Issue date: December 2013

Oral health: local authority oral health improvement strategies

Evidence table appendices

14 Appendix G: Evidence table

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Authors and Year Arora et al. 2012 **Quality score** + **Intervention outline** Information leaflets giving dental advice for parents of preschool children. **Country** Australia **Intervention category** Health Education and/or Advice **Target population** New Mothers	**Research Question/aim** What are Child and Family Health Nurses (CFHNs) reflections on the usefulness of leaflets giving oral health advice to parents of preschool children. **Theoretical Approach** NR **Method** Semi-structured, in-depth phone interviews. **By whom** Two researchers conducted the interviews. **Setting** Over the phone. Other details NR **When** NR	**Source** Nurse Unit Managers in South Western Sydney were contacted to obtain details of the CFHNs who could represent all geographical sectors of the area. The investigation was centred on CFHNs (n=19) who gave post-natal health checks to new mothers in the area. **Recruitment method** CFHNs were invited to participate in the study via a telephone call and received a letter that they would be contacted and interviewed. **Number recruited** 19/19	**Description of method and process of analysis** Interviews were audio recorded and transcribed verbatim. Two researchers analysed the data through interview debriefing and transcript thematic coding. A consensus was reached and in cases of disagreement they sought advice from a third coder. **Results** 3. Programme/intervention characteristics 3.3 Intervention resources	**Author identified limitations** Used a convenience sample of CFHNs in South West Sydney which limits the transferability of the findings to the rest of Australia. Study did not gather opinions from other members of the primary health care team who are also likely to have regular contact with disadvantaged families. Did not seek opinions of parents with preschool children living in disadvantaged areas. **Review team identified limitations** Views on the leaflets were not sought from service users they were targeted at - disadvantaged mothers. The nurses' views may not represent the views of the mothers. **Evidence gaps (author reported)** Opinions from other members of the primary health care team, such as paediatricians or general practitioners, and of parents with

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				preschool children living in disadvantaged areas could be sought in future. **Source of funding** Australian National Health and Medical Research Council and the Australian Dental Research Foundation and NSW Health.
Authors and Year Blenkinsopp et al. 2002 **Quality score** + **Intervention outline** Ran for 3 months. Eleven community pharmacists took part in a scheme to offer health promotion advice to the public about four topics: exercise, dental health, smoking cessation and medicines. The pharmacists received a specific training programme (six days in total).	**Research Question/aim** 1) To assess levels of client (service user) uptake and pharmacist involvement in provision of the health promotion service and the key factors which influenced them. 2) From the client's perspective, to assess: the acceptability of the service, the approach taken by the pharmacist, whether clients reported making any changes to lifestyle as a result of the pharmacist's input. **Theoretical Approach** The intervention training drew on the transtheoretical model (TTM) of behaviour change model and motivational	**Source population** Clients (service users), pharmacists, project board members. **Recruitment method** Clients (service users): all clients asked to complete questionnaire after their intervention. Intended to follow up with phone interviews, just 14 were completed by 1998. The "pharmacist in charge" of each of 11 pharmacies taking part was asked to participate in interviews. All members of the project board were asked to participate in interviews.	**Description of method and process of analysis** Clients: questionnaire data entered onto a computerised database, interview forms coded and analysed by content analysis of clients' comments to identify key themes. Pharmacists and stakeholder interviews: analysed by content analysis by two members of the evaluation team. One stakeholder was also a scheme participant and was coded in both groups. **Results** <u>1. Community Level</u>	**Author identified limitations** Difficult to interpret levels of service user uptake in the absence of data on the numbers of customers using the pharmacies. The South Staffordshire scheme did not include an assessment of clients' readiness to change in Level 1 interventions, a feature that could be incorporated into future schemes. Pharmacists may have felt more comfortable reverting to query-answering mode, and some topics may not have lent themselves to TTM, for example, dental health had a large component to do with factual information-giving about the

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Clients were offered a brief “Level 1” intervention (up to 10 mins) with a second, extended “Level 2” (20 to 30mins) where the pharmacist and client thought it necessary. The pharmacists were paid a fee for each brief (£10) and extended intervention (£30). **Country** England **Intervention category** Health Education and/or Advice **Target population** General population	interviewing techniques. **Method** 1) Client (service user) questionnaires immediately after brief and extended interventions 2) Brief and extended follow-up interviews with clients who had used the service 3) Semi-structured phone interviews with participating pharmacists 4) Stakeholder interviews with all members of the project board **By whom** NR **Setting** Interviews were over the phone. Client survey was posted, but the timing was unclear. **When** 1998 to 1999	**Number recruited (completed/recruited)** Client questionnaire: NR/301 level 1 interventions carried out and 30/30 level 2. Client interviews: 29 total. 14 were completed in 1998 (five dental health). Additional random sample of 15/186 receiving Level 1 intervention (none dental health) Pharmacist interviews: 9 "pharmacists in change" out of the 11 pharmacists practices taking part in the intervention. Stakeholder interviews: 7/7 members of the project board (Deputy Head of Health Promotion; the Health Authority Community Pharmacy Facilitator; National Pharmaceutical Association Regional	1.1 Funding 2. Provider Characteristics 2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of innovation/new programme or intervention 2.4 Self proficiency 3. Programme/intervention characteristics 3.2 Adaptability/flexibility 4. Organisational Capacity 4.1 General organisational factors 4.3 Specific staffing considerations 5. Prevention support system 5.1 Training 6. User Views 6.1 Acceptability	availability of services. **Review team identified limitations** Sampling rationale not reported. Limited reporting of participant characteristics. Only one level 2 intervention was for oral health (the rest were smoking) so level 2 results are not generally applicable to oral health. Unclear to what extent pharmacists were using TTM principles and motivational interviewing as per their intervention training or whether they were reverting to their more traditional information giving style. **Evidence gaps (author reported** The role and effectiveness of training in TTM for community pharmacists requires further work. Peer review of consultation style could provide valuable feedback to participating

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		Professional Development co-ordinator and four community pharmacists, one of whom was a participant in the scheme).		pharmacists and indicate the type of consultation styles in use. **Source of funding** NR
Authors and Year Blinkhorn 2008 **Quality score** - **Intervention outline** A health visitor led programme, Brushing for Life is designed to promote regular brushing of children's teeth using toothpaste with a middle range (1,000 parts per million) of fluoride content. Where appropriate, packs containing toothpaste, a toothbrush and a health educational leaflet are distributed to the parents of infants at their 8, 18 and 36 month development checks. This is supported by advice from the health	**Research Question/aim** To examine the views and experiences of deliverers of the Brushing for Life programme - primarily health visitors and oral health promotion coordinators within PCTs – using information gained from questionnaires. **Theoretical Approach** NR **Method** Questionnaire. **By whom** NR **Setting** NR **When** NR	**Source population** Health visitors involved in the scheme. **Recruitment method** NR **Number recruited** 549/747 health visitors contacted (73%) responded to a questionnaire.	**Description of method and process of analysis** NR **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.2 Specific practices and processes	**Author identified limitations** NR **Review team identified limitations** Methods of survey data collection and analysis for the health visitors NR. Authors state "this appraisal of Brushing for Life was drawn from published work, reports and other documentation" potentially explaining why methodological details are missing. **Evidence gaps (author reported)** NR **Source of funding** NR

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visitor on the care of the child's teeth. **Country** England **Intervention category** Health Education and/or Advice (advice + pack of toothpaste, brush and educational leaflet) **Target population** Under 5s "in the most disadvantaged areas of the country"				
Authors and Year Burchell et al. 2006 **Quality score** - **Intervention outline** The 'Dental as Anything' programme is a collaborative partnership between the mental health, dental and administration teams of the Inner South	**Research Question/aim** NR **Theoretical Approach** NR **Method** NR. Appears to be an author only description of the intervention and problems encountered. **By whom** NR	**Source population** NR **Recruitment method** NR **Number recruited** NR	**Description of method and process of analysis** NR **Results** <u>1. Community Level</u> 1.1 Funding <u>3. Programme/intervention characteristics</u> 3.2 Adaptability/flexibility 3.4 Contact time	**Author identified limitations** NR **Review team identified limitations** No formal qualitative methodology described throughout. Article appears to be the opinions and insight of the authors only. Unsure if they actually took a qualitative approach, however, results section includes quotes from staff so there is a suggestion it may be

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Community Health Service (ISCHS) in Melbourne. Incorporates engagement, clinical care, education and support using a health promotion framework and an assertive outreach model. A dentist, dental assistant and a mental health outreach worker take dentistry and mental health support to a variety of settings to provide increased services to marginalised clients. **Country** Australia **Intervention category** Complex Intervention. Incorporates engagement, clinical care, education and support in response to client needs. **Target population** Complex needs	**Setting** NR **When** NR		4. Organisational Capacity 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations	accumulation of more than the authors opinions. **Evidence gaps (author reported)** NR **Source of funding** Victorian Department of Human Services funded Dental as Anything.

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(People with mental health illness described as having complex oral health needs)				
Authors and Year Coles et al. 2012 **Quality score** + **Intervention outline** "Something to Smile About" (STSA). Provide staff with a framework to offer oral health advice to their homeless clients and signpost to dental services. **Country** Scotland **Intervention category** Health Education and/or Advice **Target population** Homeless	**Research question/aim** The specific objectives of the evaluation were to: 1. Explore the oral health capacity of staff. 2. Explore the degree to which staff used a client-centred approach to promote change in client oral health-related behaviours. 3. Explore strengths, weaknesses and areas for improvement. 4. Evaluate whether STSA had achieved its outcome 'to build the capacity of staff working within the local authority, health and voluntary sectors to deliver oral health interventions to people affected by homelessness'. **Theoretical Approach** NR **Data collection** Three focus groups	**Source population** Professionals from organisations that had participated in STSA. **Recruitment method** NR **Number recruited** 10 of the 20 participating organisations agreed to take part in the evaluation due to time constraints and work commitments. A purposive sample of 14 people from the 10 organisations was gathered, representing a variety of professional backgrounds. Twelve of the 14 participants were women. No further characteristics were reported.	**Description of method and process of analysis** Manifest content analysis. Unit of analysis was each focus group. Rigorous line-by-line open coding was undertaken independently by two researchers to allow concepts to emerge. The emerging themes were discussed by the two researchers; a discussion was held to reach consensus when there was difference in the interpretation of the data. **Results** <u>2. Provider Characteristics</u> 2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of innovation/new	**Author identified limitations** No clients participated in the evaluation so it was impossible to gauge the impact of STSA from a client (service user) perspective. Only 10 of the 20 organisations that took part in STSA were represented in the evaluation; staff from the remaining organisations were invited to participate but for various reasons either did not respond or did not attend the focus groups due to time constraints or other commitments. **Review team identified limitations** Only 50% response rate from organisations taking part in STSA, which could bias results. Important characteristics of people interviewed are not reported (e.g. job role/function within the intervention).

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	Method Two focus groups of five participants, and one of four participants. Each 1.5 hour focus group was audio recorded and transcribed. Staff were asked about their involvement and experiences in delivering the intervention, as well as their feelings about STSA and the impact and effectiveness of STSA resources. **By whom** Independent researcher who was unknown to the staff members. **Setting** NR **When** September 2009		programme or intervention 2.3 Self-efficacy 2.4 Self proficiency <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.2 Adaptability/flexibility 3.3 Intervention resources 3.4 Contact time <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.2 Specific practices and processes <u>5. Prevention support system</u> 5.1 Training 5.2 Technical Assistance	**Evidence gaps (author reported)** If the goal of health promotion is to assist homeless people to change their health behaviours and adhere to oral health messages, then there is a need to explore the experiential and contextual elements that influence their engagement with health promotion. In order to explore these influences it would be necessary to discover the views and opinions not only of those who interact and work with this client group, but also the expressed and felt needs of the people experiencing what it is to be homeless. **Source of funding** NR
Authors and Year Dental Health Foundation 2007 **Quality score**	**Research question/aim** 1) What are oral health promoters' perceptions and concerns of delivering health promotion programmes in schools?	**Source population** Oral health promoters, teachers and children taking part in the Winning Smiles programme in Dublin and Belfast primary	**Description of method and process of analysis** Oral health promoters chose a generative theme of "tensions"; process of analysis NR.	**Author identified limitations** In Dublin the teacher debriefing was carried out by means of one-to-one interviews in the intervention school. Not possible in the two Belfast intervention

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+ **Intervention outline** "Winning Smiles" school oral health promotion programme for 7 to 8 year olds. **Country** Republic of Ireland and Northern Ireland **Intervention category** Complex Intervention **Target population** School children "in areas of high social deprivation and disadvantage"	2) What are the teachers' views on the programme? 3) What are children's thoughts on the Winning Smiles intervention? **Theoretical Approach** A Story-Dialogue Method used 'narratology' as a method of examining the ways in which narrative structures the participants' perceptions of their professional culture, society and the issues pertinent to the Winning Smiles oral health promotion programme. **Method** 1) Oral health promoters: story dialogue workshop. 2) Teacher "debriefing" (questionnaire and interview): All the teachers in the intervention schools in Dublin (six teachers) and Belfast (five teachers) were invited to take part. The schedule explored views on the programme in relation to curriculum requirements, the children's	schools. **Recruitment method** NR for oral health promoters and children. All the teachers in the intervention schools in Dublin (six teachers) and Belfast (five teachers) were invited to take part. **Number recruited** Oral health promoters NR. 11 teachers (6 from Dublin schools 5 from Belfast). 10 groups with 44 children.	Children: method centred on tooth brushing rules worksheet and drawings; analysis NR, although results contain illustrative quotes. Results from teachers from different schools could not be merged due to different data collection methods; analysis was a descriptive summary. **Results** <u>2. Provider Characteristics</u> 2.3 Self-efficacy <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.3 Specific staffing considerations <u>5. Prevention support</u>	schools; however, they agreed to fill in the questionnaires themselves. Consequently, it was not possible to explore fully their views on the initiative as there was not as much clarity and richness of information from these two schools. **Review team identified limitations** Sample selection methods not reported; unclear whether the views of the sample are reflective of the wider group involved in the programme. Link between the data collected and the conclusions drawn/summary description is not clear or explicit. Most clear for the data from children. Less clear from teachers and oral health promoters. **Evidence gaps (author reported)** NR **Source of funding** Health Promotion Unit of the Department of Health and

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	enjoyment of it, the role of both the teachers and the oral health promoters in the implementation of the programme and the various component parts of the resource pack provided. Views on the Teachers Workshop were also explored. 3) Children's thoughts: a mixture of writing and picture drawing tasks reflecting on the tooth brushing programme. **By whom** NR **Setting** NR **When** November 2003 to May 2004		system 5.1 Training 6. User Views 6.1 Acceptability	Children and the Research and Development Office, Directorate of the Northern Ireland Health and Social Services Central Services Agency.
Authors and Year Diamond et al. 2003 **Quality score** - **Intervention outline** By partnering community-based	**Research question/aim** Process evaluation on the implementation of a community-based oral health care programme primarily targeting children in dentally underserved communities. **Theoretical Approach**	**Source population** Interviews were conducted with people by their affiliation in one of four categories: public schools, community leaders, Columbia University, and DentCare.	**Description of method and process of analysis** NR **Results** 1. Community Level 1.1 Funding 1.2 Policies	**Author identified limitations** NR **Review team identified limitations** Unclear how representative the views expressed by the sample interviewed are of wider views of those involved in the programme.

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organisations, public schools, and community health care providers, the Columbia University School of Oral and Dental Surgery (SDOS) established the Community DentCare Network (DentCare) in the Harlem and Washington Heights/Inwood neighbourhoods of northern Manhattan. **Country** US **Intervention category** Complex Intervention **Target population** School children in dentally underserved communities	NR **Method** Open-ended qualitative interviewing. **By whom** A sociologist with extensive experience in this methodology aided by a participant-observer within the DentCare programme. Researchers jointly conducted 27 interviews. **Setting** NR **When** NR	**Recruitment method** NR **Number recruited** 27 (6 from Public Schools, 6 Community Leaders, 6 Columbia University Administrators, 9 DentCare Staff).	3. Programme/intervention characteristics 3.1 Compatibility 3.2 Adaptability/flexibility 3.3 Intervention resources 4. Organisational Capacity 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations	Risk of selection bias as sample recruitment method not described. Method of interview analysis NR; unclear risk of bias. **Evidence gaps (author reported)** NR **Source of funding** Unclear. The Kellogg Foundation funded DentCare's start-up and requested that a process evaluation be performed.
Authors and Year Douglass 2005 **Quality score** -	**Research question/aim** What are the implementation issues, productivity and costs of the three mobile dental clinic programmes currently established in Connecticut.	**Source population** NR **Recruitment method** NR	**Description of method and process of analysis** NR **Results** 1. Community Level	**Author identified limitations** NR **Review team identified limitations** Sample size recruited, sample

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Intervention outline Mobile dental vans for underserved school children. **Country** US **Intervention category** Improving access **Target population** School children	**Theoretical Approach** NR **Method** After preliminary investigative visits to each mobile clinic, a 29-item structured survey was designed and sent to each programme. Information on programme age, issues encountered in planning and implementation, and on-going costs and productivity for the last financial year were obtained. The survey was followed-up with personal interviews. Information was predominantly collected from the person responsible for programme administration. **By whom** NR **Setting** NR **When** NR	**Number recruited** NR	1.1 Funding <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.3 Specific staffing considerations	characteristics, sample inclusion/exclusion criteria not reported. Views may not be representative of wider staff involved in the programme. User views not sought. **Evidence gaps (author reported)** NR **Source of funding** Connecticut Health Foundation.
Authors and Year	**Research question/aim** To inform the communication	**Source population** Parent sample:	**Description of method and process of analysis**	**Author identified limitations** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Holme at al. 2009 **Quality score** ++ **Intervention outline** "Childsmile": a childhood oral health service being rolled out across Scotland. Provides 'universal' access to Childsmile care for every new-born, including oral health promotion and clinical prevention (Childsmile Practice) and core supervised tooth brushing in nurseries and distribution of free tooth brushing packs for 0-5 years. Additional 'targeted' support for children seen to be most at risk of dental caries, including 'enhanced' care focussing on children 0-3 years together with targeted Childsmile Nursery and School components in disadvantaged areas.	strategy and the development of local social marketing campaigns designed to improve uptake of the Childsmile programme. Aim was addressed in 2 ways: Scoping exercise and literature review (not qualitative; not described here) Focus groups and mini-groups interviewing parents (10 groups) and relevant professionals (8 minigroups). **Theoretical Approach** An exploratory approach of the various programme components and the factors that facilitate and hinder engagement and delivery. **Method** Focus groups and mini-groups using a topic guide to ensure coverage of relevant issues. The topic guides reflected the research questions and were informed by the initial stakeholder interviews, literature review and input from the Steering Group. The focus groups were audio-recorded	parents/carers with a child aged 0-3 years (some also having children aged 4-8 years) living in disadvantaged areas. Included a mix of those who had or had not experienced Childsmile. The key professionals interviewed comprised: Childsmile Extended Duty Dental Nurses (EDDNs) & Dental Health Support Workers (DHSWs); public health nurses/health visitors (HVs), main referrers to Childsmile Practice; midwives (MWs) who have a potential role in referral; and nursery/nursery school and family centre staff who support Childsmile Nursery and core tooth brushing programmes. **Recruitment method** Parents/carers NR. Professionals were recruited through the relevant management	NR **Results** <u>2. Provider Characteristics</u> 2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations <u>5. Prevention support</u>	**Review team identified limitations** Numbers recruited and numbers eligible to be recruited NR. Numbers in each group or mini-group NR. It was reported that there was at least one focus group (group 10) carried out in response to low turnout for other groups (group 6 & 7). No explanation of poor turnout described. Unclear how the sample of parents and staff were recruited. Reported that direct experience of Childsmile Practice and Childsmile Nursery and School was mixed and so many interviewees were responding to the concept of service components rather than direct experience. **Evidence gaps (author reported)** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
NB: this was the same programme assessed by Macpherson et al. 2010. **Country** Scotland. **Intervention category** Complex Intervention **Target population** Under 5s (universal programme with targeted support focussing on children from disadvantaged areas).	with the consent of participants. **By whom** Groups were moderated by experienced qualitative interviewers. **Setting** Convenient 'neutral' locations such as community halls or other venues connected to the location where the respondent was recruited (e.g. family centres, work places). **When** NR	structures. No further details reported. **Number recruited** Exact numbers NR. Ten parent groups, maximum of 8 respondents per group. 8 professional mini groups, numbers recruited NR.	<u>system</u> 5.1 Training 5.2 Technical Assistance <u>6. User Views</u> 6.1 Acceptability	**Source of funding** NR
Authors and Year Kranz et al 2011 **Quality score** + **Intervention outline** Oral health interventions or advice in Early Head Start (EHS) programmes, a federally funded programme designed to address the	**Research question/aim** To report on the oral health activities of teachers in Early Head Start (EHS) programmes in North Carolina (US), to describe variation among programmes, and to identify teacher and programme-level factors associated with these activities that could potentially be modified through training programmes or other interventions.	**Source population** Staff involved in the EHS programme in North Carolina (NC). **Recruitment method** The 18 EHS programmes in NC were identified with assistance from the state's Head Start collaborator and confirmed by published lists and communication with the federal regional	**Description of method and process of analysis** Least squares regression between predictor variables and child and parent oral health activities. The most relevant survey section used a list of potential barriers and a 0-4 Likert-type scale. Staff were asked to indicate how each barrier rated as an obstacle to providing	**Author identified limitations** Although EHS programmes follow federal standards, the results may not be transferable beyond North Carolina because variation in adherence may exist among states and programmes. Finally, because the findings are based on self-completed questionnaires the results might be biased if teachers miss reported their level of participation in oral health promotion activities or incorrectly

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
social, educational and health needs of pregnant women and children younger than three years of age. **Country** US **Intervention category** Health Education and/or Advice **Target population** Under 5s (Early Head Start, families with household incomes at or below 135% of the Federal Poverty Level are targeted).	**Theoretical Approach** NR **Method** A cross-sectional survey using a self-completed questionnaire. **By whom** Questionnaires were delivered in person to each of the EHS programmes by research staff. A designated EHS staff member collected and returned all questionnaires. **Setting** NR. **When** June 2005	oversight office. **Number recruited** 18/18 programme directors and 20/20 health educators were analysed. 485 staff members returned the survey. Analysis was restricted to teachers (n=309) because they regularly interact with children and families. 231 teachers were analysed for child oral health activity outcomes, and 260 teachers for parent oral health activities.	dental activities for children and parents. Responses of “very much an obstacle” and “somewhat an obstacle” were recoded and summed to create a count of the total barriers. **Results** <u>2. Provider Characteristics</u> 2.3 Self-efficacy <u>3. Programme/intervention characteristics</u> 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.2 Specific practices and processes 4.3 Specific staffing considerations <u>5. Prevention support system</u> 5.1 Training	recalled their activities. **Review team identified limitations** Some staff groups (e.g. programme directors and health coordinators) who responded to survey were excluded from the main analysis after they had submitted their views. Main analysis was restricted to teachers only. Research instrument used scales rather than open ended questions, restricting the possible range of views expressed. **Evidence gaps (author reported**) NR **Source of funding** Medicaid services (CMS), Health Resources and Services Administration (HRSA), and the National Institute of Dental and Craniofacial Research (NIDCR).

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Authors and Year Lemay et al. 2010 **Quality score** + **Intervention outline** People living with HIV/AIDs receiving a dental case manager (DCM) **Country** US. **Intervention category** Improving access (using a DCM). **Target population** Complex needs (people living with HIV/AIDS).	**Research question/aim** To measure access to, and satisfaction with, dental services for people living with HIV/AIDS and explore the role of the dental case manager in improving access and satisfaction with dental care received. **Theoretical Approach** NR **Method** Postal 23-item Dental Satisfaction Survey with anonymous returned mailings. **By who** Self-completed postal survey **Setting** Postal survey to the participants' homes **When** October 2007	**Source population** All dental patients living with HIV/AIDS who had received services at either of two Community Dental Centres on the Cape between October 2005 and September 2007 (N = 160). **Recruitment method** Mailed letter notifying potential participants of the project an informing them that the survey would be mailed the following week. **Number recruited** 71/160 surveys were returned completed (44.4%). 3 people were no longer eligible (1 had died, 2 had relocated due to hurricane Katrina) and 26 were returned undeliverable. So revised RR was 71/131 (54.2%).	**Description of method and process of analysis** Used frequencies, chi squared and odds ratios to analyse quantitative data and compare closed survey questions. For open questions, content analysis was used. Verbatim responses were coded independently by two investigators with very high inter-coder agreement (95%). Emergent themes were identified. **Results** 6. User Views	**Author identified limitations** The opinions those responding to the survey may be different from those who did not respond. The sample size was small. The project did not address wider factors that could be influencing the findings of increased access to dental care for patients living with HIV/AIDS on Cape Cod, including policy changes and modifications to benefits structure. Responses to the question regarding whether the patient had a dental case manager indicate that there may be measurement error. All individuals who received the survey had been contacted by and/or had received services from the dental case manager. Utilising an anonymous survey limited analyses. It did not allow for analyses of the non-responders, the dose effect of contact with the dental case manager or for improvement in oral health over time. Contacting patients connected to care does not provide information

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				pertaining to needs of the population not yet connected to care. **Review team identified limitations** Response rate was relatively low so may not represent the general views of people living with HIV/AIDS. **Evidence gaps (author reported)** NR **Source of funding** Health Resources and Service Administration, Special Projects of National Significance.
Authors and Year Lemay et al. 2012 **Quality score** + **Intervention outline** Assigning people living with HIV/AIDS a dental case manager (DCM) to improve access to	**Research question/aim** To examine the perceptions, attitudes, and beliefs of dental patients living with HIV/AIDS on the role and value of the dental case manager (DCM) and the effect of DCM services on their oral or overall health. **Theoretical Approach** NR	**Source population** Everyone who had received DCM services at the 2 clinics from November 2007 through November 2009 (n = 216). **Recruitment method** Mailed invitations. **Number recruited**	**Description of method and process of analysis** Digital recordings were transcribed verbatim. Transcripts were coded then imported into Microsoft Excel. One investigator read the transcripts several times to identify emerging themes and to develop a coding scheme on the	**Author identified limitations** Small sample size due to focus group approach. Participation bias; the study participants may not accurately represent all dental clients receiving DCM services. Study conducted in only 1 place limits generalisability. Limited collection of data demographic characteristics. Characteristics of sample (non-Hispanic white men)

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
services and general oral health. **Country** US. **Intervention category** Improving access **Target population** Complex needs (people living with HIV/AIDS).	**Method** Focus groups **By whom** An experienced focus group facilitator conduct 5 groups. **Setting** NR **When** December 2009 to June 2010.	28 agreed to participate, 25 participated. Participants were required to be aged 18 or older, living with HIV/AIDS, and English-speaking.	basis of the original research questions and spontaneous comments. Two investigators categorised textual data separately according to directed qualitative content analysis. They calculated the percentage of inter-coder agreement and revised the coding scheme after each round until they reached agreement (85%). Disputed responses were reviewed until coders had achieved 100% agreement. Comments expressed most frequently were identified as major themes. **Results** 6. User Views 6.1 Acceptability	did not reflect the characteristics of the HIV/AIDS population of interest/most at risk (Latino and black men). **Review team identified limitations** Sample was restricted to English speaking adults with HIV/AIDS. Almost all (23/25) were non-Hispanic white, may not be representative of target population of wider HIV/AIDS vulnerable groups. Response rate was low 11.6% (25 participated of 216 eligible). **Evidence gaps (author reported)** NR **Source of funding** US Department of Health and Human Services, Health Resources and Services Administration.
Authors and Year Macpherson et al. 2010 **Quality score**	**Research question/aim** To describe the development and implementation of this national oral health improvement programme	**Source population** No sample recruited. Appears to be views of the study author group. This includes reference to two	**Description of method and process of analysis** NR. Appears to be views of the study author group only as part of an	**Author identified limitations** NR **Review team identified**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
- **Intervention outline** Childsmile programme, 4 interlocking elements combining both targeted and population based approaches. 1) Childsmile Practice - provision and prevention interventions targeting under-2s in deprived communities from a dental practice. 2) Childsmile Nursery and 3) Childsmile School: clinical prevention activities for children attending priority nursery and primary schools 4) Childsmile Core - free distribution of toothpaste/toothbrush packs to every child in Scotland on at least six occasions during their first five years, plus the offer of free daily tooth brushing to every 3 and 4-year old child attending nursery in	[Childsmile] for children in Scotland over its initial three-year period (January 2006 to December 2008) and into its second phase of development. **Theoretical Approach** NR **Method** NR **By whom** NR **Setting** NR **When** January 2006 to December 2008.	pieces of embedded research with a focus on barriers and facilitators of uptake of Childsmile services. One of which was relevant to this review (See Holme et al. 2009) **Recruitment method** NR **Number recruited** NR	evaluation. **Results** <u>2. Provider Characteristics</u> 2.1 Perceived need for innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.2 Adaptability/flexibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.2 Specific practices and processes <u>5. Prevention support system</u> 5.1 Training 5.2 Technical Assistance	**limitations** Origins of the views, conclusions and description are not reported. This was a narrative description of the development of the programme including embedded research on barriers and facilitators (See Holme et al. 2009). No formal qualitative methods were reported so views expressed may be biased by the author and may not be representative of the different staff groups and participants involved in the programme. **Evidence gaps (author reported)** NR **Source of funding** The Childsmile Programme is funded by the Scottish Government Health Directorate.

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Scotland. **NB:** This programme was also assessed by Holme at al. 2009. **Country** Scotland **Intervention category** Complex Intervention **Target population** Under 5s				
Authors and Year Maher et al. 2012 **Quality score** - **Intervention outline** The Early Childhood Oral Health (ECOH) Programme involves a partnership between child health professionals, oral health professionals and parents of young children, to facilitate the primary prevention, early identification and early	**Research question/aim** Has a model of shared responsibility for early childhood oral health has been implemented in NSW? What are the key achievements of the ECOH Programme and the factors enabling these? Has the programme been effective in reaching populations with a higher burden of oral disease in NSW? **Theoretical Approach** NR	**Source population** Programme implementers. Eligible number NR **Recruitment method** Preliminary survey participants were selected by their local programme co-ordinator. Health professionals to be interviewed were selected from areas that have higher levels of dental disease. These settings were selected without prior knowledge or consideration of the coverage or success of	**Description of method and process of analysis** Interviews were audio-taped, transcribed verbatim, and analysed using a qualitative template approach to content analysis. Units of meaning were identified in the interview text concerning participants' ECOH programme experience and perceptions of success. Sub-categories, categories, and themes were then identified. Each new piece of data was compared with	**Author identified limitations** NR **Review team identified limitations** No explanation reported for the sample selection of the 40 preliminary survey participants; potential source of selection bias as a local programme co-ordinator selected participants, may have selected a well performing sample. **Evidence gaps (author reported)** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
intervention of Early Childhood Caries. Parents are provided with anticipatory guidance, resources and support to enable positive oral health behaviours in the home, and to encourage parental monitoring of their child's oral health. The second objective is to support oral health professionals to focus on early management of dental disease, and to incorporate promotion and prevention into their services, working in partnership with parents and families. **Country** Australia **Intervention category** Complex Intervention **Target population** Under 5s	**Method** Programme document review: clinical guidelines, policies and training manuals, and unpublished documents such as programme proposals, reports, presentations and the results of monitoring activities. Surveys and interviews with programme implementers: 5-item preliminary phone survey addressing the frequency nurses conducted oral health promotion and screening within routine child health checks, and the participation of the nurses in oral health professional development activities of the ECOH. Semi-structured interviews: open ended questions used to explore experiences of developing, implementing, and monitoring the programme, and perception of associated successes and challenges. **By whom** Main qualitative element was	the programme in those areas. **Number recruited** 40 child and family health nurses completed the preliminary survey, 24 health professionals participated in the semi-structured interviews (five ECOH Programme Co-ordinators, 14 child and family health nurses from the three higher risk settings, and five staff from the Centre for Oral Health Strategy NSW Health (COHS).	subsequent ones allowing key patterns to emerge. The coding was discussed between three authors to improve the veracity of the analysis, and consensus reached. **Results** <u>1. Community Level</u> 1.2 Policies <u>2. Provider Characteristics</u> 2.1 Perceived need for innovation/new programme or intervention 2.3 Self-efficacy 2.4 Self proficiency <u>3. Programme/intervention characteristics</u> 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.1 General organisational factors	**Source of funding** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	the interviews. All interviews were conducted face-to-face by the first author (LM) and lasted approximately 60 minutes. **Setting** NR **When** 2010		4.3 Specific staffing considerations <u>5. Prevention support system</u> 5.1 Training	
Authors and Year Marino et al. 2005 **Quality score** + **Intervention outline** Community-based health promotion programme offered through community ethnic clubs to improve the use of oral health services, oral health knowledge, attitudes, and practices of older Greek and Italian adults. **Country** Australia	**Research question/aim** To assess the participants' views about the format, content and delivery of the programme, as well as the relevance and appropriateness of the information provided. **Theoretical Approach** NR **Data collection** 15 focus groups. **Method** 30-40 minute focus groups using recursive semi-structured interviewing based on a schedule of open-ended questions. The focus groups	**Source population** Participants from the test clubs, total number NR **Recruitment method** NR **Number recruited** 151 (53 men, 98 women). Mean age 70.8 years for the 81 Italian participants and 66.9 years for the 70 Greek participants.	**Description of method and process of analysis** The focus group discussions (FGDs) were conducted in either Italian or Greek and audio taped with participant consent to allow for verbatim transcriptions and analysis. Following familiarisation with the content of transcripts, a thematic coding schedule was developed with reference to the topics discussed during the FGDs **Results** <u>6. User Views</u>	**Author identified limitations** Each focus group consisted of volunteers recruited from test clubs, which may have resulted in a positive bias in findings. Group dynamic limitations are: the desire to please, which may affect participants' responses and participation; and disclosure of alternative views may be less likely to occur. **Review team identified limitations** As per authors'. **Evidence gaps (author reported)** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Intervention category Complex Intervention **Target population** Older persons: older migrant adults aged 55 and over.	sought participants' views about all aspects of the oral health promotion programme and delivery, including the use of educational seminars; the preparation of simple language printed material known as the ORHIS (Oral Health Information Seminars/Sheets); and the distribution and demonstration of oral care products relevant to each individual seminar. **By whom** Two bilingual facilitators trained to use a recursive semi-structured interviewing method. **Setting** Ethnic social clubs during normal club hours. **When** April to June 2002.		6.1 Acceptability	**Source of funding** Victorian Health Promotion Foundation (Australia)
Authors and Year O'Neill and O'Donnell 2003 **Quality score**	**Research question/aim** NR. Assessed as an evaluation of the healthy snacks scheme. **Theoretical Approach**	**Source population** 129 schools participating up to 2001. **Recruitment method** NR	**Description of method and process of analysis** NR **Results**	**Author identified limitations** NR **Review team identified limitations**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
- **Intervention outline** Smart Snacks Scheme: A healthy breaks initiative in the school environment. It targets schoolchildren in the primary, special and nursery/playgroup in Northern Ireland. **Country** Northern Ireland **Intervention category** Common risk factors Smart Snacks Scheme. **Target population** School children	NR **Method** Phase 1(quantitative): postal questionnaire sent to the health education co-ordinator or primary schools within the scheme (n=52), and to a control sample of schools (n=27) matched for socio-economic, geographic, demographic and religious belief Phase 2 (qualitative): one-to-one interviews with teaching staff and a sample of parents. Phase 3 (qualitative): focus groups with school children. **By whom** NR **Setting** Questionnaire was mailed out to the schools. Phase 2 and 3 involved visits to the schools. No further details reported. **When** 2000	**Number recruited** Phase 1 (quantitative): responses from 44/52 primary school teachers RR 77%. Phase 2 and 3 (qualitative): 15 schools visited for focus groups/interviews with parents and school children. Denominator NR	2. Provider Characteristics 2.2 Perceived benefits of innovation/new programme or intervention 3. Programme/intervention characteristics 3.2 Adaptability/flexibility 3.3 Intervention resources 4. Organisational Capacity 4.2 Specific practices and processes	No link between the interview/focus group data and qualitative results and conclusions. Methods of data analysis and detail of data collection methods NR. **Evidence gaps (author reported)** NR **Source of funding** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Authors and Year Owens 2011 **Quality score** + **Intervention outline** Over a period of two years, 700 non-dental professionals, who were regularly in contact with children with disabilities and their parents, were educated in oral health promotion by attending a half day course; oral health promoters were placed in the community; health promotion packs were produced for staff and intervention packs were developed for parents. **Country** Republic of Ireland **Intervention category** Complex Intervention **Target population**	**Research question/aim** To identify barriers that prevented children with disabilities from achieving optimum oral health, and to provide a greater understanding and possible solutions to these barriers. **Theoretical Approach** A blend of ethnography, narrative and constructivism was used to inform the methods and conduct the research. Used techniques "similar to the process of grounded theory". **Method** One to one interviews and focus groups. **By whom** All interviews were taped and transcribed by one researcher. **Setting** A one-to-one basis in a location of parents/carers' choosing. **When**	**Source population** NR **Recruitment method** A purposive sample of15 parents or carers of children with disabilities. Four professionals, from a variety of backgrounds – voluntary, health and social care and ancillary care and three focus groups, with a mixture of professionals, ranging in number from 3–10 took place. No further details reported. **Number recruited** 15 parents (interviews), 18 non-dental professionals (interviews or focus groups).	**Description of method and process of analysis** Thematic analysis. Themes were triangulated with the researcher's observations, and other stories told by parents and healthcare professionals. The social model of disability was used as a lens through which to view data; this meant that the researcher was looking for structural barriers to oral health promotion, rather than viewing children and parents as a problem. **Results**: parents <u>1. Community Level</u> 1.1 Funding 1.2 Policies <u>2. Provider Characteristics</u> 2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of	**Author identified limitations** Small sample size used. The researcher was not involved in the initial process of building and evaluating the intervention. At the time of study, the Health Service Executive was in a state of flux; there was an embargo on all staff, job vacancies were not being filled, and people were unsure of their job status. These factors undoubtedly affected the data collection. **Review team identified limitations** Unclear why this sample of people were chosen, or the size of the eligible source population. Hence, unclear if views sampled represent wider views of source population. High risk of selection bias highlighted by study authors as many professionals involved in the intervention refused to participate in the interviews/focus groups. **Evidence gaps (author reported)**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Complex needs (children with disabilities).	NR		innovation/new programme or intervention 2.3 Self-efficacy 3. Programme/intervention characteristics 3.1 Compatibility 3.3 Intervention resources 4. Organisational Capacity 4.3 Specific staffing considerations **Results**: non-dental professionals 1. Community Level 1.1 Funding 2. Provider Characteristics 2.1 Perceived need for innovation/new programme or intervention 2.4 Self proficiency 3.	NR **Source of funding** No funding.

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
			Programme/intervention characteristics 3.1 Compatibility 4. Organisational Capacity 4.2 Specific practices and processes	
Authors and Year Prokhorov et al. 2002 **Quality score** + **Intervention outline** No active intervention. Assessing existing attitudes and health promotion practices towards spit tobacco prevention and cessation among young people. **Country** US **Intervention category** Health Education and/or Advice **Target population**	**Research question/aim** Assess the attitudes and practices of healthcare professionals and community based educators towards spit tobacco (ST) counselling; these professionals selected as they could have a significant influence on adolescent ST use through their prevention and cessation activities. **Theoretical Approach** NR **Method** Survey of health-care professionals (family medicine and paediatric physicians, nurses, dentists and dental hygienists) and community based educators (4-H and family consumer science (FCS)	**Source population** The Texas Agricultural Extension Service map was used to identify and yield potential respondents from all geographical regions of the state. This map divides the state of Texas into 12 districts from which the sample was geographically selected, with a roughly 70% rural and 30% urban representation of respondents. The exception to this was the DARE officers, who were surveyed during a national convention. **Recruitment method** Participants received a letter explaining the	**Description of method and process of analysis** Descriptive analysis and frequency tables of survey responses. **Results** 1. Community Level 1.1 Funding 2. Provider Characteristics 2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of innovation/new programme or intervention 2.3 Self-efficacy 2.4 Self proficiency	**Author identified limitations** NR **Review team identified limitations** Used survey data only and it looked to have no open ended questions, meaning participants possible responses were limited to those pre-specified by the research team. No interviews or triangulation of other qualitative methods. Survey response rates were low for nurses (38.0%), physicians (48.0%), high school coaches (41.0%) and agricultural science teachers (59.0%). Other groups' response rates were above 60%. **Evidence gaps (author reported)** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
School children	extension agents, agricultural science teachers, high school baseball coaches, drug abuse resistance education (DARE) officers, and 4-H volunteer leaders). The 4-H and FCS agents provide education programmes to people in the state of Texas in the areas of agriculture, family consumer sciences (including nutrition and health), and youth development. Different survey groups received different surveys although they had common questions. **By whom** Self-completed survey. **Setting** Mailed survey, except DARE officers, who were surveyed during a national convention. **When** 1998	study's purpose and procedures. **Number recruited** 4,089 completed surveys, denominator NR. However, response rate reported by group ranged from 94.0% (4-H and FCS agents) to 38.0% (nurses).	3. Programme/intervention characteristics 3.1 Compatibility 4. Organisational Capacity 4.2 Specific practices and processes 4.3 Specific staffing considerations 5. Prevention support system 5.1 Training	**Source of funding** Texas Cancer Council
Authors and Year Rajabiun et al. 2012 **Quality score**	**Research question/aim** 1) What are the experiences, knowledge, attitudes, and practices toward dental care pre- and post-HIV diagnosis?	**Source population** Subsample of 60 participants recruited from a national study of HIV-positive patients enrolled	**Description of method and process of analysis** Thematic analysis. Relevant themes emerged based on	**Author identified limitations** The study consisted of a small sample of PLWHA who had access to and the opportunity for continuous dental care and

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
+ **Intervention outline** Each site implemented a programme intervention to improve access to and use of dental services for people living with HIV/AIDS PLWHA. Interventions included using dental care coordinators, improving coordination with HIV medical care, providing transportation assistance, enhancing patient education, and setting up mobile dental units. **Country** US **Intervention category** Improving access **Target population** Complex needs People Living with HIV/AIDS.	2) How does participation in the Oral Health Initiative impact participants' oral health care and practices? 3) What factors contribute to participants coming back for dental care at this setting? **Theoretical Approach** NR **Method** Interviews in Spanish or English. An open-ended interview guide was used to capture participant perceptions and experiences in their own words. **By whom** NR **Setting** Unclear. The study was designed to interview participants at the initial receipt of dental care and approximately 12–15 months later to ascertain participants' perceptions of the programme and its effect on their self-care practices, as well as their	in the Oral Health Initiative. **Recruitment method** Six study sites (two rural and four urban) volunteered to recruit 8 to 10 participants each for the study. Participants were selected to reflect each site's patient demographic distribution. **Number recruited** 39 participants across five sites completed both interviews. All participants had been out of dental care for at least one year and were recently enrolled in dental care at the Oral Health Initiative sites.	frequency of discussion and expression of importance by participants. The researchers at the participating sites and multisite research centre read each transcript and developed an initial list of codes representing these themes. The coding list was used to assign segments of the narrative data at both initial and follow-up interviews using the qualitative analysis software NVivo version 8. Two researchers at the multisite centre checked and validated the interpretations of the data. **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention <u>3.</u>	treatment. The results represent the attitudes and perceptions of a small group; nonetheless, the author's believed they may be widespread among PLWHA. The study was based on interviews and self reported changes and was not designed to conduct observations of patient practices. **Review team identified limitations** Participants had been living with HIV an average of 11 years so may not represent views of people recently diagnosed. 21/60 eligible were lost to follow up or moved from the area, their views may differ from the group that remained in the study. There is a possibility that the participants may have provided more positive feedback about participating in the programme in an effort to ensure sustainability for dental services. **Evidence gaps (author reported)**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	desire to come back for care. **When** NR		<u>Programme/intervention characteristics</u> 3.1 Compatibility <u>4. Organisational Capacity</u> 4.2 Specific practices and processes 4.3 Specific staffing considerations <u>6. User Views</u> 6.1 Acceptability	NR **Source of funding** U.S. Department of Health and Human Services, Health Resources and Services Administration.
Authors and Year Riedy 2010 **Quality score** - **Intervention outline** Community-based intervention nested within double-blind, randomised placebo control trial among pregnant women. The study aim was to determine if infants whose mothers received a chemo-therapeutic intervention	**Research question/aim** To assess the anticipated and unanticipated challenges of conducting a dental intervention study in an Alaska Native population. **Theoretical Approach** NR **Method** NR **By whom** NR **Setting**	**Source population** NR **Recruitment method** NR **Number recruited** NR	**Description of method and process of analysis** NR. Narrative report of the "lessons learned" from attempting to implement a community level intervention within a clinical trial. **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention	**Author identified limitations** NR **Review team identified limitations** Origins of the views expressed are unclear. No qualitative study methods described only lessons learned, which are not explicitly linked back to qualitative data. **Source of funding** US National Institutes of Health

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
(chlorhexidine rinse followed by xylitol gum) experienced less dental decay than infants whose mothers received placebo versions. **Country** US **Intervention category** Complex Intervention **Target population** Indigenous	NR **When** NR		<u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.2 Adaptability/flexibility <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.2 Specific practices and processes	
Authors and Year Stokes et al. 2009 **Quality score** ++ **Intervention outline** Delivery of oral health promotion as part of Healthy Schools programmes. Healthy Schools are established worldwide as mechanisms for improving the health of	**Research question/aim** What are the areas of the Healthy Schools programme which might impact on oral health? To what extent are these areas pursued within Healthy Schools programmes in the North-West of England? What are the barriers and drivers to the incorporation of oral health promoting activities within Healthy Schools	**Source population** Coordinators of the 22 LHSPs (Local Healthy School Coordinators) in the North-West of England were identified as key informants for this study. These individuals had responsibility for managing LHSPs and as such, were considered to have the potential to provide both strategic and practical insights for the current study.	**Description of method and process of analysis** A coding framework based on the themes in the interview schedule was designed. Transcripts were examined manually to identify codes using thematic content analysis and a system of constant comparison. Transcripts were coded with the final set of codes using NVIVO software (QSR International). Coding	**Author identified limitations** Difficult to disentangle the intervention being studied from other interventions. The results for example indicate that there are several other influences on policy and practice in schools such as legislation related to healthy eating and creating smoke-free environments. Care is necessary in extrapolating the results of this study to wider national and international contexts. However, there is no evidence that the North-West region is different from other

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
school communities by supporting the health education curriculum through the school ethos and environment **Country** England **Intervention category** Common risk factors (oral health promotion within Healthy School context). **Target population** School children	programmes? **Theoretical Approach** NR **Method** Semi-structured telephone interviews were carried out with coordinators of Healthy Schools programmes in the Northwest of England. **By whom** Interviewer was one of the study authors. **Setting** NR **When** NR	**Recruitment method** Mailed invitation to participate and to give information about the study. Participants who did not reply were contacted by telephone and/or email to establish whether they were willing to take part. **Number recruited** All 22/22 LHSP coordinators consented to participate in the study. The English NHSP is organised into 9 regions. The North- West was selected as it incorporates 2 large conurbations and some rural areas. Also because parts of the North-West region are among the most deprived areas in England, others are among the most affluent.	was carried out by the interviewer and was verified by a second rater. Differences in opinion were resolved by consensus discussion. **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention 2.4 Self proficiency <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations	English Healthy School regions, in the way in which its Healthy Schools programmes engage with oral health promotion. **Review team identified limitations** Setting of the interviews and method of interviews (e.g. face to face or phone) are NR. Researchers' relationship and influence on conducting interviews not described; potential bias. **Evidence gaps (author reported)** The authors recommend further research to establish which methods are the most effective and appropriate ways of promoting oral health in Healthy Schools. **Source of funding** GABA International AG
Authors and Year	**Research question/aim**	**Source population**	**Description of method**	**Author identified limitations**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Trubey and Chestnutt 2013 **Quality score** + **Intervention outline** School based daily supervised tooth brushing programme in Wales, operated by the Community Dental Service (CDS). Schools were recruited from the 150 most deprived areas in North and South Wales. **Country** Wales **Intervention category** Supervised tooth brushing **Target population** Under 5s (aged 3-5 years participating in daily in-school tooth brushing).	Determine the views of staff involved in a national school-based daily tooth brushing programme. The objectives of this study were to: • Examine attitudes of community dental service staff towards how a daily supervised school-based tooth brushing programme should be delivered. • Investigate if the differences in views of staff were related to their job status or the geographic area in which they work. • Determine the implications of any differences observed and their value to commissioners and others interested in setting up a school-based tooth brushing programme. In managing the implementation and roll-out of the programme it was thought important to gauge the attitudes and views of the staff delivering the school based tooth brushing programme, namely the Oral Health Educators, the Support Workers and the Managers.	Staff taking part in the tooth brushing programme in Wales. After 12 months this was 515 schools and 30,442 children aged 3 to 5 years. **Recruitment method** A structured sample of 24 community dental service staff were chosen to take part in the study, ensuring a balance of job roles and geographical location. **Number recruited** 24 community dental service staff managing or delivering the tooth brushing programme.	**and process of analysis** Q methodology involved presenting participants with list of statements representative of the subject under study (Q-statements) and asking them to rank them using a fixed layout (the Q-sort). By sorting the statements the respondents give subjective meaning to the statement set and so reveal their subjective viewpoint. Principle components factor analysis using varimax rotation led to 3 factor solution emerging (3 areas where views were similar). These split into 3 main staff groups (support workers, case/area/team managers, health educators). **Results** <u>2. Provider Characteristics</u> 2.3 Self-efficacy	The study cannot claim to represent the subjective viewpoints of all staff, but the factor analysis and rotation resulted in a reduction to three key viewpoints which accounted for the large majority of participants. **Review team identified limitations** Views were directed by prewritten statements; there was no room for expansion outside these statements. Not all staff interviewed fed into the 3 factor answer using the Q-sort method. 16 people contributed to the final analysis, the remaining 8 either failed to load significantly on to any of the factors (‘null sorts’) or were correlated with multiple factors (‘confounded sorts’) and so were excluded from the analysis. **Evidence gaps (author reported)** In addition to improving oral health via tooth brushing it would

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	Theoretical Approach Q-sort methodology **Method** Face to face semi-structured interview. Ranking 49-statments about the tooth brushing programme, statements derived from 15 previous qualitative interviews. **By whom** NR **Setting** NR **When** NR		<u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.2 Adaptability/flexibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.2 Specific practices and processes	be hoped that the Designed to Smile Programme would play a role in facilitating dental attendance. Work is therefore required to understand further why Designed to Smile staff do not perceive a need to make links with colleagues in general dentistry. **Source of funding** Welsh Assembly Government
Authors and Year Wolfe and Huebner 2004 **Quality score** - **Intervention outline** The Oral health Programme to Engage Non-dental health and human service Workers	**Research question/aim** To assess successes and impediments to training and implementation encountered in the early stages of OPENWIDE and make recommendations to improve the curriculum and its delivery to families and children. **Theoretical Approach**	**Source population** 1) Nearly sixty individuals in attendance at a 2h OPENWIDE presentation in 1 community health centre in north-eastern Connecticut. Group included the executive director of the community health centre, clerk receptionists, physicians, dentists, nurses, dental	**Description of method and process of analysis** NR (neither sub-study) **Results** <u>1. Community Level</u> 1.1 Funding 1.2 Policies <u>2. Provider Characteristics</u>	**Author identified limitations** Small sample size and disproportionate response rates among the different EHS/HS professional staff (e.g. relatively few teachers participated in the telephone interviews). Numerous concurrent oral health promotion and disease prevention programmes are on-

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
in Integrated Dental Education (OPENWIDE) is an oral health promotion and disease prevention education and training programme. It was aimed at non-dental health and childcare professionals. **Country** US **Intervention category** Complex Intervention **Target population** Under 5s (not clear if this extended to school age children too).	NR **Method** Main report has no qualitative methods described. However, it contains reference to 2 qualitative studies carried out since the OPENWIDE programme started: 1) A survey of a sample of individual attending one OPENWIDE presentation in one community health centre in north-eastern Connecticut. The self-report survey included attendee demographic information, six true/false questions that measured oral health awareness and knowledge pre- and post-presentation, and questions about the quality of the OPENWIDE material and presentation. 2) To examine the impact of training on practice, telephone interviews were conducted two to six months after the EHS/HS trainings (Early Head Start and Head Start (EHS/HS) are nationwide federally funded	hygienists, dental assistants, radiology technicians, and others. 2) The intended individuals to be contacted by telephone included one health manager, one family service coordinator, and one teacher from each of the twenty-eight Connecticut EHS/HS sites (n=84 people total). **Recruitment method** 1) A self-report survey distributed to all attendees ("nearly 60") 2) Individuals were chosen from each site's personnel rosters at random; they need not have attended the training to be interviewed. **Number recruited** 1) 44 completed the survey, 31 were used in the analysis but not all 31 completed both the pre-	2.1 Perceived need for innovation/new programme or intervention 2.2 Perceived benefits of innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.1 Compatibility <u>4. Organisational Capacity</u> 4.1 General organisational factors <u>5. Prevention support system</u> 5.1 Training	going in Connecticut. Not possible to control for diffusion effects of other sources of oral health information to the professional community (specifically to the health managers) or the community at large. More than half the EHS/HS respondents surveyed identified "parents" as a primary obstacle to improving oral health practices within the programme. When queried further, they cited parents' lack of interest, unavailability, lack of concern regarding oral health, and the like. This anecdotal information may reflect reporting bias born of frustration, but the frequency and consistency of the reports indicate this should not be ignored. **Review team identified limitations** The description of the 2 qualitative studies nested within the report is very limited. Unclear risk of bias using both qualitative methods. The survey sample was at single event location so may

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	programmes serving low income pregnant women and children birth to three and three to five years of age) **By whom** 1) Self-report survey. 2) A student research assistant conducted all interviews and entered all responses, additional discussions, and comments made by the respondents. **Setting** 1) NR Appeared to be immediately before and after attendance at the 2h OPENWIDE presentation/training 2) Interviews were conducted by telephone to increase the response rate and minimise disruption to EHS/HS personnel. **When** NR for both methods.	and post-test for all questions. 2) 47/84 individuals selected completed interviews (Response rate 56.0%)		not represent opinions of the majority of sessions. The OPENWIDE curriculum was designed by the author (S.H. Wolfe) of the report describing the programme so there is a risk of reporting bias in the balance of positive and negative elements in the report. However, some failures are reported and discussed (e.g. no changes in practice in some cases). **Evidence gaps (author reported)** Recommendations are made about improving the OPENWIDE programme. Research recommendations NR **Source of funding** The OPENWIDE Programme was made possible through funding from the Robert and Margaret Patricelli Family Foundation, Connecticut Health Foundation, and Connecticut Department of Public Health.
Authors and Year	**Research question/aim** A small-scale pilot study was	**Source population** Women with tetraplegia.	**Description of method and process of analysis**	**Author identified limitations** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
Yuen and Pope 2009 **Quality score** - **Intervention outline** An individualised programme of oral home telecare training using PC-based, real-time interactive video-conferencing via the Internet to meet the unique challenges of dental care for people with tetraplegia. **Country** US **Intervention category** Health Education and/or Advice (oral hygiene training). **Target population** Complex needs (adults with tetraplegia).	conducted to test the feasibility of delivering the intervention. The study also explored the acceptability and influence of the oral home telecare experience on oral health care in two female white adults. **Theoretical Approach** NR **Method** Subjects were interviewed and completed an 18-item Likert-type scale questionnaire (Oral Home Telecare Questionnaire, OHTQ) which was adapted from the Telemedicine Satisfaction and Usefulness Questionnaire (TSUQ) and the Telemedicine Perception Questionnaire. **By whom** One person, one of the study authors. **Setting** NR **When** After four oral home telecare	Two women took part in the feasibility study. **Recruitment method** NR **Number recruited** 2/2.	NR **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.3 Specific staffing considerations <u>6. User Views</u> 6.1 Acceptability	**Review team identified limitations** This was a feasibility study on just 2 women so may not reflect views of people who might experience this intervention (which may be modified) in the future. No interview methods or analysis were described (only those of the survey) so their link with the conclusions and reported findings are not explicit or clear. **Evidence gaps (author reported)** NR **Source of funding** NR

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	videoconferencing sessions with the therapist. Dates NR			
Authors and Year Yusuf et al. 2012 Included views from 6 sub-groups: 1. Dental Providers 2. Feedback from Parents 3. Community Champions 4. Reflections from the Dental Public Team 5. Oral Health Promoters 6. Tooth Champions **Quality score** ++ **Intervention outline** Keep Smiling Pilot Programme was developed and implemented to promote oral health in a deprived area of the borough; the White City ward. The	**Summary of findings from stakeholders** The evaluation report by Yusuf et al. 2012 contained a section that summarised findings from all stakeholders; this was coded separately into the themes listed immediately below. In addition, the results for each of the 6 individual stakeholder groups were coded separately due to methodological differences. **NB:** the report made numerous recommendations for ways to improve the pilot programme for future development. While these were not explicit barriers of facilitators they will be highly relevant for those seeking to implement a similar intervention. **Results** <u>1. Community Level</u> 1.1 Funding 1.2 Policies <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention 2.3 Self-efficacy 2.4 Self proficiency <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources <u>4. Organisational Capacity</u> 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations			

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pilot consisted of a fluoride varnish and tooth brushing programme targeting 3-7 year old children in primary schools and one children's centre in White City. Additional information (Oral Health Promoters): The oral health promoters were vital in delivering the tooth brushing element of the programme. They attended some of the meetings with tooth champions in schools, along with the Dental Public Health team. Furthermore, they provided oral health based resources for schools to reinforce health messages. They supported the delivery of toothbrushes and toothpastes to schools as well as delivering the tooth brushing programmes in	<u>5. Prevention support system</u> 5.1 Training			
	Dental Providers			
	Research question/aim To understand the extent and quality of communication between the dental teams, schools and dental public health team Explore the views and experiences of the dental team in terms of organisation of the fluoride varnish (FV) programme To examine any barriers and facilitators in operation of the FV programme To understand improvements to the programme for implementation of the programme in the future **Theoretical Approach** NR **Method**	**Source population** The two nearest dental practices in White City who already provided dental care for the local community involved in the pilot programme. **Recruitment method** Both dentists were contacted by email to offer them a suitable appointment to carry out the interviews. **Number recruited** There were two dentists who participated in the Keep Smiling programme and both were interviewed.	**Description of method and process of analysis** An interview script was developed to explore the key themes stated in the aims. All interviews were digitally recorded with prior permission from participants. The interviews lasted around 45 minutes. **Results** <u>1. Community Level</u> 1.2 Policies <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention 2.3 Self-efficacy <u>3. Programme/intervention characteristics</u>	**Author identified limitations** NR **Review team identified limitations** The role of the interviewer and the method of arriving at themes from the interviews were not reported; resulting in an unknown risk of bias. **Evidence gaps (author reported)** NR **Source of funding** NR

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classrooms. Additional information (Tooth champion): The 'tooth champion' would be an advocate for oral health and support the implementation of the programme within the school. They champion was a nominated person from the pilot school or child centre. **Country** England **Intervention category** Complex intervention **Target population** Under 5s School children (3-7 year old children in primary schools and one children's centre).	Two face-to-face semi-structured interviews. **By whom** Both interviews were conducted by the same interviewer. Interviewer details NR **Setting** Two different dental practices. **When** NR		3.1 Compatibility 3.2 Adaptability/flexibility 3.3 Intervention resources 4. Organisational Capacity 4.2 Specific practices and processes 4.3 Specific staffing considerations	
	Feedback from parents			
	Research question/aim What are parents' views about children's oral health, information received about the fluoride varnish (FV) and tooth brushing programmes, views about the programmes, and a consultation about the information sheet and consent forms? Did parents/carers receive adequate information on the FV programme?	**Source population** 1) Parents who had, and who had not, given consent for their child to participate in the pilot programme. Potential sample size NR 2) Potential sample size for parent/carer survey was 737 **Recruitment method** 1) A sample was selected based on schools that achieved a high consent rate and a second school	**Description of method and process of analysis** 1) Focus group tapes were transcribed and thematic analysis was used to analyse the data. A thematic chart was developed and entered into an excel database. The data were organised under the identified themes, retaining the language of the participant. The data was re-examined and the categorisations were	**Author identified limitations** 1) NR 2) Surveys: 81% of the parents who responded to the questionnaire had children who had fluoride varnish applied to their teeth. These parents are over-represented in the sample of questionnaires returned (they represent a total of 81% questionnaire responses compared to an overall percentage of 66.5% children in the four schools having fluoride varnish). Survey was limited (only 9 questions) and did not provide

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	What are parents' perceptions about the Keep Smiling Programme? Were parents and children satisfied with FV application? Was there any behaviour change in terms of tooth brushing and visiting the dentist as a result of the Keep Smiling Programme? Did parents have any suggestions for improvements of the FV programme? **Theoretical Approach** NR **Method** Feedback from parents was obtained using two methods: focus groups in two schools and a survey questionnaire targeting parents in all 5 schools. 1) Two focus groups were conducted in two primary schools which had participated in the Keep Smiling	which achieved a lower consent rate. Target number for each focus group was 6-8 people, ideally composed of a mixture of parents. 2) 4/5 eligible primary schools (children's centre was excluded). All parents/carers of children aged 3-7 years in the four targeted primary schools were sent a pre-prepared questionnaire via the school with a return envelope and a separate slip for the prize draw. **Number recruited** 1) Two focus groups: one consisted of 7 parents and the second comprised of 4 parents. 2) Four of the five pilot schools agreed to take part in the parent/carer questionnaire. Overall recruited was 150/737 (20.4%), The questionnaire response rate was low, varying between 9.6% and 33.7%	refined in order to ensure that a logical and consistent pattern. Data was then summarised and described by comparing the data from the two focus groups. 2) Survey - due to the response rates being low (below the recommended 60% for surveys) in each school the majority of the results presented have been pooled across all four schools. **Results** <u>4. Organisational Capacity</u> 4.2 Specific practices and processes <u>6. User Views</u> 6.1 Acceptability	rich information on why some children did not take part in the pilot. **Review team identified limitations** 1) Unclear how many people were in each focus group although target size was reported. 2) Views were not sought from families or carers involved in the pilot through the children's centre, only through the primary schools. Response rate was low overall and biased towards parents who had given consent for their child to take part in the pilot programme. Views of those who had not given consent to participate were not explored. **Evidence gaps (author reported)** NR **Source of funding** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	Programme 2) A questionnaire was developed for parents and carers consisting of 9 short questions. **By whom** 1) Focus group interviewer role or characteristics NR 2) Surveys were sent to parents and carers to self-complete. **Setting** 1) Schools. 2) In homes. **When** NR	across the four schools. 2) No survey's sent to parents or carers involved in the children's centre aspect of the pilot, only primary schools.		
	Community Champions (CCs)			
	Research question/aim Explore the views and experiences of the CC in terms of organisation of the Keep Smiling Programme. Examine their views on the quality of training provided. To explore how community engagement was developed	**Source population** 18 volunteers who were trained as community champions. **Recruitment method** Both community champions were contacted by email to offer them a suitable	**Description of method and process of analysis** All interviews were digitally recorded and were transcribed. A thematic analysis was adopted. The first step was familiarisation with the data followed by thematic analysis to	**Author identified limitations** NR **Review team identified limitations** Only 2 out of a possible 18 community champions were interviewed. May not be representative of views of the wider group. Unclear how the 2

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	and sustained Understand improvements to the programme for implementation of the programme in the future **Theoretical Approach** NR **Method** Two face-to-face semi-structured interviews with the two community champions. An interview script was developed to explore the key themes stated in the aims. All interviews were digitally recorded with prior permission from participants. The interviews lasted around 30 minutes. **By whom** Interviews were conducted by two separate interviewers. **Setting** NR **When**	appointment to carry out the interviews. **Number recruited** 2/18.	develop a coding system. This was followed by summarising the data under the different themes in a framework chart. A classification emerged from the charts which supported the analysis of the emerging data. **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention 2.3 Self-efficacy 2.4 Self proficiency <u>3. Programme/intervention characteristics</u> 3.4 Contact time <u>4. Organisational Capacity</u> 4.2 Specific practices and processes	included were selected from the pool of 18. **Evidence gaps (author reported)** NR **Source of funding** NR

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	NR		5. Prevention support system 5.1 Training	
	Reflections from the Dental Public Team			
	Research question/aim NR. **Theoretical Approach** NR **Method** NR **By whom** NR **Setting** NR **When** NR	**Source population** NR. **Recruitment method** NR. **Number recruited** NR.	**Description of method and process of analysis** NR **Results** 3. Programme/intervention characteristics 3.2 Adaptability/flexibility 4. Organisational Capacity 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations 5. Prevention support system 5.2 Technical Assistance	**Author identified limitations** NR **Review team identified limitations** No methods reported, unclear what views expressed were based on or how many of the dental public health team were sampled. **Evidence gaps (author reported)** NR **Source of funding** NR
	Oral health promoters			
	Research question/aim	**Source population**	**Description of method**	**Author identified limitations**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	• To understand the extent and quality of communication between the dental teams, schools and dental public health team • Explore the views and experiences of the dental team in terms of organisation of the Keep Smiling Programme • To examine any barriers and facilitators in operation of the tooth brushing • To understand improvements to the programme for implementation of the programme in the future **Theoretical Approach** NR **Method** Two face-to-face semi-structured interviews with the two oral health promoters who were responsible for the tooth brushing programme. The interviews were held separately to minimise disruption to project activities. An interview script was developed to explore the key themes stated in the aims	There were 2 oral health promoters in Inner North West London. The oral health promoters were vital in delivering the tooth brushing element of the programme. **Recruitment method** Both oral health promoters were contacted by email to offer them a suitable appointment to carry out the interviews. **Number recruited** 2/2 recruited.	**and process of analysis** All digital recordings were transcribed. A thematic analysis was adopted. The first step was familiarisation with the data followed by thematic analysis to develop a coding system. This was followed by summarising the data under the different themes in a framework chart. A classification emerged from the charts which supported the analysis of the emerging data. **Results** <u>2. Provider Characteristics</u> 2.2 Perceived benefits of innovation/new programme or intervention <u>3. Programme/intervention characteristics</u> 3.1 Compatibility 3.3 Intervention resources	NR **Review team identified limitations** Role of the interviewer was not clear, unknown potential source of bias. **Evidence gaps** NR **Source of funding** NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	above. All interviews were digitally recorded with prior permission from participants. The interviews lasted around 30 minutes. **By whom** Interviews were conducted by two separate interviewers **Setting** NR **When** NR		<u>4. Organisational Capacity</u> 4.2 Specific practices and processes 4.3 Specific staffing considerations <u>5. Prevention support system</u> 5.2 Technical Assistance	
	Tooth champions			
	Research question/aim • To understand the extent and quality of communication between the schools and different dental teams and within schools • Explore the views and experiences of school staff about the Keep Smiling programme • To gain an insight into the extent of collaboration between the schools and the different dental teams • To explore roles of schools in	**Source population** All six tooth champions were contacted (one for each setting). **Recruitment method** Contacted via email to invite them to participate in the interviews. **Number recruited** 5/6	**Description of method and process of analysis** All interviews were digitally recorded with prior permission from participants. The interviews lasted between 30 minutes to 45 minutes. The themes that emerged were classified into communication, organisation, impacts on children and the school and perceptions about	**Author identified limitations** NR **Review team identified limitations** Unclear how themes were derived from the interviews. Role and relationship of the interviewer NR; potential source of interviewer bias. **Evidence gaps (author reported)**

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	supporting the implementation of the Keep Smiling Programme • To examine the barriers in gaining positive consent from parents to allow their children to participate in the programmes • To understand improvements to the programme for implementation in the future **Theoretical Approach** NR **Method** Semi-structured interviews with tooth champions at the pilot settings. An interview script was developed to explore the key themes stated in the research question aims above. **By whom** The interviews were carried out by two interviewers. Interviewer characteristics NR **Setting** 4 were at the pilot schools, 1 was at the Children's Centre in White City.		the overall implementation of the Keep Smiling Programme. **Results** 2. Provider Characteristics 2.2 Perceived benefits of innovation/new programme or intervention 2.3 Self-efficacy 3. Programme/intervention characteristics 3.1 Compatibility 3.2 Adaptability/flexibility 3.3 Intervention resources 4. Organisational Capacity 4.1 General organisational factors 4.2 Specific practices and processes 4.3 Specific staffing considerations	NR

Study	Research parameters	Population and sample selection	Outcomes and methods of analysis (Results)	Review team notes
	When NR		5. Prevention support system 5.1 Training	

NR; not reported.