Original Article

Perception of Teachers about Implementation of Oral Health Education in Primary School Curriculum

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ABSTRACT

Objective: A decayed tooth (dental caries) affects oral health status in children's more than any other chronic infectious diseases. Untreated tooth decay in children's can cause pain and secondary infections that will create the problem in eating, playing, speaking, learning, and be successful in school. Untreated dental infections in the mouth also put children at risk for other infections such as ears (otitis media, etc.), sinuses, and other parts of their bodies. School-based oral health education (OHE), screenings, assisted referral, and delivery of oral preventive care services provide equitable, reliable entry into long-term oral health care and assist parents by reducing the need to take time from work and find transportation. Children who receive care in schools also can become an entry point for others in the family to connect with an oral health care provider. The combination of education, prevention, and access to care has the potential to nearly eliminate tooth decay in school-age children. **Methods:** The descriptive cross-sectional study was conducted among government and semi-government school located in Bhopal city for 6 months using a self-administered questionnaire. **Results:** Out of 300 school teachers, 283 teachers felt that like other general fitness OHE is also as important as general health and should be included in a school health education program. **Conclusion:** The questionnaire-based study conducted on government and semi-government school teachers supports on implementing oral health program for school children's oral health. There is a definite and immediate need for organized training of school teachers on basic oral health knowledge.

Key words: Caries, children health, dental disease, oral health education, periodontal

INTRODUCTION

Oral health is a state of being free from the chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other systemic diseases, and disorders that affect the oral cavity. Risk factors for oral diseases include unhealthy diet, tobacco use, harmful alcohol use, and poor oral hygiene.[1]

Oral diseases such as dental caries and gingival diseases affect about 80% of the school children. The cost of treating dental caries alone can overwhelm a country's health care expenditure for children. The cost of neglect of these diseases is also high due to the personal, financial, and social impacts. Poor oral health can have a detrimental effect on children's performance in school and their success in later life.[2] Children who suffer from poor oral health are 12 times more likely to have more restricted activity days (including missing school) than those who do not. More than 50 million hours annually are lost from school due to oral diseases.[3]

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In India, there is an upward trend in dental diseases in spite of developing the economy and raising dental manpower. Traditionally, oral health education (OHE) in schools has largely been impacted by dentists or dental hygienists. These dental health education (DHE) is offered to school children as part of the dental check-up and treatment camps that are organized sporadically. However, the cost-effectiveness and sustainability of such an approach are questionable.[4] There are instances where the utilization of teachers for delivering and reinforcing OHE messages has been found to be feasible and effective. However, the shortage of time and a heavy workload at schools have been cited as important factors that adversely affect the effectiveness of teachers as oral health educators.[5]

The health professional needs to adopt a practical approach for prevention of oral diseases. One of the important components of the health care delivery system in any country is the school health program, and school teachers should be trained to provide OHE.[6] In view of the important role that teachers can play in preventing oral diseases schools are a suitable platform for organizing preventive health services that can be made available to all children, including those who, for a variety of reasons, may not be receiving professional care.[7] The success of this program has been found to be linked to the input of teachers in the schools, with positive results when the teachers' attitude is supportive of oral health promotion.[8]

The previous study shows that school teachers were generally very well informed about the causes and prevention of dental decay and gum disease. Knowledge of the appropriate management of serious dental trauma was very poor although they seemed to have a greater awareness of the appropriate management for less serious dental injuries.[9] Lack of training and resources and time within the curriculum were identified as major barriers to the implementation of a DHE program in primary schools.[10] Therefore, the aim of the study is to assess the perception of school teacher about implementing OHE in the school curriculum.

METHODS

The present descriptive cross-sectional study was conducted among the various government and semi-government schools located in Bhopal city for a period of 6 months, i.e., from October 2014 to March 2015. Prior approval was obtained from Research Approval Committee and Ethical Committee of the Institution. The study participants included the primary school teachers working at various primary schools located in Bhopal city. The selection of the schools was based on the geographic terrain of the Bhopal city. The list of the schools all to the zone (East, West, North, South, and Central) was obtained from the postal of the Ministry of the Education of Madhya Pradesh.

A two-stage sampling procedure was followed in the section of the study participants during the first stage by applying the simple random sampling procedure, 10 schools from the entire city were in each zone. Thus, a total of 50 schools from the entire city were selected. In the second stage by considering each selected school as a cluster/unit, the total number of primary school teachers in each cluster who were present on the day was 300 included as study participants; thus a total of 300 school teachers constituted the final sample. Written permission was obtained from the head of the selected schools, and the appointments were scheduled before proceeding for the survey.

On the day of the survey, an informed consent was obtained from the respective primary school teachers. The teachers were guaranteed of the securely of the data. The data were collected using a self-administered questionnaire having 21 questions. The questions consisted of both closed ended question and multiple choice questions. The questions were prepared both English and local language, i.e., Hindi. The perceptions of the school teacher about implementing OHE in the curriculum were obtained through the structured questionnaires. The information about teaching experiences, gender, and type of school, i.e., government or semi-government/funded school and highest qualification of teachers was obtained.

The teachers were requested to fill the questionnaires independently to obtain the exact views on the given subject. The questionnaire was pre-tested for its validity (face value) by distributing to the primary school teachers. The duly filled questionnaires were collected from respondents on same. There were 13 questionnaires which were incomplete and excluded from the final analysis.

Data obtained were coded and then entered in the Microsoft office excel worksheet. Statistical analysis was performed using the SPSS 22.0 version. Discrete groups were compared by Chi-square (χ^2) test. A two-tailed ($\alpha = 2$) $P < 0.05$ was set as statistical significance.

RESULTS

In this study, out of 300 primary school teachers, 283 (95.3%) returned the duly completed questionnaires. All the participants felt that dental health is as important as general health and was concerned about their (school) children's oral health. Majority of them perceived that inviting a team of dentists for conducting dental health checkups periodically, making them to distribute toothbrushes and toothpaste for free and making appropriate referrals could be the means by which they can be concerned about children's oral health. There was a uniformity for the above perception among the participants with respect to their teaching experience ($P \geq 0.05$, non-significant) and a statistically significant

difference with respect to other selected variables like gender and type of the school setting ($P < 0.05$). When asked (inquired) about of DHE in school curriculum, 207 (73.1%) school teachers replied that it will be one of the most cost-effective means of preventing dental diseases in children. There were 139 (67.1%) participants who were in favor of its implementation. There was no difference of opinion for the above perception among the participants with respect to gender and types of school setting ($P > 0.05$, non-significant) but there was a statistically significant difference with respect to years of teaching experience ($P < 0.05$) [Table 1]. There were 107 (76.9%) teachers who felt that implementing OHE in school curriculum would put an extra burden and thus somebody should be made responsible for supervising the DHE in school. There was no significant difference with respect to gender and type of school for above perception ($P \geq 0.05$, not-significant) and significant difference with respect to years of experience ($P \leq 0.05$, significant) [Table 2]. When asked about who should supervise DHE in school, 87 (82%) respondents felt that class teacher should be made responsible. There was a significant difference for the above perception with respect to gender, school setting, and teaching experience ($P \leq 0.05$, significant) [Table 3].

There were 96 (82.3%) participants who perceived that lectures on preventive dental education should be conducted once in a week and there was a significance difference for this perception with respect to gender, and uniformity with respect to school setting and years of experience ($P \leq 0.05$, significant) [Table 4]. For the question on the ideal time to teach preventive dental education, 74 (58.45%) participants felt that any day in the week could be an ideal time to teach preventive dental education. There was uniformity with respect to gender, types of school setting and years of experience for above perception ($P \geq 0.05$ not-significant) [Table 5]. When inquired about the method of training children, there

Table 1: Perceptions of teachers in favor of implementing OHE in school curriculum

Variables	Yes (%)	No (%)
Gender		
Male	63 (65.0)	49 (35.0)
Female	76 (47.1)	19 (52.9)
Chi-square=13.14, df=1, *P*<0.001 (highly significant)		
Type of school		
Government	67 (48.6)	41 (51.4)
Semi-government	72 (51.2)	27 (48.7)
Chi-square=2.68, df=1, *P*=0.102 (not significant)		
Years of experience		
<5 years	36 (11.5%)	51 (88.5%)
5-10 years	64 (67.1%)	3 (32.9%)
More than 10 years	39 (78.0%)	23 (22.0%)
Chi-square=48.45, df=2, *P*<0.001 (highly significant)		

OHE: Oral health education

Table 2: Perception about "extra burden on teachers" by implementing OHE

Variables	Yes (%)	No (%)
Gender		
Male	52 (65.0)	11 (35.0)
Female	55 (47.1)	21 (52.9)
Chi-square=2.01, df=1, *P*=0.156 (not significant)		
Type of school		
Government	58 (48.6)	9 (51.4)
Semi-government	49 (51.2)	23 (48.7)
Chi-square=6.71, df=1, *P*=0.010 (moderate significant)		
Years of experience		
<5 years	18 (11.5)	18 (88.5)
5-10 years	61 (67.1)	3 (32.9)
More than 10 years	28 (78)	11 (22)
Chi-square=27.52, df=2, *P*<0.001 (highly significant)		

OHE: Oral health education

Table 3: Supervising the DHE in school curriculum

Selected variables	Perception	
	Class teacher should be responsible for supervising the DHE	
	Yes (%)	No (%)
Gender		
Male	48 (43.7)	4 (56.3)
Female	39 (74.7)	16 (25.3)
Chi-square=8.05, df=2, *P*=0.005 (just significant)		
Type of school setting		
Government	51 (39.2)	1 (60.8)
Aided	36 (80.0)	19 (20.0)
Chi-square=18.72, df=1, *P*<0.001 (highly significant)		
Years of experience		
<5 years	16 (47.5)	2 (52.5)
5-10 years	53 (95.5)	7 (4.5)
More than 10 years	18 (25.8)	10 (74.2)
Chi-square=8.19, df=2, *P*=0.017 (just significant)		

DHE: Dental health education

Table 4: Frequency of conducting lectures on preventive DHE

Selected variables	Perception	
	Once in a week lecture conduct for school children on preventive dental health	
	Yes (%)	No (%)
Gender		
Male	37 (98.2)	26 (1.8)
Female	59 (66.3)	17 (43.7)
Chi-square=5.76, df=1, *P*=0.016 (just significant)		
School setting		
Government	51 (82.4)	16 (17.6)
Semi-government	45 (87.8)	27 (12.2)
Chi-square=3.01, df=1, *P*=0.083 (not significant)		
Years of experience		
<5 years	29 (65.8)	7 (34.2)
5-10 years	37 (64.1)	27 (35.9)
More than 10 years	35 (68.9)	4 (31.1)
Chi-square=13.96, df=2, *P*<0.001 (highly significant)		

DHE: Dental health education

were 101 (82.2%) participants who felt that dentist should first train the teachers and then teachers in turn train the children with the dentists supervising the school dental curriculum periodically. There was uniformity with respect to gender, types of school setting and years of experience for above perception ($P \geq 0.05$ not-significant) [Table 6]. Regarding aid required for training, all the participants felt that there was a need for DHE aids to train the school children. All the study participants felt that all DHE material such as charts photographs, models, and audio-visual aids required to train the children.

All of the participants perceived that there should be an evaluation of children's oral health status based on the training in school and 98 (71.2%) participants felt that children's oral health status to be evaluated once in a month. There was uniformity with respect to gender and school setting for above perception ($P \geq 0.05$, not significant) but significance difference with respect to years of experience ($P \leq 0.05$ significant) [Table 7]. There were 106 (76.9 %) participants who perceived that children' s oral health status can be evaluated by inviting a team of dentist to examines school children and grading in oral health. There was uniformity for the above perception with respect to gender, types of school setting and years of experience for above perception ($P \geq 0.05$ not significant) [Table 8].

All the participants of this study felt that children should be encouraged in maintaining good oral hygiene by giving incentive and also felt that parents should be made aware by grading their children on oral health in their progress report. When asked about their stand about framing a policy by the government to implement OHE in school curriculum all the participants responded positively.

Table 5: Ideal time to conduct lecture on preventive DHE

Selected variables	Perception	
	Any day in the week could be ideal time to teach preventive DHE	
	Yes (%)	No (%)
Gender		
Male	32 (58)	31 (42)
Female	42 (63.1)	34 (36.9)
Chi-square=0.28, df=1, *P*=0.599 (not significant)		
School setting		
Government	35 (63.8)	32 (36.2)
Semi-government	39 (56.5)	33 (43.5)
Chi-square=0.05, df=1, *P*=0.820 (not significant)		
Years of experience		
<5 years	21 (68.2)	15 (31.8)
5-10 years	33 (58.2)	31 (41.8)
More than 10 years	20 (51.7)	19 (48.3)
Chi-square=0.51, df=2, *P*=0.776 (not significant)		

DHE: Dental health education

Table 6: Training of the children in preventive dental health

Selected variables	Perception	
	Dentist should first train the teachers and then teachers in turn train the children with the dentist supervising	
	Yes (%)	No (%)
Gender		
Male	48 (75)	15 (25)
Female	53 (69.4)	23 (30.6)
Chi-square=0.72, df=1, *P*=0.395 (not significant)		
School setting		
Government	54 (76.8)	13 (23.2)
Semi-government	57 (69.6)	15 (30.4)
Chi-square=0.04, df=1, *P*=0.834 (not significant)		
Years of experience		
<5 years	29 (68.2)	7 (31.8)
5-10 years	55 (92.1)	9 (7.9)
More than 10 years	27 (74.1)	12 (25.9)
Chi-square=4.22, df=2, *P*=0.121 (not significant)		

Table 7: Frequency on evaluation of oral health of children

Selected variables	Perception	
	Monthly children oral health status to be evaluated	
	Yes (%)	No (%)
Gender		
Male	48 (76.7)	26 (23.3)
Female	50 (66.3)	32 (38.7)
Chi-square=0.25, df=1, *P*=0.616 (not significant)		
School setting		
Government	42 (67.5)	23 (32.5)
Semi-government	56 (76.7)	16 (23.3)
Chi-square=2.91, df=1, *P*=0.088 (not significant)		
Years of experience		
<5 year	21 (59.7)	15 (40.7)
5-10 year	59 (95.5)	5 (4.5)
More than 10 years	18 (62)	21 (38)
Chi-square=28.15, df=2, *P*<0.001 (highly significant)		

Table 8: Method for evaluate children oral health

Selected variables	Perception	
	By inviting a team of dentist to examine the school children	
	Yes (%)	No (%)
Gender		
Male	59 (77.6)	4 (22.4)
Female	57 (97.8)	19 (2.2)
Chi-square=8.68, df=1, *P*=0.003 (moderate significant)		
School setting		
Government	56 (72.2)	9 (27.8)
Semi-government	60 (82.2)	12 (17.8)
Chi-square=0.21, df=1, *P*=0.647 (not significant)		
Years of experience		
<5 years	29 (79.2)	7 (2.8)
5-10 years	42 (95.5)	22 (4.5)
More than 10 years	35 (87.9)	4 (12.1)
Chi-square=8.28, df=2, *P*=0.016 (just significant)		

DISCUSSION

The 21st century is witnessing an upward oral disease pattern, in India. There is a steep rise in an oral disease pattern among children in India, in recent time due to these remarkable changes in the lifestyle, especially in dietary patterns toward oral health. In this study, all the participants felt that dental health is as important as general health and was concerned about school children oral health. Initially, majority of teachers felt that inviting a team of dental professions for screening, distribution a free toothpastes, brushes and make appropriate referrals could be the means by which they can be concerned about children's oral health. The teachers have opted for this because this could be their observation during the dental outreach activities in the school. However, when inquired about perception on the implementation of DHE in school curriculum majority of them replied that it will be one of the most cost-effective measures to prevent the onset of dental diseases in the children. It might be because teachers would have felt that sensitizing the children toward maintaining oral health from early ages could put a pause to the development of the oral disease. In our study, 67.1% of participants were in favor of implementation of DHE in their school curriculum. Our finding was similar with the Loupe and Frazier found that 86% of school teachers were willing to teach oral health topics and willing to takes on a wide range of teaching related to dental health.[11] Our finding is also an agreement with a study done by Sankar *et al*. in India who found that 73% of school teachers were in favor of educating about teeth and its importance to children.[12]

Education in school curriculum would put an extra burden on them and somebody should be made responsible for the same. This may be because teachers would have been preloaded with various other activities related to school and may be apprehensive about the strict expectation to meet the academic requirement of the curriculum in developing country like India. There was 76.9% study participants felt that all the teachers should be assigned equal responsibility. Our finding was also in agreement with a study conducted by Haloi *et al*. who found that maximum government school teachers are allowing class time for students to get dental care.[13]

We found that 82.3% of study participants felt that lectures on preventive dental education should be conducted once in a week. Mohamadkhah *et al*. found that a lecture intervention approach and weekly supervised tooth-brushing programed by teachers among children showed positively effect on oral health knowledge, on plaque level and the effectiveness of tooth-brushing.[14] There was 59% of study participants felt that any day in the week could be an ideal time to teach preventive dental education for school children. This may be because the teacher would have felt that continuous reinforcement (training) about dental health among children would yield a better result if done in short intervention (periodically).[15]

In our study, 82.2% study participants felt that dentists should first train the teachers and then teachers in turn train the children with the dentist supervising the school dental curriculum periodically could be the better method to train the children. Our finding was consistent with a study conducted by Tewari *et al*.[16] in Haryana, India who found that oral health status of school children has improved significantly by training the school teachers in various aspects of oral health.[15] Our finding was in contrast to the study report of Tewari *et al*. in Chandigarh, India, who reported that dentist could be the best personnel for imparting OHE to school children.[16]

In our study, all the participants felt that there was a requirement of DHE aids such as charts, photograph, and audio-visual aids to train the school children. Our finding was in accordance with the finding of Ahmad *et al*. who found that charts, videos could be the most effectively means for training the children.[17-19] In this study, 76.9% of participants felt that children oral health status should be evaluated by inviting a team of the dentist to examine the school children and grading them in oral health. This practice of evaluation and grading in oral health could encourage the school children in maintaining their oral health of the highest possible standard.[20-22]

All the participants felt that parents can be made aware about the children oral health by grading them in oral hygiene in their progress report. Teachers could felt that this could give the opportunity to the parents to understand the status of oral health of the children and could serve as a self-motivating tool in improving their (parents) oral hygiene as well.[23-24]

All the participants reacted positively about their stand on framing and implementation of policy in related to oral health in school curriculum by the government. This provides the indication that teachers would wish to become a part of the oral health team in the near future and thus may contribute to a dental disease free nation.

Generalizability of this study can be questionable. Further research should be carried out in this direction to achieve better conclusion and thereby paving the pathway for the policy makers to react positively to implement this innovative concept for our nation.

CONCLUSION

Oral health should be made an integral part of the curriculum of teachers training program. There should be a practical demonstration of oral hygiene measures to school children

through play such as puppet show and drama as a part of school dental curriculum. All the participants felt that children should be encouraged maintaining oral hygiene and parents can be made aware by grading their children in oral hygiene in their progress report. All the participants reacted positively about their stand in framing a policy by the government about the implementation of OHE in school curriculum.

RECOMMENDATION

1. The department of family and health welfare and department of education should work together to develop and implement a school-based policy emphasizing the importance of good oral health
2. Oral health should be made an integral part of the curriculum of teachers training program
3. There should be a practical demonstration of oral hygiene measures to school children through plays such as puppet shows and drama as a part of school dental curriculum
4. The public health dentistry departments should be strengthened and assigned catchment area to supervise the various schools in preventive dental education falling within that area in association with the school headmasters
5. Periodically the teachers can inspect the oral cavity of the school children as a part of the training the child and parents should be informed about the problem and consequences of not being treated
6. The teachers should be encouraged by giving incentives to carry out the task of preventive DHE more efficiently
7. The children can be given a token of appreciation for maintaining good oral hygiene in the school annual meet.

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