CHAPTER- I

INTRODUCTION

This chapter describes the current situation of the oral health problems of schools children in oral health, health seeking behavior, oral hygiene behavior, and belief of oral health. It also includes the current situation of oral health, use of folk medicine, problem of oral health and objective of the study. It also focuses on current situation of oral health in the context of Nepalese society.

1.1 Background

Oral disease qualifies as major public health problems owing to their higher prevalence and significant. Social impact on oral health is considered as fundamental to general health and well-being. A healthy mouth enables an individual to speak, eat and socialize without experiencing any active disease, discomfort or embarrassment.

The oral problem dental caries is most common disease of adolescent and one of most disease of adult. School age children are prone to develop this condition due to change in food hygiene, excessive consumption of sweat food, lack of education, no regular checkup and treatment only after pain.

The various acute and chronic conditions which can be encountered during school period include dental caries, diarrhea, worm infestation, scabies, wounds, sprains, fracture, and eye and ear infection.

Children from socio-economically deprived areas have more oral health problems than those from other groups. Tooth brushing, use of fluorides regular dental check-up, diet and habits are important in prevention of dental caries. Dental caries in children is caused by specific eating sugar habits like candies, ice-cream, canned juice which usually develop during early childhood as a result of changing life style. Dental diseases affect the child are not same as affecting that adult

Cultural factors in health and disease have engaged the attention of medical scientist and sociologist. Every culture has its own customs which may have significant influence on health and oral health. The incidence of oral cancer in India due to pan chewing habits is classical example to demonstrate the influence of culture on oral health. Cultural factors are deeply involved in the whole way of life, like in the

matters of nutrition, personal hygiene, health seeking, and adopting healthy behavior.

Health is determined through lifestyle, culture, religion, education, family income, health seeking behavior and other multiple factors. Life style is one of the most important variables, which denote the way in which person of family, or community people live and works. There is a close relationship between unhealthy life style and ill health. In fact, health is also determined by various factors such as modernization, tradition, and individual behaviors.

In the context of Nepal there is lack of research in the field of oral health is one of the biggest problem to find out exact situation of country. Recently social scientist develops interest in the field of oral health. It may be helpful to explain briefly this recent application of oral health. Sociology itself, although of fairly long standing as an academic discipline, has only in the last ten years or so gained in strength and respect among other disciplines to an extent sufficient to push out its frontiers of enquiry beyond the classical fields of poverty and social deprivation. Few studies have engaged in the issue of social class and access related to dental health care from ethnographic prospective. Social conditions in early life influences the later development of caries, and the risk related to poor dental health are accumulated during the life course.

Human health has different health aspects. Among them, oral health is one them, oral disease have a significant impact on the health through pain, morbidity and mortality. Among oral disease dental caries is the most common disease of children and adults. Oral cancer is one of the leading causes of mortality and morbidity; and is most common form of cancer in male and third most common cancer in females. (Krieger, 2011).

The mouth is a window into the health of the body. The interrelationship between oral and general health is proven by evidence. The strong correlation between several oral diseases and non-communicable chronic diseases is primarily a result of the common risk factors. Many general disease conditions also have oral manifestations that increase the risk of oral disease which, in turn, is a risk factor for a number of general health conditions.

While oral health care is integral to our general well-being, it is not readily available

or accessible to everyone who needs it. Barriers, be they financial, structural, or cultural, prevent people from accessing oral health care. Due to these barriers (and potentially others), the apparent demand for oral health care does not reflect the true need. Due to financial problem, people cannot afford dental care. Financial considerations are the reason cited most often for lack of access to oral health care.

One of the greatest barriers to accessing oral health care is a person's culture or environment, which significantly influences behavior. Culture can affect diet, oral hygiene habits, and perceptions of the seriousness of tooth decay. The influence of culture on use of dental services and oral health outcomes means that even when income is not an issue and services are available, learned behaviors can determine health-seeking behavior. Oral health is integral part and essential to general health. Oral health means more than good teeth; it is integral to general health and essential for well-being. It implies being free of chronic -facial pain, oral and pharyngeal (throat) cancer, oral tissue lesions, birth defects such as cleft lip and palate, and other diseases and disorders that affect the oral, dental and craniofacial tissues, collectively known as the craniofacial complex.

Oral health is a determinant factor for quality of life. The craniofacial complex allows us to speak, smile, kiss, touch, smell, taste, chew, swallow, and to cry out in pain. It provides protection against microbial infections and environmental threats. Oral diseases restrict activities in school, at work and at home causing millions of school and work hours to be lost each year the world over. Moreover, the psychosocial impact of these diseases often significantly diminishes quality of life.

Culture plays an important role in human societies. Every culture has its own customs which may have significant influence on health and oral health. The increased incidence of lung cancer because smoking, cirrhosis because of alcoholism in many developed countries, the surge in the incidence of oral cancer in India due to pan chewing habits are some classical examples to demonstrate the influence of culture on health and oral health. It is now fairly established that the cultural factors are deeply involved in the whole way of life, like in the matters of nutrition, immunization, personal hygiene, family planning, child rearing, seeking early medical care, disposal of solid wastes and human excreta etc.

All cultural practices are not harmful. Every human has the culturally ingrained habit

of cleaning or brushing the teeth early in the morning. The use of soap for personal hygiene, oil massaging, exposure of the new born to sunlight etc are some cultural practices that needs to be encouraged. The inclination to get into the habits of smoking, alcoholism, drug addiction in the name of civilization among the younger generation needs to be countered at the earliest; otherwise, it may have a huge deleterious impact on the health status of the generation to come.

Nepalese are very particular about oral hygiene. Many people in the countryside use twinges of neem tree as a toothbrush: some use ashes: and charcoal. The educated and those who have come in contact with urban life use toothbrushes. Indeed, cultural influences overlap with dental health literacy, socioeconomic status, and personal experience in complicated ways, but it is possible to identify some common beliefs and care-seeking practices around oral health that are culturally-based and significantly different from the western dental medicine model.

Four domains that shape people's cultural beliefs and practices related to oral health:

1 Help seeking and preventive care

2 Oral hygiene practices

3 Beliefs about teeth and the oral cavity

4 The use of folk remedies

1.1.2 Help-seeking and Preventive Care

Many cultural groups don't have a strong preventive orientation when it comes to their health care, and this is definitely true when it comes to oral health. People often seek care only when there is a problem. An individual might go to the dentist for a painful tooth after suffering with it for a while, and then simply expect to have the bad tooth extracted. Advanced interventions to save a bad tooth, such as root canals and crowns, may be common in the U.S. and other western countries, but is often the privilege of only wealthy people in other cultures.

1.1.3 Oral Hygiene Practices

In many cultures there is little understanding of gum disease. Brushing the teeth may be done to remove leftover food from the mouth, but the concept of removing plaque

and tartar is less well-understood. It follows that the use of dental floss, mouth rinse, and tongue cleaners may be virtually unheard of and might be viewed with skepticism. Americans are known around the world for being obsessive about perfectly straight bleached white teeth.

1.1.4 Beliefs about Teeth and Oral Cavity

In many cultures the esthetic appearance of teeth may be important, but having "healthy" teeth and gums is not connected to appearance in a direct way. Red or swollen gums, bleeding gums, painful chewing, loose teeth, receding gums, all these symptoms of gum disease may be ignored as long as the visible teeth "look good". An interesting example comes from China where the appearance of teeth is psychosocially important. Having nice looking teeth can influence social interaction. However, a person with carious or discolored front teeth is considered to have low intellectual competence.

1.1.5 Use of Folk Remedies

In some traditional cultures there is a preference for using traditional remedies and cures either in place of western medicine or in conjunction with it. Use of herbs or healing methods pain in any area of the body, including oral pain, is treated using culturally-accepted remedies passed down through generations. For example, the use of cotton balls soaked in aspirin solution, alcohol or salt water is a well-known home remedy for pain and swelling.

However, primary care providers receive limited training in prevention of oral diseases, while general dentists care for young children, but their small numbers nationwide made such services unavailable to most children. Socio-cultural influences affect not only individual's health status but also the entire health system. Keeping in mind, the very significant role and the culture plays on health and oral health, this is an attempt to review the effects of key cultural factors on health and oral health.

1.2 Problem of Statement

Oral health knowledge is considered to be an essential prerequisite for health related behavior. It has been shown that Nepali children have low level of oral health awareness and practice as compared to their western counterparts.

Modern medicine has often failed in conditions where behavioral, emotional, spiritual and cultural factors have an important causative role. However, given the strong association between poor oral health and socio-economic variables described above, much of the research on parental beliefs and behavior and the programs they informed seems misplaced. Researchers have generally neglected to place parent's understanding of oral health and practices, such as feeding habits, in to the context of adjustment in the United States. For example, families often make nutritional transition from a relatively un-carcinogenic diet in their home, country to one heavy in refined foods. In addition, the structure and schedule of farm work, along with federal policies that promote affordability of infant formula, encourages for the oral health consequences. (Horton &Barker 2008)

Dental caries prevalence in Nepal among 5-6 year is 67% similarly rural and urban prevalence is 64% and 78% respectively. Similarly dental caries prevalence among 12-13 years is 41% and rural urban prevalence is 35% and 54% respectively. Comparison of data over last 20 years show increased trend of untreated dental caries. (Khanal S, 2013)

According to World Health Organization 85% of total population are affected by teeth and gingival disease in Nepal and according to infectivity Nepal is in 7^{th} position. Also globally 70% to 75% are infected by teeth and gingival disease it is more provident in developing countries. (Lonim Prasai,2013)

A study of dental literature (Butani, Weintraub, & Barker, 2008) concluded that emphasis on "culture'' had led to frequently generalized, even stereotyped descriptions of population groups, a lack of conceptual clarity, and poorly explicated connections to ideas of culture. Especially in the literature on Latino populations "cultural'' beliefs are often invoked as root causes of oral health disparities. Since poor oral health, including chronic forms of decay, common cultural beliefs must be influencing health behavior and practices. As a result, individuals and families are reduced to a static set of characteristics based on ethnicity and over simplified definitions of "culture'' which often ignore the dynamic interplay between history and power as recognized in the anthropological and sociological concept of culture.

The study has following research questions.

- What is the status of knowledge and hygiene practices on oral health among adolescent students in study area?
- What is the socio-economic status of the respondents?
- What is the food habit and preventive practices among the respondents?

1.3. Research Question

What is the prevailing status of knowledge and hygiene practice on oral health among adolescent students in Pokhara –Lekhnath metropolitan city?

The study has following research questions.

- What is the status of knowledge and hygiene practices on oral health among adolescent students in study area?
- What is the socio-economic status of the respondents?
- What is the food habit and preventive practices among the respondents?

1.4 Objective

1.4.1 General Objective

To study the knowledge and hygiene practices among adolescent high school students Pokhara- Lekhanath metropolitan.

1.4.2 Specific objective

- To identify the knowledge about oral health.
- To identify the preventive practice about oral health

1.5 Rationale

School children are more vulnerable groups; therefore attention should be paid to the general health as well as oral health. Adolescents between the ages of 10-16 years are school age children which comprise about of the population are comprised of this age group. Children in school age group are prone to get specific health problems. The various acute and chronic conditions which can be encountered during school period

include dental caries, diarrhea, worm infestation, scabies, wounds, sprains, fracture, and eye and ear infection.

As the children are very vulnerable group of different disease among dental caries is also major problem. The significance of the study can be stated in the following ways.

- Study will be useful to the education planner, policy makers, curriculum designers, administrators and teachers.
- Study will be useful guide to improve the oral health status of the study area as well as whole Nation.
- Study will help to identify the status and practice of oral health.

1.6 Study Variable

This chapter includes the dependent and independent variable of the study. It includes age, sex, family type, and education etc. of the respondents.

1.6.1 Dependent Variable

Knowledge and hygiene practice on oral health.

1.6.2 Independent Variables

- Age
- Gender
- Types of family
- Income
- Education
- Brushing habit
- Eating habit
- Source of infection
- Health awareness program

1.7 Expected Outcome

The study would reveal the existing knowledge towards oral health among students and also provide the hygiene practice. Also the study will help to provide existing data to develop strategies, plan and policies for oral hygiene and school health program with the help of collected relevant data.

1.8 Operational Definition

Knowledge: Refers to the positive response and correctness of facts on oral health.

Hygiene Practice: Refer to the behavior followed by respondent in order to prevent oneself from oral health problems**.**

Adolescent: According to who adolescents refers to the age between 10-19 years.

CHAPTER- II

LITERATURE REVIEW

This chapter deals the literature related to the study which gives general guidelines to the researchers. The purpose of this chapter is to review the literature of different researchers and many other journals, some books, library of Prithvi Narayan Campus. Generally, all of these records show that oral health status of our country i.e. very poor due to many causes like lack of education, Nutrition, Diet, and lack of knowledge on oral health. In this chapter, the researcher summarizes the literature from the different thesis and research related to Adolescent oral health status.

2.1 Theoretical/Conceptual Review

2.1.1 Concept of Medical Sociology

Medical sociology is a sub discipline of sociology that studies the social causes and consequences of health and illness. Major areas of investigation include the social aspects of health and disease, the social behavior of health care workers and the people who utilize their services, the social functions of health organizations and institutions, the social patterns of health services, the relationship of health care delivery systems to other social systems, and health policy. (Cockerham, 2004)

Medical sociology is a relatively new sociological specialty. It came of age in the late 1940s and early 1950s in an intellectual climate far different from sociology's traditional specialties. Medical sociology appeared in strength only in the mid twentieth century as an applied field in which sociologist could produce knowledge useful in medical practice and developing public policy in health matters.

Medical sociology evolved as a specialty in sociology in response to funding agencies and policymakers after World War II who viewed it as an applied field that could produce knowledge for use in medical practice, public health campaigns, and health policy formulation. At the beginning of medical sociology's expansion, many people in the field had tenuous roots in mainstream sociology and an orientation toward applied rather than theoretical work.

2.1.2 Concept of Health

Health is the ability to adapt and to self-manage, in the face of social, physical and emotional challenges. This new concept was proposed because the traditional WHO definition of health 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity was considered no longer adequate. When first set out in 1948, the WHO definition was groundbreaking, as it encompassed physical, as well as mental and social aspects of health. However, at that time, morbidity mainly featured infectious diseases, while today, chronic diseases are much more prevalent. Over time, the need for a dynamic description of health that highlights the human capacity for resilience and for coping with new situation as we being felt. (M Huber, Mvan Vliet, 2016)

2.1.3 Concept of disease and illness

The Concept of "illness and disease "has been used to capture different aspects of ill health. Illness is defined as the ill health of the person identifies themselves with, often based on self-reported mental or physical symptoms. In some cases this may mean only minor or temporary problems, but in other cases self-reported illness might include severe health problems or acute suffering. It includes health conditions that limit the person's ability to lead a normal life.

Disease is defined as a condition that is diagnosed by a physician or other medical expert. Ideally, this would include a specific diagnosis according to standardized and systematic diagnostic code. The quality which identifies disease is some deviation from a biological norm.

Illness is a feeling, an experience of unhealthy which is entirely personal, interior to the person of the patient. Sometimes illness exists where no disease can be found. Traditional medical education has made the deafening silence of illness-in-the-absence-of disease unbearable to the clinician. (Carlos Alvarez, 2005)

2.2 Review of Previous Studies

According to WHO, 90% of children of FIiji (country) are suffering from dental caries, (Global Oral Data Bank, 1989-1990) and according to Anderson, Irish, Michelin and Ngan,(1994) the study taken at India, almost 20% of Indian has oral

health problem, 10% of people were killed due to oral cancer. Another study which was studied by Dental College Lukhnow (1998) this study shows 90- 95% people were affected by periodontal diseases. This study was held on five economically poor district between age group 1-20 years on 400 samples. In addition the main causes of this problem were due to the lack of oral hygiene knowledge.

"A study of oral health problem and the way of using preventive measure" shows that the real status of oral health in our society. Exactly there are more than 60% of children who can't use brush due to poverty, 40% of people are using brush and paste no in correct way. Almost of the people have their own problems for maintaining oral health, some people can afford the cost but they have problem of knowledge. Now a days we have different types of junk foods in market and they are very easily available, some advertisement in the media attracts the children's interest which the children can easily follow the thing which is not good for our health, this type of problem is main cause of decaying teeth and causes of carcinoma. This study shows the real situation of our country. Different people like students and teachers said that awareness of oral hygiene on rural Nepal is low because that is the last priority when people are just try to from day to day. Indeed, the government is not so much emphasizing on nutrition and diet in order to improve oral hygiene concerning people's health priority. We've neglected a well- functioning set of teeth where food is first processed.

A descriptive cross sectional study of knowledge on on gingivitis and oral hygiene practices among secondary school adolescent in rural and urban Morongo, Tanzania with objective: to asses and compare knowledge on gingivitis and oral hygiene practices among rural and urban secondary school students aged between 13-17 years with 196 samples. In this study 58.7% were female, and 52% were from urban schools. The response was graded into three criteria namely 'lack of knowledge, Partial Knowledge, and full knowledge. There was a partial knowledge about gingivitis and full knowledge of basic oral hygiene measure among secondary school teenagers. The difference between rural and urban residence level of understanding was statistically significant in relation to brushing practices,

Other journals write about the formal class starts about oral health curriculum development, dental hygiene education, dental hygiene profession, in developing

country like Nepal. This article provides information about the history, recent curriculum changes and the legal status of the dental hygiene education in Nepal. It also intends to show, how even in a poor developing nation, the personal drive of a native Nepalese citizen with a vision and the proper connections can lead to the establishment of a new profession, until then unknown. Since 2006, the first uther serves as curriculum advisor, allowing him access and input to drafts of the development of current changes. In 2000 the first dental hygiene course was started in Kathmandu. Since then, dental hygiene education has been going through different stage of development and professionalization. In 2005 the program was changed to 3 years in length in order for students to obtain an academic certificate in Dental hygiene. In 2006 especially the powerful Nepal Dental Association (NDA) founded the Nepal Dental Hygienists Association, resulting in greater recognition of the profession. Future challenges for the school and the dental hygienist are issues of quality insurance and scope of practice suitable for developing country. Nepal is the only country worldwide with an almost equal gender distribution in the dental hygiene profession.

According to pathak Yubraj (2006) Oral Hygiene Practices and its effects on Dental Health among the Secondary Level Students of "Walling Municipality" shows the very low level of oral health practices in the students of secondary level. This study conducted in the area that lies in the hilly, many people don't know the proper hygiene about all sectors. They don't know the technique of maintaining their oral hygiene practices, and don't know the rule of taking hygienic food. This study ahows very poor oral hygiene practices in that area, this study represent all our society.

In 2002, the Australian Dental Association, Victorian Branch (ADAVB) had lunched dental awareness and oral health month. Over the past 20 years, the ADAVB has promoted a weeklong community health education campaign known as DentalHealth and Awareness week. In 2002 the week has been extended to a month- long campaign, the theme of which is dental care and awareness for the ageing, this theme highlights the importance of adapting dental and gums to suit dental health needs at soecifuc life stage. In 1998, 2, 3 million people (12 % of the total population) were aged 65 years or over. The dental health and the knowledge of this group is an important and relevant issue. With 90% of older Australianshaving some degree of treatable dental caries, the ADVAB believes that it is the challenging and complex

issue, but certainly and achieved goal. Good oral health care habits that will benefit people throughout their lives start at very early period.parents and curers of infant and very young children need to be aware nursing decay, which can affect babies teeth extensively. Teeth most often affected are the tpo front teeth. Bottle and breast fed babies are both susceptible. Babies left with a bottle as a pacifier and those who are frequently nursed, especially at night, run the danger of bottle or nursing decay due to the prolonged exposure to ilk or juice. Good dental care in young children is a key factor in good dental health in later life

A study conducted the study on prevalence of periodontal disease and dental caries among school children of both sexes aged 5-14 years in rural areas of Delhi with sample of 458 children studying in primary school in 4 different villages with low socio-economic level and following traditional rural life style and dietary habits were examined. The study revealed that prevalence of periodontal disease and dental caries was found among children. (Pandit & Sarana 2005)

Conceptual Framework

Based on the literature review and research design following conceptual framework has been conceived to analyze the knowledge and hygiene practice among adolescents.

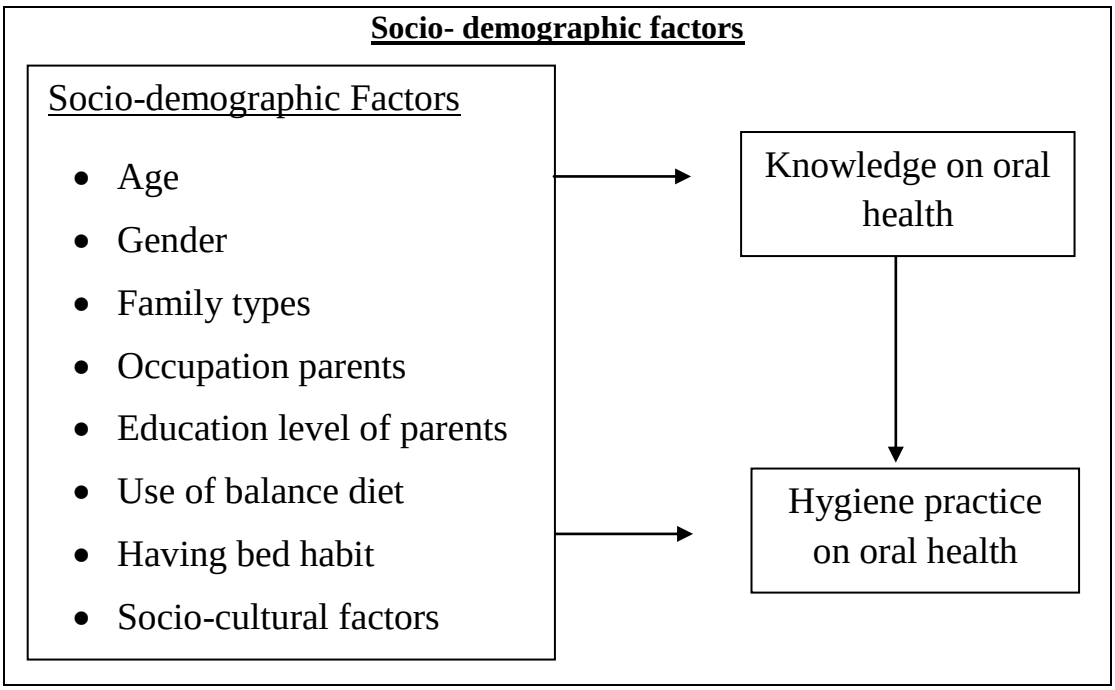


Figure 1: Conceptual Framework

Socio-demographic factors like age, gender, family type, education etc. plays important role in human health, use of tobacco, adopting un-healthy behavior gradually increase with age. In most cases male frequently use tobacco and its bi-products then female, male mostly use alcohol and other unhealthy behavior that mainly effect oral health. Health purchasing power is more in nuclear family than extended family type, occupation of the parents is directly proportional to the health purchasing power of the person. Education level of respondents as well as parents education play vital role in maintaining health of the family. Consumption of healthy diet is most important for obtaining the better health, person who use healthy diet in daily basis are more healthy than person use unhealthy diet. Various socio cultural factors like use of alcohol in some community is more common, consumption of meat, use of sweet food are the cultural factors that directly related to human health.

Knowledge on oral health is another important factor that that plays important role in obtaining good oral health. Person who have knowledge about it, ultimately have high health seeking behavior and also preventive practice.

Hygiene practice is another 3rd dimension for obtaining good oral health. Hygiene practice is mainly focusing the preventive practice of person. Person who use fluoridated toothpaste and brush for brushing their teeth are less prone to have oral disease, regular dental check-up, proper use of brushing practice are main hygiene practice that helps to maintain better oral health of the person.

So the socio demographic factors, knowledge on oral health and hygiene practice are inter related for obtaining the better health of person

CHAPTER- III

RESEARCH METHODOLOGY

This section deals with a set of methods that will be applied while conducting the research study in order to achieve the research objective. More specially design population of the study and sources of data, sample size and sampling procedure, data collection procedure, standardization of tools, methods of data analysis and interpretation.

3.1 Research design

This research was descriptive research design which is commonly used for research. Main focus of the study will be obtaining the information about knowledge and hygiene practice of adolescent students of Pokhara – Lekhanath metropolitan city.

3.2 Nature and Source of Data

Per need of the study, primary and secondary data was being collected in this study. The priority will be given to the collection of primary data. The primary data have both qualitative and quantitative, priority will be given to qualitative data but some important quantitative data will be collected questionnaire schedule, focus group discussion and informal interviews. Secondary data could be collected from different published and unpublished source as per need.

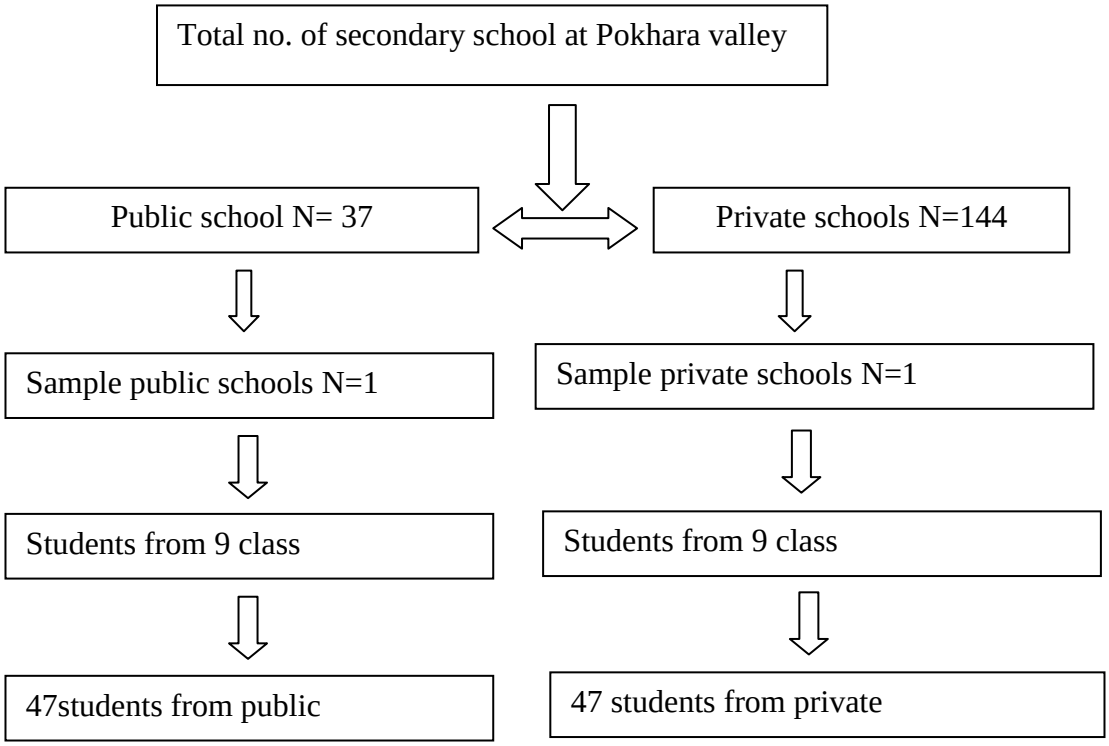
3.3 Rational of the study area

The research was conducted in Pokhara- Lekhnath metropolitan city. It specially wants to find out the situation of oral health and hygiene practice among the adolescent student of Pokhara vally. Research also wants to find out the variation among public and private schools.

3.4 Sample size

Kaski district was selected purposively. Kaski district was divided into different 16 clusters by DEO, standing on that frame PokharaLlekhanath metropolitan was taken as a study area which had 5 different clusters of schools. From each cluster one public

and one private school was chosen following random technique, from each school grade 9 were selected, comprising 47 public and 47 private schools. As total 94 adolescent students will be the respondents of the study.



3.4.1 Inclusion Criteria

- Student studying between grades 9 with in age 13-19 years.
- Both girls and boys.

3.4.2 Exclusion Criteria

- Those who are absent at the time of study.
- Those who refused to participate in the study

3.5 Data Collection Tools and Technique

For the data collection, the researcher was developed a set of questionnaire with the consultation supervisor, reference materials, journals, book, reports, other magazines etc. That can easily understand and fill by the respondents; also the data collection was done under the supervision of the researcher.

3.6 Standardization of Tools

For the validation of the study, tools and instruments required to study was pre-tested in the similar area of the study are. Then the necessary suggestion was taken from the supervisor and the tools were being revised and corrected based on suggestion given by the supervisor and the response given by the respondents.

3.7 Data Collection Procedure

Researcher was visited selected school's office with the authorized letter from the Department of campus authority. The researcher will explain the nature of the study during interview and collect information from respondents. The researcher will observe during the time of questionnaire filled by the respondents. Then the researcher will administer the research tools in order to collect necessary data and information for the study

3.8 Data processing and analysis

Data was carefully checked and verified to reduce errors on the date of data collection. The collected data was analyzed and interpreted by using SPSS 20 version and also descriptive statistical methods such as percentage, frequency was used.

CHAPTER- IV

SOCIO- DEMPGRAPHIC BACKGROUND OF THE RESPONDENTS

In this part socio- demographic characteristics of respondents such as age, sex, religion, family type, education status etc. of the respondents are described

4.1 Age of the respondents

The study was conducted between the age group 13- 18 years of Pokhara- Lekhnath municipality. Samples were selected from two different schools, 1 private and 1 public school. The distribution of the respondents by their age has been presented in the table given below.

Table 4.1: Distribution of respondents by their Age

Age	Private		Public		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
13	1	2.1	0	0.0	1	1.1
14	14	29.8	5	10.6	19	20.2
15	25	53.2	24	51.1	49	52.1
16	7	14.9	15	31.9	22	32.4
17	0	0.0	2	4.3	2	2.1
18	0	0.0	1	2.1	1	1.1
Total	**47**	**100**	**47**	**100**	**94**	**100**

Source: Field Survey, 2018

Above table shows that 15 years old age group is the largest in term age distribution with 52.1 percent among 94 respondents. 16 years old group comes second largest with 32.4 percent. Most of the students within the age of 15 form the both private and public school are relatively equal in number. Table 1 finds that within the 9 class private school students are small in age then the public school. It also shows that all age group are actively participated in the study hence the study represents adolescent age group in Nepali society.

4.2 Sex of the Respondents

The sex distribution of the sample of the study has been presented in the table given below.

Table4. 2: Distribution of the respondents by their sex

Sex	Private		Public		Total	
	No.	%	No.	%	No.	%
Male	30	63.8	26	55.3	56	59.5
Female	16	34.4	21	44.7	37	39.4
Other	1	2.1	0	0.0	1	1.1
Total	**47**	**100**	**47**	**100**	**94**	**100**

Source: Field Survey, 2018

Above table illustrate male are the largest group in this study with 59.5 percent similarly female respondents were 39.4 percent. Study also includes third gender in small no i.e. 1.1 percent. Among the respondents we find that no of male higher in private school in comparison with public school. Whereas no of female students are higher in public than private school. Hence this study is perfect for representing all sex in study area.

4.3 Family type of the Respondents

Nepali society is characterized by 3 type of family in term of family member. The family type of the respondents by their family type has been presented table given below.

Table4.3: Distribution of respondents by family type

Family Type	Private		Public		Total	
	No.	%	No.	%	No.	%
Nuclear	26	56.5	26	57.8	52	57.1
Joint	16	34.8	17	37.8	33	36.3
Extended	4	8.7	2	4.4	6	6.6
Total	**46**	**100**	**45**	**100**	**91**	**100**

Source: Field Survey, 2018

As the above table evidences that nuclear family is the largest in term of family type

of respondents with 57.1 percent similarly joint family comes second largest with 36.3 percent and extended family represents relatively small group among the respondents. Among 91 respondents extended family type is high in private than public school. Whereas nuclear and joint family found relatively similar in both type school. This study includes respondents from all 3 type of familial background in our society.

4.4 Class of Respondents

In this study samples were taken from class 9 from 1 public and 1 private school of the Pokhara Lekhanath municipality.

Table 4.4: Distribution of the respondents by their class

Class	Private		Public		Total	
	No.	%	No.	%	No.	%
9	47	100	47	100	94	100
Total	**47**	**100**	**47**	**100**	**94**	**100**

Source: Field Survey, 2018

As above table shows that class of the respondents, among 94 respondents 47/47 were from both private and public school.

4.5 Main Occupation of the Respondent's family

Nepalese society is characterized by diversity interim of occupation, we found people from different occupation within same society. The distribution of the respondents by their main occupation of family has been presented in the table given below.

Table 4.5: Distribution of the respondents by their main occupation of family

Main occupation	Private		Public		Total	
	No.	%	No.	%	No.	%
Farming	0	0.0	17	37.0	17	18.5
Service	32	69.6	9	19.6	41	44.6
Trade /Business	9	19.6	15	32.6	24	26.1
Wage/ Labor	4	8.7	0	0.0	4	4.3
Others	1	2.2	5	10.9	6	6.5
Total	**46**	**100**	**46**	**100**	**92**	**100**

Source: Field Survey, 2018

Above table illustrate that large group of the respondents were service as their main occupation of the family with 44.6 percent. Trade business comes second large group of respondent's main occupation of the family with 26.1 percents similarly small no of respondents represents as their main family's occupation as a labor.It also shows that variation between private and public students family's occupation, in service private is extremely high than public. Similarly in farming as a main occupation of the students family s from private is Zero where as in public were 17. It also found that, in trade/business and other occupation public were high than private. Students from main occupation wage and labor were high in private where as Zero in public. So this research includes all type of main occupation of Nepalese society.

4.6 Monthly income of Respondent's family

Nepalese family has vast difference in their economic status. The distribution of the respondent's family income has been presented in the table below

Table 4.6: Distribution of the respondents by their monthly income of the family

Monthly Income of family	Private		Public		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Up to 10000	2	4.3	0	0.0	2	2.2
Rs.10000-20000	5	10.9	9	20.5	14	15.6
Rs.20000-30000	12	26.1	8	18.2	20	22.2
Rs.30000-40000	3	6.5	8	18.2	11	12.2
RS.40000-50000	7	15.2	9	20.5	16	17.8
More than 50000	17	37.0	10	22.7	27	30.0
Total	**46**	**100**	**44**	**100**	**90**	**100**

Source: Field Survey, 2018

As above table illustrates 30% (N=27) of respondents monthly family's income was above Nrs. 5o thousands and only few of respondents 2.2% (N=2) family monthly income was less than Nrs.10000, followed by 22.2% (N=20), 17.8% (N=16), 15.6% (N=14), 12.2% (N=11) belongs to the income range Nrs. 20- 30 thousands, Nrs 40-50 thousands, Nrs 10-20 thousands and Nrs 30-40 thousands respectively. Table also shows monthly income of respondents family, more than Nrs.50 thousands, Nrs.20-30 thousands, and up to 10 thousands were high in private school similarly income range

between 10-20 thousands, 30-40 thousands, 40- 50 thousands found high in public school.

4.7 Caste/ Ethnic affiliation of the Respondents

Nepalese society is characterized by diversity in term of caste/ ethnicity. Here the research divides in 4 categories caste which is presented table below.

Table 4.7: Distribution of the respondents by caste/ ethnicity

Caste/ Ethnicity	Private		Public		Total	
	No.	%	No.	%	No.	%
Brahmin	6	12.8	22	46.8	28	29.8
Chhetri	5	10.6	8	17.0	13	13.8
Janajti	34	72.3	8	17.0	42	44.7
Dalit	2	4.3	9	19.1	11	11.7
Total	**47**	**100**	**47**	**100**	**94**	**100**

Source: Field Survey, 2018

As the above table evidences Janajati is largest group of respondents in term of caste/ethnicity affiliation with 44.7percent. Bhramins comes second 29.8 percent similarly Chhetri and Dalit comes third and fourth largest caste/ethnicity hierarchy in this study. This study include 4 type of caste in this research.

4.8 Religion of the Respondents

There is different type of religion in Nepalese society. We also found diversity in religion, religious factor also play a major role in health. The table below shows the religion of the respondents.

Table 4. 8: Distribution of the respondents by their Religion

Religion	Private		Public		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Hindu	33	70.2	45	97.8	78	83.9
Buddhist	12	25.5	1	2.2	13	14
Isai	1	2.1	0	0.0	1	1.1
Hindu –Bouddha	1	2.1	0	0.0	1	1.1
Total	**47**	**100**	**46**	**100**	**93**	**100**

Source: Field Survey, 2018

As the above table evidences that Hindu is the largest group in term of religion with 83.9 percent, Buddhist comes second largest group with 14 percent in this study. Similarly only few respondent also from other religion also include in this study. Hence this study represents all religion in the context of Nepal. Also found that Hindu were high in Public where as Buddhist were high in private school.

CHAPTER V

KNOWLEDGE ON ORAL HEALTH

In this part knowledge of respondents about oral health are described such as herd about oral, main source of knowledge, etc of the respondents are described.

5.1 Knowledge About Oral Health Among Respondents

In the context of Nepalese society only few people are aware about oral health. Oral health is highly neglected from the community people. The table below shows the knowledge about oral health among the adolescent of class 9 from selected sample school.

Table 5.1: Distribution of the respondent's knowledge about oral health

Knowledge about oral health	Private		Public		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Yes	32	69.6	26	55.3	58	62.4
No	14	30.4	21	44.7	35	37.6
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows most of the respondents 62.4 percent had knowledge about oral health whereas 37.6 percent of the respondents didn't have knowledge about oral health. It also found respondents have knowledge about oral health more in private than in public school.

5.2 Duration of the oral problem among Respondents

Oral health problem is main problem in community people, people are facing various oral health problems including oral cancer .Dental caries is the main problem in the adolescent age group. The table below shows the duration of oral problem among the respondents.

Table 5.2: Distribution of the respondent's duration of oral health problems

Duration of oral health problems	Private		Public		Total	
	No.	%	No.	%	No.	%
From 6 month	23	69.7	20	69.0	43	69.4
From 6 month-1 yr	7	21.2	7	24.1	14	22.6
1 yr-2 yr	1	3.0	1	3.4	2	3.2
More than 2 yr	2	6.1	1	3.4	3	4.8
Total	**33**	**100**	**29**	**100**	**62**	**100**

Source: Field Survey, 2018

As the above table evidence that largest group of the respondents having oral health problem from 6 month i.e 69.4 percent. Second largest group of respondents having oral problem from 6 month- 1 year. Similarly only small group of respondents having oral problem from more than 1 or 2 years. It also illustrates problem having from 6 month were high in both private and public school. Hence this table shows that most of the dental problem starting from the adolescent age so this study reflect the oral health problem in Nepalese society.

5.3 Knowledge About Reason of Oral Health Problem Among Respondents

Most of Nepalese people didn't have knowledge about oral health. The distribution of the respondents by their knowledge about oral health has been presented in the table given below

Table 5.3: Distribution of the respondents know about the reason of oral health problems

Know the reason of oral health problems	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	38	88.4	32	76.2	70	82.4
No	5	11.6	10	23.8	15	17.6
Total	**43**	**100**	**42**	**100**	**85**	**100**

Source: Field Survey, 2018

Above shows majority 82.4% (N=70) of the respondents know about the reason of oral health problems, where as 17.6% (N=15) didn't know the reason of oral health problems. It also illustrates respondents from private school have know about reason of oral health problems in comparison to public school.

5.4 Knowledge About Risk of Oral Problem Among Respondents

In the context of Nepal most of the people in the society didn't have knowledge about risk of the oral problem. The knowledge about the risk of oral problem among the adolescent has been presented in the table given below

Table 5.4: Distribution of the respondents know about risk of oral problems

Know about risk of oral problems	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	27	67.5	27	67.5	54	67.5
No	13	32.5	13	32.5	26	32.5
Total	**40**	**100**	**40**	**100**	**80**	**100**

Source: Field Survey, 2018

Above table shows largest group of respondents 67.5 percent know about risk of the oral problems, where as 32.5% (N=26) didn't know about risk of oral problems. It also found that both private and public schools respondents have equal knowledge about it.

5.5 Know About Oral Health Problems and its Solution Among Respondents

In the context of Nepal most of the people didn't know about oral health problem and solution of problem also. The table below shows the knowledge about oral health problem and its solution among respondents.

Table 5.5: Distribution of respondents who know about oral health problems and its solution

Know about oral health problems and its solution	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	29	93.5	33	86.8	62	89.9
No	2	6.5	5	13.2	7	10.1
Total	**31**	**100**	**38**	**100**	**69**	**100**

Source: Field Survey, 2018

Above table illustrate majority 89.9 percent of the respondents know about oral health problems and its solution where as only few 10.1percent didn't know about oral health problems and its solution. According to number and their response private school's respondents were quiet positive response then public school. Hence adolescent are more aware in oral health problem and its solution.

5.6 Know about Treatment of Teeth Among respondents

In society people adopt various traditional treatment procedures for the treatment of various ill heaths. People also adopt such treatment behavior in the context of oral health. The table below shows who know the treatment of oral health problem.

Table 5.6: Distribution of the Respondents WHO Know About Treatment OF Teeth

Know about the treatment of teeth	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	32	91.4	36	94.7	68	93.2
No	3	8.6	2	5.3	5	6.8
Total	**35**	**100**	**38**	**100**	**73**	**100**

Source: Field Survey, 2018

As the above table shows largest group 93.2 percent of the respondents had knowledge about treatment of teeth where as only few 6.8% (N=5) were don't have knowledge. It also shows that respondents from public school had more knowledge than private school's respondents. Hence this study shows adolescent had good

knowledge about oral health in pokhra valley.

5.7 Heard about Health of Mouth and Teeth by Respondents

In the context of Nepal most of the people are not aware about oral health. oral health is neglected by government as well as community people so people didn't heard about it.

Table 5.7: Distribution of the respondents whether they heard about health of mouth and teeth

Heard about health of mouth and teeth	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	42	91.3	44	93.6	86	92.5
No	4	8.7	3	6.4	7	7.5
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

As the above table shows large no of respondents heard about health of mouth i.e. 92.5 percent, where as only few 7.5 percent didn't heard. Also shows that respondents from public school were heard more than respondents from private school. Hence the adolescent of Pokhara valley are more aware in health or mouth.

CHAPTER VI

HYGIENE PRACTICE OF THE RESPONDENTS

In this chapter oral hygiene and practice and oral health practice of the respondents is presented. Hygiene practice plays an important role in maintaining good oral health in people

6.1 Having dental treatment by Respondents

Oral health is highly neglected by the people of the society. The table below shows treatment having by the respondents.

Table 6.1: Distribution of the respondents if they ever done teeth treatments

Ever done teeth treatments	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	25	54.3	27	58.7	52	56.5
No	21	45.7	19	41.3	40	43.5
Total	**46**	**100**	**46**	**100**	**92**	**100**

Source: Field Survey, 2018

As above table shows more than half 56.5 percent of the respondents had ever done dental treatment, similarly 43.5% (N=40) didn't done treatment. It also shows that respondents from public school done teeth treatment than respondents from private school.

6.2 Oral Health Program Organized in School

Oral health program are rarely conducted in school as well as community in Nepal.

Such type of program is conducted in valley but in rural area program is not conducted.

Table 6.2: Distribution of the respondents, whether oral health program organized in their school

Organizing oral health program at school	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	21	45.7	24	51.1	45	48.4
No	25	54.3	23	48.9	48	51.6
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows whether oral health program organized in their school, among the respondents 51.6% had negative response, oral health program not conducted at school. Similarly 48.4% had positive response. It also shows respondents from public school give positive response then respondents from private school. This study shows in valley oral health program begin to conduct in school.

6.3 Type of program organized in school

In the context of Nepal oral health program are not frequently conducted at school as well as school.

Table 6.3: Distribution of the respondents according to type of program organized

Type of program organized	Private		Public		Total	
	No.	%	No.	%	No.	%
Health camp	5	31.3	5	27.8	10	29.4
Chetanamulak	9	56.3	10	55.6	19	55.9
Both	2	12.5	3	7	5	14.7
Total	**16**	**100**	**18**	**100**	**34**	**100**

Source: Field Survey, 2018

Above table shows majority 55.9 % of the respondents response that chetanamulak program conducted at their school followed by 29.4%, 14.7% health camp and both respectively. It also shows such type of program was conducted more in private school than public school. The study shows in pokhara valley preventive program about oral health are conducted sometime at school.

6.4 Frequency of brushing teeth by Respondents

Most of the people in Nepal brush their teeth but they are not followed proper brushing technique. Some people use traditional type of brush and paste for brushing their teeth. The table below shows if the respondents brush their teeth

Table 6.4: Distribution of the respondents if they brush their teeth

Brush the teeth	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	46	100	47	100	93	100
No	0	0.0	0	0.0	0	0.0
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows 100 percent of the respondents brush their teeth

6.5 Frequency of Brushing by Respondent

Traditionally most of the people brush their teeth once a day. The table below show frequency of brushing their teeth by Respondent.

Table 6.5: Distribution of the Respondents by the Frequency of Brushing their Teeth in a Day

Frequency of brushing in a day	Private		Public		Total	
	No.	%	No.	%	No.	%
Once	23	50.0	26	55.3	49	52.7
Twice	23	50.0	21	44.7	44	47.3
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows more than half 52.7percent of the respondents brush their teeth once a day, where as 47.3% (N=44) brush their teeth twice a day. It also shows respondents from private school brush their teeth twice a day more than public school.

6.6 Duration of Changing Brush by Respondents

Most of the people in the community didn't have idea about changing their brush.

Some people use their brush until it destroyed or lost. The table below show the duration of changing brush by respondents.

Table 6.6: Distribution of the respondents by duration of changing their tooth brush

Duration of changing Tooth brush	Private		Public		Total	
	No.	%	No.	%	No.	%
One month	15	38.5	21	50.0	36	44.4
Two month	20	51.3	18	42.9	38	46.9
Three month	4	10.3	3	7.1	7	8.6
Total	**39**	**100**	**42**	**100**	**81**	**100**

Source: Field Survey, 2018

Above table shows most of the respondents 46.9 percent change their brush every two month, 44.4 change their brush every one month and8.6 percent change their brush in every three month. Also shows more respondents from public school change their brush within one month than private school and more respondents from private school change their brush within two month and three month than public school respectively.

6.7 Frequency of Taking Sweet Foods by Respondents

Dietary factors play a major role in general health as well as oral health. sweet foods are more cryogenic that causes more oral health problem like dental caries. The table shows the frequency of taking sweet food by respondents.

Table 6.7: Distribution of the respondents by frequency of taking sweet foods

Frequency of taking sweet foods	Private		Public		Total	
	No.	%	No.	%	No.	%
Daily	23	50.0	21	44.7	44	47.3
Sometimes	22	47.8	25	53.2	47	50.5
Never	1	2.2	1	2.2	2	2.2
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

As the above table shows largest group of respondents 50.5 percent takes sweet foods

sometimes and second largest group 47.3 percent use daily sweet food. Only small group 2.2 percent don't use sweet food. Also table respondents from private school take daily sweet food than respondents from public school where as respondents from public takes more sometimes.

6.8 Clean Mouth after Meal or Breakfast by Respondents

Hygiene practice plays the important role for maintaining the health of people. Hygiene practice is the best preventive measure for prevention of most of the oral problem. The table below shows clean mouth by respondents after meal or breakfast.

Table 6.8: Distribution of Respondents by Cleans their Mouth after Meal or Break Fast

Clean mouth after meal or breakfast	**Private**		**Public**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Yes	39	84.8	42	89.4	81	87.1
No	7	15.2	5	10.6	12	12.9
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows majority 87.1percent of the respondents clean their mouth after meal or breakfast where as only few12.9 percent don't clean their mouth after meal or breakfast. Also respondents from public school clean their mouth as comparison to private school.

6.9 Habit of Tobacco or its Product use by Respondents

Bad habit like tobacco or its product causes the most oral health problem. People who use tobacco or it product are prone to simple to complex oral health problem like pral cancer. The table shows such bad habit of the respondents.

Table 6.9: Distribution of the respondents by their habit of tobacco or its product use

Use tobacco or its product	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	10	21.7	0	0.0	10	10.8
No	36	78.3	47	100	83	89.2
Total	**46**	**100**	**47**	**100**	**93**	**100**

Source: Field Survey, 2018

Above table shows majority 89.2 percent of the respondents didn't use tobacco and its product where as only 10.8 percent use tobacco and its product. Also all of 100% (N=47) respondents from public school didn't use tobacco and its product and only 21.7 percent respondents from private school use tobacco and its product.

6.10 Ever Visit Dentist by Respondents

Regular dental visit in every 6 month is necessary for maintaining good oral health. in the context of rural Nepal there is no access to regular dental visit, but in case on study area it is possible to visit dentist in every 6 month. The table shows the frequency of dental visit by respondents

Table 6.10: Distribution of the respondents if they ever visit dentist

Ever Visit Dentist	Private		Public		Total	
	No.	%	No.	%	No.	%
Yes	21	47.7	23	50.0	44	48.9
No	23	52.3	23	50.0	46	51.1
Total	**44**	**100**	**46**	**100**	**90**	**100**

Source: Field Survey, 2018

As above table shows more than half 51.1 percent of the respondents don't visited dentist and 48.9 percent visited. Also half of the respondents from public school visited dentist where as 47.7% from private school visited dentist which is less than public school.

6.11 Duration of Visiting Dentist by Respondents

Regular dental visit in every 6 month is recommend for every people on community for maintaining good oral health. the table below shows duration of visiting dentist by respondents

Table 6.11: Distribution of the Respondents by Duration of Visiting Dentist

Duration of visiting Dentist	Private		Public		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Within 6 month	6	30.0	5	22.7	11	26.2
In 6 month -1 year	4	20.0	2	9.1	6	14.3
In 1 year-2 year	3	15.0	5	22.7	8	19.0
According to necessity	7	35.0	10	45.0	17	40.5
Total	**20**	**100**	**22**	**100**	**42**	**100**

Source: Field Survey, 2018

As above shows most 40.5 percent of the respondents visited dentist according to necessity, 26.2percent visited within 6 month 19% (N=8), 14.3 percent visited in 1 year-2 year and 19 percent visited in 6 month -1 year respectively. Also shows respondents from public school visited dentist according to necessity more than respondents from private school similarly respondents from private school visited within 6 month more than respondents from public school. Hence the study shows respondents visit dentist when they face the oral problem.

CHAPTER- VII

SUMMARY AND CONCLUSION

7.1 Summary

This study was conducted to assess knowledge and hygiene practice on oral health among adolescent student of Pokhara Lekhnath metropolitan city. Study wants to find situation of oral health and hygiene practice, it mainly focus on knowledge about oral health and hygiene practice among the students of public and private school in Kaski.

The research was conducted among the adolescent student of in Kaski district at Pokhara Lekhnath metropolitan city. The sample of study school was taken 1 private school from Pokhara city and 1 public school from out of city. The samples were form 9 class of students, 47 samples from each school.

Descriptive research design was conducted among the adolescent students of Pokhara Lekhnath metropolitan city. Primary and secondary data was collected as per need of study. Samples were taken from 1 public and 1 private school. A set of questionnaire was developed that can easily fill and understand by respondents. Also the questionnaire was pre tested similar school in Kaski. Data were collected from the two sample school by visiting the researcher with authorized letter from department. Data were analyzed by minimizing the error and using the SPSS version 20, MS-excel etc

7.1.2 Main Finding of Study

The main findings of the study were:

- The age group from 15 years were the large age group contributing 52.1% from both public and private school.
- Male were more 59.5%, representing from both school.
- Nuclear family was main family type, from both school represents large study group contributing 57.1%.
- All were from class 9 from both public and private school.

- Service was the main occupation 69.6% of respondents from private school, where as trade was the main occupation 32.6% of respondents from public school.
- Most of 30%, monthly income from both private and public school was more than 50 thousand.
- Janajati was the main ethnic group of study contributing 44.7%, from private Janajati were 72.3% whereas from public Brahmin were 46.8%.
- Hindu was main religion in both school contributing 83.9%.
- From both private and public school, most of the respondents have knowledge about oral health.
- Most of the 69.4% have oral health problem from 6 month in both school.
- Among the respondents from both schools, know about the reason about oral health contributing 82.4%
- Most of the 67.5% know about risk of oral problem and also know the solution of oral health problem as well as treatment of teeth from both school.
- Most of the 56.5% had done dental treatment from both school.
- Both in private and public school, oral health program were conducted in their school. Among them chetanamulak program was mainly conducted.
- All of 100%, brush their teeth. Among them from both school they brush their teeth once a day.
- Most of 46.9% change their brush in two month, from public school they change their brush in one month where from private they change with in two month.
- Most of 50% use sweet food, from private mostly use daily whereas from public mostly use sometime.
- Most of 89% didn't use tobacco and its product from both school.

- Most of 51.1% never visited dentist, among them from private were 52.3% and from public were 50% in ratio.

- Among them who visited dentist, most of 40.5% visited according to necessity from both private and public school.

7.2 Conclusion

Knowledge and Hygiene practice is most important for maintaining good oral health. Majority of students had adequate knowledge on basic oral health care measures necessary to maintain proper oral health, but the practice of them were relatively poor in both private and public school. Oral health program should be conducted with reinforcement, so that students can close gap between knowledge and hygiene practice. It was assessed the need for oral health program and treatment at school level.

Students brush their teeth everyday but the frequency and proper brushing technique was not proper in both the public and private school. Students from both schools know about treatment of teeth but relatively small number of them done treatment. Students from both schools had knowledge about harmful effect of consuming sweet food but not practiced in both school even though almost all students clean their mouth after meal but the different type of oral health problem is still present so proper method of brushing not followed by students.

To emphasize on need for the oral health education of the school children, aiming at improving oral health knowledge and continuous implementation of school oral health promotion program. As, adolescent age group of school students are the right time when the knowledge and hygiene practice can still be molded, leading towards correct knowledge along with positive attitude which is essential to bring about a change in their oral health. With results, we need to take into consideration various socio-economical factor. It seems a better understanding of this would increase the awareness of the importance on oral hygiene practices of the population and therefore improving their oral hygiene level both in private as well as public school arena.

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APPENDICES

Appendix A: Question Schedule

Knowledge and Hygiene Practice on Oral Health Among Adolescent Students Student of Pokhara –Lekhnath Metropolitan City

Questionnaire

Part A. Social and Demographic information

1) How old are you ……..years

2) Sex:

a. Male b. Female c. Third

3) What is your educational level?

a. Lower Secondary b. secondary c. Higher Secondary

4) What is your family Occupation?

a. Governmental b. Nongovernmental c. Agriculture d. Business

e. Others (specify) …….

5) What is your household Monthly Income……..?

6). Type of School

a. Private b. public

7) What is your ethnicity?

a. Brahmin b. Chhettri c. Janjati

d. Dalit e. Other specify ……

8) What is your religion?

a. Hindu b. Buddhist c. Christian

d. Muslim e. Other specify…

Part B. Oral Hygiene Practice Related information

9) Do you brush your teeth?

a. Yes b. No

10) If yes, how many times of day do you brush your teeth?

a. Once daily b. twice daily c. More than two-times

11) In which time do you brush your teeth?

a. Early in the morning b. After lunch c, after snack

d. After diner e. both (b and d)

12) For how long do you brush your teeth?

a. one minute b. Two minutes c. more than two minutes d. Don't know

13) What types of brush do you use?

a. soft b. medium c. hard d. don't know

14) When do you change your tooth brush?

a. After is useless b. Every 3 Months

c. Every 6 Months d. don't know when the brush has to be changed

15) What do you use for brushing?

a. Tooth Power b. tooth paste c. other specify ……

16) If you use toothpaste does your toothpaste contain fluoride?

a. Yes b. No c. don't know

17) Can you tell me the brand name of your toothpaste?

a. herbal b. close-up c. Pepsodent d. Colgate

e. other specify ……..

18) Do you use any inter dental cleaning aid?

a. yes b. No

19) If yes, what kind of inter dental aid do you have used?

a. tooth pick b. thread c. Dental floss d. Others specify ……

20) Do you eat sugary food?

a. Yes b. No

21) If yes, what type of sugary food do you eat?

a. Chocolates b. Tea/coffee c. Others…….

22) How often do you eat sugary food?

a. Daily b. usually 2/3 day's once time c. sometimes
d. don't eat

23) Do you rinse your mouth after food?

a. Yes b. No

24) Do you or your family member use tobacco? Yes b. No

25) If yes which types of tobacco do you use?

a.Surti b. khaine c. cigarate d. pukar e. Others specify…

26) If smoking then

19) No. of cigarette ……specify

20) If smokeless …… specify the frequency

21) Do you consume alcohol? (If no go to the question 23)

a. Yes b. No

22) If yes, when do you consume alcohol?

a. Daily b. occasionally c. socially d. others specify ..

23) Do you visit dentists?

a. Yes b. No

24) If yes, when did you visit the dentist last time?

a. Less than 6 month b. 6-12 month c. 1-2 years d. don't remember

25) If yes, what was the reason of you last visits to the dentists? (Multiple response)

a. Pain for teeth b. advice c. treatment for teeth d. routine checkup
e. other specify …….

Part C. Knowledge of Oral Health

26) Have you ever heard about oral health?

a. Yes b. No

27) If yes, from where you get information about oral health?

a. TV b. radio c. news paper d. parent's e. teacher

28) If there is any oral health program is organized in yours school?

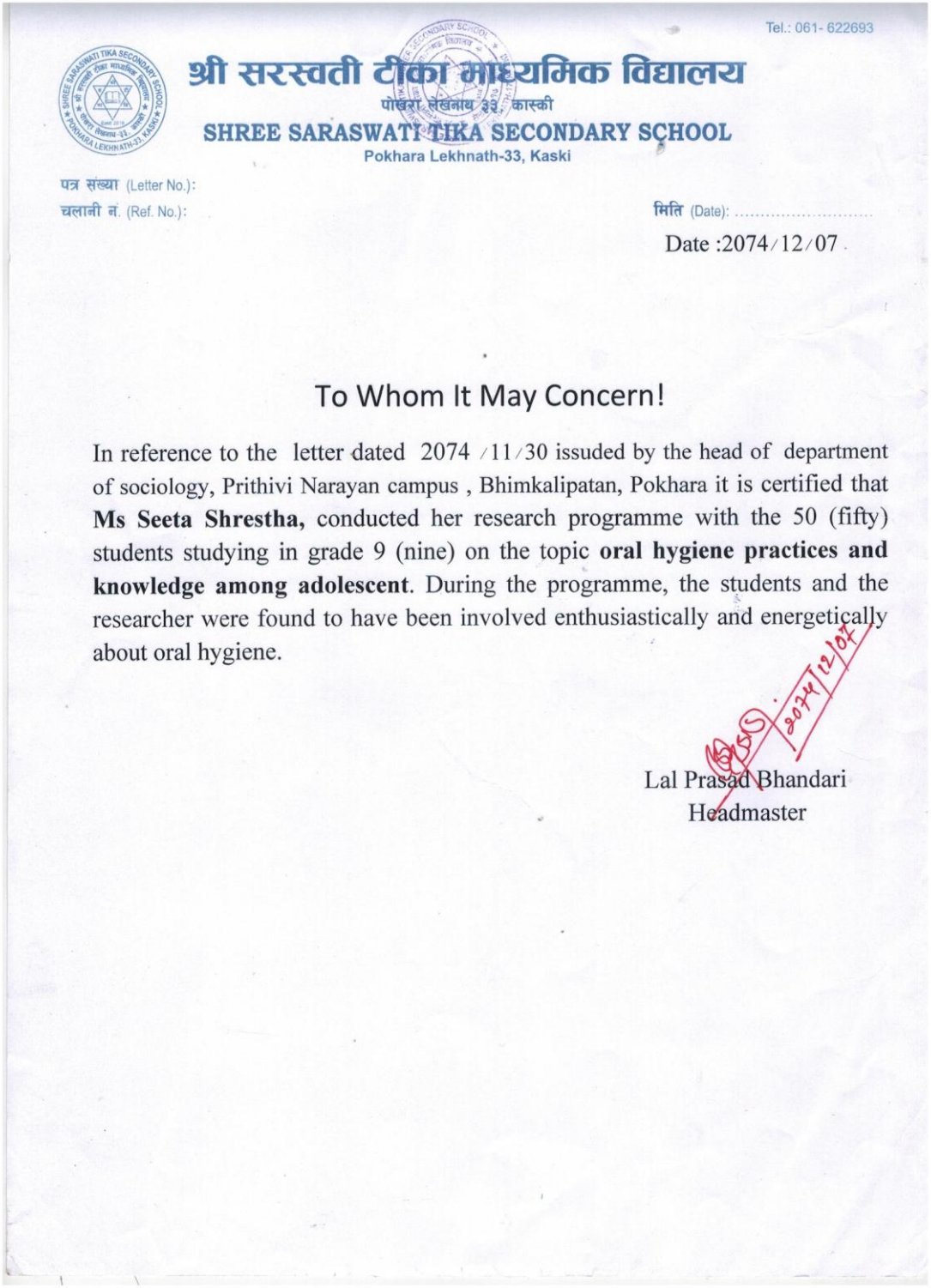
a. Yes b. No

29) If yes what types of program in organized in yours school?

a. health camp b . Awareness program c. others

Appendix B: Approval Letter

Letter from School



Tel.: 061- 622693

श्री सरस्वती टीका माध्यमिक विद्यालय
पोखरा लेखनाथ ३३, कास्की
SHREE SARASWATI TIKA SECONDARY SCHOOL
Pokhara Lekhnath-33, Kaski

पत्र संख्या (Letter No.):
चलानी नं. (Ref. No.):

मिति (Date): .....
Date :2074/12/07

To Whom It May Concern!

In reference to the letter dated 2074/11/30 issuded by the head of department of sociology, Prithivi Narayan campus , Bhimkalipatan, Pokhara it is certified that **Ms Seeta Shrestha,** conducted her research programme with the 50 (fifty) students studying in grade 9 (nine) on the topic **oral hygiene practices and knowledge among adolescent**. During the programme, the students and the researcher were found to have been involved enthusiastically and energetically about oral hygiene.

2074/12/07

Lal Prasad Bhandari
Headmaster

Reg. No: 104926/2053

NOBEL SECONDARY SCHOOL

Estd: 2052
Ranipauwa, Pokhara Lekhnath- 11
Kaski, Nepal
Phone: 061-528061/ 522636

Ref. No.: .....

Date: ....21/03/2018.....

To Whom It May Concern

This is to certify that Ms. Sheeta Shrestha, a regular student of Sociology at Prithvi Narayan Campus, Pokhara has conducted a research project on the topic **Oral Hygiene Practices and Knowledge Among Adolescent** in our school on 21 March 2018 for the students of Grade 9.

The questionnaires prepared are relevant and beneficial for the students in their day to day life.

I wish her all the best.

School Seal

Principal
Nobel Secondary School
Ranipauwa, Pokhara

Principal
Nobel Secondary School
Ranipauwa, Pokhara Lekhnath- 11
Kaski, Nepal

URL: www.nobelschool.edu.np
E-mail: info@nobelschool.edu.np

(Previous Name: New Moonlight English Boarding School)

Our Motto: "Education for Discipline & Invention"

Annex C: Photo Gallary

Glimpse During Data Collection