NATIONAL ORAL HEALTH POLICY

THE REPUBLIC OF UGANDA

Produced by:

Ministry Of Health
In collaboration with the World Health Organization

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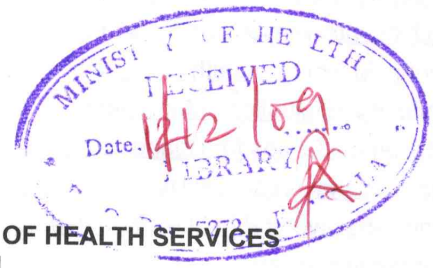
Foreword

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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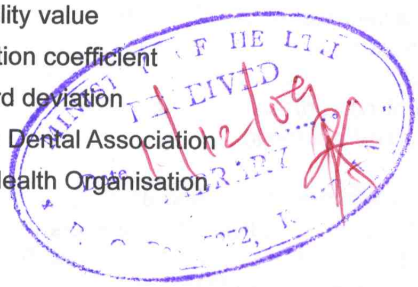
List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Atraumatic Restorative treatment
CPD	Continuing Professional Development
DMFT	Decayed, Missing, Filled Teeth
GoU	Government of Uganda
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health sub-district
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
NMHCPNational	Minimum Health Care Package
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MoH	Ministry Of Health
MoLG	Ministry of Local Government
MRC	Medical Research Council
NGO	Non Governmental Organisation
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
p	Probability value
R	Correlation coefficient
SD	Standard deviation
UDA	Uganda Dental Association
WHO	World Health Organisation



1. Introduction

1.1 Background

Oral health affects everyone personally

Oral health is central to our daily life and well-being, and exerts a fundamental influence on the quality of life of every citizen of Uganda. The familiar experiences of daily tooth brushing, the sugar foods we eat, cigarettes we smoke, number of sexual partners we have or traffic accidents with drunken drivers, all directly determine the health of our mouths.

It is quite clear from both community experience and research evidence in the literature, that oral health is more than just the absence of disease or loss of function (although who can forget the last time they had toothache?!). The population is increasingly aware that the optimal functioning of their face and mouth is important for their own comfort and for preserving their self-esteem.

Oral health is a public health concern

The high prevalence of several key oral diseases such as gum disease and dental caries means most Ugandans are affected by these conditions. Research evidence shows that even the smallest increments in economic improvement together with urbanization introduces a trend toward increasing the prevalence of these conditions mediated primarily by changes in the sugar content of the diet and tobacco exposure.

A smaller selection of oral conditions such as oral cancer, dento-facial trauma, the oral manifestations of HIV/AIDS and noma are less prevalent but have a severe impact in terms of tissue damage, mortality or both. Globally, the rise in oral manifestations of conditions prompted by reduced immuno-competence such as oral candidiasis, ulceration, Kaposi sarcoma and noma, continues to shadow the HIV epidemic.

Due to the high prevalence and severity, oral diseases and conditions have a substantial impact on individuals and society in Uganda. The combined effect of oral pain, discomfort, handicap, social and functional limitations as well as the financial burden on quality of life, are one reason that they should be considered an important public health concern. The other main reason is that they can almost all be prevented.

Oral health problems can be prevented

The risk factors and pathogenesis of the most common oral conditions have been known for a long time. Also well-established, is the finite set of evidence-based interventions that are capable of controlling or entirely preventing these conditions from occurring in the first place. There is strong evidence to show that exposure to low levels of fluoride and reducing sugar foods in the diet (and in medication) both have a powerful impact on tooth decay. Reducing tobacco exposure dramatically alters oral cancer mortality and the prevalence of periodontal (gum) disease. Safer sexual behaviour almost eliminates a range of oral medical conditions including some malignancies. Several factors contribute to lower levels of oro-facial trauma.

What is also known is the extent to which these oral disease risk factors are common to several other major systemic diseases or conditions. This means that health promotion efforts can be shared across disciplinary and departmental boundaries and budgets, benefiting from economies of scale as well as the qualitative gains of these collaborative partnerships. To focus resources and effort on just one example such as tobacco exposure, reveals the potential to reduce lung cancer mortality, respiratory disease, periodontal disease and oral cancer damage or mortality, as well as their attendant treatment costs.

The cost of dental diseases to individuals and the community is considerable. Individual treatment options are not available to most people and are mostly ineffective as strategies to improve population oral health status. An appropriate set of public health driven, population-wide oral health strategies can achieve this.

Policy to improve population oral health

A global review of oral health policies suggests that almost all were unachievable from the outset. Among African countries, few have a national oral health plan, even fewer have made any progress towards implementation and none have evaluated what was done. Most have employed uniform intervention strategies for non-uniform needs, used expensive, technology-driven approaches not always based on sound evidence, and have failed to address the key determinants of oral disease. These health strategies have failed to improve oral health. Where viable interventions or services existed in the past, their accessibility for most communities was limited or entirely excluded by the constraints of poor social, economic or political status and geographic location.

Human resource for oral health

Uganda presently trains two cadres of oral health workers; Dental Surgeons and Public Health Dental Officers.

Due to the high cost of training Dental Surgeons abroad and the increased local demand, Makerere University started a 5-year Bachelor of Dental Surgery (BDS) training programme in 1982. The current intake for this training program is 15 students per academic year. There is now postgraduate training in maxillo-facial surgery at Makerere University (started in 2008) and therefore the number of oral health specialists in the country is going to increase. The few that are currently existing (14) are on the Makerere University academic staff engaged full time in teaching undergraduate and graduate students so they provide very limited specialist oral health care to the public. By 2006 there were 72 Dental Surgeons distributed across the country (1 per 158,000 people). However 39% of these were based in Kampala district. According to the current Health and Human Resources policy, every district is expected to have a Dental Surgeon in its district hospital.

The school for Public Health Dental Officers (PHDO) established in 1972 was equipped to cater for 25 students but the current intake is 50. A 2002 inventory revealed 159 PHDOs distributed in health districts across the country, with 25% of them based in Kampala. The Health and Human Resources Policy envisions placement of a PHDO at each of the 159 Health Centre IVs in the country, however only 35% of these health facilities currently have a PHDO.

Training Dental Technologists outside the country was halted in 1975 and has not resumed. Most Technologists within the country have retired, died or near retirement age without available replacements. The only trained dental Equipment Maintenance Technicians (4) are based at Mulago Hospital and are too few for the work required.

Financing 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 health 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 secondary and tertiary services are provided at a fee. However, due to shortages of materials, supplies, equipment and manpower, patients often have to seek and pay for the basic treatment elsewhere. The burden of dental care financing has therefore been shifted onto the shoulders of patients.

Infrastructure and equipment

All government regional referral hospitals received dental equipment in 1992. Since then much of the equipment has broken down and needs repair or replacement. Thirty years down the road since they received dental equipment in 1972, the district hospitals are even worse off. It is unusable and cannot be repaired. About 80% of the Health Centre IV facilities have a hydraulic chair and a set of hand instruments for oral health procedures while the rest have nothing. This has grossly affected the delivery of oral health services in the country.

Private sector

The private sector constituted mainly of general dental practitioners, provides a significant proportion of oral health care in the urban areas of Kampala district and other large centres.

The existence of a two-sector health system poses a fundamental challenge to socio-economic equity, and monitoring the quality of private services remains difficult. They remain rich in skills and are a group with the capacity to make a substantial contribution to oral health in Uganda.

The oral health policy will apply to all dental practitioners, organizations or institutions providing oral health services from the public and private sectors, or involved in the management and regulation of oral health services as well as all parts of the public sector engaged in activities that have an impact on oral health.

2. The policy context

No health policy exists in a vacuum and this one is no different. This policy is founded on all the rights and responsibilities already articulated in the Constitution of Uganda, and further detailed in several other policies within and outside the health sector. In fact several key sectors in which health workers operate, are governed by their own statutes, including environmental affairs, education, agriculture and others. This policy assumes that the underlying development process is essential to the attainment of good health and can profoundly influence oral health.

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, Millennium Development Goals and several others.

This section recognizes and considers existing policy documents and principles that have an influence on the task of improving oral health in the Ugandan community.

2.1 The constitution, human rights and equity

The principles in the constitution and in particular its commitment to human rights and equality for all the citizens of Uganda is adopted. In all areas of oral health care this policy aims to promote the respect of human rights, culture, religion, ethics and gender of communities affected by the policy.

The policy is firmly based on the principle of equity to ensure that the benefits of the policy are available to everyone in the population irrespective of gender, age, ethnicity, culture, religion or geographic location.

Where specific gender-related concerns are recognized, these will be addressed appropriately and without discrimination, particularly in the area of health and human resources.

2.2 Existing health policy frameworks

The Uganda Health Policy (1999) introduces several important guidelines that apply to all programmes and policies in the public health sector, including this oral health policy.

Key principles articulated in the Uganda Health Policy

Oral health care delivery in all its forms will occur through existing health system structures, with districts empowered to plan, manage and implement health activities, assisted by policy guidelines from the Ministry of Health. The policy provides a systematic way in which health sub-district and district plans of activities can be firmly based on, and reflects, local needs.

Primary health care is also at the core of this policy and provides the philosophical framework for oral health strategies that prioritise promotion and preventive activity, community participation, integration and collaboration across sectors and disciplines, appropriate levels of technology to fit resource and infrastructure constraints, and a serious commitment to equity.

Oral health is one of the several important components of the Uganda Minimum Health Care Package defined in the National Health Policy. This oral health policy document will clarify the "Basic Dental Treatment Services" to which the Ministry of Health has committed itself in the National Health Policy. This is further articulated in the Health Sector Strategic Plan II (2006-2010) and the Operational Framework for Oral Health in Uganda (2007).

Health services need good information for successful management and effective delivery. This policy proposes a systematic sampling frame and two yearly data collection process to monitor oral health status, and the collection of a few selected service delivery indicators on a monthly basis across all levels of the service for use at both local and national level.

The need for ongoing research to support and assess oral health promotion and service delivery is repeated throughout this policy. The policy emphasizes the importance of identifying research priority areas in order to accelerate the adoption of evidence-based care to guide planning, implementation and evaluation.

This policy also accepts the implications for oral health care of recognising and collaborating with private sector providers of oral health care, financial coordination and adherence to appropriate ethical and legal guidelines.

Other Health policies that have a real or potential influence on oral health

To address the risk factors for oral conditions that mainly lie outside dentistry or even outside the health sector requires a collaborative effort across disciplinary and sectoral boundaries. At the highest level, this requires collaborative policy formulation. Those health policies in which an appropriate oral health policy insertion would be extremely beneficial include tobacco policy (derived from the Convention on Tobacco Control endorsed in 2007), the National Environmental Health Policy (2005), Uganda Food and Nutrition Policy (2003), School Health Policy for Uganda (2007) and selected policy guidelines on HIV/AIDS.

Other policies that are noted and adhered to in this policy include the National Drug Policy (2002), National Hospital Policy (2005), Quality Assurance for Health Workers in Uganda (1996), and the National Policy on Injection Safety and Waste Management (2004). These should be considered for future insertions that address specific aspects of oral health care.

The policy also draws on the principles and commitments reflected in two key WHO documents, including "Oral Health in the African Region: A regional Strategy 1999-2008" endorsed by AFRO in 1999, and the WHO AFRO publication "Manual for Oral Health Policy Formulation for the African Region" (2003).

3. Rationale and principles of oral health policy

The principles that underpin this policy are based on current scientific and epidemiological knowledge of the prevalence and determinants of oral conditions, and the selection of dental interventions that are evidence-based. 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.

3.1 Prevention of disease and health promotion

Where evidence exists to show that an oral health problem is preventable, the policy prioritises preparation of health promoting strategies to achieve this over alternatives that are curative, more difficult to deliver, offer poor equity to the population and are resource intensive.

3.2 Common risk factor strategies

This policy sets out to focus its major efforts on reducing or changing the exposure of the population to those risk factors that are known to lead to oral diseases or conditions. Further, it recognises that almost all the known risk factors for oral-facial conditions are shared in common with at least one other disease or problem affecting general health. The policy highlights the critical importance of oral health teams devising health promotion strategies jointly with other stakeholders engaged in addressing the same general health concerns.

3.3 Population-oriented interventions

This policy also gives preference to those health promotion strategies that have the capacity to reach the population at large and change the population profile of disease, as opposed to individually focused interventions to which few are likely to have access and most will not benefit. Examples include water fluoridation, universal school or mass media education campaigns, policy and protocol initiatives, tobacco control legislation, food labelling, food-based dietary guidelines and many others.

3.4 Integration across discipline and sector

This policy advocates the inclusion of an oral health policy element in every other health policy that has the potential to influence exposure to known oral health risk factors.

In the same way, the delivery of oral health promotion strategies and the provision of oral health care services must become part of comprehensive health promotion and service efforts at the point of delivery (hospitals, district clinics, schools etc). These will also require the recruitment and training of other cadres such as nurses, teachers and community workers for the oral health promotion process.

3.5 Interventions based on evidence

All oral health interventions (preventive or curative) must be shown to have research evidence in the literature to support their inclusion. An ongoing audit process to ensure this is proposed. Precious resources cannot be wasted on interventions that are merely popular or simply long-standing habits but are ineffective and offer no proven health gain to the community.

3.6 Customised to local community needs and resources

Every community is different. Depending on their social, economic, geographic and other developmental features, the oral health risk factors to which they are exposed are likely to vary dramatically from one side of the country to the other.

The oral health policy takes this into account by allowing several areas of flexibility in the design and delivery of a customised local oral health plan. This is based on a local assessment of disease prevalence, the risk factors present, the resources available and the capacity to deliver the chosen interventions.

4. The Uganda oral health policy

4.1 Vision for oral health in Uganda

The vision of the National Oral Health Policy is to establish a comprehensive oral health care system fully integrated in general health and based on primary health care, with emphasis on the promotion of oral health and prevention of oral disease up to the year 2015. The system will sustain the facilities required to deliver basic curative and rehabilitative oral health care, within available resources. The system will ensure equitable access to good quality oral health care services for all individuals and communities in order to achieve an oral health status that allows all to enjoy a healthy and productive life.

4.2 Goal

The goal of the policy is to improve the oral health of all Ugandans.

4.3 Policy objectives

This policy sets out to

- Provide guidelines for oral health managers and service providers for national oral health programmes
- Provide guidelines for the integration of oral health promotion strategies and policies with other health care policies and programmes
- Provide guidelines for oral health managers and service providers to facilitate population-wide initiatives to promote oral health
- Provide guidelines that assist oral health managers and service providers to customize and deliver locally effective oral health strategies
- Provide a framework for monitoring and evaluating the effectiveness of strategies taken to improve oral health.
- Sustain an ongoing process of policy review and development

4.4 Oral health priorities

The delivery of oral health services will be based on a systematic process of assessing oral disease prevalence and severity to determine local oral health needs Oral diseases and conditions will be prioritised according to the local prevalence and impact they have at the community level.
The ongoing management will be determined by regular monitoring of these levels of disease and other oral conditions.

4.5 Oral health promotion by integrating policy and practice

Almost all the determinants of oral diseases or conditions lie outside the field of dentistry and even beyond the boundaries of the health sector. To address common risk factors such as tobacco, sugar, alcohol, unsafe sex, chronic medication, violence and vehicle accidents requires the collaborative efforts of those in several key areas of health care.

To address this, an oral health policy element that identifies the risk factor and provides guidance on what can be done to address it, will be inserted into all other health policies where the same risk factor plays a role.

The specific health policies in which an appropriate oral health policy insertion will be prepared include the policy derived from the recently endorsed Convention on Tobacco Control (endorsed 2007), the National Environmental Health Policy (2005), Uganda Food and Nutrition Policy (2003), School Health Policy for Uganda (2007), selected guidelines on HIV/AIDS and policies that address maternal and child health (Child Survival Roadmap 2007).

The specific issues that will be addressed at this policy interface with other sectors and programmes include:

- Nutritional guidelines to reduce the frequency and quantity of sugar foods consumed
- Guidelines on the exclusion of sugar from formulas used in infant bottle feeding
- The replacement of all chronic syrup medications given to children with non-sucrose sweetened preparations
- The introduction of community fluoridation in areas where caries is high and access to other forms of fluoride is limited
- The provision of alternative water supplies to communities with excessive levels of fluoride exposure
- Contribute to legislation to reduce population exposure to tobacco use in all forms as well as the risk of passive smoke inhalation
- The incorporation of oral health promotion education into teacher training curricula and school based life skills programmes
- The inclusion of essential oral health research into the national programme for health systems research

To deliver these services or health promotion interventions, interdisciplinary teams will be established at the school, clinic or community level to jointly deliver key health and oral health promotion strategies.
A system of Train the Trainer programmes will be established to equip other categories of health personnel, teachers and community workers in oral health promotion skills.

The oral health care system will provide technical and educational support to these cadres in their task of carrying out periodic screening, delivering oral health education and promotion in schools and communities.

The oral health care team will ensure that the core messages of oral health promotion are included in health education programmes across the health system and in the national media.

4.6 Interventions based on the evidence

To ensure optimum use of limited resources, the selection of each health promotion or oral health care intervention will be based on reliable research evidence that they actually work. Two well-known examples include the use of fluorides and fissure sealants to prevent tooth decay.

A regularly updated list of oral health interventions that are supported by sound research evidence will be maintained by the Ministry of Health to support this decision-making process.

The implementation of all selected oral health strategies including policy will be subjected to ongoing research to determine best practices, changes in key outcome indicators etc. This will be used to accelerate the building of science and evidence-based care to guide subsequent planning, implementation and evaluation.

4.7 Matching interventions and resources

Once priority diseases and conditions and their risk factors have been identified, for each district or region, the appropriate evidence-based interventions will be selected to match the priority health needs.

All the possible oral health intervention options will be listed and ranked according to the resources or infrastructure they require for successful delivery.

From the list of intervention options, the one that is most viable to be delivered according to the resources available at that level of the health system (central, regional or district health centre), will be selected and implemented.

A set of decision tables for making these choices and a format for assessing the appropriate resource level will be included in the Operational Framework for Oral Health in Uganda that will be developed.

4.8 National Minimum Health Care Package

An important vehicle for the delivery of essential health care is the Uganda National Minimum Health Care Package. ."Basic Oral Health Care Services" are included in this package of care. The health system is therefore committed to deliver the following minimum oral health care services to every Ugandan citizen who needs it:

- An accurate and clearly communicated diagnosis and treatment proposal
- The information necessary to prevent oral disease and maintain good oral health
- The relief of oral-facial pain

- The provision of fissure sealants and other clinical preventive measures to prevent caries, particularly in children
- Limited restorative care using Atraumatic Restorative Treatment (ART) where function is impaired and resources permit.
- Referral for more complex or specialist care

4.9 Monitoring, evaluation, information

There are two key areas of oral health information that will be collected. The first is oral health status data on the profile of diseases and risk factors in each district. The second is health care delivery data to show levels of performance achieved by the health system.

To monitor community oral health:

- Goals for achieving an appropriate change in oral health status will be set for every oral condition identified at the start of the process along with indicators and target levels.
- The outcome of selected interventions will be measured to indicate the extent to which oral health is improving or deteriorating.
- Carry out an assessment in each district using a gender-balanced sample of at least three key age cohorts (6, 12, 35-44) once every three years.
- Annually review that oral health data that reflect oral cancer incidence and mortality in the national cancer registry

To monitor health service performance:

- Training in the recording and interpretation of key oral health indicators in the National Health Management Information system, will be carried out
- Each district will collect and process the oral health care indicators agreed with the HMIS
- The oral health indicators within the HMIS will be reviewed within the next three years to determine their relevance and validity.

To process and apply the information:

- These two agreed sets of oral health and service delivery information will be collected across all health sub-districts.
- It will be analyzed at local level to provide direct input to the local health

planning and decision-making process.

- The information will also be submitted to the Ministry of Health.
- The Oral Health Section of the Ministry of Health will be responsible for collecting the information provided by district health authorities and the regular dissemination of summary data and reports back to all levels of the health system.
- The Ministry will also retain this information for the ongoing policy review process.

5. Implementation guidelines for Uganda oral health policy

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.

An operational framework will be developed to provide guidance to all levels of health services delivery on evidence based oral health care interventions, prioritization criteria and guidelines on effective implementation of the different interventions, performance indicators and targets for the different levels.

This section provides guidelines on the separation of responsibilities between the national, regional, district and sub-district levels of the health system, human resources, financing and infrastructural aspects of oral health care delivery.

5.1 Organisational responsibility

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

Responsibilities at National level are:

- Formulation, implementation and review of a national oral health policy as a framework for implementation at all levels of the health system.
- 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

- Liaise directly with partners in the school health programme, mental health section and other sections involved in health promotion.
- 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
- Resource mobilisation for the education, equipment, facilities and training of appropriately skilled oral health personnel.
- Facilitate collaboration with other sectors (including private sector) and development partners.
- Facilitate research on oral health through engagement with agencies involved in Essential National Health Research activities such as the Uganda Medical Research Council (MRC).
- To identify oral health personnel, equipment and facilities requirements.
- Facilitate Government to Government training arrangements for the training of scarce categories of oral health personnel
- Contribute with the Uganda Medical and Dental Practitioners Council, and Uganda Dental Association to the formulation and dissemination of laws, regulations and enforcement mechanisms related to development and regulation of Oral Health Services.
- Monitor and supervise the use of ART in the prevention of dental caries by the districts
- Monitor the referral chain from health sub-district, to district and on to the National Referral Hospital specialist services and liaise with the head of clinical services at the Ministry.

Responsibilities at community level are:

- Raise awareness of oral health risk factors through oral health education and promotion by the village health teams.

5.2 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, district and health sub-district managers will 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 will be taken by district and health sub-district managers to ensure that their oral health plan is devised to match the specific needs and oral health risks faced by the community in their district or health sub-district:

- Assess the oral health condition of their communities
- Prioritize the problems identified according to prevalence, severity and social impact
- Identify the resources
- Select the most appropriate interventions
- Implement, monitor and evaluate the selected strategies.

5.3 Financial implications

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

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

The budgets will be prepared annually to adequately cater for:

- Human resource development of oral health personnel
- Oral health care services
- 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

5.4 Human Resources

Recruitment of oral health personnel

To improve equity of access to basic oral health care, future staffing will extend to ensure every district has at least two dentists and every HC IV has at least one dentist and two PHDO's. This will be expanded incrementally by about 10% per year to achieve 100% coverage by 2015.

A medium to long term plan to add dentists to the staff at HC IV level, will cater for the increased demand, attain better access and equity to oral health services in the country. The long term outcome is to place a dentist and two PDHO's at every HC IV clinic.

The process of engagement with HRH and the local government structures will begin with the proposed minimum staffing norms required by level and discipline is detailed in the Oral Health Operational Framework (2007).

A training and financial plan will be negotiated with the HRH Section to fit this within the budget constraints that exist over the next policy period.

The general guidelines on health Human Resources Policy will apply.

Continuing professional development

All oral health personnel are required to sustain continuing professional development activities.

A simple system of Continuing Professional Development (CPD) accreditation and self-auditing by oral health professionals will be established in consultation with the Uganda Medical and Dental Practitioner's Council and the Uganda Dental Association.

Training of dental professionals

To ensure the provision of competent personnel for the oral health services, it is essential to:

- Provide dedicated national funding which will be estimated and secured for the education and training of appropriately skilled oral health personnel.
- Ensure the curricular content includes the skills necessary for successful oral health promotion and effective clinical practice at district level.
- Establish a process of quality assurance to ensure minimum levels of clinical and professional competence which will be established together with the Uganda Medical and Dental Practitioners Council, Uganda Dental Association and the Ministries of Health and Education.
- Manage the services delivered within the training institutions as an integral part of the public oral health care system.
- Monitor the output levels to ensure the minimum number of new graduates required to fill the increase in posts planned for the national health system

Training of specialists

An increase in the number of dental specialists in training and the provision of up to four additional training posts per year will be established.

Pro-active sourcing of funds to train a greater diversity and number of dental specialists will be initiated.

For scarce categories of specialist, arrangements to train locally and in neighboring countries will be initiated

Local capacity to train specialists has been established, first for Oral and maxillo-facial surgery in 2008.

A detailed capacity development plan to introduce training for other selected specialist areas of dentistry will be prepared in the next two years.

The estimated numbers of specialists required to service the Uganda national health system are listed in the operational framework.

6. Oral health policy review and revision process

The office of the Director of Health Services (Clinical and Community Health) in the Ministry of health will convene a policy review panel not less than once every five years to assess the implementation and outcomes of this policy and make recommendations accordingly.

Policy development and implementation is a dynamic process and consequently this policy will be communicated to all stakeholders.

To determine the impact of this policy, each district will be responsible for providing the Ministry of Health with information 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