

## A Basic Study on Discernment and Oral Cleanliness Hones

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### Abstract

**Background:** Periodontal diseases, dental caries, malocclusions, and oral cancer are the most prevalent dental ailments affecting members of the Indian population.

**Materials and Procedures:** A cross-sectional study involving 224 patients who were seen in the general OPD of the SSKM Hospital in Kolkata, India, between April 1 and April 30, 2013 was conducted. The study tool was a pre-made, pre-tested semi-structured timetable.

**Conclusion:** There is room for improvement in the research population's oral health knowledge and practises.

**Keywords:** Periodontal diseases; Malocclusions; OPD; Oral health

### Introduction

Oral illnesses are a major public health concern because of their higher prevalence and detrimental effects on a person's quality of life. According to the World Health Organization, "Promotion of oral health is a cost-effective method to minimise the burden of oral disease and sustain oral health and quality of life." Periodontal disorders, dental caries, malocclusions, and oral cancer are some of the most prevalent dental illnesses affecting people worldwide as well as in the Indian society [1]. Dental caries, which can impact 60–80% of children, is a serious public health problem in India. Oral cancer has also long been a serious problem in this country. Different oral disorders may have etiological causes that include genetic predisposition, developmental problems, poor oral hygiene, and traumatic experiences.

It is possible to change the attitudes and behaviours of the general public and lower the risk of many of these diseases on both an individual and societal level by encouraging education related to oral health. For instance, vigorous brushing is necessary for effective tooth and gum cleaning. Preventive dental care is difficult to find in urban areas and practically non-existent in rural ones in India [2]. In order to prevent oral disorders, it is essential to fight them. Health promotion and education should be given top importance.

Barely 50% of Indians use toothbrushes and only 2% visit a dentist, per the Indian Dental Association's (IDA) 2005 National Oral Health Survey [3]. 95% of people in the country have gum disease. Most Indians are unaware of the importance of keeping good dental health for enhancing overall health, boosting self-esteem, improving quality of life, and performing well at work in addition to ensuring relief from the pain and suffering caused by oral health disorders.

According to the National Oral Health Initiative, a programme of the IDA, oral health is essential for overall health and wellness. This campaign embodies the IDA's 2020 ambition to eliminate the "hidden pandemic of oral illnesses" and achieve optimum oral health. The National Oral Health Care Program was launched as a pilot initiative in 1999 to address the increased morbidity brought on by oro-dental problems in the country. The main objective of this strategy is to promote primary prevention through increased awareness. The project was looked at by the National Institute of Health and Family Welfare in 2004. The National Cancer Control Program also targets the issue of oral cancers nationally [4] in addition to these actions. The eleventh five-year plan's strategies include creating capacity, developing infrastructure and human resources, implementing a Basic Package

on Oral Health for the country, and monitoring dental public health through National, State, and District Oral Health Cells. The current study's objectives, in light of this backdrop, were to identify any relationships between oral hygiene practises and sociodemographic profiles as well as patient awareness of and behaviour related to oral hygiene among those presenting to the General OPD of the SSKM hospital.

### Materials and Methods

An epidemiological study was conducted on patients at the General Outpatient Department (OPD) of the SSKM Hospital in Kolkata, India. It was cross-sectional, descriptive, and hospital-based. Data were collected for one month. A 16-item, self-made semi-structured timetable that had been previously developed and tried served as the study tool. The schedule included information about the patient's age, gender, place of residence, level of education, occupation, and socioeconomic status as measured by their PCMI, as measured by the modified B. G. Prasad Scale, as well as information about their behaviours and knowledge [5]. Exit interviews were done as part of the study, either with the patient or, in the case of patients under the age of 18, with the guardians who were present.

The general OPD of the SSKM Hospital is run by the department of community medicine and is open on Tuesdays, Thursdays, and Saturdays from 9 am to 2 pm. On average, 110 new patients are enrolled each month [6]. There were 13 days available for this study, and on average, 17 patients could be questioned daily. Therefore, 224 patients were assessed. Patients were chosen at random and one after another. The study only included participants above the age of 12 who were eager to take part, gave their verbal agreement, and could comprehend and reply to the questions. Trial participants were not permitted to have incapacitating illnesses.

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**Received:** 25-Jan-2023, Manuscript No: JOHH-23-88600, **Editor assigned:** 27-Jan-2023, PreQC No: JOHH-23-88600(PQ), **Reviewed:** 10-Feb-2023, QC No: JOHH-23-88600, **Revised:** 15-Feb-2023, Manuscript No: JOHH-23-88600(R), **Published:** 22-Feb-2023, DOI: 10.4172/2332-0702.1000360

**Citation:** Franklin J (2023) A Basic Study on Discernment and Oral Cleanliness Hones. J Oral Hyg Health 11: 360.

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## Data collecting process

Together with three subject-matter experts, the timetable was developed in advance of the study, and pre-testing was done to guarantee its validity. The schedule was then updated to reflect the necessary repairs and modifications. Patients were informed of the purpose of the investigation and provided guarantees about its confidentiality [7]. After gaining verbal consent, the information was acquired utilising the exit interview technique. The timetable was filled in an average of 15 to 20 minutes.

The general practises for oral hygiene were assessed based on their responses to questions concerning their oral hygiene practises. Responses that were true were given a value of one, while those that were false were given a value of zero. It was categorised as “good” or “not good” based on the overall result and the responses’ related mean value [8]. Scores above the mean were classified as “great practise,” and scores below the mean were classified as “not good practise.” After that, a cross-tabulation was done to look for any potential correlations between the scores and independent factors.

## Operational definitions

Use of a toothbrush and toothpaste, brushing at least twice daily, brushing in the morning and at night, using mouthwash, and going to the dentist within the last six months are all examples of good dental hygiene practises. Non-use of a toothbrush or toothpaste, brushing less frequently than twice daily, brushing only in the morning, while sleeping, or at any other time, non-use of mouthwash, and missing a dental appointment during the preceding six months are all considered unhealthy behaviours. Morality checked: This inquiry was approved by the SSKM Hospital’s Institutional Ethical Committee. The data submitted into the Microsoft Excel spread sheet were compiled and evaluated using Epi Info and SPSS software [9]. The link between the category variables was investigated using the Pearson’s Chisquare test statistic. The odds ratio was also calculated. A p-value of less than 0.05 was used to indicate statistical significance.

## Results

Ages of the 224 study participants ranged from 16 to 67, with a mean age of 40.75 years (standard deviation 9.18). The bulk of poll respondents, or 51.89 percent, was in the 20–40 age range. 74.11 percent of people were male, while 77.68 percent of people resided in rural areas. 15.18 percent of the skilled workers were women, compared to 25.89 percent of the men [10]. The population had a 24.18 percent Class II socioeconomic status, according to the updated B. G. Prasad assessment of socioeconomic status. The majority of poll respondents manually scrubbed their teeth with toothpaste or tooth powder, with the use of a toothbrush and toothpaste together coming in second. Among the participants, 35.71 percent cleaned their teeth twice a day, as opposed to 58.93 percent who did it just once. More than half of the subjects brushed their teeth in the morning and before bed, compared to 33.03 percent of the subjects.

In addition, 59.38 percent of the participants hadn’t visited a dentist in the six months prior to the study, 9.82 percent of them didn’t have a regular schedule for cleaning their teeth, and 91.07 percent of them didn’t use mouthwash. Around three-fourths of the respondents attributed tooth decay to improper tooth brushing, following bad breath and gum disease. Furthermore, smoking, pan chewing, gutkha, and other tobacco products were blamed by 73.21 percent of the participants for having a bad impact on tooth health. Additionally, excessive sweets, alcohol, and cold drinks were cited as unhealthy

dietary products by 71.42, 70.53, and 63.39 percent of the participants, respectively [11].

The majority of people learned about oral health from television, followed by dentists’ advice, magazines, and so on. The study’s participants reported “great oral hygiene practises” in 38.39 percent, while the rest 61.61 percent had “not very good oral hygiene practises.” The chi-square test also revealed that there were statistically significant differences between male, illiterate, rural, and lower socioeconomic position research participants in terms of the quantity of “positive behaviours” they engaged in. According to the odds ratio, the oral behaviours of respondents who identified as female, literate, and from urban regions were, respectively, 22.57, 3.39, and 23.05 times better than those of their male counterparts. Class I persons had practises that were 2.03 times better than those of people from lower socioeconomic classes.

## Discussion

Since the concept of oral health-related quality of life is elusive, abstract, subjective, personal, and multifaceted with no clear boundaries separating its numerous components, it is difficult to describe. As a result of altering cultural and socioeconomic norms, it also varies within and between demographic groupings. The lack of research on adult populations’ oral health knowledge, practises, and behaviours in India prompted us to perform this study. According to the recent survey, using a toothbrush and toothpaste to brush one’s teeth is the most common method.

According to the findings, the results of the current study showed that 35.71 percent of people used to wash their teeth twice every day. However, investigations indicated that only 23.0, 15.4, 22.0, 11.6, and 13.96 percent of participants used to brush their teeth twice daily, in contrast to the findings of the present study. Only 8.93% of those taking part in the current survey utilised mouthwash as a prophylactic approach for oral hygiene, according to the report [12]. However, it was shown that mouthwash is used by 64.10 percent of persons. Regarding dental appointments, the findings of the current study percent agreed with those from Mysore. Even while it was significantly lower than the results of Bhat et al. in Bangalore, this finding was rather high compared to studies conducted in Jodhpur and Gujarat, where only 10.0 and 3.65 percent, respectively, would consistently visit a dentist every six months.

Over 70% of the individuals claimed that not regularly cleaning one’s teeth results in oro-dental diseases, which is consistent with About three-fourths of the participants in the survey were aware of the detrimental effects of excessive sweets, cold drinks, alcohol use, smoking, pan chewing, gutkha, and other tobacco products on oral hygiene, according to similar results from a previous study [13]. However, the results indicated that a third of the participants knew about it. The majority of people learned about oral health from media, per the findings of earlier surveys. To raise awareness of the importance of proper oral hygiene, community-based educational programmes done by medical experts in collaboration with print and electronic media might also be effective. Family practitioners and primary care physicians should seize every chance to provide patient and family-level health education for the prevention of common dental illnesses. When compared to the results of the current study found that 38.39 percent of the individuals practised good oral hygiene. Similar to the current study; investigations found that literate and higher socioeconomic status participants had considerably good oral hygiene practises.

## Conclusion

The findings of this study indicate that the study population's oral health knowledge and habits need to be improved. Simple education can prevent the aforementioned oral hygiene issues; which is a more affordable solution than having expensive dental procedures. Periodic oral health awareness campaigns should be carried out at the school; college; university; and community levels. At each of these levels; primary care physicians hold a major role and responsibility because of their interactions with patients and families; which make them more approachable and acceptable. By enhancing public awareness of oral hygiene; attitudes; behaviours; and practises; dental professionals; dental marketing agencies; and the media can work with the government to prevent oral health issues.

## Acknowledgement

The entire experiment well explained by the author.

## Conflict of Interest

There is no any conflict of interest raised by the authors.

## References

1. Lal S, Paul D, Vashisht BM (2004) National oral health care programme (NOHCP) implementation strategies. *Indian J Community Med* 29: 1–10.
2. (2019) The Challenge of Longevity. *Ageing Demographics*.
3. Shah N (2004) Oral health care system for elderly in India. *Geriatr Gerontol Int* 4: S162–164.
4. Frenkel H, Harvey I, Newcombe R (2000) Oral health care amongst nursing home residents in Avon. *Gerodontology* 17: 33–38.
5. Bali RK, Damle SG, Muglikar SD, Yethwar RR, Mathur VB, et al. (2004) National oral health surveys and fluoride mapping 2002-2003. New Delhi: Dental council of India.
6. Wheatcroft MG (1970) Emphasis on prevention. Are we fulfilling the potential of preventive dentistry? *Preconf Papers Natl Dent Health Conf (US)* 21: 400-405.
7. Peltola P, Vehkalahti M, Wuolijoki-Saaristo K (2004) Oral health and treatment needs of the long-term hospitalized elderly. *Gerodontology* 21: 93–99.
8. Knabe C, Kram P (1997) Dental care for institutionalized geriatric patients in Germany. *J Oral Rehabil* 24: 909–912.
9. Şengül U, Saadet G, Bahar GD (2007) Oral health status of the elderly in a residential home in Turkey. *Gerodontol* 24: 22–29.
10. Peltola P, Vehkalahti M, Simoila R (2005) Oral health related well-being of the long-term hospitalized elderly. *Gerodontology* 22: 17–23.
11. Rao GTR (2014) Textbook of Community Dentistry. All India Publishers and Distributors. National Health Care Programme- Implementation of Strategy 17–24.
12. Fiske J, Lewis D (2000) The development of standards for domiciliary dental care services: Guidelines and recommendations. Report of British society for disability and oral health (BSDH) working group. *Gerodontology* 17: 119–122.
13. Shay K (1994) Practical Consideration in special patient Care, Identifying the needs of the elderly dental patients-The Geriatric assessment. *Dent Clin North Am* 38: 499–523.