FINDINGS, CONCLUSION & SUGGESTIONS

The previous chapter analysis of data was a resourceful one in providing useful and interesting findings.

Though there is no significant association between the sex and the dental diseases the prevalence of dental diseases are almost equal and affecting both the sexes. The prevalence of dental diseases caries and periodontal diseases are almost equal and affecting both the sexes by both the diseases. (Table-1)

Hence the first hypothesis that there is significant association between sex of the respondents and prevalence of dental disease has been disproved.

The distribution of dental diseases on age shows that the occurrence of both the diseases are almost equal upto the age of 50. Respondents above the age of 50 suffer more from periodontal disease which is a common feature among aged people as per the dental science. (Table-2)

Among the respondents those who had treatment in the clinic, the occurrence of both the diseases are recorded more among the Hindu respondents when compared to Muslims and Christians. (Table-3)

The prevalence of caries is two times higher than the prevalence of periodontal diseases invariably in all the caste groups. (Table-4)

The occurrence of caries is two times higher than the occurrence of periodontal disease in all the literacy level and the percentage of occurrence of dental diseases in general is more in the level of Higher Secondary and S.S.L.C.
Less occurrence is noticed in the primary school level, and uneducated group and also among the higher level of literates i.e. professionals and degree holders. (Table-5)

Hence the second hypothesis that there is a significant association between the literacy level and the prevalence of dental diseases is disproved.

Prevalence of caries is almost two times higher than the periodontal diseases among the married, unmarried and widow(er) categories. (Table-6)

Prevalence of dental diseases is higher among the nuclear family members. (Table-7)

In the occupation group, majority of the patients are from business and unemployed category. i.e. 60 percent. (Table-8)

The income and the occurrence of diseases are not related to one another. (Table-9)

Hence the hypothesis number three, higher the income level lower the occurrence of diseases has been statistically rejected.

The following findings based on the views of the respondents:

Almost all respondents viewed, that dental care education is a necessary one for the children. (Table-10)

80 percent of the respondents have stressed the introduction of dental care education at different levels with in the primary school education itself. (Table-11)

Majority of the respondents are ignorant about mouth
Three fourth of the respondents are having the impression that, habits have no relationship with oral cancer.(Table-13)

Majority of the respondents are not aware about the vitamins and its importance for dental health.(Table-14)

Among the respondents who are aware of vitamins, majority of them know vitamin "C" only.(Table-15)

Almost all respondents are not having any idea about the importance of using fluoride contended tooth pastes and tooth powders which is a prime factor for prevention of caries tooth.(Table-16)

Majority of the respondents are not knowing what dental diseases are and only One fourth of the respondents know about dental caries.(Table-18)

Most of the respondents relate dental care for general wellbeing.(Table-19)

Majority of the respondents prefer and give their opinion in favour of manufacturing tooth pastes, tooth powder and tooth brushes by the government which enables to get quality products and at a reasonable cost.(Table-21)

The following findings are based on the oral habits and oral hygiene practices:

Those who have not undergone scaling previously suffer equally by dental caries and periodontal diseases.(Table-20)

Almost no respondent is using charcoal powder or brick powder.(Table-22)
Brush users are more affected by dental diseases than the finger and chew stick users. (Table-23)

Nobody is aware of the dental floss and nearly 25 percent of the respondents are aware of the tooth picks, which are the proper methods for cleaning the interdental spaces. (Table-24)

The prevalence of dental diseases are higher among those who do not gargle after food. (Table-25)

Hence the fourth hypothesis, that there is a significant association between oral hygiene practice i.e. gargling after food, and the prevalence of dental diseases is proved.

The occurrence of dental diseases is more among the respondents those who do not brush before going to bed than the respondents who brush. (Table-26)

Soft brush users are more among the respondents when compared to the users of the medium and hard brush users. (Table-27)

Oral habits in general has got some association with the dental diseases. Statistically there is a significant association between the selected oral habits and the dental diseases. (Table-33)

Hence the fifth hypothesis, that there is a significant association between the oral habits such as alcohol, cigarette, tobacco and the prevalence of dental diseases has been proved.

The occurrence of dental diseases are more among those who do not massage their gums. (Table-30)
The following findings are based on the habits of the respondents:

Among the respondents who drink either coffee or tea the occurrence of diseases is high i.e. 80 percent. (Table-32)

There is no significant association between the types of food (Vegetarian or non-vegetarian) and the dental diseases. (Table-34). Hence the sixth hypothesis is disproved.

There is a significant association between the geographical location (Urban and Rural Areas) and the dental diseases. (Table-37). Hence the seventh hypothesis is proved.

The reason for the occurrence of dental diseases among urban people may be due to their exposure to lot of sweets, ice-creams and other oral habits, but rural people are not that much exposed to such habits and the usage of chew sticks may facilitate in preventing dental diseases.

CONCLUSION

The study started with the objectives of finding out the association of dental diseases with various factors namely socio-economic characteristics, oral habits, oral hygiene practices, geographical location and the availability of dental services.

The data were used to prove the appropriate hypothesis and chi-square test was applied. The findings gave an interesting information about the occurrences of diseases, patients views and their awareness about the dental health. Based on the findings the following methods are suggested for implementation.
SUGGESTIONS

The government of India has given nation wide importance to eradicate small pox, polio, leprosy, malaria, cholera and now recently AIDS. Though the dental diseases affects the entire population, it was not considered seriously both by the government and by the people, just because the disease is neither life threatening nor causes major deformities. But considering the national economic point of view, it needs urgent intervention and the dental health services should be extended to all.

The government alone cannot bring the prevailing worst situation under control, it is the people's responsibility to co-operate with the government. Otherwise the valuable attempts taken by the government goes in vain.

People's responsibility here means the awareness about the dental health.

For that the following steps may be undertaken.

First mass medias such as Press, Cinema (slides and documentaries), television, Radio talks/interviews, Posters, charts, models, booklets should have routine publicity about the dental health.

FOR INDIVIDUALS:

Child population of India is one third of total population. Dental health education being an integral part of personal hygiene, lessons on oro-dental hygiene be incorporated in the curriculum. It should lay stress on keeping the mouth clean, reduction in the consumption of refined
sugars i.e. sweets and candies. It will promote taking more of fibrous food, precautions from injuries to the teeth during play and sports, breast feeding, control of pressure habits, awareness for irregularly placed teeth, ill effects of smoking and tobacco chewing and any ulcers or lesions in and around the mouth cavity. This must start from primary school and be incorporated in language textbooks at primary, secondary and higher secondary school levels.

Exhibitions and Dental Camps for parents as well as for school children and teachers be organized.

All school going children must have a dental check-up once a year to detect any ensuring dental problems for preventive, interceptive and curative measures.

Undoubtedly the dental services is insufficient which was dealt in the previous chapter.

COMMUNITY HEALTH CARE:

The community health worker must receive training for at least a week regarding maintenance of oro-dental health. He should be able to tell the importance of brushing, chew stick, toothbrush, rinsing of the mouth by plain water, bad effects of excessive use of sweets, promote breast feeding, guide the parents to take the child to a regional center for an anomaly like cleft lip cleft palate. etc.

AT THE PHC LEVEL:

A dental hygienist should be available who not only advises on oro-dental hygiene but gives prophylactic treatment, demonstrates and does professional brushing, gives
first aid treatment and sends the children to taluka/tehsil hospital to be cared by a specialist (Dental Surgeon).

AT DISTRICT HOSPITAL:

There should be two specialists and a technician available for routine dental work such as fillings, extractions, fracture of teeth and jaws and loss of teeth by trauma.

Regarding the dental services, the major part lies with dental hygienists. However very few number of qualified hygienists are coming out from government dental college, Madras every year. Steps to be taken to increase the number in future.

MINIMAL INPUTS FOR PREVENTIVE, PROMOTIVE, CURATIVE AND REHABILITATIVE TREATMENT OF ORO-DENTAL CONDITIONS:

1) DENTAL CARIES:

As recommended by the expert committee on water fluoridation of WHO-1958 concluded that the drinking water containing about 1 ppm fluoride had a marked caries preventive action and that control fluoridation of drinking water was a practicable and a public health measure. In our country also, we may try to follow it.

In areas where the fluoride content of drinking water is high, defluoridation may be undertaken. Efforts should be made to provide common drinking water with appropriate fluoride content.

Tooth pastes and tooth powders containing adequate amount of fluoride be advocated.

Children should receive topical applications of fluo-
rides in the clinics.

Mouth rinsing with fluorides in school children after mid-day meal should be done as drill under supervision of the teachers.

Hawkers should not be permitted to sell sweets and candies near the schools.

2) GINGIVAL AND PERIODONTAL DISEASE:

Develop the habit of rinsing the mouth with plain water after each meal.

Emphasize the use of finger massage in cleaning the mouth, teeth and gum as well as use of chew stick (datum) especially by those who cannot afford a tooth brush.

The use of tooth brush with a paste rather than with a powder is advocated.

A provision of dental hygienist at all medical institutions and bigger hospitals be made.

The use of other oro-dental aids such as stimulators, dental floss, tooth pick, rinsing agents are helpful.

Excessive smoking should be cut down.

Use of betel leaf and nuts etc. be avoided.

Tobacco chewing should be avoided.

TAXATION ON ORAL HEALTH AIDS:

It has been universally accepted that oral hygiene has to be practiced by every individual to maintain proper oral health. So it becomes imperative that the oral health aids are made available to the common man at cheaper rates.

To implement the above it should be considered by the
Government to remove all taxation attached to the sale and manufacture of toothpaste, tooth powders and remove ban on the import of nylon for the manufacture of toothbrushes.

Reduction of duty on import of oral health equipment/material not being manufactured indigenously.

DIETARY COUNSELING:

Many individuals have a poor diet not because of economic hardship but because of lack of knowledge of the basic principles of balanced nutrition. Dental personnel providing dietary counseling for the patient are giving a two fold services. First it should be emphasised in the dental office, that the improvement of dental health through reduced intake of cariogenic food, particularly between meals. Second, the improvement of general health through the application of sound nutrition principles in everyday diet.

Above all the dental service provided both by the government and the private sector is insufficient to cater the need of the urban and rural people of Tiruchirapalli, the government may start a dental college to produce more number of dental surgeons and paradental staff.

As such there is no dental colleges even in the neighbouring districts.

PREVENTIVE METHODS

The study on the use of effective preventive methods has produced good results in developed countries, where caries is declining and periodontal disease is probably getting no worse. There are special problems with prevention in
developing countries, principally high periodontal disease prevalence, rising caries rates and lack of resources to deal with these problems. With appropriate assistance, much can still be accomplished in these developing countries. Depending on economic resources and disease patterns, the following procedures for oral disease prevention can be recommended. Priority order will vary from country to country, and national and local laws may also determine what procedures can or cannot be employed. Fluoridation of water supplies is the most effective action to prevent caries in communities where piped water supplies are in place. It is relatively cheap and does not depend on individual action. Where water fluoridation is not feasible, community-based alternatives are salt fluoridation, school-water fluoridation or supervised ingestion of fluoride supplements. Supervised mouth rinsing with fluoride solutions, usually in schools, is effective in fluoridated and non-fluoridated communities. Dentists or auxiliaries can also apply fluoride gels or solutions to the teeth of individual patients. The use of fluoride toothpastes is recommended wherever possible as a routine part of self component. Community leaders and others should be educated regarding the institutions and maintenance of community preventive measures which affect them. Individual patients should be educated regarding their oral hygiene, use of fluoride, restriction of sugary snacks between meals and the necessity for regular dental visits when services are available. Dental health education of the public can be con-
centrated in special target groups such as expectant mothers. Because dental caries is a public health problem in many countries, public policy to control the availability of highly cariogenic foods should be considered. Fissure sealants, when applied properly, are highly effective in preventing caries in occlusal surfaces. Their use is recommended on newly erupted teeth in susceptible persons, and they may be specially useful in the handicapped. Trained operators are required and the procedure is reasonably expensive; these factors may restrict the use of sealants where resources are limited. The ability of the individual patient to control plaque by tooth brushing, flossing or chew sticks should be developed to the utmost as the first step in controlling periodontal disease.

SUGGESTIONS FOR FURTHER RESEARCH:

Dental diseases not only affects the tooth and surrounding structures, but also the effects of the diseases which are manifested in other parts of the body and the association of these dental diseases with other diseases should be taken for research.

Few of the previous studies has related dental health with allergic diseases.

Poor oral hygiene with oral cancer.

Dental diseases and psychiatric patients

A comparative study of socio-economic relationship with dental diseases of rural and urban people may also be pursued.