

REPLY

Reply to Comment on: Oral health status during pregnancy: rural-urban comparisons of oral disease burden among antenatal women in Sri Lanka

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Dear Editor,

We thank Professor Matsubara and co-authors for raising valuable concerns about our recent publication^{1,2}. They suggest that the four aims of our program may be too many and that it is not determined that oral health care during pregnancy may reduce an adverse pregnancy outcome²⁻⁶. So saying, they refute one of the aims of our national program: 'to reduce the incidence of adverse pregnancy outcomes' stating that recent findings virtually negate its rationale.

Available research findings during the time of preparation of guidelines for incorporation of oral healthcare to the existing National Programme on Maternal and Child Health (MCH)⁷ predominantly suggested a possible association between poor oral health of pregnant women and their pregnancy

outcomes, such as low birth weight⁸⁻¹⁴. In addition, there are crucial structural and compositional factors in the Sri Lankan public healthcare delivery system against which our context is based. For example, the provision of healthcare to the population of Sri Lanka is predominantly delivered by the state free of charge. Oral health care is closely integrated to the existing public health infrastructure. Hence, it is feasible and cost-effective to incorporate oral health care in the existing National MCH Programme.

Second, the research findings that negate a possible association between oral healthcare provision during pregnancy and pregnancy outcomes have been conducted in western countries like the USA³. Findings clearly indicate a difference in periodontal risk profiles among Sri Lankan pregnant women and US women, the latter having a high



prevalence of deep periodontal pockets, the severe form of the disease³.

Third, there are alternative explanations of a lack of association between periodontal care and birth outcomes³. Periodontal disease does increase the risk for preterm birth, but the treatment of this exposure does not reduce the risk because causation and treatment efficacy can be interrelated or the can function independently¹⁵. The classic example in this regard is bacterial vaginosis, which is considered to be one contributing factor in pre-term birth, yet antibiotic treatment of bacterial vaginosis in controlled trials has not reduced the risk of prematurity¹⁶.

We do not support the notion that promoting oral health care is only for oral health. Oral diseases such as dental caries, periodontal disease and oral cancer and many non-communicable diseases, including ischemic heart disease, diabetes mellitus and cancers do share many common preventable/modifiable risk factors including unhealthy dietary patterns, stress and substance abuse. Against this backdrop, the 'common risk factor approach' of oral health promotion practiced in Sri Lanka is mandated by the World Health Organization¹⁷. It is an approach that addresses the risk factors common to many chronic conditions within the wider sociocultural milieu.

In conclusion, the oral health care for pregnant women in Sri Lanka that is integrated to the existing National MCH Programme is influenced by an array of unique contextual and compositional factors in public healthcare delivery system in Sri Lanka. Hence, it is all about *thinking globally and acting locally* for the benefit of Sri Lankan population.

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