THE REPUBLIC OF UGANDA

NATIONAL ORAL HEALTH POLICY

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Ministry Of Health
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Foreword

It is an honor for me to write the foreword for the first ever oral health policy in Uganda. The aim of the oral health policy is to provide a framework for prevention of oral diseases and promotion of health by supporting policies and programmes that make a difference to our health. The policy recognizes that oral health should be treated like any other serious health issue in the country.

It emphasizes the importance of equity, integration, community participation, gender, prevention and promotion, and research as major tools to be used in addressing the oral disease burden in Uganda. The oral health policy outlines objectives and suggests strategies to be followed and will therefore improve the effectiveness and efficiency of delivery of oral health care by adopting safe and effective disease preventive measures. The policy also addresses the inequalities and disparities that affect those least able to have resources to achieve optimal oral health. However the success of this policy will require the active involvement of the public and private sector as well as the community.

This policy has marked yet another milestone in Uganda Government's determination and commitment to improve the health status of its citizens. The improved quality of life resulting from enhanced health care will be translated into decreased demand for oral health services and increased productivity in the absence of oral diseases.

In conclusion, I wish to express my appreciation to all those who contributed in one way or another to the development of this policy. In particular, I wish to thank the World Health Organization (Afro and Uganda Country Office) for their support during the policy development process. I therefore call upon all stakeholders to emulate the Government's and the World Health Organization's commitment in promoting oral health in Uganda.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
DMFT	Decayed, Missing, Filled Teeth
GoU	Government of Uganda
HIV	Human Immuno deficiency Virus
HSD	Health sub-district
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
MCH	Maternal Child Health
M&E	Monitoring and Evalaution
MoH	Ministry Of Health
MoLG	Ministry of Local Government
NGO	Non Governmental Organisation
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
p	probability value
R	Corrélation coefficient
SD	standard deviation
UDA	Uganda Dental Association
WHO	World Health Organisation

Preamble

Oral health is defined as the absence "of disease and the optimal functioning of the mouth and its tissues, in a manner that preserves the highest level of self-esteem".
Oral diseases and conditions are an important public health concerns because of their high prevalence, their severity, or public demand for services because of their impact on individuals and society. The combined effect of the resulting pain, discomfort, handicap, social and functional limitations, and financial burden on quality of life, has been largely ignored. A global review of oral health policies suggests that they have been fundamentally unachievable. They have employed uniform intervention strategies for non- uniform needs, used expensive, technology-driven approaches and failed to address key determinants of disease. When such health strategies have been imported into this country, they have failed to improve oral health. Where viable interventions existed in the past, their accessibility for most communities was limited or entirely excluded by the constraints of their social, economic or political status.

The cost of oral disease to individuals and the community is considerable. The causes of oral diseases are well known, are easy to detect and are largely preventable using simple and cheap public health methods. Individual treatment options are not available to most people and are often ineffective as strategies to improve the oral health status of the population.

The management of oral discomfort and functional limitation will fundamentally improve health and quality of life. Oral disease is an important public health concern that requires an explicit policy. A situation analysis in most African countries reveals that, "only 14 out of the 52 have a national oral health plan. Very few of these have made any progress towards implementation of the plan while none has evaluated what has been done. This strongly suggests that such plans are fundamentally flawed or too ambitious.

Situational analysis

Burden and determinants of oral diseases
Currently there is inadequate data on the oral health situation in Uganda. According to a National oral survey conducted in 1987, thirty five percent (35%) of 6 year olds with D3-4MFT,

23% 12 year olds with D3-4MFT and 52% of 35-44 year olds with D3-4MFT. This survey established that the main reason for tooth loss among the surveyed communities was tooth decay. It was also found that preventive oral health programmes were of a limited nature with Public Health Dental Officers offering mainly curative services even though the rationale behind training this group of auxiliaries was to address the need for community based oral health services. More recent information (2004/2005) from a rapid assessment conducted through a community survey and key informant interviews in 10 districts highlighted that, at least 51% of the community had experienced an oral health problem in the six months prior to the survey. Of the persons who had experienced an oral health problem only 35% were received treatment. The most prevalent conditions as reported by the key informants (dental practitioners) were; tooth decay (93.1%), pain (82.1%), tooth loss (79.3%), early childhood caries (75.9%), bleeding gums (71.4%), loose teeth (48.3%), bad breath (42.9%), oral HIV lesions (28.6%), harmful practices such as tooth bud extraction (17.2%), oro-facial trauma without fractures (13.8%), jaw fractures (13.8%), oral cancer (10.3%), mouth sores (10.3%), fluorosis (6.9%) and benign oral tumours (3.4%). The most prominent determinants for oral disease as reported by the key informants were; sugar consumption, failure to use fluoride toothpaste, lack of access to fluorinated water, tobacco use, lack of community oral health education, use of traditional practitioners, low level of community awareness and failure to have oral health check ups.

Human Resources

In the African context, Uganda is unique in that government presently trains two cadres of oral health workers: dental surgeons and public health dental officers.

Dental Surgeons

Considering the high cost of training abroad and the increased local demand of Dental Surgeons, Makerere University started a 5-year Bachelor of Dental Surgery (BDS) training program in 1982. Currently the intake for this training program is 15 students each new academic year. Although postgraduate training leading to the production of oral health specialists is the cornerstone for the development of the profession it is currently lacking at Makerere University. There are virtually no oral health specialists in the country. A few of the existing ones, 14 in number are Makerere University employees who are engaged full time in teaching students with limited oral health care delivery to the public. As of the year 2006, there were 72 dental surgeons distributed across the various districts in the country (1 dental surgeon per 158,000 people), however 39% of these personnel were based in Kampala district. According to the current National Health policy, every district is expected to have a Dental Surgeon in the district hospitals.

Public Health Dental Officers

Although the school for Public Health Dental Officers (PHDO) established in 1972 was equipped to cater for 25 students, the current intake is at 50 students. An inventory conducted in 2002 revealed that there were 159 PHDOs distributed in various districts in the country, however 25% of these personnel were based in Kampala district. The National Health policy envisions the placement of a PHDO at each of the 159 Health Centre IVs in the country, however this has not been realized (only 35% of these health facilities have a PHDO).

Dental technologists

Training of Dental Technologists that was done outside the country halted temporarily in 1975 and up to now has never been revived. The majority of these Technologists in the country have retired, died or are nearing retirement age without available replacements. The Equipment Maintenance Technicians are severely inadequate. There are currently only 3 trained dental equipment technicians based in Mulago Hospital and they are not readily available to the training institutions

Financing of oral health care services

The Ministry of Health (MoH) operates on a low budgetary allocation of approximately 9% of the GDP, which is not adequate for optimal service delivery in the country. Of this the direct oral health care budgetary allocation is less than 0.1%. Basic oral health services are free in government health units, whereas the secondary and tertiary services are provided at a fee. However, due to shortages of materials, supplies, equipment and manpower, patients have to seek and pay for the basic treatment elsewhere. Therefore, the burden of financing of the dental services is borne by the patients.

Infrastructure and equipment

All the government regional referral hospitals received dental equipment in 1992, however since then some of the equipment has broken down. And need repair and replacement. District hospitals received dental equipment in 1972, however over 30 years down the road they are all broken and non functional. About 80% of the Health Centre IV facilities have a hydraulic chair as well as a set of hand instruments for oral health procedures.

Private sector

The private sector constituted mainly by private practitioners provides a significant proportion of oral health care in the country. However these private practitioners are mainly concentrated in

Kampala district and other large centres. The monitoring of the quality of services provided by a number of these practitioners remains a challenge.

Rationale of the policy

a) The last National Oral Health survey (1987) indicated that dental caries, periodontal disease, oral manifestations of HIV/AIDS and tooth bud extractions ("false teeth" extractions by traditional healers) were very prevalent. Policy guidelines are therefore necessary to explicitly address the prevalence of these diseases.
b) There is a steady increase in the numbers of trained oral health personnel in the country. A mechanism to oversee their deployment and promotion should be put in place.
c) Oral diseases have a profound impact on society in terms of pain, discomfort, social and functional limitations, handicap and the effect on the quality of life.
d) The National oral health strategic plan (2006-2010) forms part of the National Health Sector Strategic Plan and the strategic priority objectives need to be addressed.
e) The HIV/AIDS epidemic requires modification of the management procedures for the affected patients and health providers.
f) The Health Policy (1999) emphasized decentralization of health services, with the Districts being empowered to plan, manage and implement their own health activities, Such empowerment needs to be strengthened by policy guidelines from the Ministry of Health.

Scope

Policy development and implementation is a dynamic process and consequently this policy should be communicated to all stakeholders. Furthermore, it will cover the whole spectrum of oral health conditions and will be routinely reviewed in light of epidemiological and scientific information, monitored for its successful implementation and evaluated for its effectiveness. The Oral Health Policy will apply to:

- All dental practitioners from the public and private sectors
- All organisations/institutions providing oral health services from the public and private sectors
- All organisations/institutions involved in the management and regulation of oral health services

This policy is based on the principles already enshrined in the Constitution of Uganda, National Health Policy and HSSP I & II, Poverty Eradication Action Plan, Local Government Act and Millennium Development Goals. It offers an alternative way of gathering and interpreting the oral health information. It introduces an alternative approach to the process of identifying and managing priority oral health problems.

Vision for Oral Health

The National Oral Health Policy will establish comprehensive oral health system fully integrated in general health and based on primary health care, with emphasis on promotion or oral health and prevention of oral disease by the year 2015. The system shall ensure continued facilities for curative and rehabilitative care, within available resources. It is further envisioned that the system will lead to equitable access to good quality oral health care services for all individuals and communities in order to ensure improved levels of oral health and function.

Goal

The goal of the policy is to improve the oral health of Ugandans in order to promote a healthy and productive life.

Objectives

1. To provide guidelines for oral health managers and service providers that define national oral health programmes
2. To provide guidelines for oral health managers and service providers that facilitate population wide initiatives to promote oral health
3. To provide guidelines that assist oral health managers and service providers customize locally effective oral health strategies
4. To provide a framework for monitoring and evaluating the effectiveness of strategies taken to improve oral health and sustain an ongoing process of policy review and development

Guiding Principles of the Policy

The guiding principles underpinning this policy are based on current scientific, epidemiological knowledge about the prevalence and determinants of oral conditions and knowledge on evidence based dental practices. The principles are designed to guide delivery of oral health programmes

at every level of the health system and provide a basis for evaluating progress. The following constitute the guiding principles for the Oral Health Policy:

1. Primary Health Care

Primary health care shall remain the basic philosophy and to this end an appropriate mix of services shall be established and delivered through a decentralised health care system using the following guiding principles:

- Promotion and Preventive activities are to be the priority at all times
- Health sub-district and District plans of activities are to be based on, and reflect, local needs and to focus on those in most need
- Curative and rehabilitative care is to be provided at specific times and sites, at defined levels appropriate to local needs and available resources
- Curative and preventive regimes are to be selected according to evidence-based research criteria
- Community participation, shared responsibility and empowerment shall be enhanced.
- Incorporation of other health, social and economic issues for a more strategic and responsive approach to addressing oral conditions

2. Equity and Gender

The policy emphasises the importance of promoting equity to ensure that the benefits of the policy shall be available to everyone in the population, among others irrespective of gender, age, ethinicity, culture and religion.

3. Human right based approach

In addressing oral conditions, the Policy aims at promoting the respect of human rights, culture, religion, ethics and gender of communities affected by the policy.

4. Integration and Collaboration

In order to effectively address the determinants of oral diseases, oral health promotion and services shall be integrated with those of other partners, sectors and programmes concerned with community health. The existing collaboration and partnership shall be further strengthened between the public and private sectors to ensure the provision of good quality oral health services.

5. Information

Information appropriate to planning of oral health services needs to be coordinated across districts. Communication routes through the decentralised health care system will need to be established and maintained. It is important to ensure that the information collected, can be used for local planning and decision-making, as well as at regional and national level.

6. Gender considerations

There should be promotion of interventions that take into account gender concerns at all levels of care.

7. Research

The policy emphasises the importance of identifying research priority areas in order to accelerate the building of science and evidence-based care to guide planning, implementation and evaluation.

8. Continuing professional development

The policy will promote continuing professional development at all levels of service providers.

9. Training of specialists

The policy will promote training of specialists in the various fields of oral health.

Policy Strategies

The policy provides a simple set of guidelines to enable local level health care managers and providers to make the best decisions they can on what oral health strategies to implement. It is a flexible decision-making framework that enables health managers to adapt the most effective oral health interventions to the specific needs, infrastructure and resources available to each community.

1. National Programmes in Oral Health

To ensure equity and coherence, a number of activities are required at national level for effective implementation and management. These are:

- Formulation, implementation and review of a national oral health policy as a framework for policy implementation at the district and lower levels.
- Ensure that the determinants of oral health are addressed in all policy matters.

- Manage specific National interventions through monitoring the implementation of national intersectoral, promotive, oral health programmes and technical support to districts in implementation of their activities
- Coordinate oral health information collection and dissemination from districts and HSDs for planning, monitoring, evaluation and resource allocation
- Develop clinical practice guidelines through the application of evidence-based research findings and through commissioning research

2. Promotion of Oral Health

In order to protect the population against known oral disease risk factors, it is the responsibility of health managers at national, district and health sub-district tiers of the health system to reduce the risk by:

- Raising the awareness of oral disease risk and appropriate means of oral care through the development and implementation of appropriate information, education and communication strategies to foster the empowerment of communities
- Integrating oral health policy elements and strategies into programmes and policies of all sectors that have an impact on community health, including maternal and child health; HIV/AIDS and STDs; health promotion; food and nutrition; drug control; disability; agriculture; tobacco control; substance abuse; HIV/AIDS and STDs; health promotion; sanitation; chronic diseases; education, culture, beliefs and others.
- Identifying and developing collaborative approaches to initiatives that address common risk factors such as tobacco, sugar, alcohol, unsafe sex, chronic medication, violence and vehicle accidents.

3. School oral health programe

Oral health education, periodic screening of school children and training teachers on oral health education and promotion should be emphasized in harmony with the school health programe and WHO school health initiative.

Oral health and prevention of oral diseases among school children through a health diet, advocacy for reduced consumption of sugars and increased intake of fruits and vegetables.

4. Training of dental professionals

The policy should ensure the provision of dedicated national funding for the education and training of appropriately skilled oral health personnel.

Primary health and oral health care in schools should be emphasized.

5. Recruitment of oral health personnel

Creation of additional posts for oral health workers to serve in public service institutions in order to cater for the increased demand for oral health services in the country.

Creation of senior house officer positions for oral health specialists (Annex 6).

6. Locally effective oral health strategies

The communities and the circumstances in which they live are extremely diverse. A single uniform programme of interventions, goals or services is therefore inappropriate. It is the responsibility of the health system to prepare a set of intervention strategies and targets selected according to the specific needs, determinants and other circumstances of each community. An absence or limitation on resources does not need to mean non-delivery of services but simply means alternative strategies that are less resource or technology-intensive must be provided. As a minimum, it is imperative that districts and health sub-district managers ensure:

- the provision of basic oral health care
- the provision of appropriate oral disease prevention and oral health promotion measures
- the implementation of cost-effective and evidence-based strategies.

The following steps must be taken by district and health sub-district managers to ensure that an appropriate oral health plan is devised for each health setting:

1. Assess the oral health condition of their communities (Annex 1)
2. Prioritize the problems identified according to their prevalence, severity and social impact (Annex 2).
3. Identify the resources available (Annex 3)
4. Select the most appropriate interventions (Annex 4)
5. Implement, monitor and evaluate the selected strategies.

7. Monitoring and Evaluation

To determine the impact of this policy, each district is responsible for providing the Ministry of Health with information (Annex 5) describing their activities related to:

- The national oral health programmes in place
- The population strategies carried out and locally effective interventions prepared
- The oral health strategies prepared
- The interventions implemented
- The community oral health assessment data collected

District and health sub-district managers are required to ensure that an ongoing community oral health surveillance system is established.

5. Policy review and development

The office of the Principal Dental Surgeon in the Ministry of health is required to convene a policy review panel annually, to assess the implementation and outcomes of this policy, and make recommendations accordingly.

The Oral Health Section of the Ministry of Health is responsible for collecting the information provided by district health authorities and the regular dissemination of summary data and reports on the review process.

6. Institutional Framework

The policy addresses the broad principles at the National/District/HSD levels that are pertinent to Oral Health. Implementation of this policy will include but not be limited to the following:

National level

- Formulation, implementation and review of a national oral health policy to ensure that the determinants of oral health are addressed in all policy matters
- Resource mobilisation for the education, equipment, facilities and training of appropriately skilled oral health personnel.
- Develop and monitor the implementation of national intersectoral, promotive, oral health programmes, and support districts in their activities.
- Coordinate oral health information collection, analysis and dissemination.
- Develop clinical practice standards and guidelines on oral health care and services.
- Facilitate collaboration with other sectors (including private sector) and development partners.
- Facilitate research on oral health

- To identify oral health personnel, equipment and facilities requirements.

District level

In line with the national oral health guidelines the districts should;

- Develop specific operational guidelines that address the unique and pertinent oral health conditions within their communities. The broad principles of a human rights-based approach, promotion and prevention, equity, integration, appropriate mix of PHC services, community participation, information, gender considerations and research should be applied.
- Identify and allocate local resources for the provision of oral health services including out reach programs.
- Strengthen the current information system to ensure the collection, use and dissemination of oral health related information
- Monitor the process of implementing the oral health strategies at the HSD level using indicators in Annex 5.
- Evaluate the effectiveness of the policy and review as deemed appropriate.
- Recruit and promote oral health staff appropriately
- To identify oral health staff requirement and training needs.

Health Sub-District level

In line with the national and district oral health guidelines;

- Raise the awareness of oral disease risk and appropriate means of oral health care.
- Integrate oral health policy elements and strategies into programmes and policies of all sectors that have an impact on community health, including maternal and child health; HIV/AIDS and STDs; health promotion; food and nutrition; drug control; elderly, disability; agriculture; tobacco control; substance abuse; HIV/AIDS health promotion; sanitation; chronic diseases; education and others.
- Provide basic oral health care.
- Provide appropriate disease prevention and health promotion measures based on cost-effective and evidence-based strategies.

- Undertake activities to identify and develop collaborative approaches to initiatives that address common risk factors such as tobacco, sugar, alcohol, unsafe sex, violence and accidents.
- Collaborate and partner with the private sector in service provision, quality assurance, information collection and management
- Ensure the collection, analysis, use and dissemination of information related to oral health conditions at this level.

Legal Aspects

The Oral Health Section of the Ministry of Health in collaboration with the Uganda Medical and Dental Practitioners Council, and Uganda Dental Association shall formulate and disseminate laws, regulations and enforcement mechanisms related to development and regulation of Oral Health Services. Violation of the code of conduct is liable to litigation.

Financial implications

The ministry of health, development partners, local governments and NGO's will finance implementation of this policy.

Ministry of health local governments at district level, private and NGO sectors shall include oral health care and promotion strategies in their budgets and work plans.

The budgets should be made to adequately cater for the following areas;

- Human resource development
- Oral health care
- Oral health education and promotion
- Procurement distribution and maintenance of dental equipment
- Provision of dental materials and sundries
- Continuing professional development
- Research
- Monitoring and evaluation
- Training of specialists

STAKE HOLDERS

1. WHO
2. Uganda Dental Association
3. Uganda Medical Protestants Bureau
4. Ministry of Public Service
5. Ministry of Finance
6. Ministry of Justice
7. Ministry of Education and Sports
8. Makerere University Dental School
9. UNICEF
10. Private Dental Practitioners

11. Uganda Medical and Dental Council
12. Ministry of Health

Annex 1: Assessing the oral health of a community

In the complete absence of oral health data, commonly available health and socio-economic data can give a good idea of the oral health of a community. Table 1 illustrates some of these proxy-indicators that can be used.

Table 1: Suggested proxy indicators of oral disease in a relatively poor country

Macro-indicator	Oral cancer	Mucosal lesions	Noma	Dental caries	Perio-disease	Facial trauma	Harmful practices
Low Per capita GNP	High	High	High	Low	High	High	High
Low Gini coefficient (income equity)	?	High	High	Low	High	High	
High % low birth weight infants	High	High	High	Low	High		
High Infant Mortality Rate	High	High	High	Low	High		

High % malnourished children (below 3rd percentile age/weight)		High	High	Low	High		
Low % Population using safe water			High	Low	High		
Low Literacy	High		High	Low	High		
Low Measles vaccination coverage		High	High		High		
High HIV infection rate	High	High	High		High		
High Tobacco consumption	High				High		
Low sugar Consumption				Low			
High Alcohol consumption	High				? High	High	
Low Fluoridated toothpaste sales				High			
High Endemic fluorosis (certain areas)				Low			

Table 2 Simplified questionnaire for Rapid Oral Health Appraisal

1. Do you have anything wrong with your mouth at this moment of have you experienced any problems with your mouth in the past month? Y/N

2. If yes which of the following conditions best describes what you think was wrong? (Toothache/an ulcer/infection of gums/cold sore/pain on chewing/bad appearance/difficulty opening or closing your mouth/difficulty in speaking/sore gums/bad breath/other)

3. Have you been treated for anything wrong with your mouth in the past six months? Y/N

4. Do you smoke? Y/N Have you ever smoked? Y/N If you have, when did you stop (months/years)

5. Do you drink alcoholic drinks? Y/N Have you ever drunk alcoholic drinks? Y/N If yes, when did you stop? (months/years ago)

6. Think about yesterday and what you had to eat. Did you add sugar to anything you ate? Y/N How many times did you eat sugar food? (times)

7. Think about yesterday and what you had to drink. Did you have a sugar-containing drink? Y/N Did you add sugar to anything you drank? Y/N How many such drinks did you have? (cups)

Annex 2: Prioritisation of Oral Conditions & Determinants

Step One

Interview an oral health professional at a health facility on his/her perception of how serious (social impact) and how common (prevalence) the conditions listed below are felt to be. The accepted morbidity and mortality of each condition is given. Indicate the assessment of Social Impact and Prevalence as High, Medium, Low or None in the blocks provided. (During analysis the listed conditions will be prioritised depending on how many times they score a High or Medium rating in their row of the table).

Table 3 Social impact and prevalence of oral conditions

Oral disease	Social Impact	Prevalence	Morbidity	Mortality
Bad breath			Low	None
Benign oral tumors*			Medium	Low
Bleeding gums			Medium	None
Congenital abnormalities *(specify)*			Medium	Medium
Early childhood caries			High	Low
Fluorosis			Low	None
Harmful practices *(specify)*			Medium	Medium
Loose teeth			Low	Low
Mouth sores			Medium	Medium

Noma			High	High
Oral cancer			High	High
Oral HIV lesions			High	High
Oro-facial trauma without fractures			Medium	Medium
Jaw fractures			Medium	Medium
Pain			High	Low
Tooth decay (adults)			Medium	Low
Tooth loss			Medium	Low
Other *(specify*)				

Step Two

Rank the listed conditions depending on how many times they score a High or Medium rating in their row of the table. Those conditions you move to the top of the list on this basis will represent the priority oral health conditions in your particular community.

Step Three

This same group of informants can assist you identify the most prominent determinants or risk factors for disease in their community. Indicate the responses as High, Medium, Low or None in the following table.

Table 4 Determinants of oral conditions

Factors known to affect the risk of oral disease	**How widespread is this?**
Sugar consumption > 10kg/year	
Use of fluoride toothpaste	
Tobacco use	
Access to fluorinated water	
Visits for oral health check up	
Community oral health education	
Level of community awareness	
Visits to traditional practitioners	
Use of chewing stick	
Other *(specify*) e.g. disability, nutrition status, etc	

Annex 3: Oral Health Resource Assessment

In order to develop a series of decision tables matching resources and interventions, it is necessary to determine the level of resources available to implement the interventions being considered.

Table 5 Oral health resource assessment

		Yes	No	Don't Know
Finance				
1.	Is there an oral health budget?			
2.	Are there sufficient capital funds for equipment & instrumentation?			
3.	Are there sufficient recurrent funds for salaries?			
4.	Are there sufficient recurrent funds for materials and maintenance?			
Personnel				
5.	Are there sufficient, appropriately trained personnel?			
6.	Are there sufficient personnel to manage, monitor and evaluate oral health interventions?			
Equipment and Instrumentation				
7.	Is the equipment available appropriate?			
8.	Are the instruments available appropriate?			
Infrastructure				
9.	Has a needs assessment been carried out in sufficient detail to select interventions?			
10.	Are there clear lines of communication to the community?			
11.	Are there clear lines of communication for the acquisition of resources?			
12.	Are there clear lines of communication for reporting?			
13.	If yes, are they functional?			
14.	When some form of transport is necessary, (for people or goods), can you rely on the transport system to provide it?			
15.	Are there clear lines for referral of patients?			
16.	If yes, are they functional?			
17.	Is there sufficient space for the dental clinic?			
18.	Is this the current location of the dental clinic appropriate?			

Interpreting the response

Number of questions answered YES	Availability of resources
If there less than six	LOW

If there are between six and nine	MODERATE
If there are more than nine	HIGH

Annex 4: Decision Tables

After determining local oral disease priorities, each separate condition must be assessed in terms of the intervention options available and the resources or infrastructure necessary to deliver them. Based on this a selection of the best locally viable strategy (S) can be implemented. The outcome of each strategy may be measured using selected indicators such as the suggested targets included below each oral disease table.

The Oral Health Targets suggested for each of the listed oral disease or health conditions, are intended to provide a framework for health policy makers at different levels – national and district. They are not intended to be prescriptive. These Targets should be mixed and matched according to prevailing local circumstances.

Note: Intervention should be based on best practice, i.e. evidence-based.

Dental Caries	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Oral hygiene education, provide analgesics, tooth extraction for patients with pulpitis S2 = S1 + Assessment of level of fluoride in water supplies and level of fluoride toothpaste use. Advice for on use of fluoride toothpaste S3 = S2 + Fissure sealants, Atraumatic Restorative Technique, Preventive Resin Restorations, Simple endodontic therapy for patients with pulpitis of anterior teeth, Treat posterior teeth with pulpitis to retain 5 posterior occluding pairs, Use rotary instruments to place restorations if viable
Severe	S2	S3	S3	
Moderate	S2	S2	S3	
Mild	S1	S1	S3	
Suggested Indicator				**Target**
To increase the proportion of caries-free 6 year olds by				25%
To reduce tooth loss due to dental caries at age 18 years by				25%

Pain	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Provide pain relief with analgesics and/or antibiotics; extraction S2 = emergency endodontics of anteriors where indicated S3 = emergency endodontics of posteriors where indicated; pulpotomy
Adults	S1	S2	S3	
Children < 6 years	S1	S1	S3	
Suggested Indicator				**Target**

A reduction in the number of days of difficulty in eating, and speaking/communicating resulting from pain or discomfort of oral and craniofacial origin of	20%

Tooth loss	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Health Promotion and education; Advocacy and support for programmes that enhance social development S2 = S1 + Denture construction, based on availability of resources and according to current protocols
Partial edentulism	S1	S2	S2	
Complete edentulism	S2	S2	S2	
Suggested Indicator				**Target**
To increase the number of natural teeth present at ages 18 years by				20%

Chronic periodontal disease	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = self care and education; Occupational health and safety measures S2 = S1 + identify those at risk; Advocacy to reduce risk factors like poor nutrition, smoking, immunosuppression; Extraction of teeth with pain and mobility; Treatment of critical teeth to retain at least 5 posterior occluding pairs; Scaling when necessary. S3 = S1 + S2 More complex evidence-based treatment to treatment to delay/slow progress, where appropriate.
High priority Attachment Loss or pockets > 5mm	S2	S2	S3	
Low/moderate Attachment Loss or pockets < 5mm	S1	S1	S1	
Suggested Indicator				**Target**
To reduce the incidence of active periodontal infection in all ages by				15%

Noma	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = immunization, nutrition, education, feeding schemes (short-term), oral cleaning, chlorhexidine mouthwash during acute infectious disease, develop local protocol for the acute phase of noma. S2 = S1 + reconstructive surgey
Existence of noma	S1	S1	S2	
Suggested Indicator				**Target**
To increase early detection and referral by …… and …….. respectively				20 % and 20 %

Oral HIV	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	

Existence of HIV	S1	S2	S2	S1 = Advocacy and support for the health system's response to HIV pandemic; Universal Infection Control; Prevent oral lesions amongst HIV +ve people with chlorhexidine; Development of a local prorocol for all health workers. S2 = S1 + specific treatment of oral mucosal lesions, referral for other HIV prevention and care services
Suggested Indicator				**Target**
To increase the numbers of health providers who are competent to diagnose and manage the oral manifestations of HIV by				70%
Harmful practices	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Health promotion and education; Advocacy and support for programmes that enhance social development; Education and training of health workers; Treatment of severe complications S2 = S1 + Education and training of existing health workers to recognize and advocate for eradication of harmful practices; Education and training of existing oral health personnel to use only evidence-based interventions.
High	S1	S2	S2	
Low	S1	S2	S2	
Suggested Indicator				**Target**
A reduction in the numbers of individuals experiencing difficulties in chewing, swallowing and speaking/communicating arising from a variety of harmful practices of				20%

Oro-facial Trauma	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Advocacy and support for programmes that: a) enhance social development; b) decrease alcohol and drug abuse; c) improve infr-structural decelopment and d) create legislation for occupational health and safety and road safety; Adopt and use standardized treatment protocols based on availability of resources.
Existence of Oro-facial Trauma	S1	S1	S1	
Suggested Indicator				**Target**
To increase the numbers of health care providers who are competent to diagnose and provide emergency care by ……. And …… respectively				70 % and 70 %

Oral Cancer	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Train Primary Health Care (PHC) Workers in the detection of oral pre-cancer and cancer; Early diagnosis by PHC workers for pre-cancer and cancer; Advocate for functional referral system if none exists; Train general pathologists in oral cytology and classification of oral cancers; Measures to limit occupational risk factors; Advocate for registration of all oral cancers in national register; adopt and use standardized treatment protocols.
Existence of Oral Cancer	S1	S1	S1	
Suggested Indicator				**Target**
To increase early detection and rapid referral by …… and …… respectively				40% and 40%

Fluorosis	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Identify alternative water source; Advocacy and social mobilization for de-fluoridation using appropriate technology. S2 = No intervention S3 = Clinical intervention for selected severe cases.
High prevalence	S1	S1	S3	
Moderate or low prevalence	S2	S2	S3	
Suggested Indicator				**Target**
To reduce the prevalence of disfiguring fluorosis with special reference to fluoride content of food, water and inappropriate supplementation by				30%

Benign Tumours	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Training PHC workers in the detection of oral pre-cancer and cancer; Early diagnosis by PHC workers for oral pre-cancer and cancer; adopt and use standardized treatment protocols based on the availability of resources
Existence of Benign Tumours	S1	S1	S1	
Suggested Indicator				**Target**
To increase early detection and rapid referral by …… and …….. respectively				40 % and 40 %

Cleft Lip &/or Palate	RESOURCES			INTERVENTION STRATEGIES (S)
	Low	Medium	High	S1 = Counselling, Post-natal care; Surgical treatment of condition; Train PHC workers in early recognition and referral for speech therapy etc. S2 = S1 + orthodontic and prosthetic treatment based on availability of resources
Occurrence of Cleft Lip & Palate	S1	S2	S2	
Suggested Indicator				**Target**
To increase the number of affected individuals receiving multidisciplinary specialist care by				30%

Annex 5: Proposed indicators for Monitoring and Evaluation

The following information needs to be compiled annually by the Ministry of Health from its own data, and data submitted by the districts.

Programme item	Description	Status Rating		
A. National oral health programmes in place		**Yes**	**No**	**Comment**
1. Policy	Is there a district oral health operational policy? If no, why not? _____ _____ _____ When is it expected to have such a policy finalised? _____ *Attach a list of all Districts, indicating (i) whether an oral health plan has been prepared of the stage of the planning process that has been reached, and (ii) the extent to which each plan has been implemented.*			
B. Population strategies carried out				
1. Health education and promotion	Are there oral health education and promotion programmes? If no, why not? _____ _____ _____ *Attach a list of all programmes of this kind that have been implemented, indicating (i) the nature of the programme, (ii) where they have been implemented, and (iii) the beneficiaries of the programme.*			
2. Integration	Are oral health strategies integrated with other health programmes e.g. HIV/AIDS, health promotion, maternal and women's health, child and adolescent health, and nutrition If no, why not? _____ _____ _____			

C. Strategies prepared and interventions implemented			

List of oral conditions	Estimated prevalence	Priority ranking	Number of HSD/Districts with intervention strategies in place for these conditions

Total number of HSDs in District _____
Attach copies of this table for each of the districts

D. Community oral assessment data		Yes	No	Comment
	Has community oral health assessment data per HSD been collected? If no, why not? _____ _____ _____ *Attach the data set for each District for which this has been colleted*			
E. Resource assessment				
	Attach a completed copy of the form in Annex 3 for each District			

Annex 6

REQUIRED POSTS FOR ORAL HEALTH PERSONNEL IN THE HEALTH SERVICES

MINISTRY OF HEALTH HEADQUARTERS

CATEGORY/POST	No REQUIRED	DIVISION
Assistant Commissioner Health Services	1	Oral health Services
Principal Dental Surgeon	1	Clinical Services
Principal Dental surgeon	1	Community oral health
Senior Dental Surgeon	1	Clinical Services
Senor Dental Surgeon	1	Community oral health

NATIONAL REFERRAL HOSPITAL, MULAGO HOSPITAL COMPLEX

CATEGORY	POSTS	No REQUIRED	DISCIPLINES
Senior House officers	SHO	18	Oral & maxillo-facial surgery
Dental surgeons	Senior consultant dental surgeon Consultant Dental Surgeon Dental surgeon Special grade Principal dental Surgeon Senior Dental Surgeon Dental Surgeon	3 5 10 2 4 30	Oral surgery Orthodontics Prosthetics Restorative dentistry Paediatric Dentistry Oral medicine Oral pathology
Public Health Dental officers	Principal, Snr, Grade I, II	24	Prescribed duties as per training
Dental technologists	Principal, Snr, Grade I, II	18	Prescribed duties as per training
Dental Equipment Maintenance Technicians	Principal, Snr, Grade I, II	14	Prescribed duties as per training
Dental Nurses	Enrolled	10	General nursing

REGIONAL REFERRAL HOSPITAL

CATEGORY	POSTS	No REQUIRED	DISCIPLINES
Dental surgeons	Senior consultant		Oral surgery

	dental surgeon Consultant Dental Surgeon Dental surgeon Special grade Principal dental Surgeon Senior Dental Surgeon Dental Surgeon	1 2 2 2 2 4	Orthodontics Prosthetics Restorative dentistry Paediatric Dentistry Oral medicine Oral pathology
Public Health Dental officers	Principal, Snr, Grade I, II	5	Prescribed duties as per training
Dental technologists	Principal, Snr, Grade I, II	4	Prescribed duties as per training
Dental Equipment Maintenance Technicians	Principal, Snr, Grade I, II	4	Prescribed duties as per training
Dental Nurses	Enrolled	2	General nursing

GENERAL HOSPITAL

CATEGORY/POST	POST	No REQUIRED
Dental Surgeons	Senior Dental Surgeon Dental surgeon	1 1
Public Health Dental Officers	Grade I Grade II	1 2
Dental equipment maintenance Technicians	Dental Technician	1
Dental Nurse	Enrolled Nurse	1

HEALTH CENTER IV

CATEGORY/POST	POST	No REQUIRED
Dental Surgeons	Dental surgeon	1
Public Health Dental Officers	Grade II	1
Dental Nurse	Enrolled Nurse	1

HEALTH CENTER III

CATEGORY/POST	POST	No REQUIRED
Public Health Dental Officers	Grade II	1
Dental Nurse	Enrolled Nurse	1

List of acknowledgements

1. World Health Organization
2. Policy Analysis Unit (Ministry of Health)
3. Uganda Medical and Dental Practitioners Council
4. Uganda Dental Association
5. Makerere University Dental School
6. Uganda Protestants Medial Bureau

7. Ministry of Public Service
8. Ministry of Finance and Economic Development
9. Ministry of Justice
10. District Health Officers
11. Ministry of Education and Sports