



**MAXIMUS PROJECT FOR PEDIATRIC ORAL DENTAL HEALTH ACROSS 7 CAFU SUPPORTED HEALTH FACILITIES**

**FY 2015-2016 Program report**

**July 2015-January 2016**

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# Acronymns

AMS Alive Medical Services

ART Anti-Retroviral Therapy

BMC Bushenyi Medical Centre

CAFI Children's AIDS Fund International

CAFU Children's AIDS Fund Uganda

FHCJ Family Hope Centre, Jinja

FHCK Family Hope Centre, Kampala

HCW Health Care Worker

IHF Indigenous Health Facility

KCRC Kabwohe Clinical Research Centre

NA Nurture Africa

NFSC Namugongo Fund for Special Children

## Executive summary

This report details the implementation of the interventional and preventive oral dental health activities through RUN dental services to children infected by HIV/AIDS

During the reporting period (July 2015 to Jan 2016), the Maximus foundation through Children’s AIDS Fund International in collaboration with Children’s AIDS Fund Uganda (CAFU) implemented interventional and preventive oral dental health activities through RUN dental services to children infected by HIV/AIDS.

The Maximus oral dental health project was implemented at 7 Children’s AIDS Fund Uganda and reached 784 children namely: (CAFU) Indigenous Health Facilities (IHFs) in 5 districts of Uganda namely; Family Hope Centre Kampala (FHCK) and Alive Medical Services (AMS) in Kampala district; Family Hope Centre Jinja (FHCJ) in Jinja;; Bushenyi Medical Center (BMC) in Bushenyi; Kabwohe Clinical Research Center (KCRC) in Sheema ; Namugongo Fund for Special Children (NFSC) in and Nurture Africa (NA) Pediatric Medical Center in Wakiso.

The project activities were carried out in 2 phases: first phase in August 2015 and the second in January 2016. On one clinic day for each of the 7 IHFs in each phase, the following activities: oral health education for the children and caregivers; Supervised brushing Exercise; screening for oral health problems; receiving tooth brushes and a 50ml Colgate tooth paste; primary interventions (tooth extraction and temporary filling); and referrals for secondary interventions. Consent to take pictures was obtained before every exercise commenced.

The dental camp attracted a total of 784 children clients (89% of the expected 880 children), 359 (204% of the anticipated 176 treatable dental disease including extractions and temporary fillings) were treated for dental related illness, 151 had good and improved oral hygiene with no caries while 447 children had secondary oral health needs and were referred. The overall dental disease prevalence was 81% (83% during phase 1 and 76% in phase 2) at all the 7 CAFU Sites. There was a slight improvement in oral hygiene of children screened during the second phase compared to the first phase from 24.3% to 17.3%.

Overall, due to limited oral health services, most clients seen at the time of screening already had secondary and tertiary needs/complications. Most preventable dental problems like chronic marginal gingivitis could have been eliminated by only ‘tooth brushing’. The severity of tooth decay was dominant and hence needs to be checked with appropriate interventions. More focused and early tailored interventions and increased oral health promotion campaigns will go a long way to improve the oral health of children at CAFU sites.

## Executive summary

The Children’s AIDS Fund –Uganda (CAFU) funded by its partner Maximus foundation, implemented an oral dental health project to children infected by HIV/AIDS. This was a 7 month project (July 2015 to January 2016) intended to reduce oral dental disease amongst HIV children and improve their quality of life. The dental services were offered by RUN dental services. The project operated in 7 CAFU Indigenous Health Facilities (IHFs) in 5 districts namely; Family Hope Centre Kampala (FHCK) in Kampala; Family Hope Centre Jinja (FHCJ) in Jinja; Alive Medical Services (AMS) in Kampala; Bushenyi Medical Center (BMC) in Bushenyi; Kabwohe Clinical Research Center (KCRC) in Sheema ; Namugongo Fund for Special Children (NFSC) in Wakiso and Nurture Africa (NA) Pediatric Medical Center in Wakiso.

The oral dental health project activities were carried in 2 phases; phase 1 in August 2015 and phase 2 January 2016. One dental clinic day was held for each of the 7 IHFs in each phase. The project offered the following services: oral health education for the children and caregivers; Supervised tooth brushing Exercise; screening for oral health problems; donation of a tooth brush and a 50ml Colgate tooth paste to each child; tooth extraction and temporary filling and referrals for secondary interventions.

A total of 784 children clients (89% of the expected 880 children) were reached and 359 (204% of the anticipated 176 treatable dental disease including extractions and temporary fillings) were treated for dental related illness while 447 children had secondary oral health needs and were referred. The overall dental disease prevalence was 81% and 151 children had good and improved oral hygiene with no caries.

Overall, due to limited oral health services, most clients seen at the time of screening already had secondary and tertiary needs/complications. Most preventable dental problems like chronic marginal gingivitis could have been eliminated by only ‘tooth brushing’. The severity of tooth decay was dominant and hence needs to be checked with appropriate interventions

Focused and early tailored interventions and increased oral health promotion campaigns will go a long way to improve the oral health of children at CAFU sites.

# Program Area Summaries/Overview

**Background**

Over the period of July 2009 to June 2010, CAFU with the support of Maximus foundation implemented an Oral dental health project with the goal of relieving oral pain to improve nutrition and the general well being of children living with HIV.

The project reached 371 children at Family Hope Centers Kampala and Jinja through monthly mobile clinics set to coincide with the children’s HIV clinic. The project interventions included: Health education and demonstrations, donation of toothpaste and tooth brushes and screening for and treatment of dental carious teeth by extraction and temporary fillings.

**Justification**

Dental caries has been described as the world’s most common chronic disease with 60–90% of school children and nearly 100% of adults having dental cavities ([WHO 2012](http://www.who.int/mediacentre/factsheets/fs318/en/))[[1]](#footnote-1)

Although the survival rates of children with perinatal acquired HIV infection has vastly improved in the past decade, the prevalence of dental carries due to low social economic status, (poor nutritional status and poor hygiene), low immune status and the chronic use of syrups and sugar based HIV related drug formulations is high.

Since the end of the dental project in June 2010, CAFU has enrolled an additional 1,440 children into care and provided them with the best available biomedical interventions for the treatment of HIV. However, the intervention to prevent and treat dental carries remains a service gap.

**Proposal**

With a further grant from Maximus Foundation, CAFU proposed to carry out a follow on project targeting 880 children in care at 7 CAFU supported Health facilities in 5 districts of Uganda.

**Methods:**

The intervention was planned to be carried out during school holidays when most of the children would be reached on a single day. Together with partner (IHFs) CAFU scheduled for the dental clinic on specified day per facility during the school holidays and mobilized children and care givers on their regular clinic days. The project was divided in two 2 phases, first in the August/September holiday and a follow up phase in the December/January Holiday to mop up children that may have missed the first phase. Following the success of the July 2009 to June 2010 dental health project, Run-Dental Services was again co-opted for the follow on project. Following a set schedule, the dentists visited each of the 7 project sites in August 2015 and January 2016.

Based on the previous project data and budget, a total of 880 children in care over the 7 facilities were targeted for the following general and specific interventions (Table 1):

* Health education for children and their caretakers
* Screening for dental carries Distribution of tooth brushes and tooth paste
* Demonstration on how to clean teeth
* Primary interventions (tooth extraction and temporary filling)
* Referrals for secondary interventions.
* One clinic day will be held for each of the Urban IHFs (FHCK, FHCJ, AMS, NA and NFSC), and two days for the rural facilities of KCRC and BMC.

Table 1: Planned target client numbers for dental screening and intervention.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ITEM | FHCK | FHCJ | AMS | NA | NFSC | BMC | KCRC | Total |
| Number screened | **80** | **110** | **273** | **179** | **38** | **135** | **139** | **880** |
| Number of temporary fillings | **8** | **6** | **27** | **18** | **2** | **13** | **14** | **88** |
| Number of tooth extractions | **8** | **6** | **27** | **18** | **2** | **13** | **14** | **88** |

# Activity report:

## A: General Summary of Activities

The Maximus project for Pediatric Oral Dental Health across CAFU supported Health Facilities was carried out in 2 phases. Phase 1 was carried out from18th to 27th August 2015 at 7 CAFU IHF sites (FHCK, FHCJ, AMS, NA, NFSC, KCRC and BMC) over 7 days while phase 2 was carried out from 11th to 15th January 2016 at 6 CAFU sites over 5 days. In phase 2, one site NFSC was not visited as only one child had missed the first phase and was instead treated at RUN DENTAL clinic. The project offered; Oral health education; Supervised brushing exercise; screening for oral health problems and a donation of a tooth brush and a 50ml Colgate tooth paste.

The project identified and untreated dental caries, Abscessed teeth, Mal-aligned teeth, Fractured teeth, Retained teeth, Tooth attrition, Periodontal (gum disease) and stains, Infant oral Mutilation (ill effects of “False teeth” extractions by non-medical traditional practitioners) and Fluorosis of teeth. However rapid caries and periodontal disease were the commonest conditions among the children screened. All children surgically treated were given appropriate and post-operative medication and instructions and those with secondary and tertiary needs were referred for further care. The major causative factors identified were; Lack of sufficient professional dental care services in the area, Lack of dental awareness among the children and parents, High poverty levels, Lack of proper oral hygiene, Cultural beliefs- where un-erupted teeth are considered as false teeth and usually extracted by traditional doctors affecting future permanent teeth leading to mal-alignment among the effects. Many clients screened needed conservation of their teeth (filling), periodontal treatment (scaling and polishing), and other complications were referred for secondary treatment at the next visit to the sites.

The project reached a total of 784 children (89% of the project target expected of 880). 359 (203%) of the 176 target were treated or dental diseases including extractions and temporary fillings) were treated for dental related illness, 151 had good and improved oral hygiene with no caries while 447 children had secondary oral health needs and were referred for advanced care. The overall dental disease prevalence across all the CAFU Sites was 81% (83% during phase 1 and 76% in phase 2); (Table 2).

Table 2: Combined oral dental activities for both phase 1 and phase 2

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Site | No. screened | No. treated | No. with good OH | No. with dental problems | Overall Prevalence of dental disease(%) |
| NFSC | **39** | **24** | **2** | **37** | **95** |
| FHC -N | 85 | 36 | 7 | 78 | 92 |
| AMS | 213 | 84 | 48 | 165 | 77 |
| NA | 123 | 96 | 14 | 109 | 89 |
| KCRC | 136 | 40 | 26 | 110 | 81 |
| BMC | 117 | 49 | 24 | 93 | 79 |
| FHC- J | 71 | 30 | 30 | 41 | 58 |
| Total | **784** | **359** | **151** | **633** | **81%** |

Of the 562 children screened for oral related diseases in phase 1, 465(83%) had one or more of the dental problems, a dental diseases. Out of these, 260 were treated for emergency dental care due to pain and only 97 (17.3 %) children had good oral hygiene. (Table 3)

Table 3: Oral dental activities during the first phase at all 7 CAFU sites

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date- Phase-1 | Site | # screened | # treated | # with good OH | # with dental problems | Overall Prevalence of dental disease (%) |
| 18th Aug | NFCS | 39 | 24 | 2 | 37 | 94.9% |
| 19th Aug | FHC Naguru | 62 | 27 | 5 | 57 | 91.9% |
| 20th Aug | AMS | 128 | 56 | 23 | 105 | 82% |
| 21st Aug | NA | 63 | 56 | 3 | 60 | 95.2% |
| 24th Aug | KCRC | 119 | 36 | 18 | 101 | 84.9% |
| 25th Aug | BMC | 104 | 40 | 21 | 83 | 79.8% |
| 27th Aug | FHC Jinja | 47 | 21 | 25 | 22 | 46.8% |
| TOTAL |  | **562** | **260** | **97** | **465** | **83%** |

During phase 2, of the 222 children screened for oral related diseases, 168 had one or more of the above mentioned dental problems, a dental disease prevalence of 76% which is lower than one obtained during the first phase of 83%. 99 children were treated for emergency dental care due to pain. Only 54 children had good oral hygiene accounting for 24.3% an improvement from 17.3% seen during the first phase.(Table 4)

Table 4: Oral dental activities during the second phase at all 7 CAFU sites

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date-Phase-2 | Site | No. screened | No. treated | No. with good OH | No. with dental problems | Overall Prevalence of dental disease (%) | Referred |
| 11th JAN | FHC -N | 23 | 9 | 2 | 21 | 91.3% | 17 |
| 12th JAN | AMS | 85 | 28 | 25 | 60 | 70.6% | 42 |
| 13th JAN | NA | 60 | 40 | 11 | 49 | 81.6% | 20 |
| 14th JAN | KCRC | 17 | 4 | 8 | 9 | 52.9% | 8 |
| 14th JAN | BMC | 13 | 9 | 3 | 10 | 76.9% | 4 |
| 15th JAN | FHC- J | 24 | 9 | 5 | 19 | 79.1% | 13 |
| TOTAL |  | 222 | 99 | 54 | 168 | 76% | 104 |

Most clients seen had secondary and tertiary needs and many with complications probably due to limited available oral health services. In the second phase of the project the oral hygiene was better among the children screened. Notable was that most dental problems like chronic marginal gingivitis were preventable could have been eliminated by merely ‘tooth brushing’. The severity of tooth decay was dominant and hence needs to be checked with appropriate interventions.

## B. Site Summary Report

### **NAMUGONGO FUND FOR SPECIAL CHILDREN**

Phase 1 started at Namugongo Fund for special children (NFSC) various activities carried out to empower children to have good oral hygiene were carried out. Only two (2) out of 39 children screened did not have any dental related problem, a dental prevalence of 94.9%. 24 children were treated for dental caries and pain. The very high prevalence needs to be controlled through sustained oral health promotion activities and care for the children in order to boost their oral hygiene. This site was not visited in the second phase because only one child was missed the first phase and it seemed a better option to have that child treated from RUN DENTAL clinic.

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Figure 1: Children at NFSC showing off their toothbrushes and toothpaste, carrying out dental brushing exercises, getting a dental screen and a child going through a tooth extraction

### FAMILY HOPE CENTRE NAGURU

During phase 1, RUN dental clinic carried out an intensive oral health promotion campaign at Family Hope Centre Kampala.(Figure 2). 62 children were sensitized together with their parents, 57 children had dental problems, a dental disease prevalence of 91.9%. 27 children were treated and the rest with tertiary dental conditions were referred for further care. Only 5 children out of 62 had a good oral hygiene. During the second phase, 23 children and their care givers were sensitized on proper oral hygiene. After screening, 9 were treated for dental emergencies and 17 needed further interventions and were referred. Only 2 had good dental formula and proper hygiene.

Figure 2: oral health education and oral dental disease at Family Hope Centre Naguru

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### AMS NAMUWONGO

During phase one, 128 children and their care givers were reached at Alive medical services Namuwongo (Figure 3). RUN DENTAL CLINIC team carried out a dental screening and oral health education exercise. All the children present were screened for dental diseases and 105 were found with dental related problems of whom 56 were treated while others were referred. With the site dental disease prevalence of 82%, 23 children had no dental problem.

85 children were screened during phase 2 and 25 children had good oral hygiene. 28 children were treated for different dental problems while 42 were referred for secondary interventions.

Figure 3: Oral dental manifestations, tooth brush exercise, health education session and dental screening exercise at Alive Medical Services

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### NURTURE AFRICA

During phase 1, sixty children out of 63 screened had dental related problems, 56 of them were treated for emergency dental care and several others referred to the next appointment. The site dental disease prevalence was 95.2%.

During the second phase, 60 children were screened and 40 of them were treated. The site still has a higher number of children with the most burden of dental disease and more interventions are still needed to avert the situation.20 children were referred for secondary treatment while 11 children didn’t have any dental problem. (Figure 4)

Figure 4: oral dental manifestations, dental screening of child, tooth brushing exercise at Narture Africa

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### KABWOHE CLINICAL RESEARCH CENTRE

During phase 1, attendance of children and care givers was very good and out of 119 children screened, 101 had dental related problems mainly of secondary nature that needed interventions beyond the scope of the project. Although the site had a high dental disease prevalence of 84%, the most prevalent periodontal disease will be reduced to a great extent by daily teeth brushing with fluoridated tooth paste that was provided during the exercise.

During phase 2, 17 children present were screened and 4 were treated for dental caries, 8 were referred and 8 children had secondary dental needs that could not be handled in this phase of oral health promotion.(Figure 5)

Figure 5: Oral health education session, dental screening and extractions at KCRC

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### BUSHENYI MEDICAL CENTRE

During phase 1, of 104 children screened 83 had dental problems and 40 of them were in pain. They were treated for dental extractions and zinc oxide fillings. This site had a dental prevalence of 79.8% but had many children who need secondary and tertiary dental care. There were several cases of infant oral mutilation which contributes to increased mal-alignment cases There is need for more oral health promotion exercise that will help to improve the oral health among the children and consequently the quality of life.

During phase 2, 13 children were screened, 9 children were treated and again 4 were referred while 5 children had no dental caries. More efforts are still needed to control the high numbers of dental problems at this site.(Figure 6)

Figure 6: Oral health education, oral dental manifestaions and preparation of the zinc oxide fillings

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### FAMILY HOPE CENTRE JINJA

In phase 1, 47 children were reached. FHCJ one of the sites of the 2009/10 Maximus Project recorded the lowest dental prevalence of 44.7%. This may be due to the several oral health promotional activities that were carried out by RUN DENTAL organization in the previous project. Of the 24 children screened, 9 had dental related issues and were treated while 13 were referred for secondary dental problems. (Figure 7). Only 5 children had no dental problems.

Figure 7: Demonstration on brushing teeth, oral dental screening, oral manifestations and preparation for treatment at FHCJ.

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# MAJOR CHALLENGES, CONSTRAINTS AND LESSONS LEARNED

**Major challenges/lesson learnt**

* There is increased prevalence of tooth decay and gum disease among clients in the project probably due to changes in life style especially diet and ART medications without complying with the required hygiene standards.
* Increased sugar consumption is a threat to dental health with adverse effects of tooth decay in children and will immensely impact on their quality of life.
* Multiple carious lesions require extra attention from the management team for more pragmatic solutions that will not only give children better smiles but will go a long way to eliminate suffering due to oral pain and discomfort.

**Constraints**

* There was a shortfall of 96 children not screened from the first and second phase particularly at AMS and NA. The low turn up at NA was attributed to far locations and lack of transport facilitation for the dental activity while at AMS, it was attributed to the children held up in their up country villages over festive season in the second phase. Generally, lack of transport facilitation was a problem.
* Although the children reached were fewer than the target, many children had multiple teeth with dental caries 364 treatable disease up from the 176 anticipated. This increased the cost of treatable dental disease.
* The low turn up was attributed to children who come from far places fail to get transport to facilitate their movement to the project for such activities.

**Recommendations:**

* There is need for more sensitization programs for both clients and staff.
* Client’s brushing with fluoride toothpaste should be priotized by the health team at CAFU sites during the health education sessions.
* Effective primary and prevention oral health programs should be put in place to manage dental cases in their early stages.
* Training of CAFU medical Staff in a day’s seminar, on oral hygiene practices, identification and effective referral of dental problems will be a sustainable approach to the matter.
* There is a need to have a regular dental clinic running on the children’s appointment clinical days to increase attendance for better health for all the children in the project.
* All referred cases need to be addressed before it’s too late to have worse situations that will be more complicated and expensive to treat.
* RUN DENTAL has mobile equipment for filling and cleaning teeth that can be transported to all CAFU Centers for secondary treatment.

# Annexes:

# Success Stories

Figure 8: A letter of appreciation from one of the children at FHCK

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|  |

Figure 9: Testimonies from Parents of children at Alive Medcal Services

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| * Thank you so much for extending the dental services nearer to us. My daughter (who is 6 years) had a problem with her tooth; she could barely eat anything nor sleep at night but after the tooth was extracted, she felt much better and was relieved from the pain and on top of that she also learnt how to brush her teeth which she didn’t know and was given some medicines plus a free tooth brush. Now as I speak she is very okay. I would also recommend if it was possible for this service (dental checkup) to be extended to Alive Medical Services permanently because I know that there are very many children out there who need this service or at least let it be there 3 or more times in a year. Thank you so much for your generosity. |
| * She was very happy when she was called that there will be a dental checkup day at the clinic for the children because for over a month the son (Kigenyi Amuza)was suffering with a dental problem i.e. the teeth and gum were swollen for over a month and it was bringing purse which was yellow. The mother would just use warm water and salt to treat the swollen gum. **“**Kigenyi would not eat or sleep, it was a really a bad experience for both of us yet we hardly had any money,**”** the mother sadly explained. When she went to KCC Health center, they didn’t have the medication at all. Well, she wants to thank you for having a thoughtful heart of extending the dental service to Alive Medical Services. Now her boy eats very well and lots of food with a good and comfortable sleep in the nights which has made the mother very happy. However she is asking for the extension of the dental service to Alive Medical Services and also the parents and caretakers perhaps get a chance of getting such a wonderful service. Thank you so much and may God bless you abundantly. |

Figure 10: Feedback from the team at NFSC on the dental camp and a leetr of appreciation from one of the children

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| **DENTAL CAMP**  We also had a holiday dental camp for children at NFSC ART clinic on 18.08.2015 by Run Dental NGO with support from Children’s Fund Uganda (CAFU) funded by the Maximus project. On this eventful day Dr Brian Rushaju and the team trained 39 children and their caregivers on dental hygiene, carried out dental checkups (dental extractions, conservation of teeth and periodontal treatment) and held a practical session on the best practices on how the children should brush their teeth. This camp was very educational, informative and fun as Dr Brian Rushaju used a child friendly approach to educate our beneficiaries on the necessary skills to enable them be in control of their own dental health. Parents that came with their children appreciated the session and the NFSC team learned a lot from the dental team. Thank you CAFU for making this program possible and Dr Patricia for spending time with us on that day. |
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| Figure 11: A letter from the counselor at BMC on success of the dental camp and a letter of appreciation from one of the children. |
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1. <http://www.who.int/mediacentre/factsheets/fs318/en/> [↑](#footnote-ref-1)