a high amount of cavity-causing sugar.
- *Carbonated soft drinks* – Regular pop contains a high amount of sugar. Both regular and diet pop also contain acids that wear away tooth enamel.
- *Fruit drinks* – These tend to be high in sugar and acid that can damage tooth enamel and lead to decay.
- *Sports/energy drinks* – These drinks are acidic and high in sugar.
- *Acidic food and beverages* – Acids that cause dental erosion are found in numerous food and drinks such as fruit juices, ice tea, lemons, pickles, salad dressing and wine.

HEALTHY SNACKING

Healthy nutritious snacks are good for the teeth, gums and general health. A variety of snacks and drinks low in sugar and high in nutrition are best:

- Plain yogurt, hard cheese, hard-boiled eggs
- Apples, sliced mango, raw vegetables
- Nuts and seeds
- Popcorn sprinkled with Parmesan cheese
- Vegetable enchilada, sushi
- Hummus, baba ghanouj
- Naan bread, tortilla
- Water to quench thirst between meals



Vitamin/Mineral Impact on Oral Health Sources

Calcium Essential for bone health; teeth and jaws are made mostly of calcium Milk and dairy products, beans, broccoli, nuts and oyster

Iron A deficiency can cause tongue inflammation and mouth sores Red meat, poultry, fish, fortified cereals, some vegetables and nuts

Vitamin B3 (niacin) A lack of vitamin B3 can cause bad breath and canker sores Chicken and fish

Vitamins B12 and B2 Mouth sores can develop with insufficient B12 and B2 **Sources for B12:** red meat, chicken liver, pork and fish, dairy products

B2 (riboflavin) Sources for B2: pasta, bagels, spinach and almonds

Vitamin C Helps produce collagen, the connective tissue that holds bone Sweet potatoes, raw red peppers and oranges together; a deficiency may lead to bleeding gums and loose teeth

Vitamin D Enables the body to absorb calcium, which helps build strong bones and teeth Milk, egg yolks, fish and limited amounts of sunshine

Vitamin K Helps synthesize three proteins in bone needed for strength; Broccoli and leafy greens also noted for its role in blood clotting

Phosphorus Needed for healthy bones and teeth, energy metabolism and acid base balance in the body Milk, grains and lean meats

Zinc Promotes strong bones and helps develop and maintain collagen Seafood, meat and liver

Magnesium Important for bone formation Green vegetables, legumes and nuts

Potassium Helps promote good mineral density and reduces calcium loss Fruits and vegetables

Save the Date!

Saskatchewan Oral Health Coalition Meeting

Monday, October 22, 2018- Regina

8:30 am – 4:30 pm

Cumberland Room, Travelodge Hotel

4177 Albert Street, Regina

The meeting will be live-streamed! <http://www.saskohc.ca/> under SOHC Meeting Live



Source: Virtual Gurus

Future Meeting Dates:

Monday, October 22, 2018 - Regina

Monday, May 13, 2019 – Saskatoon

Consider Becoming a Member of SOHC

Join the diverse membership of the Coalition to make a positive difference for the future of Saskatchewan residents!

Membership runs January through December annually.

Organization Levels:

- \$150 – Business/For Profit Organization
- \$100 – Non-Profit Organization
- \$50 – Individual
- Free- Students (full-time)

For Business/For-profit and Non-profit organizations, the fee will cover up to 5 members.

Download the Application Form [Here](#)

SOHC DIRECTORS

Barbara Anderson (Admin)
Susan Anholt
Jerod Orb (Treasurer)
Leslie Topola (Director)
Kellie Watson (Chairperson)
Dr. Parviz Yazdani

Contact Info:

sohcadmin@saskohc.ca

Contact Us

Barbara Anderson
Administrative Coordinator
Saskatchewan Oral Health Coalition

Contact Info:

sohcadmin@saskohc.ca

Our Website:

www.saskohc.ca

Chairperson Kellie Watson
Saskatchewan Dental Hygienists' Association
1024 8th Street East
Saskatoon, SK S7H 0R9