Oral Health

4.1 Knowledge, Attitudes and Beliefs of Black and Minority Ethnic (BME) Populations in Relation to Oral Health and Nutrition

Background
The Action Plan for Improving Oral Health and Modernising Dental Services and Equally Well Implementation Plan state that NHS boards should roll out programmes for improving oral health of vulnerable groups and progress work to address inequalities in oral health.1,2

The prevalence of dental caries in children is higher in minority ethnic communities in comparison to the white population.3 The Pakistani community is the largest non-white ethnic group in Lanarkshire making up 0.6% of the total population in North Lanarkshire and 0.3% in South Lanarkshire.4

In 2007, North Lanarkshire Council participated in a Home Office and United Nations programme to settle Congolese refugees. In 2010, there were 17 Congolese families living in Motherwell, many with newly born children.

Evidence suggests that initiatives used to date are ineffective when adapted for minority ethnic populations because they fail to take into account the different beliefs, attitudes and behaviours of the target population.5

Methods
As part of a programme to ascertain the knowledge, attitudes and beliefs of Black and Minority Ethnic (BME) people in relation to oral health and nutrition, four focus groups were undertaken, three with the Pakistani population and one with the Congolese population.

Results
The Congolese group identified some issues which are barriers in accessing health services and information, and they often relied on emergency dental treatment and extraction.

‘...some people are going to hospital. The hospital gives them someone to translate...’

The group knew of few oral health messages. The quotes below suggest they were unaware of the importance of fluoride toothpaste and the ‘spit, don’t rinse’ message.

‘I first use the toothpaste for 15 minutes and then I rinse the mouth with water, I don’t just spit it out. The water needs to be kept in the mouth for a while’.

‘So if it happens that you do not have toothpaste, you can use salt instead’.

They questioned the role of sugar in causing dental decay and could not read or understand food labels.

‘So sometimes lack of information means that something has sugar. So it means it would be helpful to read a bit more’.

Some Pakistani participants used a toothbrush and toothpaste, but many used miswaak (a commercially packaged twig from the Salvadora persica tree) to clean their mouth. Substitutes to toothpaste were also identified.
‘Even in Islam, it’s been told at every prayer you must clean your teeth with miswaak. Five times a day you should clean your teeth with miswaak’. Only a few were able to identify that sugary foods and drinks should be kept to mealtimes. If food labels were examined, they were for religious reasons only. Foods that are currently contraindicated for children under one were often given from birth.

‘I can tell you it was since he was born my mum-in-law gave him honey’.

Key Points

• Religious and cultural practices were identified that will influence the development of health improvement programmes in black and minority ethnic groups.
• There was evidence of a lack of knowledge in both populations of key oral health and nutrition messages.
• Language and culture can be barriers to accessing health services and information.

Priorities for Action

• Develop programmes with both populations to improve knowledge and disseminate culturally specific oral health and nutrition information.
• Ensure health improvement programmes have translated information where appropriate.
• Replicate the study in other significant minority ethnic communities in Lanarkshire such as the Chinese and Polish population.

References

3 Conway DI, Quarrell I, McCall DR, Gilmour H, Bedi R, Macpherson LMD. Dental caries in 5-year-old children attending multi-ethnic schools in Greater Glasgow – the impact of ethnic background and levels of deprivation. Community Dental Health 2007;24:161-65.

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Prisoners are vulnerable to poor oral health with underlying causes related to deprivation, tobacco, alcohol, drug use and poor oral hygiene. A number of national health directives have identified prisoners as a priority group for oral health improvement.

In 2011, an oral health needs assessment was conducted as part of the Scottish Oral Health Improvement Prisons Programme. A convenience sample of prisoners was selected from three prison establishments, one of which was the adult male prison HMP Shotts in Lanarkshire. A questionnaire was used to assess their general health, oral health and behaviours such as tobacco use. An oral examination was offered to each participant.

A total of 110 prisoners from HMP Shotts participated. The mean age was 36.2 years. The mean number of years in prison was 4.4 years. Most participants (77%) reported to be smokers. The mean number of cigarettes smoked daily was 17. Seventy-six per cent admitted to having used drugs at some time.

Results of the survey at HMP Shotts compared to previous surveys are shown in Table 4.2.1. The obvious decay experience was measured by the total number of decayed, missing (extracted due to decay) and filled teeth. The Care Index is used to describe the proportion of obvious decay experience that has been treated restoratively and is expressed as a percentage. As found in the Scottish Prisons’ Dental Health Survey 2002, the oral health of prisoners was characterised by a pattern of increased numbers of missing teeth and fewer filled teeth. The Care Index of Scottish prisoners has remained in the order of 30% since 2002. Other findings reflected a pattern of irregular dental attendance associated with pain which was sometimes related to previous drug use.

Table 4.2.1 Obvious decay experience in adults as reported by oral health surveys in 1998, 2002 and 2011

<table>
<thead>
<tr>
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<th>UK adults (weighted) 1998</th>
<th>Scottish prisons 2002</th>
<th>HMP Shotts 2011</th>
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</thead>
<tbody>
<tr>
<td>Percentage with no obvious decay experience</td>
<td>7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mean number of decayed, missing and filled teeth</td>
<td>13.29</td>
<td>15.32</td>
<td>15.75</td>
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<tr>
<td>Mean number of decayed teeth</td>
<td>2.26</td>
<td>2.56</td>
<td>1.09</td>
</tr>
<tr>
<td>Mean number of missing teeth</td>
<td>5.10</td>
<td>8.21</td>
<td>9.83</td>
</tr>
<tr>
<td>Mean number of filled teeth</td>
<td>5.93</td>
<td>4.55</td>
<td>4.83</td>
</tr>
<tr>
<td>Care Index (percentage)</td>
<td>45</td>
<td>30</td>
<td>31</td>
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</tbody>
</table>

* To allow direct comparisons, weightings were applied to the data from the 1998 UK Adult Dental Health Survey as reported in the Scottish Prisons’ Dental Health Survey 2002.
The poor oral health of prisoners was highlighted as having an impact on their quality of life. Eleven per cent stated that they were very often handicapped by oral health issues making their life less satisfying, compared to only 1% of UK adults.

Key Points

- An oral health needs assessment of prisoners in HMP Shotts was carried out.
- The levels of oral disease among the prisoners were much higher than adults living in the general population.
- Comparison between the 2011 and 2002 oral health surveys of prisoners in Scotland reflected that there was little difference in the Care Index (percentage of decayed teeth restored).

Priorities for Action

- Offer prisoners one-to-one tailored advice on oral health.
- Raise the importance of oral health improvement with prisoners, staff and managers.
- Implement a dental appointment system for routine treatment and check-ups for prisoners.

References


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