EDITORIAL

Noma is regarded as a disease of poverty resulting from malnutrition and neglect. It may be prevented if children make regular visits to the clinic. These visits provide the opportunity to screen for oral diseases, institute prompt management and reinforce preventive oral health habits. Children should be able to make regular dental visits if and when their parents initiate the process. However, poverty may limit access of children to dental service utilisation. Poverty is also a risk factor for malnutrition. Poverty is a cause of neglect. Noma seems to be a disease of poverty at the interception of malnutrition and neglect.

Noma may not be a disease exclusively attributable to poverty. Currently, 133 million (63%) Nigerians live in multi-dimensional poverty.[1] In 2022, there were 35,022,483 under-5 children in Nigeria[2] of which 54% lived in multi-dimensional poverty,[3] 32% were stunted[4] and 2 million (5.7%) children suffer from severe acute malnutrition.[4] Yet 3.3% of children in Noma endemic regions in Nigeria live with Noma.[5] These statistics indicate that not all children who live in poverty come down with malnutrition, and not all children with malnutrition come down with Noma. So, what are the drivers of Noma? There are almost no studies on the psychosocial and economical risk factors for Noma. Can it be possible that psychosocial factors are stronger risk factors for Noma than poverty? Can parental neglect be the stronger risk factor for Noma? Can the strategies use in managing diseases of neglect work for Noma control?

Caries in children is also a disease of neglect.[6] Can the identification of the commonalities between oral diseases in children associated with neglect help with the development of cost-effective approaches using the common risk factor approach? Caries and Noma in children have common risk factors – poverty, malnutrition and neglect. Are there associations between caries and Noma that need to be explored further?

In this edition of the journal, authors wrote on a diversity of oral health issues affecting diverse populations. Adesunloro et al explored the knowledge of physicians and dentists working in a tertiary health institution in Nigeria about the management of dental trauma in children. Dental trauma in children may result from child neglect.[7] Ogordi et al assessed the risk of 6-12-year-old children for caries using a publicly accessible caries risk assessment tool. For a country like Nigeria where about 62% of the population of children and adolescents in Nigeria has had one or more adverse childhood experiences,[8] caries risk assessment tools that are contextualized to include psychosocial and economic risk factors should also be explored as a measure of caries risk. Oyedele et al's study highlighted the positive association between biannual dental visits and good oral hygiene status among a population of undergraduate students. Chukwumah et al discussed the preferences of spaces for conferences - virtual, physical or hybrid.

These studies hopefully, move us closer to generating information to inform evidence-driven oral health programming in Nigeria; and stimulate answers to the burning questions raised about the intersections between caries and Noma in children, as they contribute to the slowly growing body of knowledge about oral health in children, adolescents and young people in Nigeria.

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