ORIGINAL ARTICLE

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Analysis of a unique global public-private partnership to promote oral health

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ABSTRACT

Partnerships for health promotion are between two or more partners to work co-operatively towards a set of shared health outcomes; few public-private partnerships in oral health promotion have been established. **Aim:** To undertake a detailed analysis of a unique global public-private partnership to promote oral health between a global company, Unilever and the *Féderation Dentaire International* (FDI), a membership organisation representing more than one million dentists worldwide. **Methods:** Qualitative and quantitative, including: collating and analysing a wide range of partnership documents (n = 164); reviewing film and pictorial records; undertaking structured interviews (n = 34) with people who had a critical role in establishing and delivering the aims of the partnership, and external experts; and site visits to selected global projects active at the time of the evaluation. **Results:** Over 1 million people have been reached directly through their engagement with 39 projects in 36 countries; an oral health message about the benefits of twice daily tooth brushing has appeared with the authority of the FDI logo on billions of packs of Unilever Oral Care's toothpastes worldwide; many individual members of National Dental Associations have participated in health promotion activities within their communities for the first time; some organisational challenges during the development and delivery of the partnership were recognised by both partners. **Conclusions:** The first phase of this unique global partnership has been successful in making major progress towards achieving its goals; lessons learned have ensured that the next phase of the partnership has significant potential to contribute to improving oral health globally.

Key words: *Public-private partnership*, *Live.Learn.Laugh.*, *oral health promotion*, *global*, *evaluation*

The World Health Organisation (WHO) defines public-private partnership, PPP, as the "*means to bring together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles*"[1]. In health, the most common PPPs are in health care services and in drug delivery. A notable example is the GAVI Alliance, formerly the Global Alliance for Vaccines and Immunisation, a public–private partnership whose primary objective since 2000 has been to increase poor countries' access to immunisation[2]. There are increasing numbers of global public-private partnerships for health[3], often as a mechanism to mobilise additional resources and support for health activities, particularly in under-resourced developing countries[4,5]; and investigations and recommendations for enhancing their governance and success [6–8]. Guidelines have been developed by the WHO for its own involvement in global health partnerships, notably, that the roles of partners should be clear; should ensure adequate participation of stakeholders; pursuit of the public health goal should take precedence over the special interests of participants; and, that partnership should have a self-monitoring mechanism[9].

Undoubtedly, global health partnerships can help to increase the visibility of certain health conditions; lever political support; help to bring together different groups of people mobilising varied skill sets; helping to bring a different view to intractable problems; provide much needed medicines, services and materials. Public-private partnerships for health promotion are less common than those for healthcare.

"*A partnership for health promotion is defined as a voluntary agreement between two or more partners to work co-operatively towards a set of shared health outcomes*"[10].

"*The rationale for public-private collaboration in health work is not simply to capture money from profit-making enterprises. True partnership is about combining different skills, expertise and resources, ideally in a*

framework of defined responsibilities, roles, accountability and transparency, to achieve a common goal unattainable by independent action"[3].

This paper describes an analysis of a unique global public-private partnership in oral health promotion designed to improve oral health across the world.

THE PARTNERS

The *Féderation Dentaire International* (FDI), is a membership organisation composed of more than 200 member National Dental Associations and specialist groups, altogether representing more than one million dentists worldwide. The organisation is governed by a Council of delegates from member associations that are elected by a General Assembly during the FDI Annual World Dental Congress. FDI has five standing committees in: communications and member support; dental practice; education; science; and, world dental development and health promotion. The FDI has stated its main roles as:

- To bring together the world of dentistry
- To represent the dental profession of the world
- To stimulate and facilitate the exchange of information across all borders with the aim of optimal oral health for all people.

Unilever Oral Care is part of the multi-national corporation, Unilever, a leading manufacturer of oral care products in over 50 countries. Around four billion people, approximately 70% of the world's population, have access to Unilever Oral Care products. In 2004, a partnership between the FDI and Unilever Oral Care was established to promote oral health worldwide. The partnership was titled, *Live.Learn.Laugh*. (LLL) and completed its first phase at the end of 2009.

An external evaluation and analysis of the partnership was commissioned by both partners, to report on this first phase and this paper presents key aspects of this evaluation. The benefits of an external evaluation were recognised in providing: perspective, objective measurement, independence; an opportunity to reflect in a neutral space, an analysis from policy to practice; and, that such an evaluation could provide a platform to inform the future shape of partnership between the two organisations. In evaluating the conduct of the partnership, it is necessary to appreciate how the two organisations are structured. The FDI has a Head Office in Switzerland with a team of less than 20 staff; the central FDI team had oversight and management of the partnership at the international level, for FDI with administrative support funded through the partnership. The FDI is an association of National Dental Associations (NDAs) whose members are dentists registered to practise in that country. In a few countries, dentists are required to be members of the national organisation in order to practise. Each NDA has its own national officer team usually elected by the membership; policy areas of interest, logo, relationship with local, national and international dentally-related industry. For the purposes of the evaluation, the NDA staff are considered as local members of the partnership. In Unilever, the international Oral Care team are headquartered in London, for clarity in the Evaluation this team is called Unilever Oral Care Global. At the time of the Evaluation, Unilever offices within countries had separate budgetary arrangements, were able to set local activities to meet their own objectives and develop their own programmes. This country level is termed Unilever Oral Care Local, UOCL. Therefore, when the partnership began, some NDAs had long-standing existing relationships with their UOCL within their own countries. Similarly, some UOCL had existing programmes in oral health promotion, independent of the NDA.

GOALS OF THIS PUBLIC-PRIVATE PARTNERSHIP TO PROMOTE ORAL HEALTH

The partnership, which became known as *Live.Learn.Laugh.*, LLL, had three goals:

- To raise awareness of oral health globally
- To enable and support FDI member associations in promoting good oral health
- To increase the visibility of the FDI and authority of Unilever Oral Care oral care brands worldwide.

The partnership consisted of three main strands of work:

- FDI granting the right to use the FDI logo on Unilever Oral Care products together with a supportive health message about brushing twice daily with fluoride toothpaste
- Health promotion programmes that became known as Country Projects between NDAs and UOCL companies were funded through the partnership
- Global Projects described as activities of the FDI to promote oral health worldwide were funded separately through the partnership.

This partnership has policy direction set at the international level with two global organisations with delivery both within countries for Country Projects; and, internationally for Global Projects. Informed by the international partnership policy, the Country Projects were initiated by NDAs and have been implemented led by local teams, both NDA and UOCL. Therefore, this evaluation was implemented at three levels, namely:

- International level (FDI/Unilever Oral Care Global partnership)
- National level (National Dental Association/Unilever Oral Care Local company and any other institutions involved) including the interaction between FDI and NDAs

- Project level: people and institutions involved in the direct implementation.

This is the first known global, oral health partnership of its kind. It operates at multiple levels, with policy set at the international level with local decision-making and local delivery. In evaluating how partnerships operate from policy to practice, aspects that should be included in the analysis are: governance; legitimate representation, involvement in decision-making; accountability; competence and appropriateness, balance of aims; resources: both financial and human[6]. The organisations considered that measurement of the partnership needed to include resultant benefits for FDI and for Unilever Oral Care, and some assessment of the partnership's potential impact.

AIMS OF THE EVALUATION

The aims of the evaluation were discussed, documented and agreed in writing over a period of several weeks between the two partners and the Evaluation Team in 2008 and early 2009. These were documented as to evaluate progress towards achieving the three main goals of the partnership, namely:

- To raise awareness of oral health globally
- To enable and support FDI member associations in promoting good oral health
- To increase the visibility of the FDI and authority of Unilever Oral Care oral care brands worldwide.

A secondary aim of the evaluation was to explore how this unique, international partnership has developed during the implementation of the LLL programme informing how future partnerships could be structured. A third aim was to document the whole range of activities and programmes supported (including logo use, Global Projects and Country Projects) and to assess their reach and outcome. Finally, to evaluate in depth a sample of Country Projects to determine their potential to impact on oral health; and, as a later agreed aim: to evaluate in depth a sample of Country Projects to determine their potential to achieve the behaviour of twice daily brushing with a fluoridated toothpaste.

METHODS

The evaluation used a mixed methods approach, both qualitative and quantitative, including: collating and analysing documentary material; reviewing film and pictorial records; undertaking structured interviews with people who had a critical role in establishing and delivering the aims of the partnership, and some external experts; and, finally, site visits to selected projects active at the time of the evaluation. The written evidence of the partnership was located in policy documents, reports of initiation of Country Projects, progress reviews and reports of Global Projects; visual and spoken evidence from film, documentary, and workshops. A critical overlay was achieved by carrying out structured interviews with people involved from international policy level to local delivery within both organisations. Interviews (n = 34) were either conducted by telephone or in person (e.g. at regional workshops) depending on access, timing and role of the interviewee in the partnership.

A list of those to be approached to be interviewed in each organisation was agreed by the FDI and Unilever Oral Care. Questions were structured differently to those interviewees involved at a policy level compared to those delivering projects. Views of representatives of organisations involved in the Global Projects were obtained, e.g. the International Association of Dental Research (IADR). Three regional LLL workshops were attended by the evaluators in Europe, Asia and Africa, during spring and summer 2009. Attendance at the workshops provided an opportunity for the Evaluation Team to see and hear projects being presented; to cross-check written reports with design and outcomes presented directly by project teams; to interview project team members. The administrator for the Evaluation Team visited the project administration office in Geneva in April 2009 to gather all documentary evidence: project reports, evaluation reports, finance reports, video material and press releases, for each Country Project. These documents were all used in the Country Project evaluation. Further material was uploaded by the LLL project administrator onto a secure repository site at the University of Salford. A total of 164 documents were examined by the Evaluation Team. A secure electronic repository was set up at the University of Salford to house all the background written material of the partnership.

CASE STUDY SELECTION OF COUNTRY PROJECTS

Review and analysis of the extensive written material, visual and audio material and interviews were complimented by field visits by the Evaluation Team to some of the Country Projects. This allowed triangulation of the written and verbal information by the Evaluation Team being able to see, record and analyse what was happening in the field by direct observation of a selection of active projects. At the time of the Evaluation, there were 39 projects in 36 countries around the world with a wide range of designs. After discussion with members of the teams at both FDI and Unilever Oral Care, the following classification was developed and Country Projects were selected from these categories to be visited for the evaluation. Programmes were categorised into one of 4 types as follows, providing a sampling framework for site selection:

A. Multi-objective public health programmes (oral health is one component)
B. Directly delivered by the dental team
C. Indirectly delivered via trainers
D. Dental treatment provided in addition to health promotion.

After discussion, sites were selected that had been active for more than a year, with completed reports, and were active during the evaluation period. Those chosen were:

A. Philippines, Poland (chosen in addition for its whole country coverage)
B. No active site
C. Indonesia
D. Nigeria (and Kenya).

The site visits took place, between March and June 2009, with one member of the Evaluation Team visiting each site for approximately two days. The itineraries were determined by the Country Project in question with the brief to enable access for the evaluators to see the project being implemented i.e. to enable the project to be seen 'in action'.

RESULTS

The results are considered in relation to evaluating progress towards achieving the three main goals of the partnership. The first aim was to raise awareness of oral health globally. This was reflected directly in the first part of the partnership which resulted in an oral health message about the benefits and importance of twice daily tooth brushing appearing with the FDI logo on billions of packs of Unilever Oral Care's toothpastes worldwide. Clearly, the first aim was successful in achieving major exposure of the health message, with the FDI logo, on toothpastes. The use of the FDI logo on packs was governed by an agreed set of guidelines. A few problems that were encountered at the outset were swiftly dealt with and no recent problems had been reported. Although there was significant reach of the products with logos globally, and it effectively addressed the aim of increasing the visibility of the FDI and authority of Unilever Oral Care oral care brands worldwide, the impact of the logo on consumers and dentists was beyond the scope of this evaluation.

The second aim of enabling and supporting FDI member associations in promoting good oral health was addressed through the introduction and establishment of Country Projects. This aspect of the partnership was evidenced in the development and use of the Live.Learn.Laugh. logo with LLL often used as shorthand for both the projects and the broader partnership. There was a clear governance structure around the Country Projects and at the time of the Evaluation, 39 health promotion projects in 36 countries had been initiated across the world and hundreds of thousands of people had been reached. Applications were called for by the FDI to NDAs and asked that they work with Unilever Oral Care locally within each country to develop a joint oral health project. Each project was funded for 10,000 Euros per year. The head office of Unilever Oral Care was not involved in the selection of projects, judging this to be a professional and academically-based decision of the FDI. The applications were reviewed by a sub-group of one of the committees of the FDI, namely, the World Dental Development and Health Promotion Committee (WDDHPC). This Committee was established in 2001 and is the nexus for oral health development activities within the FDI, developing and co-ordinating strategic programmes. It also promotes initiatives and actions for the improvement of oral and general health for disadvantaged populations. As the partnership became more established, committee members led on providing facilitative workshops to assist NDAs in the methodology and delivery of the Country Projects including considering how projects could be evaluated.

Although several of the projects had written evidence of joint development between the NDA and UOCL, some did not, and this lack of joint planning caused some difficulties later in delivery for a small number of projects. In some cases, the lack of joint application reflected that the project chosen by the NDA did not align with priorities of the local Unilever Oral Care company. To some extent this was to be expected, given that the partnership was in its early phase and that the central global Unilever Oral Care team did not and could not have a directive approach to local companies, as there was historically local discretion in development of their own programmes to reach company objectives. However, where programmes were jointly submitted and aims aligned, there was clear evidence of UOCL adding resources and materials above that funded through the LLL project.

The partnership has resulted in some dentists becoming engaged in community health activities for the first time working outside their own dental practices. The initiation and establishment of projects conducted within several countries has engaged ministries of health and education. Several programmes have extended beyond health promotion and have provided emergency dental treatment to populations with little or no previous access to dental care. In some countries, 10,000 Euros is a very modest level of financial support. Nevertheless, many projects were substantial and had levered additional resource. Enthusiasm and commitment was seen in every site visited. The projects had reached hundreds of thousands of people who have been exposed to oral health issues and some had simple dental treatment provided. There was clear evidence of capacity building to deliver oral health promotion projects amongst members of NDAs whose previous

experience had largely been confined to clinical matters. There was also considerable evidence of personal development of dentists who had taken part in LLL projects and an increased commitment to a preventive philosophy. Detailed evaluation of Country Projects visited by the Evaluation team is presented in the companion paper[11].

Within the early years of the partnership, the FDI developed a group of activities termed Global Projects. These were undertaken by the team at the international office level of FDI and included international symposia on the benefits of fluoride which were valued. Later, although not available at the time of the evaluation, a global atlas of oral health conditions was developed and published. However, it was unclear how and why other activities were chosen and both FDI and Unilever Oral Care recognised a lack of agreed objectives for the Global Projects. Before the end of the first phase of the partnership, governance issues were recognised around the Global Projects, including value for money to both partners. Therefore, these were concluded and funds diverted into the Country Projects. The Evaluation Team found good governance of the financial aspects of the Country Projects.

DESIGN OF THE COUNTRY PROJECTS

During the conduct of the Evaluation, both FDI and Unilever asked the Team to include an additional aim, which was to identify the reach and potential benefit to oral health of the Country Projects. Therefore, the Evaluation Team scrutinised all documents carefully, combined with data from workshops and interviews to compile a detailed analysis of the structure, design and conduct of the Country Project. This is presented in *Table 1* using headings that assist in judging reach and impact, and provides a detailed summary of the results of the main business of the partnership, i.e. 39 health promotion projects in 36 countries. From this analysis, it is evident that the projects all had the potential to raise awareness of oral health at some level, the stated aim of the first phase of the partnership. However, only a minority of projects clearly demonstrated the potential to improve oral health in a sustainable way (*Table 1*).

At the outset, the partnership did not specify project design. Not unreasonably, the initial focus was to get project activities up and running. This lack of specification led to a richness of projects coming forward, ranging from prevention programmes for pregnant women to smoking cessation in dental practitioners. In addition, this open approach to ideas encouraged a wide engagement of countries to come forward, tapping into the enthusiasm of individual NDA members. This approach has much to commend it at the outset of a partnership as it raised enthusiasm, engagement and encouraged experimentation. Some sites used the project funds to buy toothpaste and toothbrushes and to produce oral health materials (posters, leaflets, booklets, videos). These materials were all different in terms of content and design, not optimising use of resources and often reducing the ability to make comparisons of effect. Levels of internal evaluation and monitoring of the projects, in terms of changing knowledge, attitudes and behaviour, and enhancing health outcomes varied considerably. Some sites showed some evidence of being more thorough and systematic than others and had some internal evaluation. However, the overall lack of evaluation seen means that it is not possible to quantify benefit. This is further confounded by a significant plethora of designs.

It became very clear during the evaluation that many people considered that it was now important to move on from the free-ranging experimental approach to design, towards providing clear parameters and support in order to implement an effective programme that would lead to sustained health benefits. The Evaluation Team were asked to advise how this might be accomplished and therefore, the following analysis is included.

A fundamental aspect of a successful health promotion programme is the design. When considering the three major oral health diseases of dental caries, periodontal disease and oral cancer, they are highly correlated with the social determinants of health with common aetiological factors with other chronic diseases; supporting an approach to health promotion that recognises common risk factors[12]. At the community and individual level, these factors are also manifested in risky health related behaviours – frequent sugar snacking, none or ineffective oral hygiene, smoking, and excessive alcohol use. Treatment of oral diseases, principally repair and replacement of damaged tissue, will aid in secondary and tertiary prevention[13]. However, treatment alone in the presence of continued risky behaviours can only provide a short term panacea. In designing for prevention, successful health promotion programmes will need to recognise and address the underlying wider social determinants of health that lead to the inequalities in disease prevalence and health outcome[14]. Therefore, such programmes will benefit from engagement with government, linking in with ministries of health and education to address wider determinants and put primary prevention high on the agenda. A key component of a programme to embed sustainable change is local or national government engagement and support from health and education departments. In the Country Projects, level of political support was found to be variable and different approaches had been taken to secure this in the case study sites[11].

Programmes that can support oral health long-term may focus on the establishment and maintenance of

Table 1 Analysis of Country Projects

Project classification	Country	Project description	Setting/ population	Reach	Components of programme					Political engagement e.g. Ministry of Health	Potential impact
					Know-ledge	Skills		Frequency of Exposure to Message			
						Training	Doing	Single	Multiple		
A	Morocco	Teaching Supervised brushing in schools Community engagement	Children/ community	100*	Y	Y	Y		Y	Y	1
A	Philippines	Handwashing, tooth brushing, de-worming, low sugar diet	Pre-school children/day care centres	9000*	Y	Y	Y		Y	Y	1
A	Poland	Education materials for parenting classes	Pre-natal parents/hospital and clinic	5000 educational packs	Y				2	Y	3
B	Egypt	Dental health education	Pre-school/nurseries	18,000*	Y			Y*		Limited	3
B	Tunisia	Smoking cessation for dentists	Adults	Not reported (NR)	Y			NR	NR	NR	Cannot be assessed (CBA)
B	Cambodia	Dental health education (leaflets, posters)	Children/primary school	170,000*	Y						3
B	India	Dental health education (drama, media)	Children and parents/ community	66,000*	Y	Y		Y*		NR	2a
B	Croatia	Dental health education (posters, website)	Children 14–18 yrs/school	10 schools (1200*)	Y			NR	NR	NR	3
B	Germany	Smoking cessation brochure	Adults/dental surgery	NR	Y			NR	NR	NR	3
B	Hungary	Dental health education	Pre-school children/nursery	1,800	Y				2 sessions a year	NR	3
B	Spain	Smoking cessation in dentists	Adults/workshop	80 dentists*	Y			NR	NR	NR	CBA
B	Jordan	Dental health education and brushing programme (posters)	Children/Primary school	Small sample of schools	Y	Y	Y		Y*	Ministry of Health	1*
C	Ghana	Dental health education (training nurses and teachers) Education materials	Children/Primary school	NR	Y					Ministry of Education	3
C	China	Dental health education and toothbrushing instruction (training teachers)	Children/ kindergarten	20,000 children 306 teachers 208 dental assistants	Y	Y	Y	NR	NR	NR	2a

Table 1 *Continued*

Project classification	Country	Project description	Setting/population	Reach	Components of programme					Political engagement e.g. Ministry of Health	Potential impact
					Know-ledge	Skills		Frequency of Exposure to Message			
						Training	Doing	Single	Multiple		
C	Indonesia	Dental health education and toothbrushing in schools (training volunteers)	Children/primary and secondary school	12,000 445 trainers*	Y	Y	Y		Y*	Local	2a
C	Austria	Mass media Toothbrushing techniques, healthy foods(training dental health educators/formerly nursery nurses)	Children/parents nursery and primary	NR	Y				Y 2x year	NR	3
C	Belgium CSD	Training sessions for nurses (video)	Elderly/care homes	NR	Y			NR	NR	NR	3
C	Belgium SMD	Training sessions for school nurses	Children/schools	NR	NR	NR	NR	NR	NR	NR	CBA
C	Finland	Dental health education manual for school teachers	Children/Secondary schools	1,000 schools 198,000*	Y			NR	NR	NR	3
C	Switzerland	Dental health education	Children/primary and secondary schools	1,600 oral health assistants*	Y					NR	3
D	Cote d'Ivoire	Treatment plus dental health education	Children/primary and secondary schools	2,800* 400	Y					Y	2b
D	Kenya	Treatment plus dental health education	Children with disabilities or abandoned/day centres and hospital	300*	Y		Y			Ministry of Health	2b
D	Nigeria	Dental health education, screening and referral for treatment	Children and adults/community	23,000 10,000 screened	Y	Y		Y		Ministry of Health	2b
D	Kazakstan	Dental health education, screening and toothbrushing instruction	Children 8–11 years/school	5,000*	Y	Y		Y		NR	3
D	Pakistan	Dental health education, brushing demo, screening and treatment	Children/school	5,620 children 625 adults	Y				Y	NR	2b

Table 1 *Continued*

Project classification	Country	Project description	Setting/population	Reach	Components of programme: Know-ledge	Skills: Training	Skills: Doing	Frequency of Exposure to Message: Single	Frequency of Exposure to Message: Multiple	Political engagement e.g. Ministry of Health	Potential impact
D	Sri Lanka	Dental health education, screening and treatment	Adults and children/ community	10,000*	Y			Y	NR	NR	2b
D	Vietnam	Oral care treatment programme	Children/primary schools	2 primary schools 2,000 children/ adults*	Y					Ministry of Health	2b
D	Czech Republic	Provision of dental passes Education of dentists	Mothers with newborn children	545,000 dental passes 242 dentists	Y					Ministry of Health	3
D	Greece SSG	Summer dental health education and screening/ treatment camps	Children/summer camps	4,870 children	Y			Y			3
D	Saudi Arabia	Dental health education, treatment	Children/primary schools	NR	Y	Y		Y		NR	2b
D	Brazil	Dental health education, treatment	Children/youth	NR	Y	Y			Y	NR	2b
D	Chile CCDC	Dental health education, Treatment	Young workless adults	NR	Y					NR	3
D	Chile SOCH	Dental health education, treatment	Children/nursery – secondary school Special needs	NR	Y			NR	NR	NR	3
Other	Greece HDA	Clinical trial, dental health education	2–5 year olds/day care centres	1,600 children 600 teachers							OC

NOTE: The assessment of potential impact assumes projects were delivered as described.
Project classification:
A. Multi-objective public health programmes (oral health is one component)
B. Directly delivered by the dental team
C. Indirectly delivered via trainers
D. Dental treatment provided in addition to health promotion.
Y = YES
KEY: 1 = potential to sustain health behaviour change and improve health in the longer term
2a = potential to lead to short term behaviour change and health impact
2b = potential to lead to short term health impact
3 = potential to raise awareness of health
* denotes an estimate of numbers reached from the available documentation or site visit.
OC = Other category; research project rather than health promotion.
NR = not recorded in written reports at the time of Evaluation; some may have been ongoing or recently initiated projects. It is also noted that the original documentation did not require all this information to be recorded; therefore NR does not denote lack of record keeping, just absence of this specific information.
CBA = cannot be assessed, due to insufficient detail available in written reports, as for NR.

health-related behaviours within a context of wider determinants. A usual pre-requisite of moving to healthy behaviours, where these are not habitual, is knowledge and understanding. However, it is well established that knowledge alone will rarely change behaviour[15]. The next stage is recognition and relevance of the behaviour to individuals i.e. acceptance of susceptibility and valuing health. In oral health behaviours, notably oral hygiene, the acquisition of skills to implement the behaviour is required alongside self-efficacy i.e. the belief that the behaviour can be effectively implemented[16]. Habituation of the healthy behaviours is necessary to establish maintenance and avoid relapse[17]. It is also recognised that a focus on individual behaviour alone may be ineffectual when the political and social environment is not supportive. For example, if designing a school programme to change oral health behaviour it is important to consider, relevance of the programme to the child, the engagement of the child with the programme and the frequency and consistency of exposure to the health message. The potential for the programme to change behaviour will be enhanced if the child is actively engaged in the programme, it is personally relevant to them and they are exposed on more than one occasion to a single, consistent message and that behaviour is supported by parents and is relevant and is culturally acceptable to that community[18,19]. Health promotion programmes in which target groups are visited only once, say every few years, e.g. single visits to summer camps, single visits to large numbers of people in the community, are unlikely to change behaviour or have any sustainable health benefits[20]. In several of the Country Projects, the number of people reached had been prioritised over quality intervention time with target groups. It was evident that some of these issues have been recognised by the partners and attempts to address this lack of experience of health promotion planning, project design and implementation have been made principally through training workshops which were highly valued by participants.

ORGANISATIONAL LEARNING

Both organisations had worked together before but it appears that this had been on a sponsorship basis only. In sponsorship, funds are given to support a single specific activity, e.g. a conference with a very low reputational risk on both sides. When a relationship is purely based on sponsorship, understanding the detail of how each other's organisation works is usually unnecessary. However, establishing a successful long-term partnership with joint goals requires recognition of differing organisational structures, drivers and objectives. This partnership has meant that much has needed to be learned and many difficulties overcome. Each has recognised the need for review, tighter planning and focus in the future. There was clarity in the contract on the use of the logo and the total amount of money to be paid to the FDI. However, in relation to the health promotion activities (Global Projects and Country Projects) a partnership business plan or financial plan had not been developed. Similarly, no evaluation plan had been drawn up to assess the benefits of the use of the logo or the health promotion activity of the partnership. As these had not been included at the outset, it limited the ability for any evaluation carried out at a later date to draw detailed conclusions of impact. This is particularly the case for the health promotion activities which require baseline data in order to quantify benefits. Organisational structure of partners and lines of accountability were not clearly articulated and understood by partners prior to the start of the LLL programme. It is important to note that these omissions reflect the early stage of the partnership and the exploratory working together. They also reflect the shift in aims that was starting to happen towards the end of the first phase of the partnership with wanting to quantify reach and impact in terms of health benefit, moving beyond the stated partnership aim of raising awareness of oral health matters.

The effectiveness of country level partnership working on LLL projects tended to vary depending on the strength of the relationship between the NDA and local Unilever Oral Care representatives. This was influenced by issues such as the alignment of the aims of the local LLL project with the local marketing strategy of Unilever Oral Care. Lack of alignment tended to lead to problems with the partnership process, for example, variable engagement with the project by Unilever Oral Care locally including difficulties in supplying products, hence some cases of project funds being used to purchase toothpaste . Projects aligned to the local Unilever Oral Care business were most successful in delivering to both sides of the partnership and levered additional resource from the local company.

SUMMARY OF ANALYSIS

This was found to be a unique public-private partnership for oral health. The first phase of any partnership is the most challenging. Nevertheless, the partnership has made significant progress towards achieving each of its three main goals. Namely, to raise awareness of oral health globally; to enable and support FDI member associations in promoting good oral health; and to increase the visibility of the FDI and authority of Unilever Oral Care oral care brands worldwide. It is evident from this Evaluation that the consensus of all those interviewed was that this partnership is worth continuing and has resulted in a number of benefits. For

FDI, this was seen by some senior members and external experts, to be a key part of re-positioning FDI towards health promotion. The partnership contributed to strengthening the partnership between National Dental Associations and the FDI. Since the Country Projects were focussed on oral health promotion rather than the business of dentistry, in some countries, it has given the FDI better access to governments on health matters. The development process for Country Projects has built some capacity amongst NDAs to undertake health promotion. The FDI has recognised financial benefits of the partnership in bringing discretionary funds to support promoting oral health globally. From Unilever Oral Care perspective, the partnership aligns with aspects of Unilever Oral Care's Social Mission. Alignment with at least one component of each partners' purpose is necessary for engagement and continued commitment of both parties.

CONCLUSIONS

This partnership has made major progress towards achieving its three main goals. Although the distribution of an oral health message on many millions of packs of toothpaste globally has the potential to raise awareness of oral health; this could not be measured. By the time of the evaluation, both partners desired to know the impact of their efforts. Therefore, a recommendation for the next phase of the partnership is that as objectives are defined, their measurement is considered at the outset to ensure partners can undertake appropriate and effective analysis of their achievement. Undoubtedly, the first phase of the partnership has enabled and supported some FDI member associations in developing projects to promote good oral health; and, increased the visibility of the FDI with member associations. It cannot be judged from this evaluation whether the partnership has increased the authority of Unilever Oral Care brands worldwide.

This analysis has explored how this unique, international partnership has developed during the implementation of the LLL programme and through the analysis, made suggestions of how aspects of the partnerships could be structured in the future. This Evaluation has documented the whole range of activities and programmes supported (including logo use, Global Projects and Country Projects) and, as far as possible assessed their reach and outcome (*Table 1*) and, from this analysis, it is concluded that over 1 million people have been reached directly through their engagement with 39 projects in 36 countries. Detailed recommendations on project design were made to both organisations. In summary, these included moving project design towards enhancing health beyond raising awareness, incorporating evaluation from the outset and strengthening administration.

In the year following the presentation of the Evaluation report, following a period of reflection, principal recommendations of the Evaluation Team were adopted for the next phase of the Partnership. Phase II of the partnership will again involve NDAs working in partnership with Unilever Oral Care locally, with "*a new goal to work together to measurably improve oral health through encouraging twice daily brushing with a fluoride toothpaste.*" This single focus, development of a set of common materials and support for Country Project design provides a strong basis for future success of the partnership aimed at improving oral health globally.

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Limitations of the evaluation and declarations of interest by the authors

Limitations of this evaluation are similar to any project evaluation; namely constraints on the time allowed and on the budget available. However, within both of these a comprehensive review has been completed. It is noted here that evaluation of the effect of the FDI logo and LLL brand, is limited. In order to undertake a comprehensive review including general practitioners and consumers, additional survey work would be required. The Principal Investigator, Professor Pine is not employed by either organisation but, in common with many senior research colleagues, has undertaken advisory work for different oral care companies including Unilever Oral Care and, her employing university has previously received funding for a clinical trial. However, she has not been involved in any of the Country Projects or Global Projects. Professor Pine is a member of the British Dental Association. Professor Dugdill, co-investigator and Professor in Public Health is not a dentist and has no previous experience with either organisation.

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