Workshop Report

Title : Workshop for development of oral health policy and strategies in Myanmar

Date : June 8 -10, 2019

Venue : Shwe San Eain Hotel, Nay Pyi Taw, Myanmar

Presenters : Prof. Hiroshi Ogawa, Prof. Prathip Phantumvanit, Prof. Ko Ko Soe

The workshop for development of oral health policy and strategies in Myanmar was opened by Prof. Paing Soe, President of Myanmar Dental Council, by welcoming the participants at 9:00 AM of the day 1. It was conducted with forty participants in Nay Pyi Taw from 8 to 10 June, 2019 under the partnership with WHOCC Niigata University, the Borrow foundation and the Ministry of Health and Sports in Myanmar (Photo 1).

Photo 1: Group photo in opening ceremony of the workshop

I. Highlights

Prof. Hiroshi Ogawa highlighted some remark points from the result of National Oral Health Survey, and provided some proposal for further development and minimize the gap/barriers (Photo 2).

1. Review of National Oral Health Survey (2017)

Children were suffering dental caries both in primary and permanent dentition. Majority of children have left their primary teeth untreated. There were only few cases for filling. Dental caries status was not satisfied and a public health problem for preschool children and young adolescents.

The periodontal diseases were prevalent in adults. Tooth brushing behaviors are not appropriate as well. Therefore, oral health status of Myanmar people is still poor.

In Myanmar, ageing population is increasing year by year, so it is necessary to take our attention not only for children and adults but also for elderly people. Having a good eating habit for elderly people should be given more attention to increase their nutrition status which may lead to enhanced QOL.

Photo 2: Prof. Hiroshi Ogawa highlighted the review of national oral health survey (2017) and proposed for further development

2. Proposal for further development and minimize the gap/barriers

2.1. Establish an appropriate system of monitoring data collection for oral health

National and regional cooperation as well as integration should be enhanced with non-dentists such as doctors, nurses, nutritionists, schoolteachers, etc.

Evaluation process is almost nil in the oral health promotion activities in Myanmar. It is therefore uncertain whether the current on-going activities are effective or efficient to have good achievements. System for appropriate data storing is reinforced using the standardized oral health assessment form. It is suggested that annual data collection and reporting of dental caries prevalence and severity data for age 5-6 and 12-13 in the school settings and routinely collected oral health data for all ages in the hospital settings are crucial. It is proposed to have format oral health record forms for data collection, and so an example of how to collect oral health data among schoolchildren was given. It is also important to notify what kind of preventive strategies would be provided to community by using the data obtained from data collection.

National oral health surveys is recommended to conduct routinely (e.g. every 5-6 years) and well-plan for further surveys in order to allow monitoring of changes in oral health in Myanmar.

2.2. Improve quality of oral health services

Development of relevant policies was proposed to guide the provision of oral health care services including preventive services. For instance, the oral health promotion programs should include effective oral health education for improving dental awareness and clinical preventive programs such as silver diamine fluoride application, fissure sealants, ART, etc. for pre-school as well as school children. He suggested to use high concentrated fluoride varnish or gel to prevent root surface caries for ageing population.

Oral diseases (dental caries, periodontal diseases, oral cancer, etc.) are involved in non-communicable diseases because of sharing common risk factors. As oral diseases related with general health, general health care should be acknowledged as part of oral health education. For instance, exceeding consumption of free sugars may lead not only to risk of dental caries but also to obesity and diabetes mellitus.

As public health activities are teamwork approach, it is suggested that involvement of dentists, dental auxiliaries and multi-sectors are necessary for collaborative work. In schools, the

cooperation with teachers is encouraged in regards to the school health activities including oral health promotion to schoolchildren. Schoolteachers should also be motivated to have school oral health records.

2.3. Minimize the gap and barriers

It was discussed to identify the gap between demand and ability of the country to provide it, and the ways to minimize gap and barriers (Photo 3).

As the role of oral health personnel is to support the community people for a leading outcome and better process of health promotion, increment of dental human resources is keenly important for better oral health situation in Myanmar. In particular, to facilitate better primary health care services, workforce development for dental auxiliaries are noticed and emphasized.

There is lack of well-functioned oral health system in Myanmar, so establishment of a national oral health database system is suggested. Because access for data is recognized as big barrier, it is fully agreed that public health information shall be shared. Moreover, consideration for research activity was proposed.

There is an urgent need to address oral health inequalities between urban and rural areas because of a barrier to access oral health care services in remote areas (geographic barriers). Further, existing collaboration and partnership of oral health personnel should also be reinforced. Strengthening and improving the existing oral health programs by identifying and developing multi-sector collaborative approaches to address common risk factors is necessary. For instance, it is suggested to raise public awareness of sugar consumption for prevention of dental caries and obesity.

Myanmar government has aimed to ensure access to a basic essential package of health services (EPHS) for a whole population. It is therefore a unique policy opportunity for oral health to involve in EPHS. Necessary oral health care services such as extraction, scaling and filling so on in EPHS is being fostered for community people with an easy access.

Photo 3: A participant discussed for minimizing gap and barriers

II. Identify the role and action for development of oral health policy and strategies

After a lunch break, Prof. Ko Ko Soe went on to his presentation on the concept of role and action for development of oral health policy and strategies (Photo 4). Primary prevention is currently frail in Myanmar although secondary and tertiary preventions were performing extensively. It was encouraged thus to shift the role of dentists to prevention sector.

The DMFT trend of 12-year-old children from 1977 to 2017 didn't get a satisfactory change. It is necessary to draw more attention to focus on health promotion, and so he advised to control the nutrition (e.g. sugar control), environment and life style for risk prevention based on principles of health promotion. Moreover, almost all of carious primary teeth were noticed as 'untreated teeth'. As a reason for less time consuming and low risk of cross infection than ART, silver diamine fluoride would be effective for early childhood caries management in Myanmar situation.

There are eleven programs in Ministry of Health and Sports whereas oral health project is involving in Reproductive, Maternal and Child Health Program. Ministry of Health and Sports is also providing Universal Health Coverage to community people as Essential Package of Health Services by National Health Plan (2017-2021). The NHP will be operationalized

nationwide to deliver the basic EPHS based on existing capacity. With the emphasis on primary health care, he proposed for public health dentists and hospital-based dentists to be integrated with essential health services within community.

In Myanmar, there are 4875 dentists and about 1200 dentists are serving as government dentists (200 dentists are in teaching while 1000 dentists are in public health or hospitals). Calibration trainings was suggested for public health dentists to develop skills in further community oral health programs. The presentation was proceeded to consider the capacity development of dental auxiliaries to offer available dental services especially for rural areas. Further, it was proposed an opinion to develop a better inter-professional cooperation.

Photo 4: Prof. Ko Ko Soe presented the role and action for development of oral health policy and strategies

III. Supportive environment for implementing oral health promotion

The session then continued with Prof. Prathip Phantumvanit presenting for creating supportive environment (Photo 5), beginning with emphasis on the relationship between oral diseases and general diseases with some examples. With the focus on health promotion, it is thus suggested for dental professionals to give attention not only to oral health but also to general health.

He then moved to the concept of early childhood caries, which is severe oral health problem in Myanmar. Fluoride toothpaste, fluoride mouth rinse, sugar control and OHI could be used as primary prevention; fluoride varnish, fissure sealant and silver diamine fluoride as secondary prevention; and ART and SMART as tertiary prevention. Further, he pointed out the caries status in Myanmar and Thailand compared with Japan, and then discussed how to move the current situation better with the concept on health promotion. Concerned with periodontal diseases, it is suggested OHI, dietary control and tooth brushing as primary prevention; oral prophylaxis as secondary prevention; and treatment such as root planing as tertiary prevention. As most of oral diseases are preventable, he recommended that early detection is necessary for early prevention in an early age.

It was noticed that government support is not very strong. However, other resources such as local organizations, external resources (e.g. Borrow Foundation, JICA, WHOCC, etc.) were supporting and assisting the oral health programs in Myanmar. Moreover, he suggested that community participation is vital for creating supportive environment. Health promotion to environment is necessary instead of individual health promotion (creation of healthy school canteen).

There is a shortage of oral health human resources and the number of dentists, dental auxiliaries per population ratio is limited. It is recommended to perform collaborative works with other health workers in oral health promotion programs. He then encouraged dental professionals to have advance studies or trainings in dental public health to Japan, Thailand, etc. through various scholarship and fellowship programs.

Following the presentations and Q/A discussions, the workshop was closed for the day 1.

Photo 5: Prof. Prathip Phantumvanit suggested for creating supportive environment in oral health promotion programs

V. Group works

The second day began with group works, to explore and share their opinions for development of oral health strategies through some limitations in Myanmar. The participants were divided into three groups, and each group was assigned a topic for group discussion and plan of action based on problem with the help of experts (Photo 6).

After a lunch break, a representative from each group then presented the result of their discussions, and the rest of participants from other groups contributed their comments on each of the presentations (Photo 7).

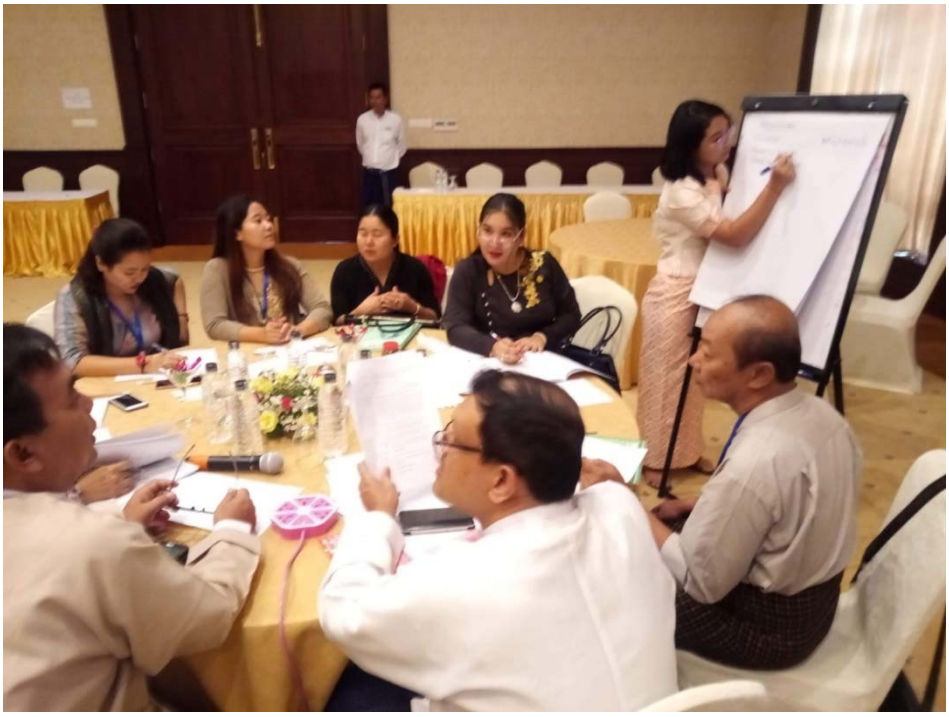

Photo 6: The participants performed group discussion and plan of action based on the problem

Photo 7: A representative from each group presented their assigned topic for future oral health development

Group1: How to establish an appropriate oral health monitoring system, and build-up oral health policy and strategies in Myanmar?

According to group discussion, the following recommendations were noted:

1. As data monitoring is important, it was agreed to perform data collection with format survey forms. Currently, the data are collecting using the WHO survey form formatted by Ministry of Health and Sports.
2. With proper data collection system, regular evaluation, modification if necessary and plan action would be performed.
3. It was proposed to perform routine data collection and preventive services during childhood vaccination period for children 0-2 years old and during antenatal care and postnatal care time for pregnant mothers.
4. Consideration for budget allocation was a prerequisite for oral health promotion especially in school health program with the support of central oral health unit.

Group2: How to eliminate barriers and obstacles, and create supportive environment for oral health promotion in Myanmar?

According to group discussion, the following opinions were proposed:

1. To minimize or remove the language barrier in rural areas, midwives and basic health staff in those areas were suggested to involve in oral health education.
2. As individual negligence is one of the barriers in Myanmar, the oral health awareness would be performed to improve by various ways such as social media, telephone message, poster, pamphlet, school textbook, etc.
3. Consider for an improved level of oral health care services especially to the poor and to the areas of greatest needs.
4. Multi-sector collaborative works with other ministries should be developed and active involvement of school teachers in school oral health promotion programs.
5. Members of regional dental association would be encouraged to support government dentists in oral health promotion programs.

Group3: How to re-orientate oral health resources and capacity development, and strengthen community action in Myanmar?

According to group discussion, the following opinions were suggested:

1. Develop the number of dental auxiliaries and train them for various oral health care programs in Myanmar.
2. The capacity development would be upgraded by increasing supportive materials and equipment.
3. Monetary support from various resources such as national aids (salary, travel allowance, regional allowance, etc.), local aids (cost sharing, insurance system, essential package of health services, donors, etc.) and foreign aids (WHO, INGO, etc.).
4. Dietary advices and repeated oral hygiene instruction should be provided for strengthening the community action.
5. The routinely collected data was ensured to analyze, re-evaluate and modify if needed for the action.

In the last session of the day 2, Dr. Kaung Myat Thwin reported the workshop summary and highlighted the proposed opinions and suggestions based on presentations (Photo 8).

Photo 8: Dr. Kaung Myat Thwin reported the workshop summary based on presentations

VI. Future Perspectives

Future action plan

On the morning of the day 3, Prof. Hiroshi Ogawa remarked the future action plans with suggestions from local stakeholders (Photo 9). Based on the discussion, it was agreed to move on (explore) practical action as the next. A working group consisted of international experts and key stakeholders will be established to work for "model oral health planning" and practically discussed in August, 2019 for future oral health programs in Myanmar.

A model will be initially developed for certain area to test its efficiency and then will be distributed through the country in the future. In order to secure practical oral health care performance, it was agreed that a model will be settled in Nay Pyi Taw territory at first. There are eight townships in Nay Pyi Taw territory, one urban and one rural will be selected for model activity.

The key ages will be decided as 0-2 years (at RHC), 3 years (in preschools), 6 years (in primary schools) and 12 years (in junior high schools).

For the young children (0-2 years)

In addition to OHE, oral health interventions such as fluoride gel/ varnish and silver diamine fluoride in small active caries will be applied. Oral health programs will be combined with immunization program at RHC.

1. Regular check-up and record it with standard forms (one sheet has many charts, refer Japanese system) by dentists.
2. Advice midwives for necessary oral health activities (OHE, fluoride applications, ART, etc.)
3. Networking – public health dentists + hospital dentists + private dentists (at least for model areas)
4. Public health dentists – OHP at RHC in immunization days (in other days, refer to hospitals and hospital dentists will do OHP)

For 3 year-old-children

There are oral health promotion programs in current situation, but with neglected recording system.

1. Regular check-up and record it with standard forms (one sheet has many charts, refer Japanese system) by dentists.
2. Activities such as after lunch tooth brushing, fluoride varnish/gel for prevention and SDF/ART for treatment would be performed.

For 6 year-old-children (target for permanent teeth)

The first permanent molar prevention is important for the age of 6. For first molar prevention, OHE, FMR, sealant, dietary restriction would be performed.

1. Encourage and motivate oral health by social impacts (e.g. village leader, monk)
2. FMR is more simple, more beneficial and easier to perform in public health approach. School teachers will be key persons for FMR program. Oral health education would be provided to school teachers as well as parents. FMR programs will be started at the age of 5 before first permanent molar eruption.
3. Sweets and sticky sugars restriction should be performed.
4. Healthy school environment (no snacks selling)

For 12 year-old-children

It may need to make attention for gingival status at the age of 12.

1. Encourage and motivate oral health by social impacts (e.g. village leader, monk)
2. FMR will be continued till middle school age (up to end of permanent tooth eruption).
3. Sealants would be used for prevention of molar cavities.
4. Educate to use dental floss
5. Healthy school environment (no snacks selling)

For adult age groups

1. Oral health awareness will be improved by various ways such as social media, telephone message, pamphlets, etc.
2. Oral health care services (not only treatment but also maintenance) will be provided to community.
3. Charity outreach activities should be continued with emphasis of preventive procedures.
4. For elderly groups, it should be considered for replacement after tooth loss. It should be established some campaign for elderly (e.g. 8020 campaign in Japan). However, as

short life expectancy in Myanmar, we may need to consider the campaign around 60-70 years old.

The workshop was then successfully closed by Prof. Hiroshi Ogawa and Prof. Prathip Phantumvanit at 12:00 noon.

Photo 9: Prof. Hiroshi Ogawa remarked the future action plans with suggestions from local stakeholders