Oral Health Education and Advocacy Programme for Orphans and Vulnerable Children (OVC) – a Preliminary Retrospective Study

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Abstract

Targeted oral health services for orphans and vulnerable children are rarely available in our communities. Oral health education preventive interventions present the only strategy to address this problem. In a descriptive retrospective study using the structure, process and outcome factors we evaluated oral health education and advocacy programme conducted by the Community Dentistry Unit, University of Benin Teaching Hospital, Benin City, Nigeria over 5 years to orphanages. A total of 14 visits were conducted involving 362 orphans. The number of orphans per home ranged from 12-80 children with a mean of 26 orphans while that of caregivers ranged from 2-8 persons giving ratio of caregiver to orphan of 1:8. Majority of the orphanages (85.7%) were private, owned and funded by personal donations while 14.3% were owned by religious organizations. Furthermore, 57.1% of the orphanages made use of rented facilities. Oral health education was carried out with equal distributions of indoor and outdoor. Only about 7.1% of the orphanages had a sickbay on-site. None of the orphanages had access to oral health and all requested for subsequent visits. These findings support a need for orphanages to have oral health aids, functional facilities and a clear access to oral health care. Also, sustained source of funding, regular visits by oral heal health personnel, caretakers training are needed.

Keywords: advocacy, oral health education, orphans, vulnerable children, Benin City

Introduction

Orphans and vulnerable children (OVC) are children aged below 18 years whose mother or father or both are not alive or unable to access their basic needs, rights to survival, development and protection. An orphanage is a place where they are accommodated and taken care of by caregivers trained to provide basic care, safety, health promotion and psychosocial support.[1]

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Significant differences exist in the way oral health care is accessed by orphans and vulnerable children which necessitates oral health education and promotion.[2]. There is consistent evidence that these children suffer a heavier burden of oral health problems than their regular peers.[3]

Socioeconomic inequalities in oral health are a major challenge for health policy- disadvantaged groups such as OVCs which can worsen their health status.[4,5,6]

It is important that oral health -related institutions undergo regular critical appraisal of the quality of service with appropriate intervention to improve the quality of care and services.[7-10]

Nigeria has a national oral health policy on orphans and vulnerable children but several authors have pointed out gaps in the knowledge and implementation of recommendations of oral health care for OVCs who make up 17.5 million(24.5%) of the Nigerian children.[11,12,13,14]

The National Guidelines and Standards of Practice on orphans and vulnerable children as in other countries seeks to support and protect the orphans and vulnerable children ensure availability of basic health education access preventive, curative and rehabilitative health services on an equal basis with other children.[15,16]

There is therefore the need for assessment of the situation of OVC response and practices regarding basic oral health education.

This study aimed to appraise the access to oral health education and care services including the barriers by orphans and vulnerable children in Benin City.

Materials and Methods

Setting: Benin City is the capital and largest city in Edo State of southern Nigeria. Its population[17] is currently estimated to be 1,727,169 with a growth rate of 3.04%

Study design: This descriptive retrospective study used quantitative and qualitative data gathered over 5 years on the orphanage oral health education programs conducted by the Community Dentistry Unit, Benin City, Nigeria.

Orphanage or OVC oral health education outreach programme was introduced as an adjunct to school oral health programme conducted by the Unit because the OVC setting is similar to school setting with peculiar socio-economic situation.

The oral health education team consists of dentists, dental surgery technicians, and dental students.

The process of conducting oral health education usually begins by informing and obtaining permission from the proposed orphanage organization or centre. During the visit, the process include introduction of the team, delivery of audience-specific oral health message at a suitable site or location within the premises, demonstration of tooth brushing using giant mouth model and toothbrush, and questions and answers session. Basic screening for common oral diseases which is not part of this study was then carried out as an incentive.

Ethical approval was obtained from the Ethics and Research Committee of the University of Benin Teaching Hospital. The data for this study were collected retrospectively for the stated period. The Structure Process and Outcome method of quality assurance was used to appraise the centres.[18]

Structure was evaluated based on, sponsorship, accommodation, availability of trained caregiver. The process component was evaluated by the number of OVC centres with oral health education, aids, access to oral care and referral. The outcome component was assessed by response to the programme. Other information obtained included basic profile of the orphanage. The data collected were entered into SPSS version 21 software and analyzed.

Results

A total of 14 oral health education visits were conducted during this period involving 362 orphans. The number of orphans per home ranged from 12-80 children with a mean of 26 orphans while the number of

Table 1 Pattern of orphan-caregiver frequency at the orphanage (ovc) centres

Minimum	Maximum	Total
Number of orphans	12	80	362
Number of caregivers	2	8	48
Ratio of caregiver to orphans	1:8		

Orphan-caregiver ratio

Of the 362 orphans at the visited orphanages within the period, the range of orphans per site was 12-80, while that of caregivers was 2-8 out of the total 48. This gave an orphan-caregiver ratio of 1:8.

Table 2: Funding sources of orphanage (ovc) centres

	Frequency	Percent
Individual donations	12	85.7
Church	2	14.3
Total	14	100.0

Majority of the OVC centres depended on donations from individuals while a small percentage received regular church support.

Table 3: Pattern of oral health education location at orphanage (ovc) centres

	Frequency	Percent
Outdoor	7	50.0
Indoor	7	50.0
Total	14	100.0

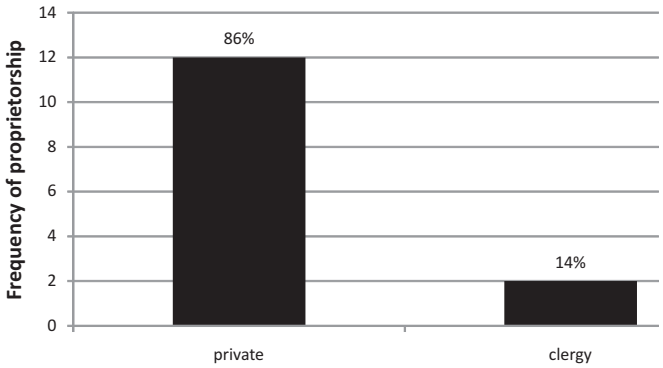

Figure 1 Proprietorship of (ovc) centres

Sponsorship of OVC center

Most of the orphanages (86%) were privately sponsored, with a minority (14%) promoted by faith-based organisation

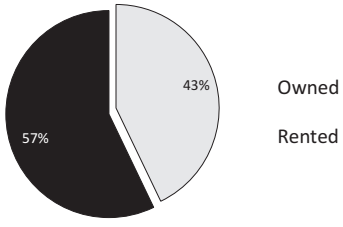

Figure 2 Accommodation ownership pattern of orphanage (ovc) centres

Physical structure ownership

Over half of the orphanages occupied by the orphanages were owned by the organization while less than half (43%) were rented.

caregivers ranged from 2-8 persons. The ratio of caregiver to orphan ranged was 1:8. Majority of the orphanages (92.9%) had no form of health emergency or first aid kit or facility. Similarly, none of the orphanage centre had access to oral health, no form of health insurance or safety net services.

Discussion

This study was conducted to assess the baseline structure, process and outcome of oral health-related activities at the orphanages. Information improved understanding of issues involved and leading to useful recommendations and possible policy review. The Edo State Ministry of Social Development & Gender Issues and Ministry of Women Affairs and Social Development, Abuja and similar governmental agencies are responsible for transitioning child welfare. The Child Welfare Unit develops, reviews and monitors child welfare policies and programmes.[10,12,16]

The OVC agencies monitor health status, provide access to care and address barriers to health care. The personnel structure of these agencies should include staff, caregivers and community health workers whose duties include giving health education, regular health check-ups, assessing shelter and providing material care needs. [19]

The Ottawa charter of health promotion recommends creating an enabling policy and a conducive operational environment for quality service delivery and coordination. [20]. The ability to ensure a suitable accommodation depends on proprietorship. In the present study majority (86%) of the OVC centres were under private proprietorship whose capacity to ensure a sustainable health promoting environment was lacking. (Figure 1).

Availability of a standard physical structure and facilities is key to ensuring the standard of care. In many centres space constraint was a problem, necessitating the use of outdoor sites for oral health education.(Table 3)

Caregivers are responsible for the physical, mental and emotional needs and well being of a child and give care in the home environment and should be available in adequate number. The caregivers require training in early childhood and care, oral health education, auxiliary nursing, parenting, counseling, first aid, and environmental care.[16,19]

In our study 362 orphans were at the orphanages visited within the period, the range of orphans per site was 12-80, while number of caregivers(48) range was 2-8 giving an orphan-caregiver ratio of 1:8.The number of orphans and vulnerable children per centre varies widely, The KwaZulu Natal report with 8 locations, 227 caregivers and 1764 orphans gives a caregiver: orphan ratio of 1;8 which is similar to our study finding of 1:8 (Table 1) except that the population of orphans per location/centre in their report were much higher, probably due to better sustainable funding, purpose-built centres and government support. [19.]

More than half of the OVC centres (57%) were residing in rented buildings. This is an indication of inadequate funding or financial support. (Figure 2)

The International Non-governmental Organizations (NGOs), local NGOs, Faith based organizations (FBOs), and Community-based organizations (CBOs) have roles to play in OVC work[13], but appears currently inactive in Benin City. USAID (SMILE PROJECT) Program a five-year (April 2013 to March 2018) Cooperative Agreement between Catholic Relief Services (CRS) and the US Agency for International Development (USAID) operated in the state to create access to quality care and coverage of services .[21]

In our study, majority of the centres (85.7%) depended on donations from individuals with no report of government or International NGO financial support or access to health insurance. In KwaZulu Natal and other centres in South Africa which met the criteria, US President's Emergency Plan for AIDS Relief (PEPFAR) and the United Nations Children's Fund (UNICEF); United States Agency for International Development (USAID) provided some support..[18]. There is therefore the need to proffer specific innovative models or programmes of care to cover the orphans and vulnerable children.

India, a developing country, utilized the dental safety net services to carry out targeted basic and emergency oral health care services to the vulnerable.[22]

In the USA, Healthy people 2020 programme was introduced to create access to preventive services and increase the proportion of low-income children and adolescents functions well to provide public subsidies or direct payments for dental services. The Affordable Care Act of 2010 was introduced to create the opportunity for states to widen eligibility for children. [23,24,25]

Furthermore, Community-based services, as a feature of Primary Health Care is a way to reach vulnerable populations and connect them with appropriate care.[26]

The Association of Territorial and Dental Directors (ASTDD) also in the United States utilize mobile dental clinics to bring oral health services to underserved populations. Dental services provided include preventive care, oral examinations, radiographs, and sealant placement, restorative and specialty care.[27,] [28]Additionally, the Danish Public Dental Health Service (PDHS) have guidelines on how to offer regular dental examinations, comprehensive treatment and preventive care which is beneficial to orphans and vulnerable children.[29,30]

Access to regular dental care has been recommended to enable them to benefit from

preventive interventions, early diagnosis and treatment of dental disease when necessary to prevent dental neglect.[31,32]

The outcome of this study was that the orphaned children received oral health education services and incentive for improvement in oral hygiene status. All the children and OVC centres' staff were enthusiastic about the programme and wanted it repeated regularly.

Conclusion:

This study showed that orphanages were mainly privately owned and lack health aids or facilities with no clear access to oral health care. Most centres were dependent on goodwill donations with no financial support from major agencies or the government. Also, no previous oral heal health education programme existed. The outcome was that children receive oral health education services and incentive for improvement in oral hygiene status. Caretakers should be educated and trained in oral hygiene practices. It is recommended that government and relevant agencies provide funding and policy to support the centres and oral health education programmes.

References

1. Khedekar M, Suresh KV, Parkar MI, Malik N, Patil S, Taur S, et al. Implementation of oral health education to orphan children. J Coll Physicians Surg Pak 2015;25:856-9.

2. Ogunbodede EO, Kida IA, Madjapa HS, Amedari M, Ehizele A, Mutave R, Sodipo B, Temilola S, Okoye L.. Oral health inequalities between rural and urban populations of the African and Middle East region.AdvDent Res.2015, 27(1):18–25.

3. Petersen PE: The world health report 2003. WHO, Geneva, 2003.

4. Kunst A, Mackenbach J: Measuring socioeconomic inequalities in health. WHO, Regional Office for Europe, Copenhagen, 1997

5. Locker D: Deprivation and oral health: a review. Community Dent Oral Epidemiol.2000, 28: 161-9.

6. Locker D: Measuring social inequality in dental health services research: individual, household and area-based measures. Community Dental Health 1993, 10: 139-150.

7. AHRQ (Agency for Healthcare Research and Quality). 2018. National healthcare quality & disparities reports: https://www.ahrq .gov/research/ findings/nhqrdr/index.html 27/3/20

8. Public Health England. Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities. 2014; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf(accessed 27/3/2020)

9. National Institute for Health and Care Excellence. Oral health: local authority oral health improvement strategies. London, 2014. https://www. nice. org. uk/ guidance/ ph55 (accessed 22/3/2020

10. Federal Ministry of Women Affairs and Social Development (2009). Monitoring and Evaluation Plan for The Orphans and Vulnerable Children (OVC) Response in Nigeria

11. Federal Ministry of Health.National Oral Health Policy, Abuja, Nigeria. 2012

12. Federal Ministry of Women Affairs and Social Development (2007).National Guidelines and Standard of Practice on Orphans and Vulnerable Children. Abuja, Nigeria. http://www.crin.org/docs/NigeriaOVCNationalGuidelinesHV.pdf (Accessed on.27/3/2020).

13. Godfrey B, Ebunlomo W, Jonathon S, Jill C, Jen B, Bram B. Nigeria research situation analysis on orphans and other vulnerable children country brief 2009. Boston University Center for Global Health and Development. Available: https://pdfs.semanticscholar.org/4694/5bde5e734eb0a90f3b282515b68e29c723c5.pdf 27/3/2020(accessed 27/3/2020)

14. Fatusi OA, Ogunbodede E, Sowole CA, Folayan MO. Gaps in oral health-care service provision systems for children in Nigeria: A case study of a tertiary health institution. Indian J Dent Res 2018;29:622-6

15. OlagbujiY W, OkojieOH. Assessment of the implementation of the national policy on orphans and vulnerable children in Benin City, Edo State, Nigeria. International Journal of Sociology and Anthropology 2015 7(9); 204-213.

16. National Standards and GuidelineS for care for Vulnerable Children 2014 Ministry of Social Development Lesotho September 2014

17. World Urbanization Prospects - United Nations population estimates and projections of major Urban Agglomerations' https://worldpopulationreview.com/world-cities/benin-city-population/ may 6 2020

18. Donabedian A. Quality assurance. Structure, process and outcome.Nurs Stand 1992;7(Suppl QA):4-5.

19. Tessa SM. Orphans and Vulnerable Children (OVC): end of project assessment report . Technical Report February 2015 DOI: 10.13140/RG.2.1.4811.1606

20. World Health Organisation. Ottawa Charter for Health Promotion: First International Conference on

Health Promotion Ottawa, 21 November 1986. Retrieved from https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf (Last accessed 27/3/2020

21. Ooms, G. and R. Hammonds.. "Anchoring Universal Health Coverage in the Right to Health," World Health Organization2015

22. Rao, K. D. and A. Sheffel, "Quality of Clinical Care and Bypassing of Primary Health Centers in India," Social Science & Medicine, vol. 207 (June 2018), 80–88.

23. Centers for Medicare & Medicaid Services 2020 Baltimore, Maryland,USA..https://www.medicaid.gov/medicaid/eligibility/index.html. Last accessed 27/3/2020

24. Healthy People 2020 Office of Disease Prevention and Health Promotion. (2018). Oral Health In Healthy People 2020. U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health Last accessed 27/3/2020

25. Milgrom, PP. Hujoel D. Grembowski R. Fong.. A community strategy for Medicaid child dental services. Public Health Reports1999, 114(6):528-532.

26. Macinko, J., B. Starfield, and T. Erinosho., "The Impact of Primary Healthcare on Population Health in Low-and Middle-Income Countries," Journal of Ambulatory Care Management, 2009,. 32(2) 150–71.

27. ASTDD. 2011b. Mobile and portable dental services in preschool and school settings: Complex issues. Sparks, NV: Association of State and Territorial Dental Directors.

28. ASTDD. 2011c. Mobile portable dental manual. http://mobile-portabledentalmanual.com/ index.html (Last accessed 27/3/2020).

29. Christensen, P.E. Petersen, B. Hede. Oral health in children in Denmark under different public dental health care schemes. Community Dental Health doi:10.1922/CDH_2424Christensen08

30. Davies GN, Downer MC, Holloway PJ. (1982): An Evaluation of Danish Child Oral Health Care Service. Danish Dental Association, Copenhagen.

31. Harris JC, Balmer RC, Sidebotham PD. British Society of Paediatric Dentistry: a policy document on dental neglect in children. Int J Paediatr Dent. 2009 May 14.

32. Onigbinde OO, Kikelomo AO, Modupeore SE, Adenike AO. Assessment of periodontal status of children and adolescents in orphanages in Lagos, Nigeria. Niger J Basic ClinSci 2017;14:41-4