Implications of Low Oral Health Awareness in Nigeria

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I congratulate the Nigerian Medical Association on this Golden Jubilee celebration. It is my opinion that time is apt for us all to have to reappraisal of health care delivery in Nigeria and fashion a practical and achievable way forward for the betterment of the health of the poor Nigerian. I thank the association for inviting me to participate in this symposium on "50 years of oral health in Nigeria". It is my hope and prayer that deliberations at this meeting would signal the beginning of a well planned and structured oral health care delivery system for Nigeria. My brief is to discuss the implication of low oral health awareness in Nigeria.

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INTRODUCTION

To talk about oral health awareness, as understanding of what constitutes oral health is essential. There are several definitions of oral health. Locker (1988) developed a conceptual model of oral health which defines health as not merely an absence of disease but also incldes functional aspects, social and psychological wellbeing thereby focusing on optimal functioning and social role[1]. Another definition described oral health as a comfortable and functional dentition that allows individuals to continue their social role[2]. The achievement of what constitutes the entity referred to as oral health is got through several measures and activities; these includes the acquistion of knowledge especially of oral diseases and their prevention, acceptable oral health behaviours such as maintenance of good oral hygiene and non-harmful dietary practices as well as utilization of available facilities. Central also to achieving oral health is a well planned and structured oral health care system, which involves policy formulation, organization of services as well as financing such services. I would therefore like to approach the issue of oral health awareness from three perspectives: the public, other health care professionals as well as policy makers.

Oral Health Awareness

This is the individual or collective alertness to the existence and prevention of oral diseases and an equal alertness in taking necessary steps to obtain treatment for these diseases when they occur[3]. The question we need to answer first is oral health awareness low in Nigeria? Are there scientific evidences to prove this statement? Beyond the realm of anecdotes, studies on different population groups in Nigeria indicate a low awareness and poor attitude to oral health care regardless of education[4,5,6]. This is especially more on the scope and purpose of oral health care.

Oral health awareness in the Lay Public

Oral health knowledge and attitudes and practices among Nigerian mothers, school teachers, adolescents as well as community dwelling residents among others have been studied[4,5,6]. In these studies, it was reported that between 52% and 80% of the respondents had never been to a dentist. This however should not presume that they do not have any oral health needs as another study on community dwelling residents spread across four Local Government areas in Lagos and Ogun State found that 37.8% of them had experienced oral pain in the last one year[7]. Of those reporting oral pain, only 12.4% visited a dentist and 30% of them did nothing about the pain. Most of them did not seek dental treatment because they were of the wrong opinion that the visit would necessarily lead to extractions, which they did not want.

Oral Health Awareness in other health professionlas

Studies on oral health perceptions and knowledge of other health care professionals especially general practitioners have also indicated poor attitudes to oral health care and inadequate knowledge. In a study on a group of family physicians in Lagos, only 51.9% of them had ever received dental treatment and only 22.2% had ever had preventive oral care (scaling and polishing). A proportion (12.4%) of them admitted that they currently had oral problems which they had done nothing about. Their knowledge of common oral diseases was also unsatisfactory as just about half of them; 54% and 45.7% were able to give a correct definition of dental caries and periodontal diseases respectively[8]. In developing countries with low oral health manpower and inadequate oral health facilities, physicians are probably the first port of call for patients with oral diseases and are thus in a position to facilitie early detection and prompt referrals for oral diseases. This was confirmed in the aforementioned study in which 95.1% of the family physicians had been consulted by their patients about oral complaints, of which 51.9% referred a to a dentist. Also a study on doctors at HIV dedicated clinics found that 75.6% of them had been consulted for one or more oral problems by their patients and only 30.5% of them referred to the dentist[9].

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Oral Health Awareness and Policy Makers

There is presently no structured oral health policy for Nigeria. This has made planning for oral health care delivery focus loss. Although the Nigerian government is said to recognize oral health as a component of Primary Health Care (PHC), it is yet to be integrated into the PHC services in the country[10]; which of course would improve acess to oral health care especially for rural dwellers.

The aspects of the NHIS dealing with oral health care shows poor understanding od oral health issues: dentists are designed as secondary providers and physicians are saddled with the responsibility to make diagnosis (wjicj they are not well trained for) and make referrals. This of course results in a lot of time being wasted and probably loss of interest by the patient. Also importantly, preventive care in form of scaling and polishing is not covered by the scheme. This shows a lack of knowledge of the interrelationship between oral and systemic health because the policy makers obviously had the perception that scaling and polishing was simply aesthetic treatment.

Implications of Low Oral Health Awareness

Having expounded evidence to show that oral health awareness is indeed poor in Nigeria, what ae the possible implications of this?

Implications on oral health status: when there is low oral health awareness, thereis a direct effect on the illness seeking behaviour of the individual and population. People are not well informed about steps to take both in preventing as well as treatment of these diseases. There is subsequent underutilization of oral health facilities and late presentation at the clinic with resultant complications. For instance, let us consider the oral disease burden in Nigeria; while epidemiological studies on some sub sections of the Nigerian population put the prevalence at about 20% with mean DMFT of less than 2-6;[11,12,13] which is considered to be in the "low" category, the public health concern is that majority of the caries seen were untreated resulting ultimely in avoidable pain. The most common reason for dental visits in Nigeria is thus pain[14,15].

Chronic periodontal diseases have been found to be highly prevalent among Nigerians right from the 1960s to date and studies have shown that over 75% of Nigerians need scaling and polishing and plaque control[16,17,18]. The primary aetiological factor in periodontal diseases is dental plaque, which, is a tenaciously adherent biofilm on teeth and gingival surfaces and is 70% bacteria[19]. Acumulation of plaque has been linked in recent times to several systemic outcomes.

Implications on General Health: Oral health is an integral part of general health. For a long time, oral health has been treated in isolation from the general systemic health but with growing understanding of the interrelationship between the two, it is important that dental patients are seen beyond their mouth by dentist and beyond their systemic health by doctors. Current research works have linked the condition of the oral cavity especially plaque accumulation and periodontal health to a number of systemic diseases including cardiovascular diseases, diabetes mellitus, preterm low birth weight as well as myocardial infarction.

Several case-control studies published in the early 1990s found that patients with a history of myocardial infarction has worse oral health than controls. A meta-analysis of observational studies found that subjects with periodontal disease have higher odds and higher risks of developing cardiovascular disease although reduction in risk of cardiovascular events associated with treatment of periodontal disease remains to be investigated[20]. However, several well designed studies have demonstrated a bidirectional relationship between diabetes and periodontal disease.

Randomised clinical trials have demonstrated that people with diabetes were 2.5 to 4 times more likely to develop periodontal disease than non-diabetes. These trials also showed that treating periodontal disease can stabilise glucose status of the patients[21]. Any oral disease in the mother from mild gingivitis to severe periodontitis causes infection and inflammation in the mother and accumulating scientific evidence is unveiling the biological plausibility of oral infection causing pregnancy complications such as preterm low birth weight babies22.

The implications of these associations from a public health persepective, is that periodontal disease is both preventable and treatable, therefore while evidence is still being gathered on the link to these systemic disease, treating periodontal disease is far cheaper than treating cardiovascular disease and prematurity and health insurance companies are responding to this in more industrialised countries.

Currently HIV prevalence in Nigeria is put at 3.9% currently but in terms of absolute numbers, Nigeria ranks second in Sub-Saharan Africa[23]. Over 60% of HIV infected patients would present with at least one oral manifestation in the coure of the disease. Poor oral health in HIV patients has direct impact on their quality of life and also contributes to poor nutrition which also would have an effect on the response to medical management. Oral health is simply a component of health and should not be thought of as being separate from the health of the rest of the body.

As a result of an oral condition, a person may be in pain, feeling ill or not eating properly, and these problems are manifestations of poor overall health. A person is simply not well systemically if they are not well orally.

Implication on Access to care: Failure to access oral health care could be as a result of lack of perceived need for treatment by the patient. This is oftenn a function of level of awareness of oral diseases and their prevention. This gap may be bridged by oral health education. The other aspects of access to care are related to the lack of a structured national oral health policy. The failure of itnegration of oral health care into the PHC activities has the resultant effect of inequitable distribution of oral health services. Majority of the population especially in the rural areas do not have access to basic oral health care.

Poor funding for our facilities is another reflection of poor perception of oral health care on the part of policy makers, who probably do not see any usefulness in spending the huge amount of money necessary for maintaining a functional dental

facility. Also, inflation and high exchange rates are factors militating against sophisticated dental practice. These may be ameliorated by favourable tax policies. Another failure of policy development is lack of oral manpower development with grossly inadequate dentist: population ratio.

Public Health Challenges of Low Oral Health Awareness

- The integration of oral health care into PHC activities with the basic Package of Oral Care (BPOC)
- A review of NHIS policy with regard to oral health is essential.
- A change in perception of policy makers about the importance of oral health in relation to general health. This requires advocacy to inform individuals at local, state and federal levels.
- Changing perception of othe health care professionals in the aspects of oral health education, collaboration and dental referrals.
- Oral health education methods must be strengthened and rigorously carried out while bearing in mind the social determinants of health in our environment without which oral health talks would have not impact.

CONCLUSION

There is no doubt that the oral health awareness in Nigeria is low in all its ramifications and the implications of this may be graver than we hitherto assumed. We need an enormous amount of political goodwill on the part of policy makers to improve oral care delivery and the establishment of a structured oral health policy for Nigeria is of utmost importance. While we wait for the government to plat its role, as health professionals, we need to establish NGOs with goals to improve oral health knowledge and perception, advocate against smoking and provide oral health services for understand populations.

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