Policy issues by the Ministry of Health regarding Child Oral Health

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Introduction

Provision of health services in Tanzania began in 1888 during the Germany era. The coastal areas of Tanga, Pangani, Dar es Salaam and Kilwa were the initial beneficiaries. By 1893, health workers were posted in Morogoro, Marangu, Old Moshi and Kilema in Kilimanjaro region (Clyde, 1962). The German's approach was to provide basic and complex social services to the entire population, using uniform population based standards for infrastructure and staff. Between 1916 and 1922, the British took over from the Germans and reconstructured and/or re-establish the civil medical practice, upon which the current medical services are based. No major policy and/or structural changes were made during the British era.

Six years after independence, the government, in 1967, ushered in the Arusha Declaration, emphasizing health care delivery in the rural areas, thus the beginning of the Primary Health Care Strategy. In 1977, private medical practice for profit was banned, and universal free medical services for all Tanzanian was declared. This led to massive expansion of the physical infrastructure, health workers, and health training institutions. As a result of this, 72% of Tanzanian are within 5 kilometers and 90% within 10 kilometeres of a health facility, and there are 106 health training institutions in Tanzania.

Policy Issues

According to the Health Care Policy in Tanzania (1990), the emphasis on the provision of health care services is on equitable universal availability of effective essential health care at a cost the country and the community can afford. The policy predicates continued stress on public health, spending on preventive and promotive health services and the involvement of new partners in health. The poor, disadvantaged and vulnerable groups will be given special attention.

In the National Plan for Oral Health (Revised (1994), the main strategy consists of four main elements; promotion of lifestyles conducive to oral health; reduction of preventable oral condition; provision of basic curative and rehabilitative oral health services to those in the target population in greatest need and; development of the oral health services to cover the entire population with emergency and preventive oral health care.

Details of Strategies in the NPOH regarding child's Oral Health

Goal 1 states that seventy five percent of 5-6 years olds will be caries free. Achieving behavioral modifications in young children and their parents through health education, to keep the frequency of sucrose intake low and use of fluoridated tooth paste should be encouraged at all levels. Goal 3 indicates that twelve year olds children on average will have no more than 0.6 DMF teeth. This will be achieved by increasing the coverage of the populations with primary oral health care services and efforts should be made to get annual average DMFT for schools within the reach of dental personnel. Goal 4 stipulates that gingival bleeding will occur, on average, in not more than 1.5 sextants of 12 year olds, using the CPITN index. To achieve this goal, oral hygiene instructions should be reinforced in primary schools. Goal 6 puts emphasis of that all MCH clinics and 20% pf schools will run Oral Health Education classes on a regular basis. The aim here is to raise awareness of children on oral health risks so that promotive behavior can be acquired from early childhood. Lastly, goal 7 says that the DMFT will be composed 80% the decayed component (DT), 10% the missing component (MT) and 10% the filled component (FT). Available data indicate that 90% of the DMFT is composed of the DT component, 10% MT component and 0% FT component. To achieve this strategy effective service to provide simple restorations in urban health centres, district, regional and consultant hospitals will increase the FT component.

According to the 1999 Oral Health Statistics for Tanzania Mainland, 22% of all those who attended for oral health care were children. The majority of the children had their teeth extracted (94%), while fillings were done in only (6%) of the children (Table 1).

Conclusions

In both the German era and British era provision of health services was based on the provision of basic and complex social services to the entire population (curative and urban based). The PHC strategy deals with health promotion and prevention and health care delivery in the rural areas. The Health policy (1990) points out continued stress on public health spending on preventive and promotive health services.

The National Package of Essential Health Interventions in Tanzania emphasizes reduction of the burden of diseases in children (provision of information,

education and communication). The NPOH stresses promotion of lifestyles conducive to oral health and development of OHS to those in target groups in greatest need and lastly Goals 1, 3, 4 6 and 7 in the NPOH (1994) deals with children's oral health.

References

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4. Ministry of Health. The National Plan for Oral Health, Dar es Salaam, Tanzania, 1988.

Table 1: Oral Health Statistic's – Tanzania 1999

	Adults		Children	
	No	%	No	%
Attendance	171,962		37,409	22
Caries	137,008		30,142	22
Extractions	127,604		28,293	93.9
Fillings	8,404		1,849	6.1