INTERNATIONAL JOURNAL OF CURRENT RESEARCH IN BIOLOGY AND MEDICINE
ISSN: 2455-944X
www.darshanpublishers.com
DOI:10.22192/ijcrbm Volume 2, Issue 5 - 2017

Original Research Article

DOI: http://dx.doi.org/10.22192/ijcrbm.2017.02.05.006

Evaluation of the pattern of oral health conditions of patients attending the demonstration dental clinic of rivers state college of health science and technology, Port Harcourt

***Ozims,S.J.[1], Amah,H.[2], Eberendu,F.I.[3], Agu,G.C.[3], Nwosu,D.C.[2], Nwanjo,H.U.[2], Edward,Amaka[2] and Onu,I.[2]**

[1].Department of Public Health, Faculty of Health Science, Imo State University, Owerri
[2].Department of Medical Laboratory Science, Faculty of Health Science, Imo State University, Owerri
[3].Department of Optometry, Faculty of Health Science, Imo State University, Owerri
*Corresponding Author

Abstract

An assessment of the pattern of oral health conditions of patients attending, Demonstration Dental Clinic of School of Health Science and Technology, Port Harcourt was carried out. The aim was to determine the pattern of oral health conditions of patients attending the clinic, so as to ascertain the prevalence of the various oral health conditions of the patients attending the demonstration clinic as well as other factors influencing the pattern of oral health conditions of patients. Eighty (80) respondents were interviewed using structured questionnaires to extract relevant data to successfully to carry out the study. The prevalence of poor oral health condition of patients was very significant. The attitude of oral health condition was discouraging mainly due to the fact that they were ignorant of the cause. Their method of treating Oral disease was mainly by self medication, even though there are dental facilities in the area, the peoples efforts towards procuring dental treatment is absent, it is recommended that the government should site more dental hospitals in the school.

Keywords: Pattern of oral health conditions, Demonstration Dental Clinic, Port Harcourt

Introduction

Preventive oral health is a function of resolution of conflicts among needs, motives and perceived causes of action. Oral health education depends in a large measure upon acquisition of accurate and useful knowledge concerning oral health on the part of an individual. Oral health education is successful when that knowledge is put into daily practice resulting in a behavioral change and a behavioural change in an individual is far more important than mere retaining of oral health content i.e. (knowledge of dental health).

Promotion of health and prevention of disease have not always maintained the priority they do today. Although, man has always been concerned with health, a lack of understanding of the conditions linked with disease has often times hindered the process of disease prevention. This has been true in dental health as well as in general health. A large part of population knows little or nothing about oral health. It is our duty as professionals in the field to educate the masses. The individual must be convinced on the need to adopt good oral health before a change can occur. If this change occurs, he or she must be reinforced to maintain the change.

The profession of dental hygiene had its modern beginning in the early 1990s when Dr. Alfred C. Fones determined that properly trained individuals could provide oral health education and prophylactic care to patients (Aderinokun, 2002).

Since that time, the focus of dental hygiene services has been, and remains to be, the oral prophylaxis included in this area are therapeutic scaling and root planning, and periodontal maintenance care

Objectives and study

The main objective of this research work was to study the level of healthy workers awareness of the existence of oral health education in the school community hospitals in order to improve their oral health conditions. The specific objectives are therefore:

1. To determine the prevalence of oral and dental problems in the school community.
2. To determine the peoples attitude to oral problems.
3. To find their method of treating oral problems.
4. To determine if they have had any public enlightenment programme on oral health in the school community.
5. To find out the efforts of the people in providing health facilities to their school.

Methodology

Research design

The research design used in this study was a cross sectional survey of the health workers in the school community. This design was used because it cuts across all ages in the community that can give reliable information on peoples oral and other health problems of the areas.

Area of study

The study area is River State College of Health Science and Technology (RSCofHST) Community in Port Harcourt, River State, in the South-South Geo-Political Zone of Nigeria. It has a total population of 210,000 people according to the 1996 census projection figure obtained from the National Population Commission, Rivers State. This population is composed of civil servants, health workers, business men, teachers, pastors, pensioners, students and others.

Sample size and sample procedure

The sample size is about 98 individuals selected from 7 health centers in the community. The sample technique adopted is the random sampling of 14 persons per health centre for proper coverage of the population. We also selected two individuals from the demonstration clinic. This brought our sample size to 100 individuals.

Instrument for data collection

The instrument used for this study was structured questionnaires, oral interviews and physical examination of the respondents oral structure. The oral interviews were based on the questions in the questionnaire. This was used for the illiterate respondent's only.

Reliability and validity of instrument

To ensure the reliability and validity of instruments, they were subjected to the scrutiny of my supervisor. Also, all the questionnaires were delivered as handbills to the respondents to ensure that they reach the appropriate persons. Furthermore, the researcher conducted the interview for the illiterate respondents and the responses were ticked immediately. Finally, all responses were treated confidentially.

Method of data collection

The structured questionnaires were distributed to the sample population and their responses collected immediately. For the illiterate respondents, the questions in the questionnaires were read out orally in the form of an interview in their native language and answers were collected and correctly marked on their questionnaire immediately. While collecting the data, the researcher also made sure that all the respondents understood what the full meaning of the questions was so as to obtain the correct answers.

Method of data analysis

The collected data were sorted into categories including age groups, sex and occupation, grouped into frequencies, compiled and arranged in tables for easy comprehension, description; statistical formulae were used for analysis. These formulae include simple percentages, averages, e.t.c.

Data Presentations

Table 4.1: Age groups of respondents

Age Group	Number of respondents			
	Number of males	Number of females	Total	Groups (%)
20-29	1	6	7	7.61
30-39	5	5	10	10.87
40-49	7	6	13	14.13
50-59	11	14	25	27.17
60-69	11	9	20	21.74
70-79	5	6	11	11.96
80 and above	2	4	6	6.54
Grand total	42(45.6%)	50(54.35)	92	100

Table 4.2: Educational statuses of respondents

Educational status	Number of respondents	Percentage
No formal education	1	1.09
Primary	13	14.13
Secondary	30	32.61
Tertiary	48	52.27
Total	92	100.0

Table4.3:Occupation of respondents

Occupation	Number of respondents	Percentage
civil servant	53	57.61
Public servant	17	18.48
Primary health workers	7	7.61
Business men	5	5.43
Teachers	3	3.26
Pensioners	3	3.26
Pastors	2	2.17
Others	2	2.17
Total	92	100

Research question 1:

Here, we sort to know if oral and dental problems exist in Rivers State College of health science and technology.
Table 4.4: Presents our results

Answer	Number of respondents	Percentage
Yes	64	69.57
No	28	30.43
Total	92	100

Answer

Table 4.5: Patients currently having dental and oral health problems
of
Percentage
Number
Respondents

Yes	44	47.87
No	48	52.27
Total	92	100

Table 4.6: Attitude to treatment and prevention of oral and dental problems

Response	Number of respondents	Percentage
Can be treated/prevented	82	89.13
Can't be treated/ prevented	10	10.87
Total	92	100

Table 4.7: Reasons against going to hospital at the fee 1 of any dental and oral disease/problem.

Response	Frequency	Percentage
Yes, if there is money	23	25.00
No, unless the pains are intense	38	41.20
No, minor problem lasts for a short time	28	30.43
No, will interrupt my work	0	0.00
No, part of my life will soon disappear	3	3.26

Table 4.8: Places where respondents received treatment for oral and dental problems.

Place of treatment	Number of respondents	Percentage
Hospital	30	32.61
Traditional healers	1	1.09
Drug vendors	11	11.96
Chemist	42	45.65
Healing homes	5	5.44
Others (self medication)	46	50.00

Table 4.9: Cost of travel to place of treatment by respondents.

Cost (N=)	Number of respondents	Percentage
Below 50.00	hi-1	T5.28
50- 100	35	43.72
Above 100	46	50.00
Total	92	100

Table 4.10: Respondents feeling about treatment of dental and oral problem

Belief	Number of respondents	Percentage
For a short time	13	
Permanent treatment	60	65.22
Just to reduce pains	8	8.70
Government tricks for extortion	0	0.00
Others (I don't know)	11	11.96
Total	92	100

Table 4.11: Respondents feeling about replacing lost tooth (teeth).

Response	Frequency	Percentage
Will replace	37	40.22
Not necessary	33	35.87
Will not replace	8	8.70
Waste of funds	1	1.09
Others (only if interiors)	13	14.13
Total	92	100

Table 4.12: Respondent's feelings about correction of malocclusion.

Answer	Number of respondents	Percentage
Not necessary	24	26.09
Yes	50	54.35
No	18	19.57
Total	92	100.0

Table 4.13: Awareness of dental health facilities around.

Answer	Number of respondents	Percentage
Yes	14	15.22
No	78	84.78
Total	92	100

Table 4.14: Community awareness of dental hospital in rivers state college of health science and technology. Port Harcourt.

Answer	Number of respondents	Percentage
I am not aware	8	8.70
I am aware	84	91.30
Total	92	100

Table 4.15: Method through which awareness of dental hospital was acquired.

Method	Number of respondents	Percentage
I went there	4	50.00
I heard from a friend	3	37.50
Electronic media report	1	12.50
A visiting health team	0	0.00
Others	0	0.00
Total	8	100

Table 4.16: Existence of dental facilities in rivers state college of health science and technology, port Harcourt.

Response	Number of respondents	Percentage
Negative	92	100
Positive	0	0
Total	92	100

4.17: Public health enlightenment programme (received by rivers state college of health science and [technology, Port Harcourt.

[Subject of programme	Number of respondents	Percentage
Everything about health	41	44.57
About AIDS	28	30.43
About diseases of the mouth	0	0.00
About breast feeding	0	0.00
About malaria	21	28.83
Others (river blindness)	11	11.96
Polio	5	5.43
Immunization	6	17.39

Table 4.18: Respondents feeling about health education programmes

Response	Number of respondents	Percentage
Yes•	92	100
No	0	0.00
Total	92	100

Table 4.19: Initiators of public health enlightenment programme

Initiators	Number of respondents	Percentage
Community	0	0.00
Government	62	60.87
Single indigene	0	0.00
Youth/age grade	0	0.00
Others (church)	7	7.61

Number

Table 4.20: Presence of oral health education within the school community.

Response of Percentage respondents		
Yes	0	0.00
No	92	100
Total	92	100

Table 4.21: Community's intention to procure dental facilities

Response	Number of respondents	Percentage
Yes	92	100
No	0	0.00
Total	92	100

Table 4.22: Knowledge of government intention to provide dental health facilities in the school

Response	Number of respondents	Percentage
Yes	0	0.00
No	92	100
Tote I	92	100

Table 4.23: Intention to procure dental health facilities by individual or group of individuals in the school community

Response	Number of respondents	Percentage
Yes	92	100
No	0	0.00
Total	92	100

Table 4.24: Respondents feeling towards provision of dental health facilities

Response	Number of respondents	Percentage
Yes	92	100
No	0	0.00
Total	92	100

Discussion

It can be observed from the study that most respondents were within the age range of 50-59 years and 60-69 years. This could be as a result of rural-urban migration of the youths in search of greener pastures. The low number of more elderly groups could be due to low life expectancy age in Nigeria, which is about 65 years (Hussian, 1997). It was also observed that 50 out of 82 respondents were females and this could be linked to the higher female population (55.21%) as determined by the 1996 census projection figure obtained from the National Population Commission.

A high percentage (69.57%) of respondents have had oral or dental problems while 47.83% admitted they still have one form of oral disease or another. This could be because oral diseases are symptomless in the early stages, also problems like attrition, strains, malocclusion, calculus, halitosis and overcrowded teeth that don't involve pain are not appreciated as oral and dental problems. For those with advanced cases, it could be because when dental caries reaches the pulp and kills the living cells (nerves) the pain associated with it is no longer felt, so it is believed to have been cured (Hussain, 1997). The high intake of carbohydrates by the community members coupled with poor oral hygiene have played active roles in this situation (Amaeshi, 1997). On the respondents' knowledge of the treatment of oral and dental diseases, subsistent and petty traders could afford it. It could therefore be due to the low premium they attached to oral/dental problems, that has made many not to travel to nearby hospitals for oral treatments. Although (65.22%) of the respondents were aware of the effectiveness of hospital treatments of oral problems, a reasonable number (32) were not. This might be due to the fact that after dental treatment and extraction of carious teeth. Some people do not improve on their oral hygiene and there is a consequent reoccurrence of dental and oral problems. They are therefore ignorant of this fact and tend to blame it on inability of hospitals to provide lasting treatment.

The respondents' attitudes towards replacing missing teeth showed that only 40.22% were willing towards replacing lost teeth while others gave various reasons against it. This again highlights the people's poor attitude towards dental and oral health. Dunning, (1970) stressed that because most rural dwellers have been able to cook food and nourish themselves without restoration of missing teeth, they tend to care less about dental care. Furthermore, 54.35% of the respondents considered correction of malocclusion important. This might be due to the fact that their aesthetics were affected.

On the knowledge of any existing dental health facilities around them, it was detected that 84.78% were not aware of any. This could be due to their low level of dental health awareness.

Dunning (1970) said that the dental manpower available today in most countries is hopelessly in adequate to create a reasonable level of awareness in rural areas through comprehensive dental care supply due to ignorance based on the peoples exposure through education and communication and effective leadership to attract certain government facilities.

Dunning (1970) stated that the lower social class consists of the unskilled labourers, people who shift from job to job, have a limited education and who exhibit no stable pattern of life. He further said that as a group they are the ones who consistently reveal most negligence of teeth and often serious and difficult problems in dental awareness and education.

It was also observed that the community members appreciated health education although without any oral health education. This buttresses the importance of health education in improving the health of the populace. It removes ignorance and paves the way for improvement in health.

On the community's effort to provide dental and oral health facilities, there was no intention. The same goes for effort on an individual or group of people. This could be because the people have not considered it as a necessary self-help project and have hoped the government would do everything for them.

Conclusion

An assessment of the school community's awareness of pattern of oral health conditions was carried out in the school community and the conclusions drawn from the study's relevant findings are thus:

School dwellers were aware that oral facilities existed. In other words, their knowledge was obtained through conversations with few enlightened people within the community. There is high prevalence of oral and dental problems in school community and this is influenced by their consumption of mostly

carbohydrate foods, the method and place for treating oral diseases, and their attitude to oral health matter.

Also, the attitude of the school dwellers to oral problems is very poor and it is worsened by the absence of any dental health information in the community. Lack of any public enlightenment programme on oral health in the community coupled with the inability of the community members to alleviate their predicament has further affected the state of their weak awareness.

References

Aderinokun, G. (2002). An introduction to oral health care for community health workers. Ibadan: A service and service publisher.

Amaeshi, M.S. (1997). Periodontal diseases among Nigerians.NADTH5 Dental Guide Magazine 1: 20-22

Dunning, J.S.(1970).Principles of dental public health.Cambridge: Harvard University Press.

Hussian, B. H. (1997).Oral Health in Nigeria. NADTHS Dental Guide Mag

.

Access this Article in Online	
	Website: www.darshanpublishers.com
Quick Response Code	Subject: Health Sciences

How to cite this article:
Ozims,S.J., Amah,H., Eberendu,F.I., Agu,G.C., Nwosu,D.C., Nwanjo,H.U., Edward,Amaka and Onu,I.. (2017). Evaluation of the pattern of oral health conditions of patients attending the demonstration dental clinic of rivers state college of health science and technology, Port Harcourt. Int. J. Curr. Res. Biol. Med. 2(5): 28-36.
DOI: http://dx.doi.org/10.22192/ijcrbm.2017.02.05.006