

HALDIMAND AND NORFOLK

Dental Health Report



Dental health plays an important role in the overall health and well-being of children and adults.¹ Among children, poor dental health can lead to painful infections, premature loss of primary teeth, poor eating habits, speech problems, expensive dental treatment and can negatively affect

growth and development.² Among adults, oral health can negatively affect general health status, wellbeing and quality of life.³ Several research studies suggest that there is a positive relationship between gum infection and morbidity.⁴ Heart disease, stroke, diabetes and respiratory disease are also positively correlated with gum infections.⁴ Moreover, it was found that gum disease negatively affects birth outcomes, namely premature babies, and has a strong correlation with low-birth-weight babies.⁵

The Haldimand-Norfolk Health Unit conducts oral health dental screening in Haldimand and Norfolk elementary schools and various community sites to identify children in need of dental treatment. Various dental financial assistance programs are available to assist children, students and families. The Health Unit is also committed to improving the oral health of the community through oral health promotion initiatives targeted to individuals, parents, community partners and schools.

The Haldimand and Norfolk Dental Report 2007 is the first focused dental report to be completed for Haldimand and Norfolk and provides a brief overview of dental health in the community. In particular, dental visits, dental insurance, teeth brushing, oral cavity and pharynx cancer, deft Index (d=decayed, e=extracted due to caries, f=filled and t-teeth) and DMFT Index scores (D=Decayed, M=Missing, F=Filled, T=Teeth) and dental screening were examined. This report is intended to provide physicians, health-care professionals, local politicians, members of the media, other health units and schools with useful information for the purpose of oral health promotion.

Overall, this report demonstrates that there are some formidable challenges in dental health in Haldimand and Norfolk.

Overall, more than half of Haldimand and Norfolk residents do not visit the dentist more than once a year for checkups as recommended by the Ontario Dental Association. Moreover, approximately one-third of the population does not have dental insurance that covers all or part of dental expenses, of which a higher proportion that do have dental insurance have an employer-sponsored plan, which may, in fact, be inadequate.

The average-age-standardized incidence rate of oral cavity and pharynx cancer was higher in Haldimand and Norfolk than in Ontario. The mean deft score (d=decayed, e=extracted due to caries, f=filled and t-teeth) for children age seven increased from 2004 to 2007. The deft index determines dental caries status for primary teeth. Whereas, the mean DMFT (D=Decayed, M=Missing, F=Filled, T=Teeth) score for children age 13 that is used to determine the dental status for permanent teeth, increased from 2002 to 2007. Therefore, the proportion of caries-free children age seven and 13 has been declining with each successive year between 2002 and 2007. In the past seven years, more than 34,272 elementary students have been screened by dental hygienists, of which 10.5% (n=3,266) of these children were identified with urgent dental needs that required immediate treatment.

The number of children screened at various dental screening clinics has increased with each successive year and more than doubled in 2006 compared to 2002. Furthermore, although a higher proportion of Haldimand and Norfolk residents report brushing their teeth twice or more each day, a significantly lower proportion of Haldimand and Norfolk residents do not comply with the recommended teeth brushing guidelines compared to Ontarians.

Recommendations

1. To adopt improved health promotion strategies to improve dental health status in Haldimand and Norfolk that focus on primary prevention and not primary care.
2. To support initiatives that advocate on behalf of child poverty, as child poverty negatively affects dental health status.
3. To create awareness of oral health disparities in Haldimand and Norfolk associated with living in a rural community and adopt appropriate strategies to address these disparities.
4. To increase awareness of oral health-care services among service providers that may facilitate a seamless infrastructure of service delivery to improve the quality of oral health care among Haldimand and Norfolk residents.

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References

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HALDIMAND-NORFOLK HEALTH UNIT

Rural Health Report



As part of the Health Unit's strategic direction to strengthen our leadership in rural health strategies, the Haldimand-Norfolk Health Unit Report, *Rural Health: A Qualitative Research Approach to Understanding Best Practices for Rural Health Service Delivery in a Public Health Setting* was developed that provided an in-depth overview of leadership, challenges, models, best practices, expertise and recommendations for working effectively in a rural area. This study used a qualitative research methodology and focus groups to gather data. Five focus groups were organized consisting of Haldimand-Norfolk Health Unit staff and Program Coordinators. The focus groups were facilitated by Dr. Heather Lee Kilty, from Brock University. The Report consists of four chapters: Introduction to Rural Health, Focus Group Results and Discussion, Models, Theories, Frameworks and Best Practices for Rural Health Planning and Recommendations and Specific Strategies.

The results of the report suggest that the study participants reported that they work in a rural area because of the geographical distribution, they had a different way of thinking and living that made them feel that they lived in a rural area, they had acquired a strong sense of community relationships, and they expressed a lack of resources and access to services.

Moreover the participants identified what was unique and/or positive about working in public health in a rural area. Overall, they stated that they had a strong sense of collaborative community relationships,

the pace of life and way of life in the rural area was less stressful, the community itself was resourceful, and they had the ability to make decisions and felt that they had more control in creating programs.

The participants reported that some of the challenges about working in public health in a rural community were the lack of confidentiality, urban dwellers, shortage of physicians and limited access to health and other services, and specific populations like youth, migrant workers, women, elderly, and farm workers were identified as having unique challenges. Moreover, their challenges to recruit, train and retain rural public health staff, economic challenges, and there was a co-existence of rich and poor populations.

In addition, the participants identified particular knowledge, skills, and experiences as being essential to work in rural public health to include: the need to be a jack of all trades and acquire more skills, mobilize communities, the need to have a high level communication and practical skills, and the ability to facilitate leadership. Moreover, the participants' felt that they needed to be passionate about their work, be client centered and have the ability to be flexible, adaptable, creative and resilient and know how to support each other to be able to measure outcomes and effectiveness in a rural area.

Recommendations

There were recommendations in the various areas:

1. Recruitment, education, and retention of staff.
2. Organizational structure and supports for public health work in rural areas.
3. Models, best practices and framework to use for public health.
4. New programs or services initiatives to address specific rural health needs.
5. Taking leadership and sharing expertise in rural health and best practices.
6. Future research and evaluation.