Seychelles Oral Health Services

STANDARD OPERATING PROCEDURE

Antenatal Care (ANC) Oral Health Program

The Oral Health Service is an organisation that prides itself on delivering high-quality preventive based and patient centred services. One aim of standard operating procedures is to ensure that systems and procedures are in place that are evidence informed and outcome focused.
Central to person-centred care is that the practitioner understands their responsibility to ensure effective and open communication takes place and encourages active engagement between themselves and their patient (family or carer) and other health care workers involved in antenatal care. The Antenatal Care (ANC) Oral Health Program is a component of comprehensive prevention based oral health care that is integrated into overall Antenatal Health care.

Purpose

To standardise and streamline the implementation of the ANC Oral Health Program, ensuring consistency, quality, and accountability for positive oral health outcomes and a healthy pregnancy.
To ensure the identification of woman at risk of dental caries and other oral diseases.

Scope

This procedure applies to all oral health professionals, including dental hygienists, dental therapists, nurses, dental surgery technicians (DST) and medical practitioners participating in the delivery of ANC OH services at community health centres, dental clinics and outreach programs.

Definitions

ANC	Antenatal Care a program run at every community health centre in Seychelles
Caries Risk Assessment (CRA)	A systematic approach to identify individuals at risk of developing caries (and those who are not). It helps the oral health professional to tailor their recommendations for preventive care and treatment, and focusing on individuals who need help most.
Motivational Interviewing (MI)	A collaborative, goal-oriented style of communication designed to strengthen a patient's motivation and commitment to change. It's a patient-centred behaviour approach that helps patients resolve doubts about change by prompting their own reasons for change, rather than imposing external pressure or directives.
Patient centred Care	Care which is responsive to patients needs, preferences and goals, and empowers active participation in their own health care. It involves partnership between patients and healthcare providers, with patients actively involved in decisions about their care. This approach goes beyond treating health conditions by considering the patient's well-being (emotional, social, financial) and personal values and beliefs.
Risk Based Approach	Oral diseases are caused by a range of modifiable risk factors common to other NCDs, such as sugar, tobacco, alcohol and poor hygiene, with underlying social and commercial determinants. Overall risk is determined by the balance of these risk and protective factors (fluoride, saliva, oral hygiene, regular check-ups). Understanding a person's risk helps plan preventive care and frequency of checks.

Principles

This procedure is underpinned by the principles of:

- Patient centred care
- Atraumatic dental care and minimal intervention dentistry (MID)
- Risk based approach which prioritises those in most need and/or risk
- Early identification of oral disease and early preventive interventions
- Evidence informed policy and procedure design
- Constant quality improvement cycles based on outcome data.

Objectives of ANC OH Program

- Integration of oral health promotion into routine ANC program.
- Identification of at risk pregnant women (and families).
- Target interventions to prevent ECC developing in the new child.
- Increase oral health literacy of pregnant woman (and partners).
- Systematically track and follow up at risk ANC clients.
- A seamless handover to MCOH after the birth of the child.

Responsibilities

Role	Key Tasks
Manager **Outreach Dental Program**	• Overall coordination of the National ANC Oral Health Program • Evaluation and reporting. • CPD and incident investigations. • High level liaison and planning with PHC staff and stakeholders.
Regional Dentist	• Placement and supervision of regional oral health staff • Liaison with Community Health Nurse Managers • Authorise regional reports
Regional Coordinator	• Plan counselling sessions, screenings, coordinate appointments • Supervise service delivery, report compliance and training • Documentation, data collection and regional reporting • Maintain registers, form security, track recalls and follow up high risk.
Clinic Staff	• Deliver oral health education sessions • Preventive based care and disease control • Treatment as required
ANC Nurse	• ANC coordination, problem solving, community engagement • Reinforce oral health messaging • Issue materials and communications.

Common Oral Health Conditions during Pregnancy

Pregnancy gingivitis	Increased inflammatory response to plaque during pregnancy causes the gingiva to swell and bleed more easily. Most common in the 3rd trimester. Women with gingivitis before pregnancy are more prone to exacerbation during pregnancy.
Periodontitis	Untreated gingivitis can progress to periodontitis (destructive infection in the gums and bones). The teeth may loosen, bone may be lost, and a bacteraemia may result.
Benign oral gingival lesions: (Pyogenic granuloma, Granuloma Gravidarum, Pregnancy Epulis)	5% pregnancies may develop a highly vascularised, hyperplastic and often-pedunculated lesion (< 2 cm diameter), usually in anterior gingiva. Cause: heightened inflammatory response to oral pathogens. Rx: usually regress after pregnancy, excision only needed if there is severe pain, bleeding, or interference with function.
Tooth mobility	Periodontal ligaments may temporarily loosen during pregnancy resulting in increased tooth mobility, unless other complications are present resolves without complication.

Tooth erosion	Erosion is common due to morning sickness and increased exposure to gastric acid (vomiting and gastric reflux) during late pregnancy. To reduce the impact of acid exposure: • rinsing the mouth with a solution of bicarbonate of soda • wait for at least 1 hour before brushing teeth after vomiting • use fluoridated mouthwash and toothpaste (spit don't rinse) • eat small amounts of nutritious (non-cariogenic) foods during the day • chew sugar-free gum after meals or high sugar/acidic drinks.
Dental caries	Pregnancy may increase dental caries risk due to oral acidity, increase intake of sugary snacks/drinks (pregnancy cravings) and less attention to prenatal oral health care.

Procedure Check List

1. Identification and Visit Scheduling

- Access the register of pregnancy in each region ANC is required.
- Working with ANC nurses to plan and coordinate education sessions and screening visit.

2. ANC Visits **Pre-screening Oral Health Education often in a group session** (see Annex 1):

General preventive oral health information	• Oral hygiene instruction and dietary counselling, • Leaflet provided to reinforce messaging and to confirm understanding at later visits • Bottle feeding / Breast feeding • Information on oral habits and trauma (early childhood **Note:** Use standard MoH-approved leaflets and visual aids Replace missing or outdated cards/leaflets.
Specific preventive OH information during pregnancy	• Erosion and reflux • Caries • Periodontal risk

3. Screening/Check Up

- Use online WHO STEP Survey which includes a basic oral examination
- Caries risk assessment of pregnant women: risk/ preventive factors identified
- Treatment planning
- Intensive/Specific health literacy support for pregnant women/partner based on caries risk.

4. Documentation

- Patient's treatment records – record STEP survey conducted, risk level and any details of dental conditions and charting.
- Treatment plan
- Recall planning - standard: 6 months; high risk: 3 months or less.

5. **Refer to MCOH program** after birth

Women determined as High Risk

Note: Children of parents with dental caries have a higher risk of developing caries.

Studies have shown that children with mothers/primary caregivers who have active decay or do not have regular dental care are at a greater risk to develop ECC. We should be attentive of family risk as all people in the same house will exposed to same risk factors. Providing preventive based dental care to the high risk mother should be first part of the approach to protecting the child eg refer mother (and partner) for treatment, intensive education and prevention at their community dental clinic. **Note**: long waiting times for appointments may need to be negotiated for care to align with pregnancy, quarantining of some appointments could be applicable in some clinics.

Risk factors:	Protective factors:
• Existing /untreated dental caries • Other members in family with active caries • Frequent snacking on high sugar foods/drinks • Poor oral hygiene • Smoking • Alcohol use • Special health needs – medications, dry mouth, gastric reflux/vomiting	• Regular dental checkups/reviews - high risk review every 3-6 months • Intense OH education and dietary counselling focused on family's diet and bottle feeding. • Use of fluoride toothpaste 2x/day • Fluoride varnish applications every 3 months. • SDF application and ART (as required) • Good communication with family's medical team

Monitoring & Evaluation

- Access the community health center's ANC Register
- Maintain ANC OH Register: Name, DOB, visits, partner in notes.
- OHE sessions recorded and evaluated
- Complete data entry on line form
- Monthly/Quarterly report submission by ANC OH Regional Coordinator to Manager ODS
- DPH (data manager) – shares dashboard on KPI, services provided, treatment plans completed
- Flag non-attendance multiple cancellations for follow-up.

Key Performance Indicator 1: > 80 % of pregnant women registered with ANC receive OH screening, OHE advice and completion of immediate care needs. (see Annex 5)

Key Performance Indicator 2: All pregnant woman at high risk of dental caries are identified

Key Performance Indicator 3: ANKs for ANC OH program are <20%

References

1. ANC Oral Health program Review 2024
2. WHO STEP Survey guidelines
3. MCOH SOP

Approved by	Date approved	Document owner	Revision date
Oral Health Clinical Committee	13/11 /2025	Manager Outreach Dental	01/01/2028

Annex 1: Anticipatory Guidance during pregnancy

Women during pregnancy are particularly receptive to health promotion messages and more motivated to reduce risky behaviours such as smoking and alcohol consumption, improve their health and prevent harm to the developing foetus.

Research has shown a reduction in caries among children whose mothers received OH advice during pregnancy (Plutser & Spencer 2008) and receiving information about perinatal OH significantly improves the uptake of dental services among pregnant women (Boggess and Edelstein 2006).

Topics to Cover in OHE Program for Pregnant Women:

Diet: A healthy diet is necessary to provide adequate nutrients for the mother-to-be and unborn child. Food cravings may lead to the consumption of foods that increase the mother's caries risk. Dietary education for parents includes the cariogenicity of foods/drinks, role of frequency, and demineralisation/remineralisation.

Fluoride: Use fluoridated toothpaste and consider rinsing with 0.05% NaF mouthrinse 1x/day or 0.02% NaF rinse 2x/day (AAPD 2003) for high risk group. Alternatively apply fluoride varnish every 3 months.

Oral Hygiene: Brushing with fluoridated toothpaste and flossing.

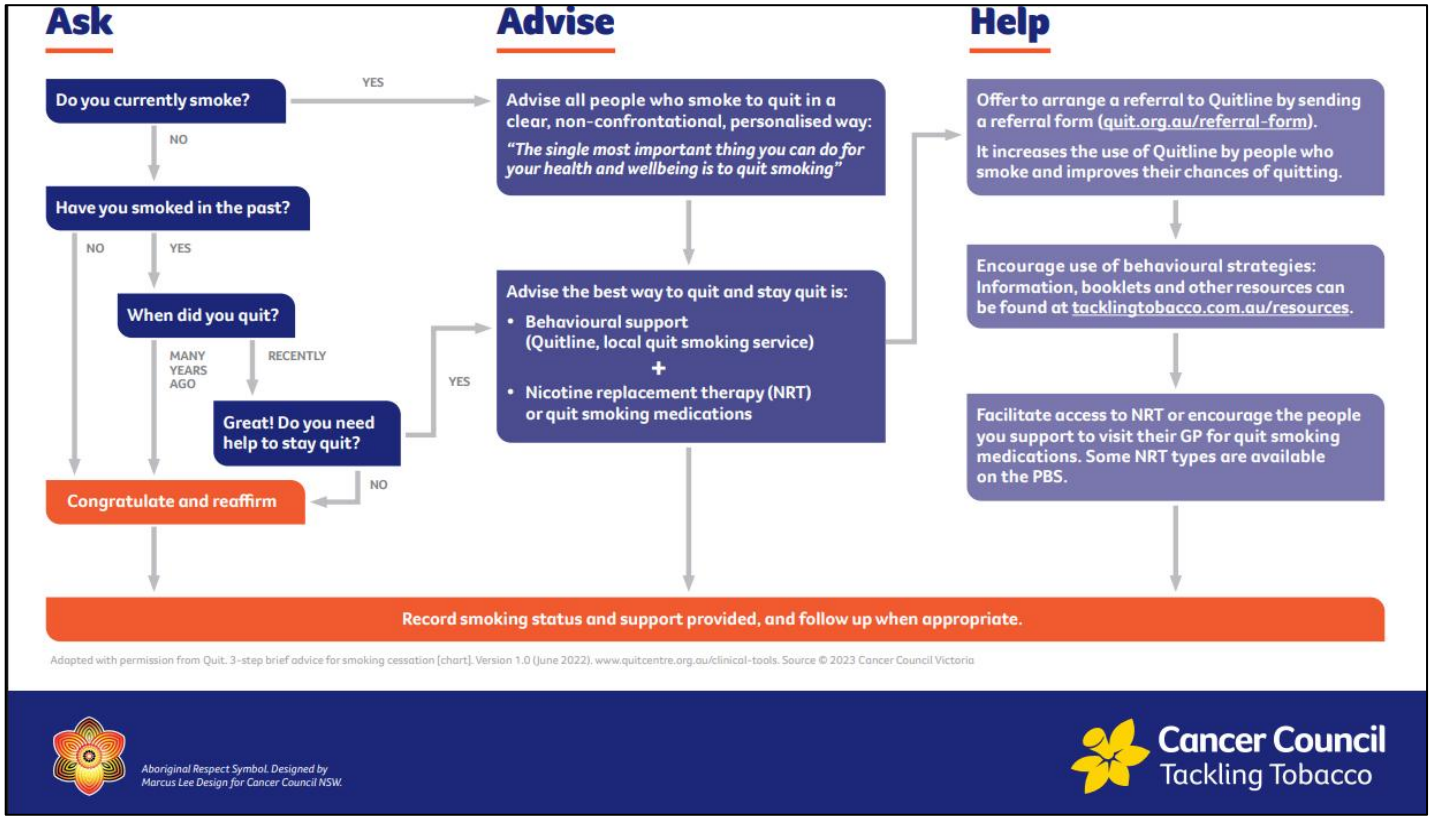
Chewing gum: Xylitol chewing gum (4-5x/day) can be protective.

Smoking Cessation: Stopping smoking is one of the most important behaviour changes a pregnant woman can make for her own and the developing foetus's health. Smoking is a major risk factor for oral cancer and periodontal disease. The oral health team play an important role in helping clients to quit using brief chairside interventions that can result in 20% of people making a quit attempt. The 3-step Brief Advice Model of Ask, Advise, Help (see below)can be applied to all people who smoke, even when not ready to quit and at any time and by all members of the oral health team, including DSTs.

Note: Asking about smoking status, without offering advice or help to a person who smokes, actually reduces a person's likelihood to quit. Providing personalised advice without connecting to broader help services has no influence on a person trying to quit. It is the offer of help (connecting with specialist medical and quitting services/pharmacotherapy) that makes the difference.

Oral health team members should:

- have general knowledge about smoking cessation and oral consequences
- deliver the chair side Brief Advice model (see below)
- provide self-help material to supplement advice and support
- encourage pregnant woman to see their medical practitioner for personalised medical advice
- provide advice and help to the woman's partner if they smoke - the highest predictor of women returning to smoking is when their partner smokes (RANSCOG 2001).



This guide is here to help you when offering brief advice. Outlined below are the three steps to the Ask, Advise, Help (AAH) model and what can be discussed at each step. There are also suggestions of what resources/support you could offer.

Stage	What happens?	Conversation prompts	Supporting info/resources to help you

ASK	1. Ask about smoking status.
	2. Document this in your organisation's data collection system.
		"Do you currently smoke?"
		"Have you smoked in the past 30 days?"
		"Since we last spoke, how have you been going with your smoking?"
			• Recording smoking status and delivery of quit smoking support:
			  • supports continuity of care for the person,
			  • helps estimate the rates of smoking and support provision at your organisation, and
			  • provides data that can be used to support future grant and funding opportunities.
			Data collection and monitoring guide

ADVISE	1. In a ***clear, non-confrontational, and personalised way***, advise the person that quitting smoking is one of the ***best*** things they can do for their health. 2. Let them know that the best way to quit smoking is using pharmacotherapy (such as **NRT** or **quit smoking medications**) combined with behavioural support from a service such as **Quitline**.	"I'm sure you already know this, but it's important that I let you know that quitting smoking is one of the best things you can do for your physical and mental health". "Quitting smoking is not only really good for your health, it will help you save money too!" "Quitting smoking will not only reduce your risk of getting sick, it will also help improve your sleep, lower your stress levels" "Here at [insert organisation] we can help you quit for good" "Quitting smoking will support your recovery goals"	• Personalise the conversation by linking the benefits from quitting that resonate most with the person e.g. to save money. • Use reflective listening skills to make sure the person feels heard. Benefits of quitting poster Financial benefits of quitting
HELP	**Help could be in the form of offering:** 1. A referral to behavioural support, 2. Facilitating access to NRT/quit smoking medications through your organisation, local pharmacies and/or GPs, or 3. Additional quit smoking tools.	"If you'd like to give NRT a go, we have some here that you can try for free." "There's telephone support available through Quitline. We can call them together if you like?" "Talking to your doctor about medications to help you quit smoking is an option, if you think that is something you'd like to try?"	• Quitline is a free* service that is available for further support and advice. They can be contacted by calling **13 7848 (13 QUIT)**. • Digital services people can access: iCanQuit (website) My QuitBuddy (app) • Information booklets: Not ready to quit Thinking about quitting Ready to quit Staying quit *The cost of a local call with higher costs from mobile phones. Referral to Quitline (13 78 48)

Follow-up with the person
Check in with the person regarding their use of quit support and any quit attempts they may have made, at an interval that is appropriate for you and the person you're supporting.

For people who have quit:	For people who are yet to quit:
Congratulate them and reaffirm their decision to quit!	Offer brief advice again using the same model.

Annex 2: OHE Session Log Template

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Annex 3: Special Precautions: Pregnancy during Dental Treatment

This table guides the safety of common dental treatments across different trimesters of pregnancy.

Procedure	**1st Trimester**	**2nd Trimester**	**3rd Trimester**
Oral Health Education	✓ Safe		
Routine Check-Up	✓ Safe		
Scaling & Polishing	✓ Safe		✓ Safe(positioning precautions)
Emergency Extractions	✓ If urgent	✓ Safe	✓ Safe (positioning precautions)
RCT	Temporise. Delay due to long appointment times and physical discomfort		
Fillings	✓ Safe (However do not use amalgam)		
X-Rays	✓ Use lead apron, avoid repetition and OPGs		
Elective Treatments	✓ Safe (positioning precautions)		
Local Anesthesia	✓ see below		

Positioning the Pregnant Client

During treatment, a pregnant woman should be placed in a semi-reclining position as tolerated:

- Encourage frequent position changes, and/or
- Place a small pillow under the right hip to elevate by 10-12 cm prevent postural hypotensive syndrome. i.e. pressure from the gravid uterus can impede venous return by compressing the vena cava, leading to postural hypotension.

Pharmacological Considerations

Pharmacologic treatment during pregnancy is of concern as the maternal metabolism of drugs is altered by the normal physiologic changes of pregnancy, and certain medications can reach the foetus and cause harm. Some commonly used dental agents are listed below.

Pharmacological Agent	**Indications, Contraindications and Special Considerations**
Analgesics	
Paracetamol	May be used during pregnancy
Codeine	
Ibuprofen	May be used for short duration during pregnancy (48 to 72 hours) Avoid in the 1st and 3rd trimesters
Aspirin	
Antibiotics	
Amoxicillin	May be used during pregnancy
Clindamycin	
Metronidazole	
Penicillin	
Tetracycline	Never use during pregnancy
Anaesthetics	
Lignocaine, Bupivacaine, Prilocaine (Citanest) Mepivicaine (Scandonest)	May be used during pregnancy
Articaine	Avoid as no conclusive evidence currently regarding side effects.

Nitrous Oxide	May be used during pregnancy. Pregnant women need lower levels of nitrous oxide for sedation; consult prenatal care health professional.
Antimicrobials	
Chlorhexidine	May be used during pregnancy
Fluoride	
Smoking cessation medications	
Varenicline, Bupropion	Not recommended to be used during pregnancy
Nictonine replacement therapy	Only under close supervision of a medical practitioner

Diagnostic Radiation

There is no need to defer dental radiography during pregnancy on the grounds of radiation protection.

Radiography is important in the diagnosis and treatment of dental problems and is considered safe during pregnancy (Toppenberg 1999, Matteson et al.1991)

Radiation Practice in Dentistry (2005); Radiation Protection Series Publication No. 1 (ARPANSA 2002) recommends "When taking a radiograph of an area distant from the foetus, such as dental radiography, this can be taken at any time with insignificant dose to the foetus any time during pregnancy. Use of a lead protective drape is recommended when the radiation beam is directed towards the patient's body, for example when taking occlusal views of the maxilla." (Australian Radiation Health Committee, 2005).

Should the pregnant woman require consecutive radiation exposure, such as during endodontic treatment, the foetus should be afforded the same level of protection as a member of the public, which is set at the rate of 1 mSv per year

Annex 4: Referral Form

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Annex 5: Monthly/Quarterly Reporting Template

Region/Clinic 27/6/2025	**No. of patients on ANC register.**	**No. of patients screened.**	**% of patients screened.**	
Perseverance/English River	79	57	72%	54% Perseverance
Anse Royale	58	34	59%	
Anse Boileau	27	9	33%	
BSA Praslin	22	9	41%	
La Digue	11	0	0%	
Les Mamelles/Mt Fleuri	57	6	11%	Patients seen at YR only. No data for LM.
Beau Vallon	32	0	0%	