

KNOWLEDGE, ATTITUDE AND PRACTICES TOWARDS FALSE TEETH EXTRACTION AMONG THE COMMUNITY MEMBERS OF ATANGA SUB-COUNTY, PADER DISTRICT. A CROSS-SECTIONAL STUDY.

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Abstract

Background:

This was a community-based study conducted to assess the knowledge, attitude, and practices of community members towards false teeth extraction among the community members of Atanga Sub-County, Pader District, Uganda.

Methodology:

The study took a cross-sectional design with a sample size of 68 participants obtained using a random sampling method by casting a lot easier those participants to be selected.

Results:

Findings from this study showed good numbers of the community members knew false teeth 42 (61.8%) had related it to the first teeth which erupt after the child is borne, and 46 (67%) of the respondents said the sole reasons why they extract these false teeth were to reduce on fever from their children. According to 63 (92.6%) of the respondents, children who are affected by this are once under 6 months old, and from the samples, of the 68 respondents, there were 287 children of which 155 (54%) had their teeth extracted due to this practice.

From the study, 18 (26%) still agreed strongly that the practice of false teeth extraction should continue and 50 (74%) of the respondents disagreed strongly with the continuation of the practice. 53 (78%) of the respondents reported that if the site of extracted teeth failed to heal, they fear taking their child to the health facilities.

Conclusion:

Good numbers of the respondents were adequately knowledgeable about false teeth and obtained the information on false teeth mostly from friends and medical personnel and they described false teeth as the teeth that erupt as milk teeth.

Recommendations:

Various concerned stakeholders carry out regular sensitization on the consequences and the dangers of false teeth extraction even to the related cultural practices and to awaken the medical personnel and communities' relationship to reduce the fear community have upon health workers.

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1. Background

Globally, false teeth extraction occurred in most of the continents; however, the difference was the nature of the methods used in extracting them were very risky and unsterile since mostly done by traditional healers. As the world is coming closer due to effective transport, communication, and technology, this practice of false teeth extraction has been widely practiced (Basavaraj, 2014).

In Africa, it was believed that false teeth (nylon teeth or Ebiino) cause diarrhea, fever, loss of appetite, cough, vomiting growth retardation as well which were believed as the key symptoms of the disease and they believed that worms infest the tooth bud eventually leading children into sickness (Kahabuka, 2015).

The removal of the erupting canine teeth both mandibular and maxillary teeth in the infant was a practice carried out in many parts of African countries in Ethiopia was found that 70% quickly choose to go for traditional medicine as their priority even in such a case of false teeth 'gi-dog' eruption (Emily, Roberts, LaRee, & Clark, 2018).

These negative practices arose due to negative attitudes, behaviors, and beliefs that they are killer canine teeth causing diarrhea, fever, and other related illness in infants therefore should be removed. Since the removal is done by traditional healers, they then use unclean instruments like sharpened bicycle spokes, knives, razor blades, and any other sharpened instruments (Emily, Roberts, LaRee, & Clark, 2018).

A study done by Mbarara University of Science and Technology researcher showed that in African society, the practice of false teeth extraction was highly spreading throughout the countries in the continent more so in remote at about 15% to 80% in areas like Angola, Tanzania, Somalia, Kenya, Sudan, Nigeria and Uganda, where it was found that Uganda was at 14% (Martin, 2017).

Parents still don't believe what the scientists say about false teeth and they are still stacked in

their belief concerning the cause of diarrhea in infants. Most researchers have reported in their several studies that this practice of false teeth extraction in African communities has been linked to the belief that they were vomiting, growth retardation among the infants, vomiting, and growth retardation among infants (Consolini, 2020).

In most parts of Uganda, false teeth extraction has been the result of a strong cultural belief that it causes diarrhea, fever, cough, weakness in the child, and loss of appetite hence making the breastfeeding child refuse breastfeeding and death accompanying it (Atim, et al., 2018).

In Atanga Sub-County there is no documented report of the practice and complications of false teeth extraction, however, the community often fears opening up to the medical personnel and tries their ways to heal the wound like applying salt, soda ash, and leaves on the site of extraction as reported by VHT members that the practices are done in faraway villages.

2. Methodology

2.1.

2.1.1. *Study design and rationale*

The study was a descriptive cross-sectional design employing quantitative data collection methods.

2.2. *Study setting and rationale.*

The study was conducted on the community members of Atanga Sub-County, Pader district. This Sub-County recently has grown and gave birth to Atanga Town Council, and good enough changed its Sub-County headquarter far away to a remote area of Lapul-Ocwida village. The Sub-County is bordered by Atanga town council from the North East, Angagura from the West, Ajan from the East, and Lapul from the South.

The area is having 59 villages with at least 2 members of the Village Health Team (VHT) per village who are always concerned with many activities among which providing referrals of children under 5 years of age who might be having fever, diarrhea, and cough to mention but a few.

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Atanga Sub-County which is located midway between Gulu city and Kitgum municipality highway has a population of 17,200 as reported by the Uganda Bureau of Statistics (UBOS) with the lowest population who have attained a higher level of education and the average household per village is 15.

2.3. Study population.

The study targeted community members living within Atanga Sub-County.

2.4. Sample size determination

Using Krejcie & Morgan formula, $n = \frac{Z^2 p(1-p)}{e^2}$

Where

n = sample size for infinite population

p = assumed true population and by convention is 50% (0.5)

$(1-p)$ = the probability of not having respondents pq

e^2

Z = standard normal deviation at 90% confidence interval corresponding to 1.65

e = Margin Error at 10% (0.1)

$$n = \frac{(1.65 \times 1.65 \times 0.5)(1-0.5)}{0.1^2}$$

$$n = \frac{2.7225 \times 0.5 \times 0.5}{0.01}$$

$$n = \frac{0.680625}{0.01}$$

$$n = 68.0625$$

$$n = 68$$

Therefore, the total number of correspondents was 68

2.5. Sampling procedures.

The researcher used simple random sampling procedures to obtain the sample size of the study, whereby casting of the lot was made from a box containing a paper written YES and NO. The researcher allowed the participants who picked a YES among the parents found at home was the one who participated in the study until they reached 68 participants.

2.6. Inclusion Criteria

The study included only parents and grandparents of children of the community members of Atanga Sub-County, Pader district who were present during the data collection period and were free and willing to voluntarily consent to participate in the study.

2.7. Definition of variables

Independent variables will include.

Knowledge of the community members on false teeth.

Attitudes of the community members towards false teeth.

Practices of the community members on false teeth extraction.

Dependent variables will include.

Prevalence of false tooth extraction.

2.8. Research instruments

Data were collected using approved questionnaires which were used to interview respondents. This tool was used because the study was involving a mixed group of respondents, whereby some respondents were literate while others were illiterate and thus unable to read, write and understand English used to develop questionnaires.

2.9. Data collection procedure

Three research assistants were identified and trained for two days mainly in the objectives of the study questionnaire administration and ethical conduct of research. The research assistant proceeded to present the questionnaires to 68 respondents who were interviewed for 14 days.

2.10. Data management

Data were edited to ensure completeness before leaving the area of study and to ensure that there were no mistakes.

2.11. Data analysis and presentation

The collected data were first analyzed manually by the use of papers and pens and tallies, thereafter the researcher presented tables, graphs, and pie-chart as well.

2.12. *Ethical consideration*

This research was conducted while following all ethical issues. It was subjected to the approval of the research and ethics committee of Lacor Hospital which provided permission. Only participants who consented to the study were allowed to participate in the study. All data collected were only used for this study.

2.13. *Dissemination of Results*

The results were shared with the office of the Local Council III (LC III), the Incharge of serving health centers like Atanga Health Center III & Lapul-Ocwida Health Center III, the Uganda Nurses and Midwives Council (UNMU) and Lacor School of Nursing and Midwifery.

3. Data presentation, analysis and interpretation

3.1. *Socio-demographic characteristics*

table 1 Shows the socio-demographic characteristics of the community involved in the study of the 68 respondents in which the majority 33 (48.5%) were within the age bracket of 18-29 years, followed by 18 (26.5%) who were within 40-60 years and 17 (25%) who were within the age bracket of 30-39 years old. The majority of the respondents 42 (62%) were female and 26 (38%) were male.

Concerning their faith base, the majority of the respondents 41 (60%) were Catholic, followed by 15 (22%) who were Protestants, 1 (2%) who were Muslim, and finally, 11 (16%) who were under other religions.

Concerning their educational status majority of the respondents 37 (54%) were at the primary level, 18 (26%) didn't acquire any formal education, 10 (15%) acquired a secondary level of education only 3 (5%) who acquired tertiary education.

This meant that the community of Atanga Sub-County who participated in the study were mostly middle age female adults who had some little educational background, and they were in Catholic faith-based thought on how to differentiate between good and bad.

In figure 1, respondents 33 (48.5%) were within the age group of 18-29 years, followed by 18 (26.5%) who were within 40-60 years while at least 17 (25%) were within 30-39 years. The study signified that the community members of Atanga Sub-County were mostly middle-aged adults who participated in the study and since the highest percentages were female, it means they were the ones found at home.

In table 2 above, most respondents 65 (96%) were peasant farmers followed by 3 (4%) were self-employed and none were either civil servants or retired citizens. This showed that the community members of Atanga Sub-County who participated had at least enough products from farming since they were peasant farmers.

3.2. *Knowledge of the community towards false teeth extraction.*

table 3 shows that the majority of respondents 42 (61.8%) said yes, 19 (27.9%) said no and 7 (10.3%) said they don't know. This signified that at least good numbers of the members know what false teeth was.

Figure 2 shows that the majority of the respondents 29 (42.6%) said both mothers and grandmothers are the ones who take their child for false teeth extraction, 20 (29.4%) said that grandmothers move alone to take their child for false teeth extraction, 14. (20.6%) said that mothers take the child by themselves and 5 (7.4%) said fathers take the child by themselves. This meant that there were very few inputs from the fathers on false teeth extraction, and they have little knowledge of false teeth extraction.

Figure 3 shows that out of the respondents who were asked about the reasons as to why the children are taken for false teeth extraction, 46 (67.6%) said it was due to fever, 20 (29.4%) said it was due to diarrhea, 2 (3%) said it was due to vomiting and none said it was as a result of cough. This signified that the majority of the community members of Atanga Sub-County knew that the major cause of false teeth in children was fever though some few said diarrhea.

Figure 4 shows that the majority of the respondents 31 (46%) said the child would die if the

Table 1: Socio-demographic characteristics. n=68

Characteristics	Category	Frequency	Percentage
Age (years)	18-29	33	48.5
	30-39	17	25
	40-60	18	26.5
	Total	68	100
Gender (Sex)	Male	26	38
	Female	42	62
	Total	68	100
Religion	Catholic	41	60
	Muslim	01	02
	Protestant	15	22
	Others	11	16
	Total	68	100
	None	18	26
Educational level	Primary	37	54
	Secondary	10	15
	Tertiary	03	05
	Total	68	100

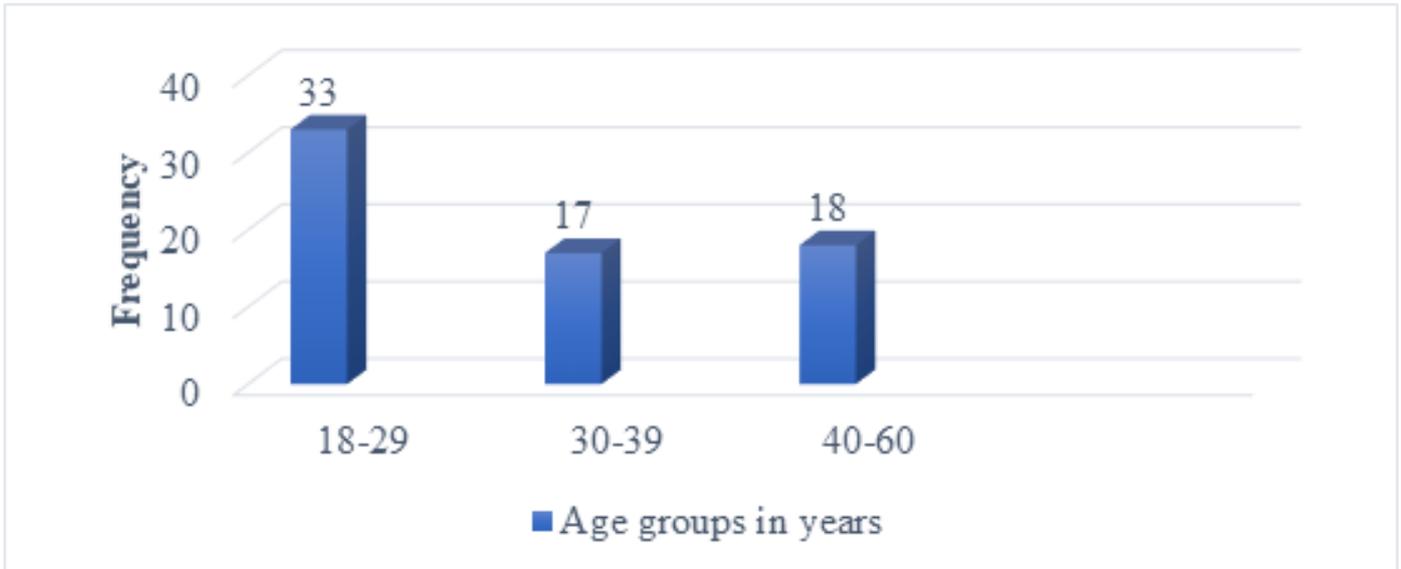


Figure 1: Distribution of respondents by ages. n=68

Table 2: Distribution of respondents by occupation n=68

Responses	Frequency	Percentage (%)
Peasant Farmer	65	96
Self -employed	03	04
Civil servant	00	00
Retired citizen	00	00
Total	68	100

Table 3: Knowledge of respondents on what false teeth extraction is. n=68

Responses	Frequency	Percentages (%)
Yes	42	61.8
No	19	27.9
Don't know	07	10.3
Total	68	100

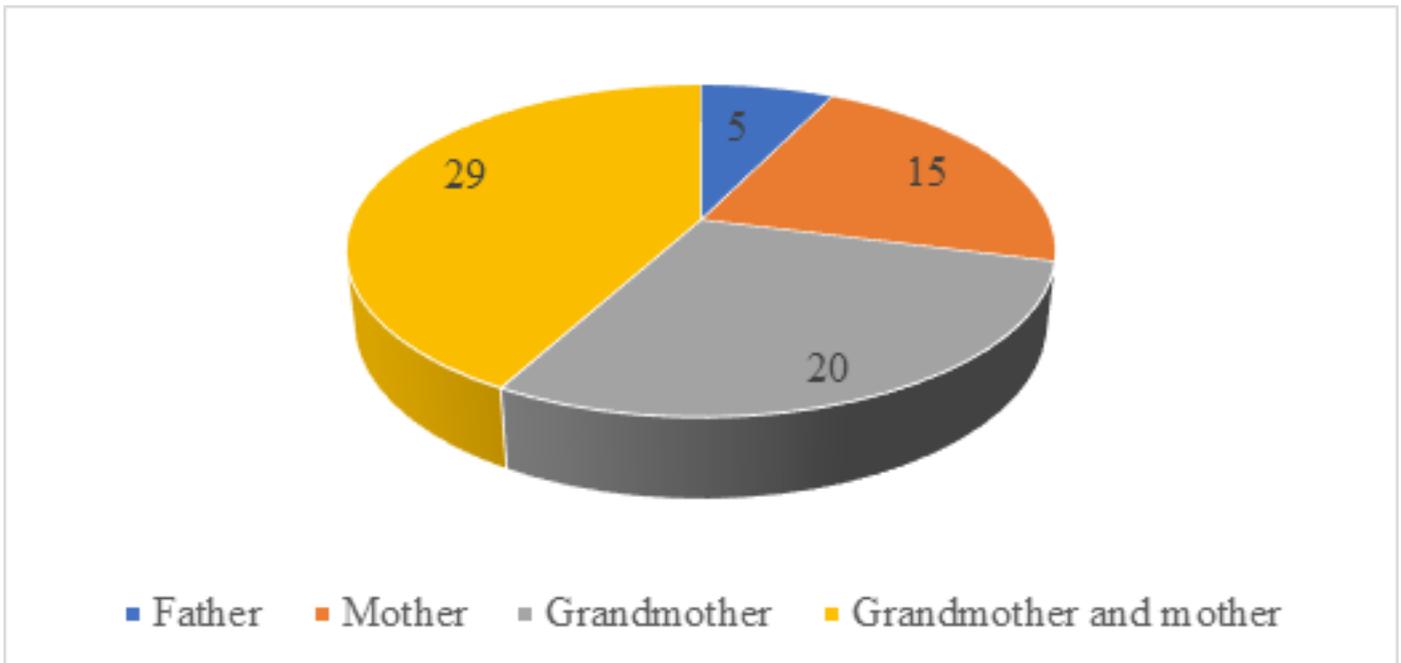


Figure 2: Knowledge of respondents on whois involved in false teeth extraction. n=68

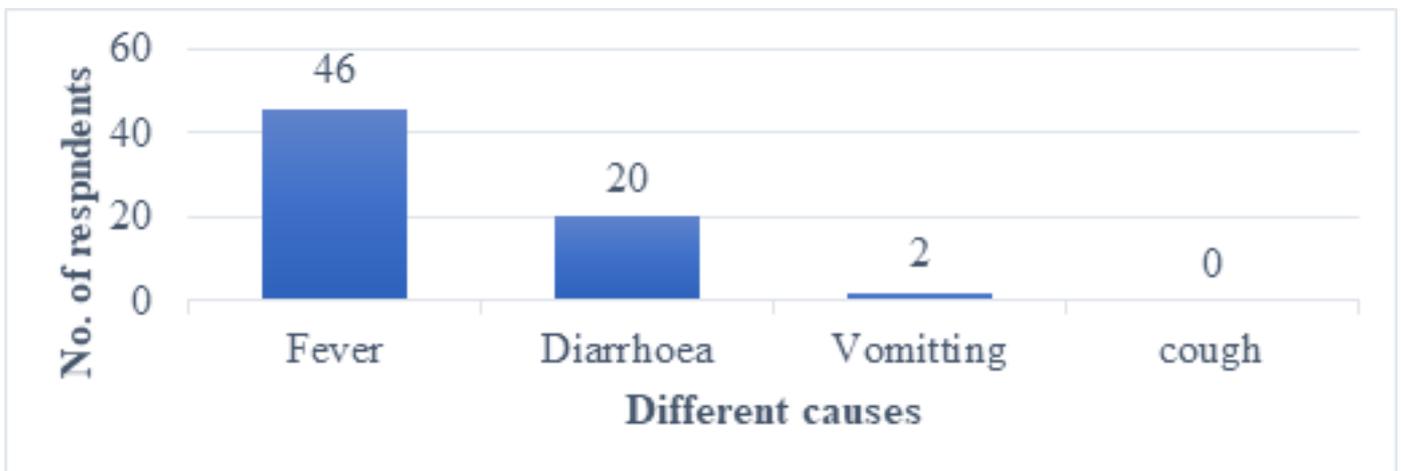


Figure 3: Knowledge of respondents on the reason why children are taken for false teeth extraction n=68

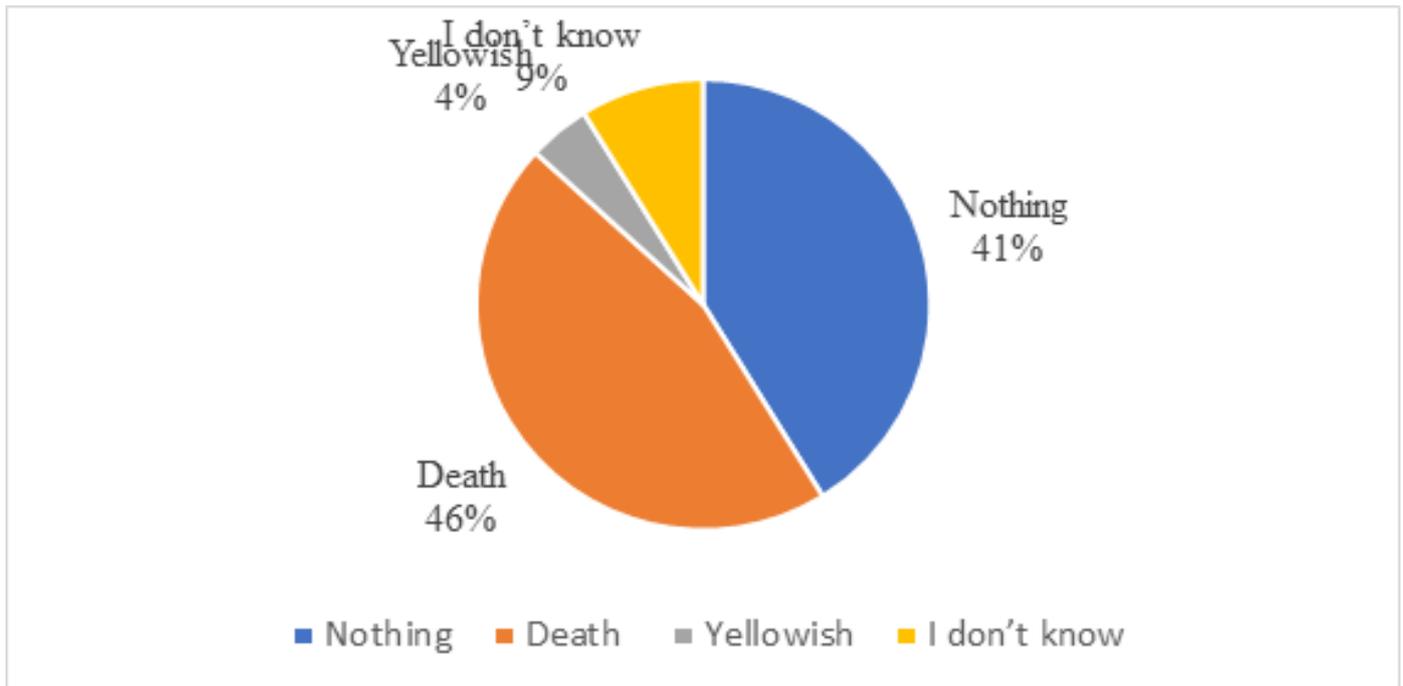


Figure 4: Knowledge of respondents towards the impacts of not extracting false teeth n=68

false teeth extraction is not done, 28 (41%) said nothing happens when the false teeth are not extracted while 3 (4%) said the child turns yellowish and 6 (9%) said they don't know what happens when the false teeth are not extracted. This showed that at the moment the community members knew that the effect of false teeth in children is death those some knew nothing happened.

Table 4 shows that the majority of the respondents 63 (92.6%) said that the best age for removing the false teeth is when the child is below 6 months, 4 (5.9%) said the best age is when the child is between 6 months to 12 months while 1 (1.5%) said when the child is from 1-5 years. The knowledge of the community was that the age bracket at which false teeth disturbed children below 6 months.

Figure 5 shows that the majority of the respondents 45 (66%) responded that parents do not take their children to the health facilities, in any case, they don't heal while 23 (34%) said the children are taken to the health facility. The majority after knowing that the wound has not healed, don't take their children to the health facility.

3.3. The attitude of the community toward false teeth extraction

Figure 7 shows that the majority of the respondents 50 (74%) disagreed strongly that the practice of false teeth extraction should continue while some respondents 18 (26%) agreed strongly that the practice of false teeth extraction should continue. This really showed that the majority of the respondent had a strong disagreement on false teeth extraction, therefore, they had a negative attitude toward false teeth extraction.

Figure 8 shows that the majority of the respondents 40 (59%) did not accept that only first-born children should have their false teeth extracted while at least 28 (41%) accepted that only false teeth of first-born children should be extracted. This implied that the majority of the respondents had a negative attitude toward false teeth extraction.

3.4. Practices of parents toward false teeth extraction

Figure 9 shows that the majority of the respondents 44 (65%) said that they no longer want the false teeth of their children to be extracted while 24 (35%) said they would still want the false teeth

Table 4: Knowledge of respondents towards on the specific age group whom their false teeth are usually extracted

Age group	Frequency	Percentage (%)
Below 6 months	63	92.6
6-12 months	04	5.9
1-5 years	01	1.5
Total	68	100

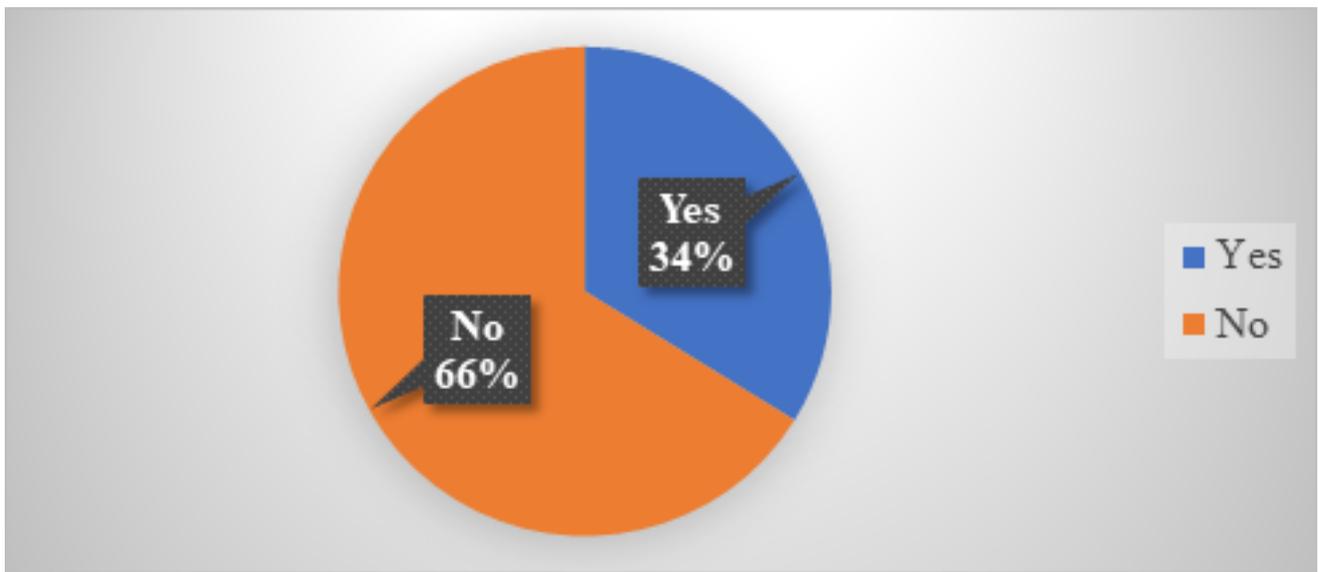


Figure 5: Knowledge of respondents towards taking their children to the health facility if their wound failed to heal. n=68

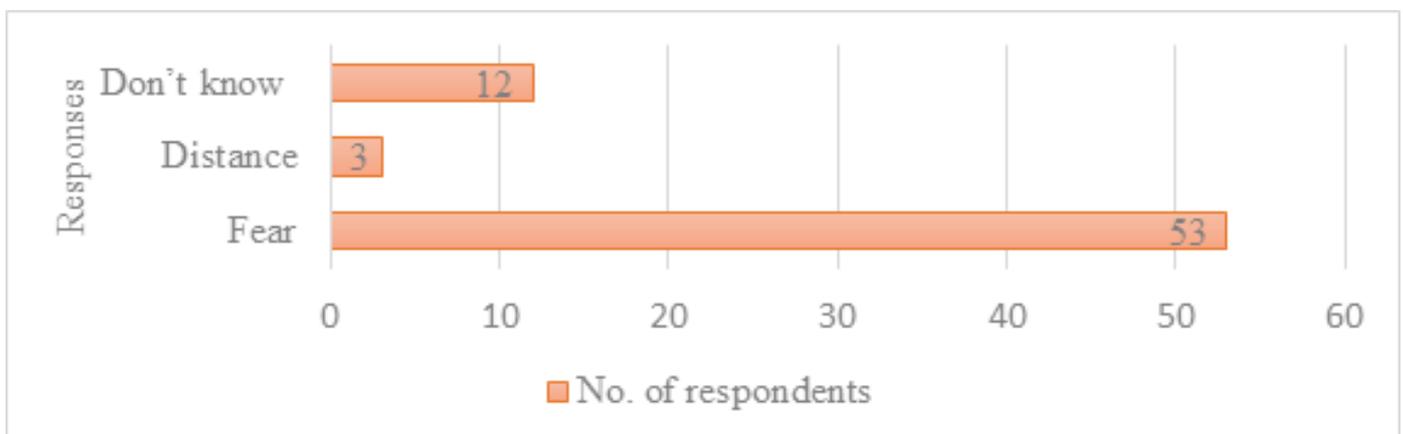


Figure 6: Knowledge of respondents on why parents don't take their children to the health center if the wound failed to heal n=68

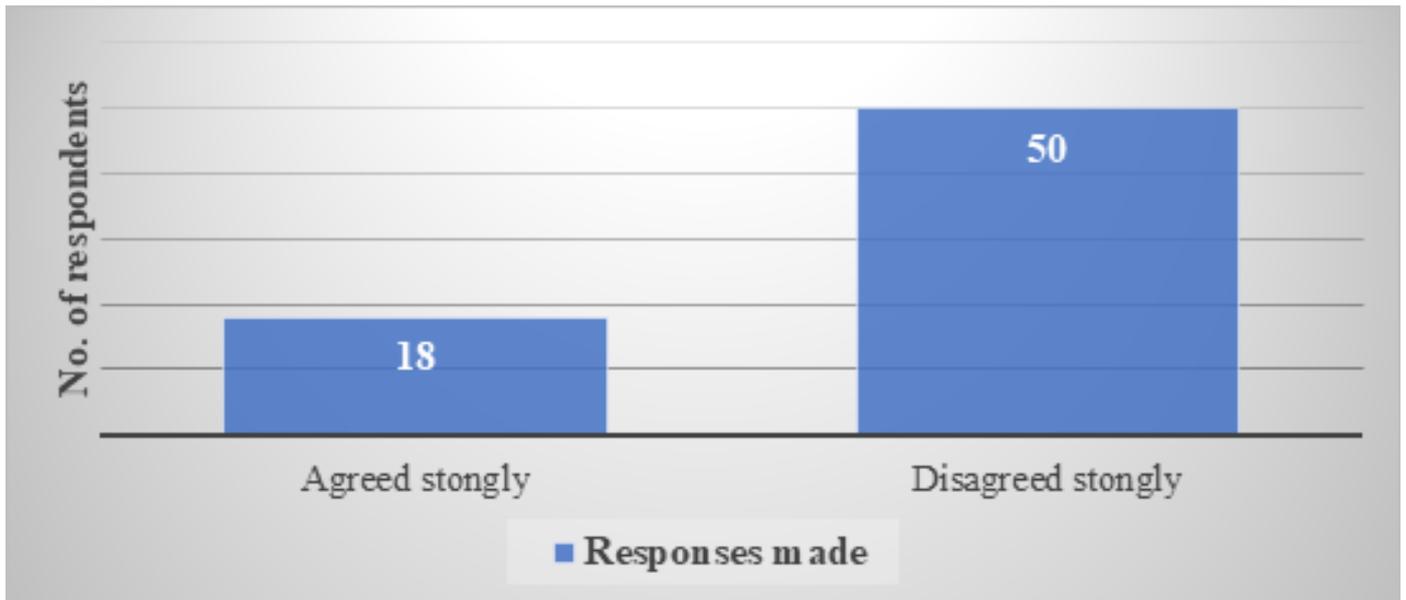


Figure 7: Attitudes of the respondents toward the continuation of false teeth extraction. n=68

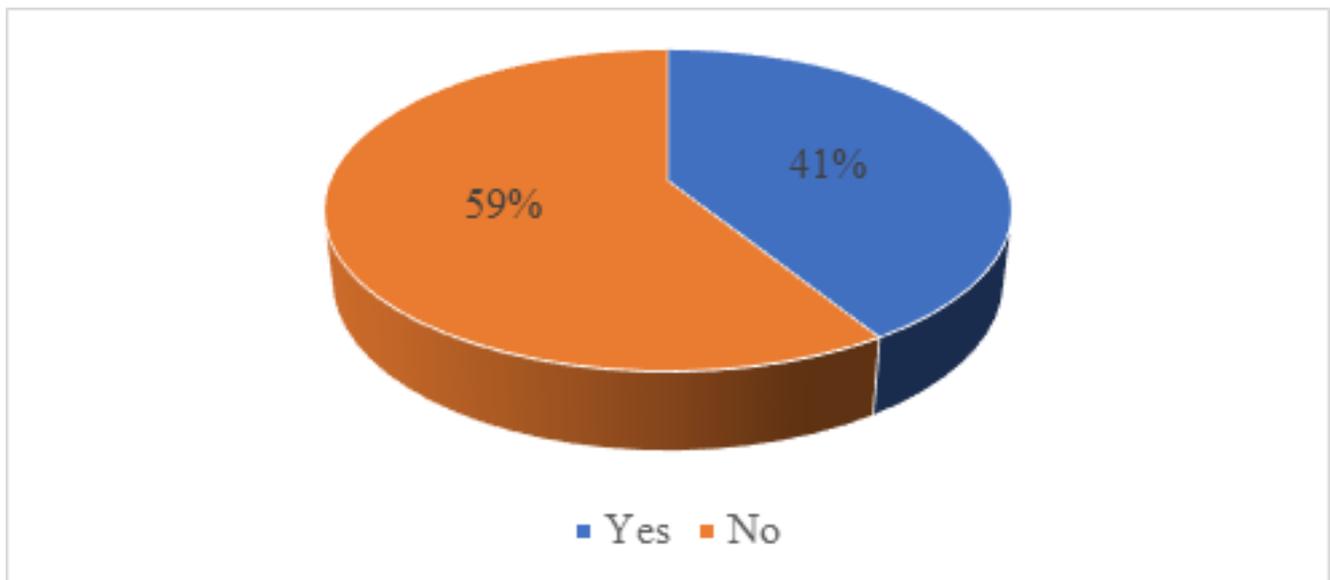


Figure 8: Attitude of respondents towards false teeth extraction of the first-born children. n=68

of their children to be extracted. This evidenced that the majority of people don't want the practice to continue with their children.

In figure 10 above, the majority of respondents 16 (67%) out of those who answered YES in the previous question reported that grandmothers were the ones who take the child for false teeth extraction while 8 (33%) reported that the traditional healers perform them. This revealed that the influence of the grandmother on false teeth

extraction was very high.

table 5 above shows that the majority of the respondents 24 (35%) said that the item used was a bicycle spoke with 21 (31%) said that the item used was a razorblade, 14 (21%) said the item used as wires, and 6 (10%) said the item used was knife and 2 (3%) said by an arrow. This showed that the majority of community members used metallic items to carry out false teeth extraction.

In figure 11, the majority of respondents 39

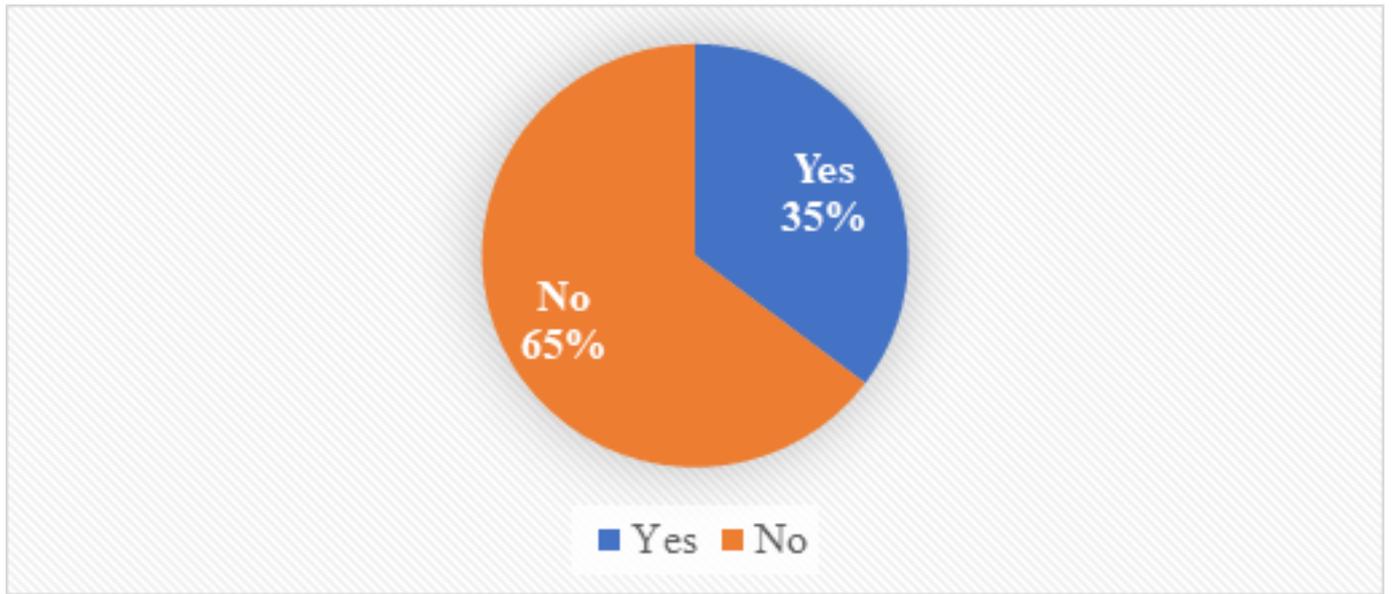


Figure 9: Practice of respondents regarding their wish for the continuity of false teeth extraction.

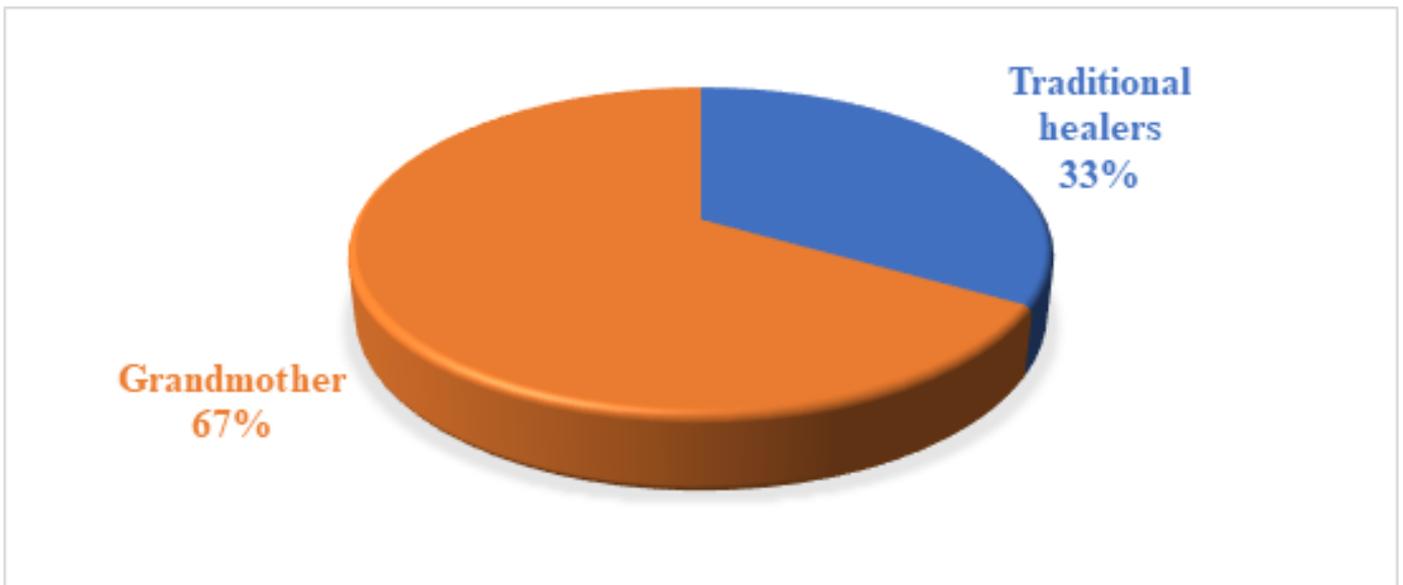


Figure 10: Practice of the respondents regarding those who practice false teeth extraction. n=68

Table 5: Practice of respondents regarding the list of items used for false teeth extraction. n=68

Items	Frequency	Percentage (%)
Bicycle spoke	24	35
Wire	14	21
Knife	06	10
Razorblade	21	31
Arrow	02	3
Total	68	100

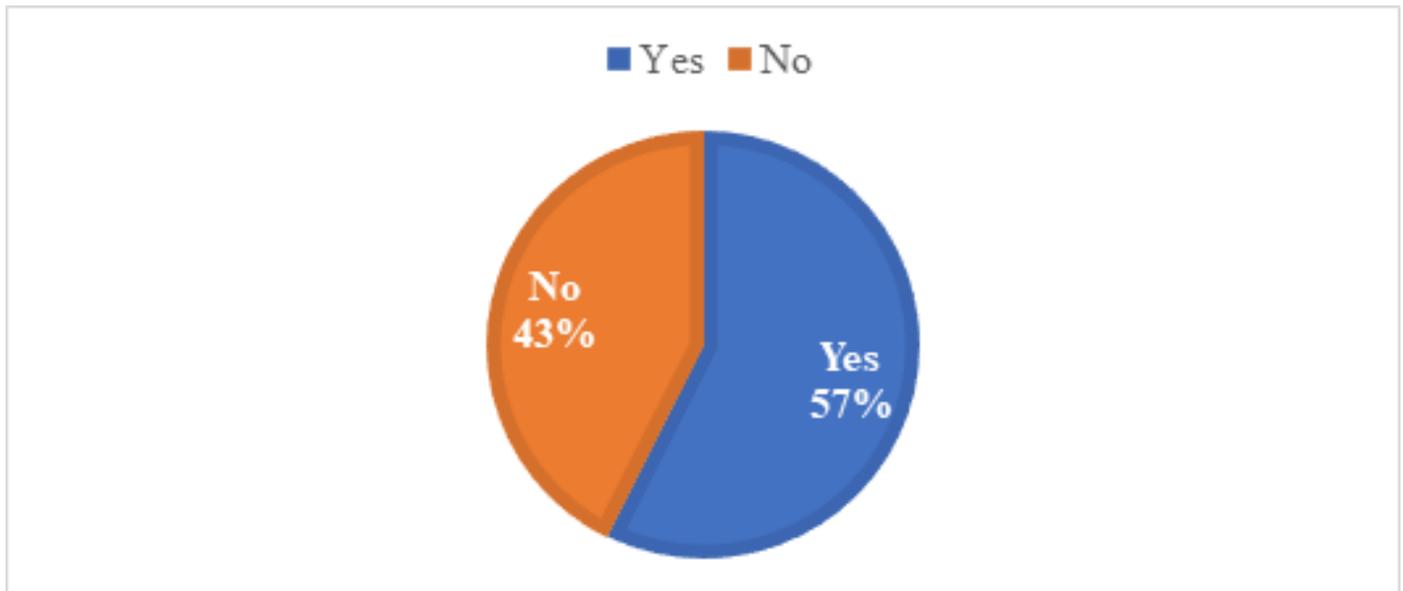


Figure 11: Practice of respondents regarding whether the items used for false teeth extraction were shared. n=68

(57%) reported that the items used for false teeth extraction were shared while 29 (43%) reported that the items were not shared. This showed that the metallic items used by the people during extracting false teeth extraction were shared.

Figure 12 above shows that the majority of the respondents 52 (76%) said they were not thought the danger of false teeth extraction and 16 (24%) said they thought of the danger of false teeth extraction. This revealed that the majority were not thought about the dangers of false teeth extraction.

Figure 13 shows that the majority of the respondents 50 (74%) said they put herbs, 11 (16%) said they put salt, 6 (9%) reported that they used pen-v and only 1 (1%) said that they used soda ash. This showed that the majority of the community members put herbs at the wound.

Figure 14 above shows that the majority of the children 155 (54%) had extracted false teeth while 132 (46%) of the children had their teeth intact out of all the 287 children sampled. This showed that the majority of the participants' children underwent false teeth extraction.

table 6 shows that the majority of the respondents 51 (75%) said they would not extract their children's false teeth while 17 (25%) said they would still extract their children's false teeth.

This showed that the majority of the respondents if they were to be immigrants, would not have extracted the false teeth of these children.

4. Discussion:

4.1. Socio-demographic characteristics

Most respondents 33 (48.5%) were within the age bracket of 18-29 years. This showed that the community members were actually in middle age which limited their ideas on false teeth extraction. Probably, the responses would be different if the respondents included were couples above 60 years. The majority of the respondents 41 (60%) were Catholics, followed by 15 (22%) Protestants with only 1(2%) Muslim and others made 11 (16%) who might be Born-again Christians. This finding would have been far different if the respondents mostly were Muslims and their beliefs would affect the research findings. However, the distribution depended on the influence of religion in the community/area of study. The majority of respondents 42 (62%) were female while the least 26 (38%) were male. This was randomly done and the views of the female-dominated the research findings. However, women are more responsible than men. This meant that the community of Atanga Sub-County who participated in

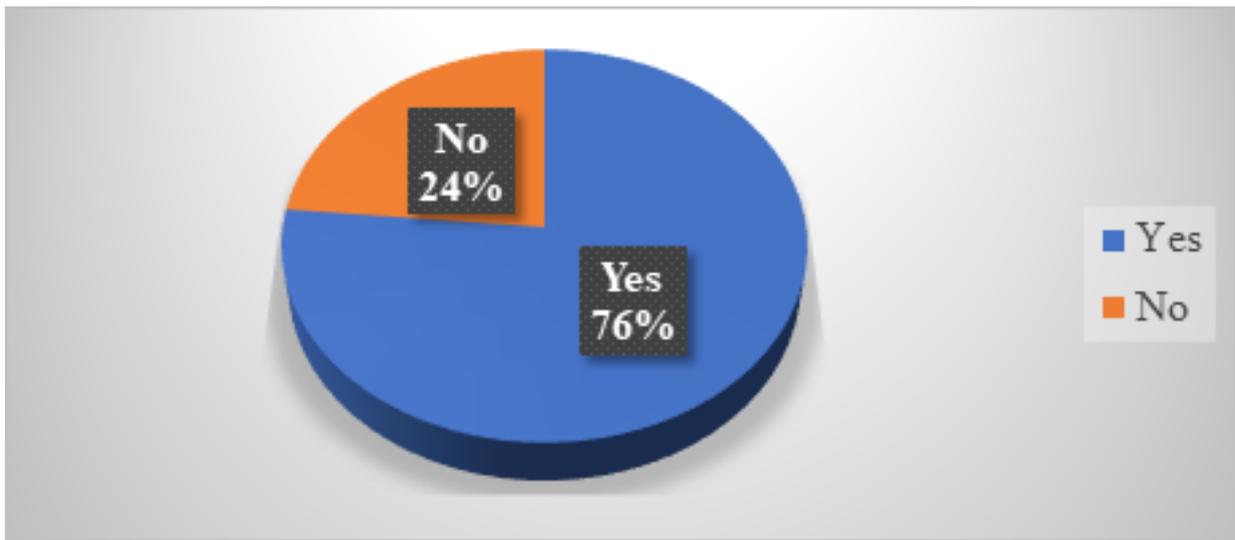


Figure 12: Practice of respondents regarding the dangers of false teeth extraction. n=68

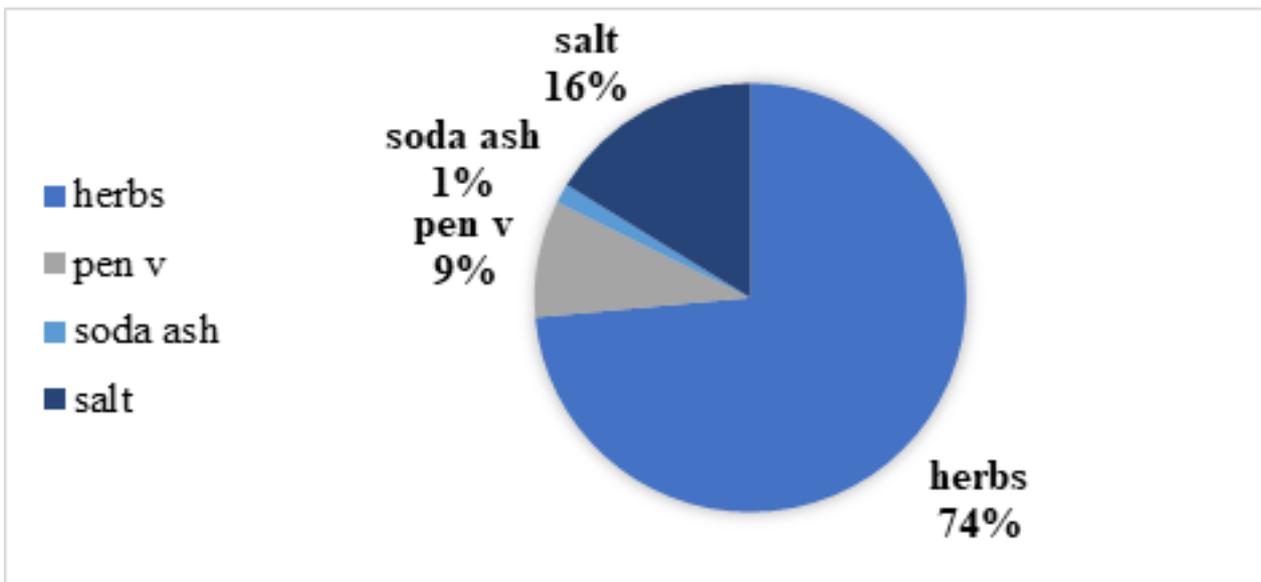


Figure 13: Practice of respondents regarding the items put at the site of the wound to aid healing.

Table 6: Practice of the respondents regarding the continuation of false teeth extraction even if they were to be migrant in Kampala during insurgency. n= 68

Responses	Frequency	Percentages (%)
Yes	17	25
No	51	75
Don't know	0	00
Total	68	100

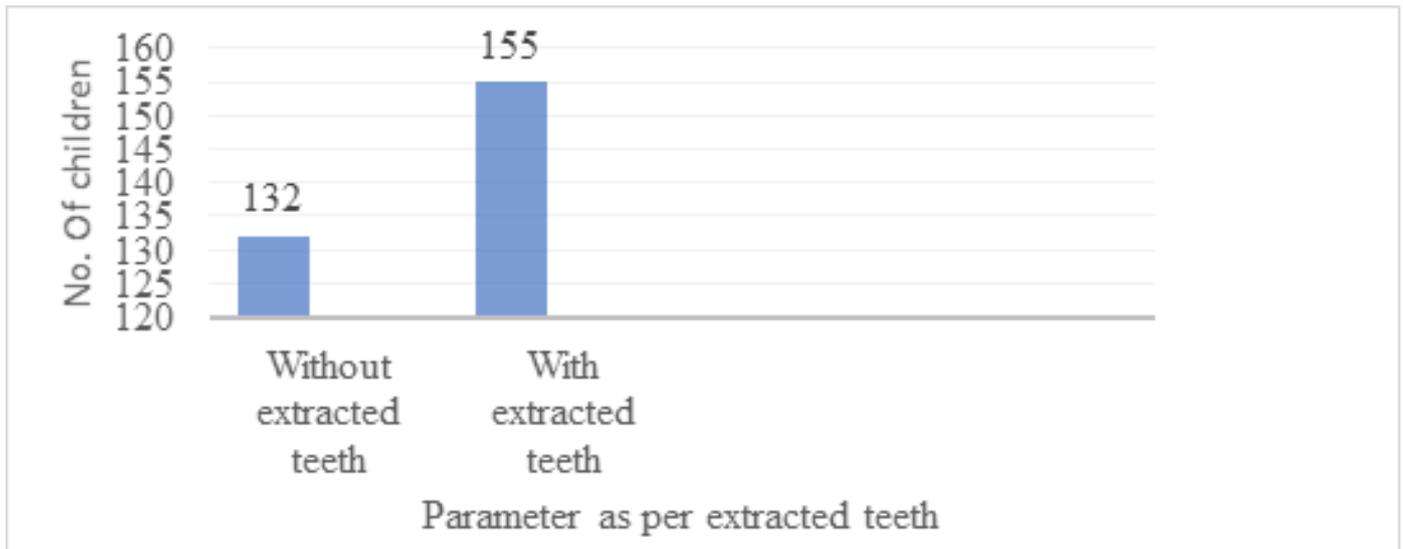


Figure 14: Practice of respondents whose children had scars due to false teeth extraction n= 287

the study were mostly middle age female adults who had some little educational background and they were in Catholic faith-based thought on how to differentiate between good and bad. Most respondents 37 (54%) attained primary level, followed by those who did not acquire any formal education in any way. This showed that most respondents had a low level of education, which implied that they would be with little knowledge with minimal awareness of the dangers of false teeth extraction. The prevalence of false teeth extraction can be attributed to a lack of awareness including their cultural practices.

4.2. Knowledge of the community towards extraction of false teeth extraction

Findings from this study revealed that 42 (61.8%) knew what is meant by false teeth. This signified that at least a good number of the members in Atanga Sub-County know what false teeth were as supposed by (Musinguzi, Kemoli, & Okulu, 2019) in the study conducted in Rukungiri to assess knowledge of the community members revealed a poor level of knowledge on false tooth extraction since majority 70% did not know that false teeth occur in every child and has no relationship with the disease causation. The majority of the respondents 29 (42.6%) said both mothers and grandmothers are the ones who take their child for false teeth extraction, 20 (29.4%)

said that grandmothers move alone to take the child for false teeth extraction, 14 (20.6%) said that mothers take the child by themselves and 5 (7.4%) said fathers take the child by themselves. This, therefore, meant that there were very few inputs from the fathers on false teeth extraction and they have little knowledge of false teeth extraction. Therefore, this showed that both mother and the grandmother had some knowledge of false teeth extraction. The majority of the respondents 46 (67.6%) said it was due to fever, and 20 (29.4%) said it was due to diarrhea. This signified that the majority of the community members of Atanga Sub-County knew the major cause of false teeth in children was fever though some few said diarrhea. The finding agreed with the study done on Mpigi condition (Degonda, 2012) which showed that 47.7% of female in that community who are far away from health facilities tends to continuously relate most of the common childhood medical symptoms like fever, passing of loose stool frequently and loss of appetite to be by false teeth in children, simply because they had little knowledge about teething in children. The majority of the respondents 63 (92.6%) said that the best age for removing the false teeth is when the child is below 6 months. This showed that the community knew the age bracket at which false teeth disturbed children which disagreed with the study done in

Saudi Arabia where 84% of mothers report symptoms of false teeth from age of 3 months, and in females appears earlier with signs of salivation still they community members extract them due to knowledge gap they have on teething and yet thereafter they take for extraction by traditional healers (Elur, Yousif, Albarraq, & Mustafa, 2015). This might be because the age bracket in the questionnaire did not make smaller age grouping like 0-3 months, 3-6 months, and 7-12 months among others.

4.3. The attitude of the community toward false teeth extraction

The majority of the respondents 50 (74%) disagreed strongly that the practice of false teeth extraction should continue while some respond. This showed that the majority of the respondent had a strong disagreement on false teeth extraction, therefore, they had a negative attitude toward false teeth extraction which agreed with the study done by one of the researchers who interviewed on false teeth extraction, and the respondents of 89 (40.5%) disagreed that false teeth extraction should continue, 78 (35.5%) strongly disagreed on the continuation of false teeth extraction, 27 (12.1%) of the respondents agreed that the practice should go on, on the other hand, 23 (10.5%) strongly agreed on the continuation of the false teeth extraction and 3 (1.4%) were not sure therefore greater percentages had a positive attitude towards false teeth extraction (Abang, 2016). This could be because of the much awareness being given by the health personnel. The majority of the respondents 53 (78%) said that fear makes the parents not take their children to the facility if the wound failed to heal this agreed with the study done in Kenya about deciduous tooth bud extraction and nutritional status, it was reported that highest percentage of parents to children 2-5 years old in Kajiado District, Kenya, had good knowledge of deciduous canine tooth extraction at 91% of the interviewed having full knowledge on this but only feared reporting those who still extract them to the health professionals (Kipchumba, 2012). The majority knew medical personnel as tough people and they feared tak-

ing their children to the health facility if their wounds failed to heal, this signified a poor attitude toward seeking medical services among the community members.

4.4. Practices of parents toward false teeth extraction

The majority of the respondents 44 (65%) said that they no longer want the false teeth of their children to be extracted while 24 (35%) said they would still want the false teeth of their children to be extracted. And out of the 24 (35%) of the respondents, the majority 16 (67%) reported that grandmothers were the ones who take the child for false teeth extraction while 8 (33%) reported that traditional healers perform them. This revealed that the influence of the grandmother on false teeth extraction was very high which could have been their earlier habit which might not be easy to quit at once. The majority of the respondents 24 (35%) said that the item used was a bicycle spoke with 21 (31%) said that the item used was a razorblade, 14 (21%) said the item used wired which agreed with those negative practices arose due to negative attitudes in University of North Carolina, whose behaviors and beliefs were that killer canine teeth cause diarrhea, fever, and other related illness in infants, therefore, should be removed. Since the removal is done by traditional healers, they then use unclean instruments like sharpened bicycle spokes, knives, razor blades, and any other sharpened instruments (Emily, Roberts, LaRee, & Clark, 2018) This showed that the majority of community members used metallic items to carry out false teeth extraction. The majority of the respondents 52 (76%) said they were not thought the danger of false teeth extraction and 16 (24%) said they thought of the danger of false teeth extraction. This was the opposite of the stud done by a researcher sometime back via the daily monitor Uganda where 64.1% thought that false teeth are harmful while others (37.6%) thought they were maggots hence they have the highest risk of false teeth extraction victims. This shows evidence of positive attitudes toward false teeth extraction and they support the activities of its extraction

by traditional healers (Nalujja, 2021). This revealed that some community members were not thought about the dangers of false teeth extraction. This could be because they do not attend outreach or the medical workers do not prioritize that in their health education list. The majority of the respondents 50 (74%) said they put herbs whenever the wound failed to heal. This agreed with the study conducted on knowledge concerning the magnitude of tooth bud extraction (TBE) in Bushenyi, Uganda, was reported that the highest number of children who were victims of this stayed with their guardians simply because of little knowledge of false teeth and complication that arises after extraction and yet after this 93% received traditional medicine to put at the site of injury (Tirwomwe, Agwu and Ssamula, 2014). This implied that the majority of the community members of Atanga Sub-County put herbs at the wound which might host the sources of infections of many kinds. The majority of the children 155 (54%) had extracted false teeth while 132 (46%) of the children had their teeth intact out of all the 287 children sampled. This showed that the majority of the participants' children underwent false teeth extraction which agreed with the study. In a similar research topic done on rural inhabitants in Uganda specifically Bungatira the respondents who were assessed to find out their awareness of false teeth extraction shows 98.7% agreed that they had heard about false teeth extraction and most of them who heard had their children false teeth extracted (Wendy, 2014). This could be because of the influences of the elders due to cultural beliefs. This signified that the practices are still in some places despite the effort being made by medical personnel and the media section as well. The majority of the respondents 51 (75%) said they would not extract their children's false teeth while 17 (25%) said they would still extract their children's false teeth. This showed that the majority of the respondents if they were to be immigrants, would not have extracted the false teeth of these children. This agreed with a similar study where many people moved from one place to another as migrants and were interested in cultural socialization, the teaching of the children about

the ethnic customs and traditions although the immigrant children needed to preserve and maintain their culture as a result of positive attitude towards false teeth extraction. This could be due to strong beliefs and practices of culture.

4.5. *Conclusion*

Based on the results of the study, the following conclusions were made:

In conclusion, good numbers of the respondents were adequately knowledgeable about false teeth and obtained the information on false teeth mostly from friends and medical personnel and they described false teeth as the teeth that erupt as milk teeth. However, the majority of the respondents still thought that there was quite a great advantage of extracting these false teeth including ensuring healthy growth of their children, preventing fever, and diarrheal prevention as well. Measures to discourage false teeth extraction are necessary. Furthermore, the majority of the respondents were not aware of the potential consequences of false teeth removal including infection like HIV/AIDS especially after sharing the equipment used for the extraction. Most community members had negative attitudes though still there were some other respondents with a positive attitude towards this practice, simply that it prevents death. This implied that the community held strong misconceptions about false teeth extraction, which continuously put the children at great potential risk. Overall practices of the community members were poor as some ensured that all their children had their false teeth extracted. Furthermore, the tooth extraction was carried out by the grandmothers who has never got any infection control training, this made them never use sterile equipment and they kept on sharing among the children.

5. **Recommendations**

The ministry of health should put in place national sensitization campaigns and warnings against the dangers of risky practices such as false teeth extraction.

The district health officer should make sure that there is enough training based on the proper clerkship of patients and increasing the level of patient-medics relationship to reduce the community fear for the health workers.

The health workers serving the Atanga sub-county should have regular sensitization in terms of outreaches and within the health center to the community on the dangers of false teeth extraction and the promotion of the best practices which improve the attitude of the community members on seeking medical interventions.

The community members of Atanga Sub-County should ensure that they receive sensitization about the dangers and risks of false teeth extraction to stop this rampant practice since it causes many consequences to the health of the child.

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7. Lists of Abbreviations

CTBE	-	Canine Tooth Bud Extraction
FTE	-	False Teeth Extraction
H\C	-	Health Centre
IOM	-	Infant Oral Mutilation
LC	-	Local Council
MoH	-	Ministry of Health
UBOS	-	Uganda Bureau of Statistics
UNMU	-	Uganda Nurses and Midwife Union
VHT	-	Village Health Team
WHO	-	World Health Organization

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