UTILIZATION OF ORAL HEALTHCARE: A CASE FOR THE CHILD WITH HIV/AIDS

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LEC_TURE OUTLINE

1. Introduction & brief outline of caries experience in children with HIV/AIDS in Kenya

2. Barriers to the utilization of oral healthcare among caregivers of children with HIV/AIDS

3. Patterns of the utilization of oral healthcare by children with HIV/AIDS in NCC, Kenya

4. Conclusions & recommendations
INTRODUCTION

• Treatment modalities for HIV have consistently improved life expectancy of children with HIV/AIDS & delayed the onset of debilitating illnesses

• However, having HIV/AIDS increases one’s risk of oral health problems

• With the advent of HAART, soft tissue lesions of HIV have dramatically reduced but dental caries & periodontal disease remain a concern

• Despite a preponderance of oral diseases, this population continues to face limited utilization of oral healthcare
HIV & DENTAL CARIES?

- Not clearly explained
- Immunosuppression
- Dietary supplementation of refined substrates due to FTT
- Prolonged exposure to sugar-containing medication
- HIV affects salivary gland function & buffering capacity
- ARVs affect salivary flow & alter nature of bacteria
- Low socioeconomic status of the children
In Kenya, the prevalence of caries among 2-15 year-old children and adolescents with HIV/AIDS in Nairobi & Mombasa was reported to be 78.3% in the deciduous dentition (dmft 6.38) & 84.4% in the permanent dentition (DMFT 3.35)

(Anver, et al., 2006)

Masiga et al reported an overall prevalence of 65% in 3-15 year old children on HAART at KNH. The prevalence in the deciduous dentition was 50% (dmft 1.7) & in the permanent dentition 30.9% (DMFT 1.08)

(Masiga et al., 2012)
More recently, the prevalence of gingivitis was reported to be 86.5% among a cohort of children living with HIV/AIDS (Hussein & Opinya, 2017)

In all the studies decay made up the biggest component of the dmft/DMFT indices, reflecting clear unmet dental needs among the children
Oral Healthcare Utilization:
71-82% children had not received any form of oral healthcare
(Masiga, et al., 2012, Masiga, et al., 2017)

This is in spite of a positive association existing between caries experience & reduced QoL among the children
(Masiga, et al., 2013)
National data on caries experience (KNOHS, 2015)

• The Kenya National oral health survey placed the average caries prevalence at 23.9% among 5, 12 & 15-year-old children (dmft/DMFT 0.73) & 46.3% among 5-year-old children (dmft 1.87)

• 46.7% children have never visited the dentist

(KNOHS, 2015)
• With an increased oral health burden, it is clear that oral healthcare should form a critical component of comprehensive healthcare for children with HIV/AIDS

➢ What are the barriers to the utilization of oral healthcare among caregivers of children with HIV/AIDS?

➢ What is the resultant pattern of the utilization of oral healthcare for these children?
BARRIERS TO THE UTILIZATION OF ORAL HEALTHCARE FOR CHILDREN WITH HIV/AIDS
A study was carried out to evaluate the societal determinants of the utilization of oral healthcare among female caregivers of children with HIV/AIDS

This was a hospital-based mixed methods cross-sectional study at GHC, MCRH & KNH in Nairobi City County, Kenya

(Masiga & Wandibba, 2017)
221 female caregivers of children with HIV/AIDS & their health providers constituted the study population

Mean age of caregivers was 37.48 (SD ± 26.48)

76% were biological mothers of the children

Highest percentage (43%) had only attained primary level education

72% engaged in non-formal activities, casual labor for income generation or were unemployed

41.9% reported average monthly income of <=KES 10,000
Caregiver’s decision to utilize oral healthcare for children is a composite of perceptions, health beliefs & culture, socio-economic circumstances and structural factors of the National Health System which frequently resulted in untimely and/or non-utilization of oral healthcare for children with HIV/AIDS in NCC.

The health beliefs and cultural practices are holistic & woven into the social fabric of the caregivers’ daily lives.
‘Good’ oral health is based on aesthetic appearance rather than absence of disease, giving a diminished discernment on severity of dental illness.

Caries is but a discoloration of teeth attributed to the use of ARV drugs. As such, it does not require medical attention unless there is the onset of pain.
<table>
<thead>
<tr>
<th>Beliefs</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comes from using ARV drugs</td>
<td>128</td>
<td>58</td>
</tr>
<tr>
<td>Occurs in families</td>
<td>66</td>
<td>30</td>
</tr>
<tr>
<td>Disease of taking sugar</td>
<td>104</td>
<td>47</td>
</tr>
<tr>
<td>Black marks on the teeth</td>
<td>98</td>
<td>44</td>
</tr>
<tr>
<td>Dirty teeth</td>
<td>84</td>
<td>38</td>
</tr>
<tr>
<td>Rotting teeth</td>
<td>94</td>
<td>42</td>
</tr>
<tr>
<td>Teeth that want to come out</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>Common in children</td>
<td>64</td>
<td>29</td>
</tr>
<tr>
<td>Poor eating</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>Infection from other people</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td>Don’t know</td>
<td>46</td>
<td>21</td>
</tr>
</tbody>
</table>

*Percentage is more than 100% due to multiple responses

(Source: Survey data, 2016)
Children’s first teeth are temporary and remain in the mouth for only a short while.

Treatment for them is unnecessary & wasteful health expenditure.

Extraction of the offending tooth (both children & adults) is the preferential dental treatment. It is cheap (affordable) and a quick remedy for a painful tooth.
Cultural Practices

- Caregivers subscribe to the excision of ‘plastic’ or ‘nylon’ teeth in babies to prevent childhood illnesses, for which they seek the services of traditional healers or older women in the villages.

- They are not averse to engaging the use of traditional herbs or mitishamba to relieve symptoms of teething such as fever and diarrhea in infants.

- Often, they utilize home remedies as first-aid measures for relief of pain & swelling, only visiting the dentist when pain becomes unbearable.
### Socioeconomic Factors

1. **Low oral health literacy** which gives caregivers an unfelt need to utilize oral healthcare.
2. **Oral healthcare services** unaffordable against meager resources.
3. **Multiple competing household expenses**.
4. **Mode of payment from OOP expenditure** which is not always readily available.
Low & unreliable incomes preclude enrolment with health insurance (as well as misinformation & tedious operations of the scheme)

68% respondents did not have any form of medical insurance to access medical and/or dental services
The National Healthcare System

- The State does not provide health coverage to act as a safety net in accessing healthcare.

- Consequently, oral healthcare is mainly sourced from small unregulated dental facilities located in proximal vicinities.

- This provides the convenience of walking or using quick means of transport to reach these facilities.

- Additionally, there are shorter queues, quicker service, friendlier health-worker attitudes and extended opening hours at these facilities.
Doctors in public hospitals are perceived to have greater competences & skills but there is dissatisfaction with long queues, drug shortages & poor health-workers attitudes.

The time spent visiting a health provider has a bearing on opportunity costs to caregivers who is in informal employment due to loss of income from missed work.

There is a trade-off in perceived quality of care & prices of care, with caregivers choosing facilities that offer them the greatest convenience.
PATTERNS OF THE UTILIZATION OF ORAL HEALTHCARE FOR CHILDREN WITH HIV/AIDS IN NCC, KENYA
There is poor consumption of oral healthcare for children in proportion, rate, and timelines of utilization (71% had never visited the dentist and dental visits were frequently delayed).

Oral healthcare utilization was mainly for pain relief, precluding preventive care and/or early intervention of disease.

93% children did not have a usual source of oral healthcare, resulting in indiscriminate, *ad hoc* pattern of utilization.

(Note: This was in contrast to the long distances they travelled to designated facilities for medical care.)
Children with HIV/AIDS are disadvantaged (& marginalized) & are at risk of high burden of dental diseases

They suffer lack of access to oral healthcare despite adequate access to medical care
RECOMMENDATIONS

- A robust universal health coverage to reduce the financial burden of accessing healthcare (Government’s Big 4 agenda-range of services?)

- Policies to support basic oral healthcare for children with HIV/AIDS within the framework of comprehensive healthcare delivery

- Establishment of satellite/community dental clinics to reduce distances travelled to regulated dental health facilities.
PRIMaRY ORAL HEALTH (POHC) APPROACH

✓ Oral health promotion

✓ Oral health education & literacy

✓ Prevention

✓ Emergency care

✓ Multisectorial approach
But where is the dentist??
REFERENCES


Masiga M.A. and S. Wandibba. Health beliefs, perceptions and cultural practices on infant and childhood dental conditions and how they influence the utilization of oral healthcare for children with HIV/AIDS *(in press)*

THANK YOU FOR YOUR ATTENTION!
SOFT TISSUE MANIFESTATIONS IN HIV/AIDS