



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

**An Oral Health Promotion Programme for Traveller  
Families in County Offaly**

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## **Glossary of terms**

### **Ethnic group**

A group of people who share a collective identity based on a common history. They possess their own culture, customs, norms, beliefs and traditions.

### **Tullamore Traveller Movement (TTM)**

TTM is a partnership of Travellers and settled people who are committed to Travellers' right to self determination and equality within Irish society. The aim of TTM is to promote the recognition of Travellers as a nomadic ethnic group within Irish society, having its' own distinctive lifestyle and culture. It is funded under the Department of Community, Rural and Gaeltacht Affairs.

### **Primary healthcare programme for Travellers (PHCP)**

In 1999, the former Midland Health Board established the PHCP in partnership with FAS, TTM and the Traveller community. This provides a community development framework for health services, Travellers and other agencies to work in partnership to improve Travellers poor health status in a culturally sensitive manner.

## Executive Summary

The former Midland Health Board (MHB) identified that a need existed in dental health for Traveller families in the MHB region (Midland Health Board 2000). In research undertaken in the MHB area *“one of the strongest points to emerge from the focus group discussion is that dental care is reactive not preventative for Travellers”* (Department of Health and Children 2002 p.2). The Primary Health Care Programme (PHCP) for Travellers in Co. Offaly in partnership with the Dental Health Services with the support of the Traveller Health Unit undertook an oral health needs assessment of the Traveller population in Co. Offaly to identify specific needs and develop culturally appropriate services.

Based on the findings from the PHCP’s assessment of oral health needs of the Traveller population in Co. Offaly and a consultative process with the Traveller community a two-strand oral health promotion programme was proposed:

- **Strand one:** aimed at addressing the issues outlined from the assessment through a training programme for the Community Health Workers in the Traveller Primary Healthcare Programme. A pre- and post questionnaire was used to evaluate this strand of the programme.
- **Strand two:** was clinically based and included an audit of clinical charts. Additional questions in the post-questionnaire were used to assess this strand of the programme.

The results of strand one of the programme yielded positive results and with modifications it is recommended that it be rolled out to the Traveller community in Co. Laois. Unfortunately, the results of strand two of the programme proved disappointing in comparison. Despite the attendance of staff at the cultural awareness day and awareness-raising of the rationale for the Programme, adherence to standard operating procedures and other aspects of the programme was poor.

## 1. Introduction

### 1.1 Background

*“Travellers are one of the most significant minority groups in Irish society today... a distinct ethnic subgroup”* (Midland Health Board 2000 p.11). It is also worth noting that this group are designated as a special needs group, and in common with other special needs groups are marginalised and stigmatised (Department of Health and Children 2002). *“Studies indicate that marginalised populations are suffering disproportionately from poor health and have less access to health care services”* (Department of Health and Children 2002 p.60).

For many years and for a variety of reasons, the Traveller population has experienced a level of health which falls far short of that enjoyed by the general population and as a result Travellers *“die at a younger age than the population in general”* (Department of Health and Children 2002 p.4).

As with general health, inequalities exist in oral health. The National Traveller Health Strategy (2002) prioritises the need for culturally appropriate dental health services to be delivered in response to Travellers needs. Evidence available to date on the oral health status of Travellers indicate that the Travellers have high needs and would benefit from a culturally appropriate oral health promotion services.

In research undertaken in the former MHB area *“one of the strongest points to emerge from the focus group discussion is that dental care is reactive not preventative for Travellers”* (Department of Health and Children 2002 p.2). Generally dental health was something taken for granted by Travellers and *“Dental health services were not seen as a resource or as a means to affirm dental health but rather as a means to alleviate dental pain”* (Department of Health and Children 2002 p.2).

Individuals wishing to adopt a healthy lifestyle may be prevented from doing so by environmental and socio-economic factors, which are often beyond their individual control. For example up to 80% of Travellers are unable to read, meaning that they may be unable to access health promotion messages. It is acknowledged that video and posters have been shown to be the most effective media for conveying important health messages to the Traveller community (Department of Health and Children 2002). For Travellers in particular the lack of culturally appropriate education and training materials has contributed to the low uptake and utilization of preventative action and curative services (Department of Health and Children 2002).

## **1.2 Travellers oral health promotion programme**

The establishment of Primary Health Care Programme (PHCP) for Travellers was one of the actions proposed in the National Travellers' Health Strategy (Dept of Health and Children 2002). In 1999, the former Midland Health Board (MHB) established the PHCP in partnership with FAS, Tullamore Travellers' Movement (TTM) and the Traveller community. The PHCP is coordinated by a Public Health Nurse, a Community Development Health Worker and also has six Traveller women employed as qualified Community Health Workers (CHWs) for Travellers. These women have completed a four year training programme with the aim of working in partnership with Travellers and the health services to improve the health status of Travellers.

In 2004, the PHCP for Travellers in Co. Offaly, in partnership with the Dental Health Services, undertook an oral health needs assessment of the Traveller population in Co. Offaly to identify specific oral health needs and develop culturally appropriate services. This initiative was funded and supported by the Traveller Health Unit.

This assessment took the form of a questionnaire delivered via the Community Health Workers (CHWs). Based on the findings of this process a two-strand oral health promotion programme was proposed. The main aim of which was to

contribute towards improving the general and oral health of Traveller families. *“Experience has shown that the success of these initiatives is closely related to the extent of the involvement of Traveller organisations in the drafting, design and disseminating of the material used”* (Department of Health and Children 2002 p.49); hence the participation of the CHWs and members of the Travelling community.

The oral health promotion programme utilised a two strand approach: Strand one of the programme addressed the issues outlined from the needs assessment through a training programme for the Traveller Primary Healthcare CHWs. Such issues included:

- Dental entitlements and available dental services
- Oral hygiene
- Fluoride and its' uses
- Diet and label interpretation
- Smoking and Oral Health
- Trauma to teeth
- Fear.

It was hoped that by training the CHWs in these issues that this knowledge would be disseminated throughout the Traveller community, as word of mouth and oral transfer of information is an integral part of the Travelling community. This was also facilitated by the limited delivery of a number of presentations ( $n=5$ ) in Tullamore, Birr and Mountmellick and to Traveller parents and their children in two pre-schools in Tullamore.

Strand two of the programme was a clinical dental programme. The aim of this strand was to call in all Traveller children under 16 years of age for a dental assessment. Consent was obtained from Traveller families to enter their names and contact details on a register (See Appendix 2). This register was used to establish a database of all Traveller children less than 16 years of age who would be entitled to free dental treatment within Co. Offaly. The children on the

register were then allocated by family to a community dental surgeon according to the area in which they lived in (i.e. their nearest health centre). Each Community Dental Surgeon was then required to call in their allocated children for dental examinations and treat or refer to other oral health specialists as appropriate. The register was updated accordingly (i.e. if families entered or left the area).

All Dental staff in the Co. Offaly area also attended a Traveller cultural awareness day in order to understand why the programme was been implemented and to gain a better understanding of the Traveller culture. Standard operating procedures (SOPs) were also established in conjunction with the Community Health Workers and the Dental Services in order to deliver the Dental Service in a more culturally appropriate manner (see Appendix1).

The programme time-frame is presented in Appendix 7.

### **1.3 Programme objectives**

In the short term, the main objective was to improve the Travelling community's oral and general health knowledge, and encourage them to access available dental services.

In the medium term, the main objectives were to bring about an improvement in the oral hygiene practices of adult Travellers, increase their ability to access available Dental Services, increase attendance rates for routine dental appointments, especially for preventive treatment, and reduce the number of failed attendance at appointments. It is hoped that this in turn would directly impact upon the oral health of Traveller children.

The long term goal is to bring about a change in attitude and behaviour in both Traveller adults and children in such areas as regular tooth brushing, the use of fluoride toothpaste and adopting healthy eating habits. It is also hoped that the programme will empower Travellers and enable them to take control over their

own health. From the Dental Services perspective the long term goal is to develop a culturally appropriate Dental Service.

## **2. Evaluation**

### **2.1 Aim of the evaluation**

To assess whether the Traveller Oral Health Promotion Programme achieved an increase in knowledge/information with regard to diet, oral hygiene practices, dental entitlements, dental trauma and the use of fluoride amongst members of the Travelling community

To determine if the programme resulted in increased attendance rates, a reduction in the failed appointment rate and increased uptake of oral health preventive services; thus indicating that the oral health service is moving from a reactive service to a pro-active service.

### **2.2 Methods**

Given the aims and objectives of the evaluation, and current resources available, a quantitative research strategy was employed for the evaluation of the Travellers oral health programme. Data was collected through:

- Adult questionnaire: pre and post strand one (see Appendix 3)
- Mothers questionnaire: pre and post strand one ( see Appendix 4)
- Clinical audit forms: strand two.

#### **2.2.1 Questionnaire**

In order to evaluate the effectiveness of strand one of the programme two open-ended questionnaires were designed, targeting both adults ( $n=201$ ) and mothers ( $n=89$ ) from the Travelling community in the Offaly area. Questionnaires were administered pre and post strand one of the programme. Mothers were requested to complete both questionnaires. All questionnaires were anonymous.

The questionnaire was developed by the oral health promoter who was responsible for the overall programme. Questions asked were based upon the oral health needs assessment base line survey (MHB 2002).

A total of 26 open-ended questions were included in the adult questionnaire (see Appendix 3). The questions assessed:

- Dental entitlements and available dental services

- Oral hygiene
- Fluoride and its' uses
- Diet and label interpretation
- Smoking and oral health
- Trauma to teeth
- Fear.

A total of 18 open-ended questions were included in the mother's questionnaire. The mother's questionnaire focused primarily on oral hygiene and dietary practices in relation to their children (see Appendix 4).

Mothers who attended the Midland area Dental Services within the last twelve months were also asked additional questions post strand one to assess the implementation of the SOPS developed (See Appendix 5).

The questionnaires were administered by the Traveller CHWs. If literacy problems were an issue, assistance in completing the questionnaire was also provided.

### **2.2.2 Clinical audit**

In order to evaluate strand two of the programme an audit tool was developed by the oral health promoter. The tool sought to audit the clinical dental charts ( $n=309$ ) of all children recorded on the Traveller register (see section 1.2). Permission to access the charts was granted by the Principal Dental Surgeon, and the charts were viewed by dental staff only (See timeframe presented in Appendix 7).

The audit tool assessed the following:

- The number of DNAs (did not attend/failed attendance for appointments) pre- and post intervention
- The number of casual/emergency appointments pre-and post-intervention
- Whether these emergency appointments were due to trauma or pain as a result of dental caries
- The number of non-casual appointments pre-and post- intervention
- The number of hygienist referrals and attendance of same
- Adherence/compliance with regard to the standard operating procedures: all appointments after 11.30 a.m., all appointments between September to May, the reminder system was implemented and adhered to, data book filled in correctly and corresponding to the charts and the day book
- Percentage of children actually called for appointment off the traveller register.

### **2.3 Sampling frame**

The sampling frame included both mothers and adults who consented to inclusion on the oral health register in the Offaly area:

- Mothers ( $n=89$ ) (with children under 16 years of age)
- Adults ( $n=212$ ) (inclusive of mothers  $n=89$ ).

### **2.4 Analysis**

Data was analysed using SPSS V.14 (Software Package for the social sciences). Frequencies were carried out on all data entered. A thematic analysis was carried out on all open-ended questions.

### **2.5 Confidentiality**

All data collected was treated confidentially and anonymously. Data collected in the course of the overall evaluation will be retained in accordance with the standards set out in the Data Protection Act 2001.

## **2.6 Ethical considerations**

Consent was obtained from Traveller families to enter their names and contact details on a Traveller register. This register was used to establish a database of all Traveller children under 16 years of age who would be entitled to treatment within Co. Offaly. The role of the CHWs was to support Traveller families to make an informed decision whether to participate or not in this oral health assessment. Only families that agreed to participate and duly signed the consent form (See Appendix 2) proceeded to complete the oral health questionnaire.

## **2.7 Limitations**

In relation to the questionnaire, additional questions were asked in the post questionnaire in relation to demographic details and the standard operating procedures hence no baseline data are available for comparison purposes. This demographic data was requested by other services within the HSE.

All of the questions were open ended and some would have been more suited to a quantitative approach which in turn would have made analysis less time consuming.

Ideally each questionnaire should have been given a unique identifier (i.e. chart number) to facilitate accuracy in terms of matching data for analysis pre and post-intervention. However, this was discussed with the CHWs and it was agreed that this might reduce participation rates and was subsequently decided against.

For the mothers questionnaires responses post-intervention ( $n=112$ ) were higher than those received pre-intervention ( $n=89$ ). In the adults questionnaire the post-intervention returns ( $n=185$ ) were lower than those received pre-intervention ( $n=212$ ). Given the fact that a unique identifier had not been used it was not possible to identify persons who had completed the post-intervention questionnaire and not the pre-questionnaire.

### **3 Results**

The following section presents the results from the evaluation of the Traveller Oral Health programme. It will be presented in three parts: the results from the mother's questionnaire are presented followed by the results from the adult's questionnaire. The third part of the results will refer to the clinical audit of the Traveller oral health records. Discussion of the results is also included in this chapter where appropriate.

*Throughout the report the symbol \* is also used to indicate total percentages that add up to more than 100%. This occurred when respondents were given the option to tick more than one response.*

#### **3.1 Mother's questionnaire**

There were 89 mothers questionnaires completed at the pre-intervention stage and 112 questionnaires completed post-intervention. Baseline data is unavailable for comparison pre and post-intervention in the following Tables: 3.1.1; 3.1.3, 3.1.5-; 3.1.7, 3.1.13-3.1.14 and 3.1.16

Tables 3.3.7-3.3.12 are related to the analysis of implementation of standard operating procedures (SOPs) for the clinical programme which was introduced after the initial education programme was initiated. Hence these results will be presented later as they relate to strand two. All recommendations outlined in section 3.1.1 are taken from the Forum on Fluoridation Report (2002) and the Health Development Agency (2001).

##### **3.1.1 Dental practices**

Tooth brushing is important for maintaining gingival (gum) health. Studies have failed to establish a clear association between tooth brushing and caries incidence (Health Development Agency, 2001). Hence plaque removal by tooth brushing alone cannot be advocated for caries prevention. Brushing with fluoride toothpaste, however, is the most important method of delivering fluoride to the tooth surface.

- **Amount of toothpaste used**

**'Recommendation: Pea sized amount'**

Thirty eight percent of mothers were observed using the recommended pea sized amount of toothpaste and 32% using a small amount (see Table 3.1.1). Clarification, however, was not sought as to what mothers meant when they reported using a 'good amount' or 'small amount' of toothpaste.

**Table 3.1.1** How much toothpaste to you use? (n=108/112)

Amount of toothpaste used	Frequency	Valid % (n=108)
Pea size	43	39.8
Good amount	24	22.2
Small amount	36	33.3
Other	5	4.6
Total	108	100.0

- **Type of toothpaste used**

**Recommendation: Adult fluoridated toothpaste for all over two years of age.**

A 13% increase was observed in the number of mothers reportedly using adult fluoridated toothpaste post-intervention (see Table 3.1.2). Furthermore, there was a 22% decrease in the use of paediatric toothpastes post-intervention. This is in accordance with the Forum on Fluoridations recommendations 2002: *'Paediatric toothpaste with low concentrations of fluoride requires further research before recommending their use'*.

**Table 3.1.2** What type of toothpaste do you use?

Type of toothpaste used	Pre (N=89)	Post (N=112)
Colgate (fluoridated)	43%	70%
Fluoride (fluoridated)	16%	2%
Milk-teeth	8%	1%
Anything	10%	3%
Any baby-toothpaste	20%	5%
Other	-	13%
Missing	3%	6%

- **Supervision of children brushing teeth**

**Recommendation: Until 7 years of age**

As can be seen from Table 3.1.3, the ages of when mothers thought children can brush their own teeth ranged from one year to ten years of age post-intervention. One fifth of respondents reported the correct age of 7-8 years.

**Table 3.1.3** Age at which children can brush their own teeth (n=107/112)

Age	Frequency	Valid % (n=107)
1-1.5yrs	5	4.7
2-3yrs	11	10.3
3-4yrs	19	17.8
4-5yrs	5	4.7
5-6yrs	18	16.8
6-7yrs	15	14.0
7-8yrs	21	19.6
8-9yrs	3	2.8
9-10yrs	3	2.8
Other	7	6.5
Total	107	100

- **Frequency of brushing**

**Recommendation: Twice a day**

There was an increase of 10% post intervention in the number of mothers who reported their children as brushing their teeth twice a day (see Table 3.1.4)

**Table 3.1.4** Number of times teeth are brushed per day

Times per day	Pre (N=89)	Post (N=112)
Once per day	14%	4%
Twice per day	77%	87%
Three times per day	5%	4%
Other /irregular	3%	1%
Missing	1%	4%

### ***Spitting or rinsing after brushing***

#### **Recommendation: to spit after brushing**

From the additional questions asked post-intervention, it was ascertained that over half of the mothers surveyed (55%) thought that children should spit after brushing their teeth (see Table 3.1.5), as is recommended by the Forum on Fluoridation 2002.

**Table 3.1.5** To rinse or spit after brushing your teeth (n=100/112)

Action after brushing teeth	Frequency (n=100)	Valid % (n=100)
Rinse	41	41.0
Spit	55	55.0
Neither	1	1.0
Both	3	3.0
Total	100	100.0

### **3.1.2 Dietary habits**

- ***Causes of tooth decay***

The main causes of tooth decay identified by those surveyed post-intervention included sugar (27%), sweets and fizzy drinks (64%), and not brushing ones teeth (21%) ,(See Table 3.1.6).

**Table 3.1.6** Causes of tooth decay post-intervention (n=112/112)\*

Causes of tooth decay	Frequency	Valid % (N=112)
Sugar	30	26.8
Sweets & Fizzy drinks	72	64.3
Not brushing teeth	23	20.5
Other	6	5.4

- **Appropriate times for sugar intake**

Mothers were asked 'if they were giving their child sweets or fizzy drinks what would be the most appropriate or best time to do so?' And as recommended over half (63%) of the mothers surveyed post-intervention reported meal times as being the best time to give their children sweets or fizzy drinks and 10% reported never (see Table 3.1.7). The questionnaire, however, did not seek to establish whether or not their views translated into practice.

**Table 3.1.7** Best times for sweets or fizzy drinks (n=103/112)

Best times for sweets or fizzy drinks	Frequency	Valid % (n=103)
Meal times	65	63.1
Never	10	9.7
Occasionally	14	13.6
Don't know	5	4.9
Other	9	8.7
Total	103	100.0

- **Contents of children's lunch boxes**

Overall, the results of the Oral Health Promotion Programme with regard to diet were positive with some areas showing marking improvement, for example the percentage of mothers adding fruit to children's lunch boxes rose by 31% post-intervention (see Table 3.1.8). The main foods reportedly included in children's lunchboxes pre and post-intervention were sandwiches, fruit, fruit juices and dairy products.

**Table 3.1.8** Contents of children's lunchboxes pre and post-intervention\*

Contents of children's lunchboxes	Pre % (n=89)	Post % (n=112)
Sandwiches	63%	55%
Fruit	64%	82%
Dairy (i.e. milk, cheese, yoghurts)	25%	21%
Fruit juice/juice	25%	27%
Snacks (i.e. popcorn, cereal bars, bars)	16%	5%
Healthy lunch	10%	1%
Ribena/diluted drink	6%	3%
Nothing	3%	-
Other	4%	-
Missing	13%	14%

- **Contents of baby's bottles**

With regard to the contents of baby's bottles, the main drinks reported post-intervention included milk (59%) and water (15%), (See Table 3.1.9). There was an increase of 5% in both of these post-intervention and a 9% reduction in the use of Ribena. The observed increase of 15% in the reported use of baby food can be attributed to advice given to the community from the oral health promoter in line with current community nutritional advice (see Table 3.1.9).

**Table 3.1.9** Contents of baby's bottles pre and post-intervention\*

Contents of baby's bottles	Pre (n=89)	Post (n=112)
Milk	54%	59%
Ribena	12%	3%
Orange juice/juice	13%	19%
Water	10%	15%
Fizzy drink	1%	2%
Dilute drink	7%	4%
Yop	1%	-
Baby food	1%	16%
Tea	1%	1%
Missing	27%	20%

There was an increase of 20% of mothers not putting anything additional into their baby's bottles (see Table 3.1.10).

**Table 3.1.10** Additions to contents of baby's bottles pre and post-intervention

<b>Additions to contents of baby's bottles</b>	<b>Pre (n=89)</b>	<b>Post (n=112)</b>
Yes	17%	5%
No	62%	82%
Missing	21%	13%

### 3.1.3 Behaviour

- **Appearance**

Ninety-two percent of mothers considered the appearance of their children's teeth to be important, the reasons for which included health, appearance, confidence and to prevent bullying. This is clearly captured in the following quotes:

***“yes because it sometimes can affect a child's confidence or appearance  
 “yes so they are not called names in school because of bad teeth  
 “yes even white teeth make a child more confident”  
 “yes because they would be very self conscious if they had no teeth or bad teeth”.***

- **Reason for attending dental services**

The importance of appearance is also reflected in the fact that 51% of mothers post-intervention reported bringing their children to the Dentist for their check up in order to protect their children's teeth. Other reasons cited included 'when in pain' and 'when needed' (see Table 3.1.11).

**Table 3.1.11** Why bring a child for dental treatment pre and post-intervention\*

<b>Why bring child for dental treatment*</b>	<b>Pre (n=89)</b>	<b>Post (n=112)</b>
Check up/protect teeth	51%	51%
When in pain	15%	9%
When needed	9%	21%
Other	16%	-
Missing	14%	18%

### Dental emergency

In the majority of cases, should a dental emergency arise, mothers reported going to the Dentist. There was, however, a decline (9%) in those reportedly going to the Dentist post-intervention, and an increase of 10% going to the Health Services and of 11% going to the hospital (see Table 3.1.12).

**Table 3.1.12** Where to go in a dental emergency pre and post-intervention\*

Where to go in a dental emergency*	Pre % (n=89)	Post % (n=112)
Dentist	58%	49%
Doctor	1%	4%
Hospital	13%	24%
Health Services	17%	27%
Do not know	1%	-
Health centre	15%	11%
Other	2%	-
Missing	3%	5%

If a child was to receive a blow to their front tooth the majority of mothers reported that they would go to the appropriate services, whether that be the Dentist or casualty (see Table 3.1.13).

**Table 3.1.13** Where to go if you receive a blow to the front tooth (n=106/112)

Where to go if you receive a blow to the front tooth	Frequency	Valid % (n=106)
Casualty	14	13.2
Dentist	79	74.5
Health centre	1	0.9
Other	4	3.7
Health centre and/or casualty	5	4.7
Hospital and/or dentist	3	2.8
Total	106	100

In relation to a front tooth being knocked out (avulsed tooth), 23% reported correct first aid procedures (i.e. put in milk or inside jaw and seek dental or medical advice). In addition over a third (37%) reported going to a dentist (see Table 3.1.14).

**Table 3.1.14** What to do if the front tooth is knocked out. (n=104/112)

What to do if the front tooth is knocked out?	Frequency	Valid % (n=104)
Seek help from Dentist	38	36.5
Get a false one	28	26.9
Put in milk and seek dental help	16	15.4
Put in milk and seek medical help	1	1.0
Put inside of jaw and seek dental help	7	6.7
Other	12	11.5
Don't know	2	1.9
Total	104	100.0

**3.1.4 Dental services**

An increase of 17% of respondents reported that their children were not nervous when going to the Dentist (see Table 3.1.15). Of the 22% that still reported their children to be nervous post-intervention the main reasons cited were related to the children's fear of needles (44%) and possible pain experienced (20%), (See Table 3.1.15).

**Table 3.1.15** Is child nervous going to dentist?

Is child nervous going to dentist?	Pre (n=89)	Post (n=112)
Yes	45%	22%
No	43%	60%
Don't know	2%	1%
Sometimes	1%	2%
Missing	9%	15%
Why are they nervous?*	(n=40)	(n=25)
Needles	40%	44%
Tools	23%	4%
Treatment (fillings, extraction, noise, blood)	20%	4%
Bad experience	3%	-
Don't know	5%	-
Pain	8%	20%
Missing	-	28%

- **Fissure sealants**

Fissure sealants are preventative plastic coatings for posterior teeth. According to the National Survey of Children's oral health (2002), *'Not only are decay levels higher among the disadvantaged, they have fewer protective sealants on their teeth'*. Hence a component of Strand one of this programme was on fissure sealants to address this inequality. However it emerged that only 21% of mothers knew what fissure sealants were post-intervention. Data was unavailable to draw pre-post comparisons. Table 1.9 outlines an overview of what mother's thought a fissure sealant to be.

**Table 3.1.16** Description of fissure sealants (n=85)

Description of fissure sealants	Frequency	Valid % (n=85)
Filling	9	10.6
Paste on back teeth	5	5.9
Paste on teeth	12	14.1
Plastic coating on teeth	1	1.2
Teeth	17	20.0
Don't know	12	14.1
Other	29	34.1
Total	85	100.0

### 3.2 Adult's questionnaire

A total of 212 adult questionnaires were completed at the pre- intervention stage and 185 post-intervention of strand one. Following the results of the pre-questionnaire it was concluded that additional questions would be of benefit in the post-programme questionnaire. Where base line data is unavailable for comparison pre and post-intervention, this will be evident upon presentation of the following data: Table 3.2.2, 3.2.4, 3.2.8-3.2.10.

In addition, demographic data was collated at the request of other services within the HSE (see Appendix 6).

#### 3.2.1 Dental practices

- **Frequency of brushing**

**Recommendation: Twice a day**

The majority (71%) of respondents post-intervention report brushing their teeth twice a day, which was a 5% increase compared to figures received pre-intervention (see Table 3.2.1).

**Table 3.2.1** Frequency of brushing teeth pre and post-intervention

<b>Frequency of brushing teeth</b>	<b>Pre n= 212</b>	<b>Post n=185</b>
Once per day	17%	15%
Twice per day	66%	71%
Three or more times per day	8%	9%
Irregular	5%	2%
Don't know	3%	1%
Missing	1%	2%

- **Spitting or rinsing**

**Recommendation: Spitting**

In accordance with the Forum on Fluoridation 2001, data from the additional questions asked post-intervention, indicates that 44% reportedly spit after brushing their teeth and 54% rinse (see Table 3.2.2).

**Table 3.2.2** Respondents who reported rinsing or spitting after brushing teeth

Action taken after brushing teeth	Frequency	Valid % (n=179)
Rinse	96	53.6
Spit	78	43.6
Both	5	2.8
Total	179	100.0

- **Type of toothpaste used**

**Recommendation: Adult fluoridated toothpaste**

In terms of toothpastes used there was a marked reduction of 10%, in the reported use of abrasive toothpastes in the adult population post-intervention (see Table 3.2.3).

**Table 3.2.3** Types of toothpaste used pre-and post intervention

Type of toothpaste used	Pre (n= 212)*	Post (n=185)
Fluoride including Colgate	60%	55%
Smokers/Pearl	13%	3%
Any type	6%	16%
Other	15%	19%
None	1%	2%
Missing	3%	4%

- **Gingival Health**

As highlighted in Tables 3.2.4 and 3.2.5, 87% of those surveyed post-intervention consider their gums to be healthy, and 75% report not having bleeding gums.

**Table 3.2.4** Healthy gums (n=183/185)

Healthy gums	Frequency	Valid % (n=183)
Yes	159	86.9%
No	21	11.4
Don't know	3	1.6
Total	183	100

**Table 3.2.5** Bleeding gums

Bleeding gums	Pre (n=212)	Post (n=185)
Yes	23%	16%
No	63%	75%
Sometimes	12%	7%
Don't know	0.5%	1%
Missing	2%	1%

### 3.2.2 Behaviour

- **Appearance**

Ninety one percent of those surveyed consider the appearance of their teeth to be important. Similar reasons as to why they consider their teeth to be important were reported in the mother's questionnaire: health, appearance and confidence. The following quotes capture some of the reasons expressed by those surveyed:

***"I think my mouth would feel funny without them and your lip goes ugly"***

***"More girls will notice white teeth"***

***"If you have nice teeth you look good"***

***"I am more happy when I smile with healthy teeth".***

It was interesting to note that no one related maintaining good oral health to their overall health.

- **Dentures and denture hygiene**

A small percentage (7%) of those surveyed post intervention report wearing dentures, 46% of these reported wearing them at night. In terms of cleaning their dentures, 46% report using toothpaste, an increase of 14% pre and post-intervention, and 31% report using tablets, a modest increase of 4% pre and post-intervention. There was a 14% decrease in the 'other' section which pre-intervention had included solutions such as bleach. There was also marked increase (22%) in the percentage number of respondents reporting to clean their dentures twice a day (see Table 3.2.6).

**Table 3.2.6** Respondents wearing dentures and cleaning of dentures pre and post-intervention

<b>Wear dentures</b>	<b>Pre (n=212)</b>	<b>Post (n=185)</b>
Yes	10%	7%
No	83%	91%
Missing data	7%	2%
<b>Wear dentures at night</b>	<b>(n=22)</b>	<b>(n=13)</b>
Yes	41% (n=9)	46% (n=6)
No	54%(n=12)	46%(n=6)
Sometimes	5%(n=1)	8%(n=1)
<b>Clean dentures with:</b>	<b>(n=22)</b>	<b>(n=13)</b>
Toothpaste	32%(n=7)	46%(n=6)
Water	4%(n=1)	8%(n=1)
Tablets	27%(n=6)	31%(n=4)
Other	14%(n=3)	-
Missing data	23%(n=5)	15%(n=2)
<b>Frequency of denture cleaning</b>	<b>(n=22)</b>	<b>(n=13)</b>
Once per day	27%(n=6)	23%(n=3)
Twice per day	9%(n=2)	31%(n=4)
Twice per week	5%(n=1)	-
Missing	59%(n=13)	46%(n=6)

- **Dietary habits**

There was a decrease of 15% in the percentage of respondents who reported taking sugar in their tea and there was also a decrease of 12% of respondents who reported smoking (see Table 3.2.7).

**Table 3.2.7** Behaviour pre and post-intervention

Take sugar in tea?	Pre (n=212)	Post (n=185)
Yes	67%	52%
No	32%	47%
Missing	1%	1%
How much sugar?	(n=143)	(n=96)
½	-	3%
1	15%	24%
2	67%	55%
3 or more	13%	10%
Missing	5%	8%
Smoke	(n=212)	(n=185)
Yes	55%	43%
No	43%	54%
Sometimes	1%	1%
Missing	1%	2%

- **Dental emergency**

If respondents were to experience a blow to their front tooth the majority (88%) of them reported going to the Dentist or hospital. Five percent, however, reported not knowing what they would do (see Table 3.2.8.)

**Table 3.2.8** Where to go if you experience a blow to the front tooth (n=171/185)

	Frequency	Valid % (n=171)
Go to Dentist	136	79.5
Go to Hospital	13	7.6
Go to Health-Centre	1	0.6
Don't know	9	5.3
Other	12	7.0
Total	171	100

And if respondents were to have their front tooth knocked out, 46% reported going to the dentist or hospital, or getting a false tooth. In relation to correct first aid procedures for an avulsed tooth i.e. put in milk or inside jaw and seek dental or medical advice 12.9% answered correctly (see Tables 3.2.9 and 3.2.10). Although 38% reported getting a false tooth we cannot determine at what stage they would consider visiting the dentist to have this done, particularly for those who reported not being overly concerned with the appearance of their teeth.

**Table 3.2.9** What to do if a front tooth was knocked out? (n=177/185)

What to do if a front tooth was knocked out?	Frequency	Valid % (n=177)
False tooth	70	39.5
Dentist	56	31.6
Hospital	6	1.3
Milk and dentist	17	9.6
Inside jaw and dentist	6	3.4
Inside jaw and hospital	1	0.5
Don't know	8	4.5
Other	13	7.3
Total	177	100.0

### 3.2.5 Knowledge

- **Causes of tooth decay**

When categorised, the main causes of tooth decay to emerge included high consumption of sugar (41%), sweets and fizzy drinks (51%) and not brushing ones teeth (33%).

**Table 3.2.10** Causes of tooth decay\*

Causes of tooth decay	Frequency	Valid %
Sugar	72	40.7
Sweets & fizzy drinks	90	50.8
Not brushing teeth	59	33.3
Gum disease	4	2.3
Plaque	10	5.4
Other	13	7.3

### 3.2.6 Dental services

The majority (76%) of respondents post-intervention reported going to the dentist for treatment. Whilst 42% go regularly, 46% go only when in pain, a decrease of 24% post-intervention. A 10% decrease was also observed in the numbers reportedly being nervous when going to the dentist. See Table 3.2.11 for a break down of behaviour in relation to dental treatment and potential nervousness.

**Table 3.2.11** Dental treatment and related nervousness pre and post-intervention

<b>Where to go for dental treatment?</b>	<b>Pre (n=212)</b>	<b>Post (n=185)</b>
Dentist	83%	76%
Clinic	0.5%	1%
Hospital	0.5%	-
Health Board/health centre	2%	3%
Do not know	1%	1%
Do not go	5%	5%
Other	5%	-
Missing data	3%	14%
<b>How often do you visit the dentist?</b>	<b>(n=212)</b>	<b>(n=185)</b>
Go to dentist regularly	21%	42%
Go to dentist when only in pain	70%	46%
Other	7%	-
Missing	3%	12%
<b>Nervous going to dentist?</b>	<b>(n=212)</b>	<b>(n=185)</b>
Yes	29%	19%
No	68%	76%
Don't know	1%	3%
Missing data	2%	2%
<b>Why nervous* ?</b>	<b>(n=61)</b>	<b>(n=36)</b>
Needles	43%(n=26)	19%(n=7)
Tools	3%(n=2)	3%(n=1)
Extraction	3%(n=2)	-
Fear/Hate	6%(n=4)	8%(n=3)
Bad experience	3%(n=2)	5%(n=2)
Don't know	8%(n=5)	3%(n=1)
Pain	-	17%(n=6)
Other	16%(n=10)	-
Data	18%(n=11)	52%(n=19)

### 3.3 Strand two: clinical audit of the Traveller oral health records

#### 3.3.1 Client charts

- **Tullamore**

There are 234 clients on the Traveller dental health register in Tullamore. The clients chart was available for audit in only 65% (151/234) of cases. A chart was not available in the remaining 35% (83/234) of cases. The majority (92%) of clients on the Traveller dental health register in Tullamore were non-transient. The mean age of clients was 8.6 years (S.D = 4.4 years). Table 3.3.1 below outlines the results from the audit.

**Table 3.3.1** Results from audit of Traveller dental health records in Tullamore

	<b>n</b>	<b>%</b>	<b>Missing data</b>
Called by surgery for appointment	106/234	45%	2%
Did not attend (DNA)for appointment	38/106	36%	-
Patient screened/seen	68/106	64%	2%
Treatment required	57/68	84%	1%
<b>If treatment required what was the treatment:*</b>			
Hygienist referral	34/68	50%	3%
Fillings	21/68	31%	3%
Fissure sealants	10/68	15%	3%
Tooth extraction	6/68	9%	3%
Ortho	4/68	6%	3%
<b>Standard operating procedure</b>			
After 11.30am appointment	83/106	78%	6%
Reminder of appointment	52/106	49%	4%
Appointment given between May - Sept	76/106	72%	1%
Data book filled out after each appointment	37/106	35%	1%

\* Some clients required more than one type of treatment.

- **Birr**

There were 53 clients on the Traveller dental register in Birr, in 49% (26/53) of cases there was no chart available for audit. The majority (91%) of clients on the register in Birr were non-transient. The mean age of clients was 8.5 years (S.D = 4.3 years).

**Table 3.3.2** Results from audit of Traveller dental health records in Birr

	<i>n</i>	%	Missing data
Called by surgery for appointment	9/53	17%	19%
DNA / Failed appointment rate	2/9	22%	-
Patient screened/seen	7/9	78%	-
Treatment required	7/7	100%	-
<b>If treatment required what was the treatment*:</b>			
Hygienist referral	2/7	29%	-
Fillings	4/7	57%	-
Fissure sealants	1/7	14%	-
Tooth extraction	3/7	43%	-
Ortho	-	-	-
<b>Standard operating procedure</b>			
After 11.30am	7/9	78%	
Reminder of appointment	0	0%	11%
Appointment given between May – Sept	8/9	89%	-
Data book filled out after each appointment	9/9	100%	-

\* Some clients required more than one type of treatment.

- **Ferbane**

There are 22 clients on the Traveller dental register at the Ferbane clinic. All of the charts were available for audit for each client. Twenty-seven percent (n=6) of clients were non-transient. The mean age of clients was 7.9 years (S.D = 3.8 years).

**Table 3.3.3** Results from audit of Traveller dental health records in Ferbane

	N	%	Missing data
Called by surgery for appointment	21/22	95%	-
DNA/Failed appointment rate	9/21	43%	-
Patient screened/seen	12/21	57%	-
Treatment required	5/12	42%	-
<b>If treatment required what was the treatment:</b>			
Hygienist referral	-	-	-
Fillings	-	-	-
Fissure sealants	-	-	-
Tooth extraction	-	-	-
Ortho	-	-	-
<b>Standard operating procedure</b>			
After 11.30am	13	62%	-
Reminder of appointment	9	43%	-
Appointment given between May – Sept.	21	100%	-
Data book filled out after each appointment	19	86%	-

### 3.3.2 Did not attends (DNA)

- **Tullamore**

There was an increase in the number of DNA in the post-intervention period compared to the pre-intervention period. This, however, may be due to the fact that the pre-intervention period ran from July 2004 to December 2004 which is a period of six months whilst the post intervention period ran from January 2005 to July 2005 which is a period of seven months.

The number of casual appointments, appointments for pain and appointments for trauma all decreased in the post-intervention period. There was a significant increase in the number of hygienist's appointments ( $P < 0.05$ ) at the post-intervention stage. Table 3.3.4 below outlines this in further detail.

**Table 3.3.4** The number of DNAs and types of appointment during the pre and post-intervention period in Tullamore

	Pre	Post
Number DNAs	39	82
Number of casual appointments	11	6
Number of pain appointments	10	6
Number of trauma appointments	1	0
Number non-casual appointments	34	80
Number of hygienist visits	8	51

The reason why the number of DNAs may have increased at the post intervention stage may be due to the fact that the intervention involved contacting clients for appointments thus increasing the overall number of appointments. During the pre-intervention stage some clients were not contacted for appointments thus explaining the low DNA rate at pre-intervention stage.

The increase in the number of non-casual appointments maybe due to the fact that perhaps there was an increased awareness in the Travelling community of the services available to them and the fact that the intervention involved contacting clients for appointments thus increasing the number of appointments. Hygienist's appointments were high post intervention; this is due to increased screening and hence increased referral.

- **Birr**

There was very little difference in the number of DNA's in the pre and post-intervention period; this was also the case with the number of casual appointments, appointments for pain, trauma, non-casual appointments and hygienist appointments with just small increases and decreases in the number of appointments. This difference, however, may not be very obvious due to the small numbers of clients called by the Dental Health Services for an appointment. Table 3.3.5 below illustrates this further.

**Table 3.3.5** The number of DNAs and types of appointment during the pre and post-intervention period in Birr

	Pre	Post
Number of DNAs pre-intervention	3	2
Number of casual appointments	1	3
Number of pain appointments	1	3
Number of trauma appointments	0	0
Number non-casual appointments	9	5
Number of hygienist	5	2

- **Ferbane**

The number of DNA's increased in the post-intervention period compared to the pre- intervention period this was also the case for the number of non-casual appointments. There was no difference in the number of casual appointments i.e. appointments for pain and trauma. There was, however, an increase in the number of visits to the Hygienist post-intervention (see Table 3.3.6).

**Table 3.3.6** The number of DNAs and types of appointment during the pre and post-intervention period in Ferbane

	Pre	Post
Number of DNAs pre-intervention	0	20
Number of casual appointments	3	3
Number of pain appointments	3	2
Number of trauma appointments	0	0
Number non-casual appointments	8	15
Number of hygienist	5	12

The reason why the number of DNAs may have increased at the post-intervention stage maybe attributed to the fact that the intervention involved contacting clients for appointments thus increasing the overall number of appointments. During the pre-intervention stage clients were not contacted for appointments thus explaining the low DNA rate at pre-intervention stage.

The increase in the number of non-casual appointments maybe attributed to the fact that there was an increased awareness within the Travelling community of

the services available to them. Hygienist's appointments were high post-intervention; this is due to screening and hence increased referral.

It was hoped that with the introduction of the reminder system there would be a marked reduction in DNA's. Due to the erratic implementation of the system, however, it remains unknown whether a reminder system would have impacted on this.

### **3.3.3 Standard operating procedures (SOP)**

#### **1 All dental health appointments should be scheduled after 11.30am and between the months of September and May.**

- **Tullamore**

As stated in the SOP, the majority of clients were called for their appointment after 11.30am (78%) and between the months September to May (72%). The procedure of giving a reminder of the appointment, however, has not been fully adhered to with just under half (49%) of clients receiving a reminder of their appointment or a record was not kept if they were reminded. Furthermore, completion of the data book following each appointment requires further attention with only 35% complying with this aspect of the guideline (see Table 3.3.1).

- **Birr**

The majority of clients who had been called for an appointment were called after 11.30am ( $n=7$ ) and during the months September to May ( $n=9$ ). Completion of the data book following each appointment was fully adhered to, with 100% of cases complying with this guideline. This, however, may have been completed retrospectively as opposed to contemporaneously. No client, however, was given a reminder of their dental appointment or if they were no record was kept of the reminder (see Table 3.3.2).

- **Ferbane**

All clients who were contacted by the Dental Health Services for an appointment were given their appointment between the months of September to May and over half (62%) were given an appointment after 11.30am. The reminder system, however, was not fully adhered to with only 43% of clients who received an appointment being reminded of this appointment or if they were reminded no record was kept of the reminder (see Table 3.3.3).

## **2 The Dental Department will operate a 'Reminder System' to remind the Traveller family of their dental appointment...**

To reduce the failed attendance at appointment rate the Dental Nurse is required to ring and remind the family of the appointment one or two days prior.

- **Tullamore**

Only 45% of clients on the dental health register in Tullamore had been contacted by the Services for a dental appointment. Of those clients who had been called 64% had been seen by the dental health staff and almost all (84%) required some form of dental treatment. A visit to the Hygienist was the most common treatment required by those who were seen by dental health staff. Almost one third (31%) required fillings (see Table 3.3.1).

- **Birr**

Only 17% (n=9) of clients on the dental health register in Birr had been contacted by the Services for a dental appointment. Of these nine clients seven were seen by the Dental Health Services and all seven required some form of further dental treatment, with over half (n=4) requiring fillings (see Table 3.3.2).

- **Ferbane**

Almost all clients on the dental health register in Ferbane were contacted by the Dental Health Services for a dental appointment. Fifty-seven percent of those who were contacted for an appointment were screened/seen by the Dental Health Services; 42% of these required treatments. The type of treatment required, however, was not recorded (see Table 3.3.3).

Analysis of the questionnaire also indicates that only 39% of mothers who responded to the questionnaire in the Offaly area reported being contacted prior to their appointment. Although 61% reported having not been contacted, it is unknown as to how many unsuccessful attempts may have been made by Dental Services to confirm appointments.

**3 To ensure the Dental Service is literacy friendly, staff will be informed if a Traveller family are expected and the need to support the family/person with signing in...**

On the introduction of the clinical element of the programme culturally appropriate SOPs were introduced to be implemented by dental staff. Additional questions were included on the post-questionnaire to assess whether these SOPs were adhered to or not, (See Appendix 5).

To ensure the Dental Services were literacy friendly for the Travelling community, staff should have been informed if a Traveller family were expected and the need to support the family/person with 'signing in'. On arrival at the Dental Services the majority (95%) of mothers went directly to the desk and informed staff of their arrival.

On arrival at the Dental Services the majority (95%) of mothers went directly to the desk and informed staff of their arrival (see Table 3.3.7).

**Table 3.3.7** Reported arrival at dental services

Reported arrival at dental services	Frequency	Valid %
Went to desk and told them	86	94.5
The Nurse/Dentist found me	2	2.2
Other	3	3.3
Total	91	100.0

**4 To ensure confidentiality at all times and to support literacy needs all medical questionnaires and consent forms will be completed in the privacy of the surgery with the support and assistance of staff.**

On their last visit, 68% of mothers completed the post-intervention medical questionnaire in the waiting area (see Table 3.3.8).

**Table 3.3.8** Completion of medical questionnaire post intervention

Completion of questionnaire in:	Frequency	Valid %
Waiting area	62	68.1
Dental surgery	7	7.7
I didn't	22	24.2
Total	91	100.0

Of the total mothers who completed the questionnaire (76%), 46% did not receive help, whilst 38% did. In the majority of cases (31%) the Dental Nurse provided such assistance, with the dentist providing assistance in only 1.5% of cases (see Table 3.3.9 and 3.3.10).

**Table 3.3.9** Help received in completing questionnaire post intervention

Received help	Frequency	Valid %
Yes	33	37.5
No	40	45.5
N/A	15	17.0
Total	88	100.0

**Table 3.3.10** Individual reported to have provided assistance to respondents post-intervention

Assistance provided by:	Frequency	Valid %
Dental nurse	21	31.3
Dentist	1	1.5
Family member	9	13.4
Other	1	1.5
N/A	35	52.2
Total	67	100.0

Again to ensure the dental service was literacy friendly staff was advised to provide verbal as well as written instructions for prescriptions and other post

operative advice. On their last visit 40% of mothers were given a prescription or instructions, 25% of which were both explained and written down (see Table 3.3.11).

**Table 3.3.11** Prescription or instructions received

Prescription or instructions received?	Frequency	Valid %
Yes	36	39.6
No	55	60.4
Total	91	100.0

**Table 3.3.12** Instructions on receipt of prescription

Instructions on receipt of prescription?	Frequency	Valid %
Explained & written down	22	24.7
Written but not explained	6	6.7
Explained but not written down	8	9.0
N/A	53	59.6
Total	89	100.0

## **4 Conclusions and recommendations**

### **4.1 Strand one**

The results of strand one of the Oral Health Promotion Programme yielded positive results and with modifications to the evaluation process it is recommended that it be rolled out to the Traveller community in Co. Laois.

Modifications and additions will be made to the layout and content of the questionnaires; thus ensuring that satisfactory baseline data will be available for comparison in evaluating the programme. It is recommended that this be done in consultation with the Clinical Audit and Research Service.

### **4.2 Strand two**

Unfortunately, the results of strand two of the programme proved disappointing. Despite staff attending a cultural awareness day and being made aware of the rationale for the programme, adherence to SOPs, delivery and data recording was poor. This strand of the programme did not meet its desired objectives and will be abandoned in its present form.

Based on the results of this evaluation a dedicated motivated team consisting of one Dentist and two Dental Nurses will be assigned specifically to this area. The equivalent of one session per week will be allocated to this work.

Closer monitoring of delivery and record keeping will also be necessary. This programme should also be evaluated at an earlier stage. Strand two will not be initiated in Co. Laois until satisfactory results emerge from the modified programme in Co. Offaly.

## **5. Action plan**

Consult Clinical Audit and Research in the review of evaluation questionnaire:

Person responsible: Eileen Lee

Pilot revised questionnaire with members of the Travelling community:

Person responsible: Eileen Lee

Appoint Dentist and two Dental Nurses to assume complete responsibility for programme implementation and adherence to SOPs:

Person responsible: Dental team

For future programme development and evaluation:

Persons responsible: Olivia Murray, John Lee, Eileen Lee and Clinical Audit and Research Service.

## **6. References**

Midland Health Board (2000). The Voice of Traveller Women through Research, Summary Document.

Department of Health and Children (2002a). Traveller Health: A National Strategy.

Department of Health and Children, March (2002b). Executive summary, Forum on Fluoridation Ireland.

Health Development Agency, (2001). The Scientific Basis of Dental Health Education (A Policy Document), Part 1.

### Appendices:

1. Standard operating procedures
2. Consent form for Traveller database
3. Adult questionnaire: Pre and post strand one
4. Mothers' questionnaire: Pre and post strand one
5. Mothers' questionnaire: Post add on questions.
6. Demographic details
7. Time frame

## **Appendix 1: Standard Operating Procedures**

FOR THE DENTAL HEALTH SERVICES IN COUNTY OFFALY IN RELATION TO THE TRAVELLING COMMUNITY.

- All dental health appointments should be scheduled after 11.30 a.m. and between the months of September to May.
- Appointment cards should have the child's name and the first names of both parents printed clearly.
- The Dental Department will operate a 'Reminder System' to remind the Traveller family of their appointment. The dental nurse will call the family the day before the appointment.
- The designated health liaison staff member will refer Travellers who have no official home address or Travellers who have failed to attend their appointment to the Community Health Workers.
- These appointments will be given by the designated health liaison staff member to the Community Health Worker in a sealed envelope with the child's name and the first names of both parents should be printed clearly on the envelope.
- The appointment may only be opened by the Community Health Worker if specifically requested by the parent.
- If the Community Health Worker is unable to locate the family she returns the unopened envelope to the liaison person and informs her that the family could not be contacted.
- To ensure the dental services are literacy friendly, staff will be informed if a Traveller family are expected and the need to support the family/person with 'signing in'. The Dental Nurse at the window should be made aware a Traveller family is expected so the nurse can sign them in if necessary.
- To ensure confidentiality at all times and to support literacy needs all medical questionnaires and consent forms will be completed in the privacy of the surgery with the support and assistance of staff.

**Appendix 2: Consent form for Traveller Dental Register**

**HSE- Dublin Mid-Leinster**

**Des. PHN For Travellers and Community Health Worker Service**

I understand that the Des. Public health Nurse & Community Health Worker service is granted on a provisional basis and that the service may be withdrawn by the Board at any time.

Family Name \_\_\_\_\_ Address \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Telephone no. for contact \_\_\_\_\_

\*\*\*\*\*

I understand that the information I give can be recorded on the computer system The information collected is not passed routinely onto other workers, but the information is shared on a need to know basis by Des.PHN Travellers.

Signed \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*I agree to provide part-time Community Health Worker service to:

---

I accept and understand the Guidelines and Code of Conduct for Community Health Workers as outlined overleaf.

I understand that this temporary contract may be terminated by the HSE Midland Area or Community Health Worker at any time.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. for Contact \_\_\_\_\_ (M) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

PHCP CO-Ordinator

### **Appendix 3: Adults questionnaire: Pre and post strand one**

How often do you brush your teeth?

What type of toothpaste do you use?

After brushing your teeth should I rinse my mouth with water or just spit out?

What causes tooth decay?

Do you take sugar in your tea and how much?

Where do you go for dental treatment?

Do you go to the dentist regularly or only when in pain?

Do you think your gums are healthy?

Do your gums bleed when you brush your teeth?

Is the appearance of your teeth important to you? (and if so why?)

What would you do if you got a blow to your front tooth?

What would you do if your front tooth was knocked out?

Are you nervous going to the dentist (and if so why)?

Do you wear Dentures (False Teeth)?

Do you leave them in at night?

What do you use to clean your dentures (and how often)?

When did you last have a dental check-up?

Do you smoke ?

Age            16 -25  
                  26 - 35  
                  36 - 45  
                  46 - 55  
                  56 – 65  
                  65 +

Where do you live?            Official Halting Site  
    Un-official Halting Site  
    Local Authority House  
    Rented Accommodation  
    Roadside  
    Private House

What is your marital status?            Single  
    Married  
    Widowed  
    Separated  
    Other

Do you have running water?

Have you a Medical Card?

How many children have you?

What is your occupation?

What is your partners occupation?

#### **Appendix 4: Mothers' questionnaire: pre and post strand one**

When did you start to brush your child's teeth?

When did you start to use toothpaste when brushing your child's teeth?

What type of toothpaste do you use?

How much toothpaste do you use?

At what age can children brush their own teeth?

How often do your children brush their teeth?

After brushing their teeth should your child rinse his mouth with water or just spit out?

What do you put in your child's lunch-box?

Why do you usually bring your child for dental treatment?

Is the appearance of your child's teeth important to you? (and if so why?)

If you had a dental emergency where would you go?

What would you do if your child got a blow to his front tooth?

What would you do if your child's front tooth was knocked out?

What are fissure sealants?

Is your child nervous going to the dentist (and if so why)?

When is the best time to have sweets or fizzy drinks?

Do you add anything (such as sugar or rusks) to drinks in your baby's bottle?

What types of drinks do you put in your baby's bottle?

## Appendix 5: Post-intervention mothers' questionnaire

### ADD ON TO MOTHERS' QUESTIONNAIRE:

1. Have you attended with your child to the midland area dental services in the last twelve months?

Yes

No

2. When you arrived how did you let them know that you had arrived?

- Went to the desk,
- Nurse or dentist found me,
- Had to go and find somebody.

3. Where did you fill out the medical questionnaire?

- In the waiting area
- In the dental surgery

4. Did you get any help filling it out?

Yes

No

5. If yes from whom:

- Dental Nurse
- Dentist
- Family/friend
- Child
- Other \_\_\_\_\_

6. If you were given a prescription or instructions were they

- Explained and written down
- Written down but not explained
- Explained but not written down

7. If you were given an appointment did someone ring you to remind you of the appointment?

Yes

No

8. Can you think of any way that the children's dental services could be improved for you or your child?

## Appendix 6

### Demographic details

The age of all adult respondents ( $n=185$ ), ranged from 16 to 65+ years of age (see Table 6.1). Thirty-five percent are single and 44% are married (see Table 6.2). Of those with children, the numbers of children within each family ranged from one to fifteen (see Table 6.3). Fifty two percent of respondents reported being unemployed and 31% as being housewives. Thirty nine percent reported their partners as being unemployed and 13% as being housewives (see Tables 6.4 & 7.5).

Thirty one percent are living in local authority housing, 21% reported living in either official or unofficial halting sites (Un OFHS), 10% on the road side and only 4% reported living in private accommodation (see Table 6.6). Although 19% reported having no access to running water, we cannot conclude from this whether they have no access to fluoridated water.

**Table 6.1** Age of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	16-25	51	27.6	29.1	29.1
	26-35	46	24.9	26.3	55.4
	36-45	43	23.2	24.6	80.0
	46-55	21	11.4	12.0	92.0
	56-65	7	3.8	4.0	96.0
	65+	7	3.8	4.0	100.0
	Total	175	94.6	100.0	
Missing	missing	10	5.4		
Total		185	100.0		

**Table 6.2** Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	single	64	34.6	36.2	36.2
	married	82	44.3	46.3	82.5
	widowed	8	4.3	4.5	87.0
	separated	12	6.5	6.8	93.8
	other	11	5.9	6.2	100.0
	Total	177	95.7	100.0	
Missing	missing	8	4.3		
Total		185	100.0		

**Table 6.3** Number of children in each family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	65	35.1	36.1	36.1
	one	21	11.4	11.7	47.8
	two	11	5.9	6.1	53.9
	three	16	8.6	8.9	62.8
	four	21	11.4	11.7	74.4
	five	12	6.5	6.7	81.1
	six	8	4.3	4.4	85.6
	seven	7	3.8	3.9	89.4
	eight	9	4.9	5.0	94.4
	nine	3	1.6	1.7	96.1
	ten	1	.5	.6	96.7
	eleven	1	.5	.6	97.2
	twelve	2	1.1	1.1	98.3
	fourteen	1	.5	.6	98.9
	fifteen	2	1.1	1.1	100.0
	Total		180	97.3	100.0
Missing	missing	5	2.7		
Total		185	100.0		

**Table 6.4** Occupation of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	unemployed	86	46.5	51.5	51.5
	employed	15	8.1	9.0	60.5
	housewife	51	27.6	30.5	91.0
	student	9	4.9	5.4	96.4
	pensioner	5	2.7	3.0	99.4
	other	1	.5	.6	100.0
	Total	167	90.3	100.0	
Missing	missing	18	9.7		
Total		185	100.0		

**Table 6.5** Occupation of respondent's partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	unemployed	62	33.5	39.0	39.0
	employed	11	5.9	6.9	45.9
	housewife	20	10.8	12.6	58.5
	student	1	.5	.6	59.1
	pensioner	5	2.7	3.1	62.3
	N/A	60	32.4	37.7	100.0
	Total	159	85.9	100.0	
Missing	missing	26	14.1		
Total		185	100.0		

**Table 6.6** Type of residence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Official Housing	17	9.2	10.8	10.8
	Unofficial housing	21	11.4	13.4	24.2
	Local Authority Housing	59	31.9	37.6	61.8
	Rented Accommodation	34	18.4	21.7	83.4
	Roadside	18	9.7	11.5	94.9
	Private	8	4.3	5.1	100.0
	Total	157	84.9	100.0	
Missing	missing	28	15.1		
Total		185	100.0		

Ninety one percent of respondents reported being a holder of a medical card (see Table 6.7).

**Table 6.7** Medical card holder

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	169	91.4	94.4	94.4
	no	10	5.4	5.6	100.0
	Total	179	96.8	100.0	
Missing	missing	6	3.2		
Total		185	100.0		

## Appendix 7 Programme Time frame

<b>Action</b>	<b>Timeframe</b>	<b>Key Stakeholders.</b>
<b>Assessment of Travellers Health Needs</b>	<b>2000</b>	<b>TTM and MHB</b>
<b>Baseline Health Survey</b>	<b>2002</b>	<b>PHCP</b>
<b>Oral Health Needs Assessment</b>	<b>February 2004</b>	<b>PHCP Eileen Lee, Oral Health Promoter(OHP).</b>
<b>Development of oral health questionnaires</b>	<b>March 2004</b>	<b>Community Health Workers, PHCP and Eileen Lee, OHP.</b>
<b>Pre-questionnaires piloted</b>	<b>April 2004</b>	<b>Community Health Workers, PHCP and Eileen Lee, OHP.</b>
<b>Informed consent and formation of traveller register</b>	<b>April/May 2004</b>	<b>Community Health Workers.</b>
<b>Pre-questionnaires administered</b>	<b>April/May 2004</b>	<b>Community Health Workers</b>
<b>Evaluation of pre-questionnaire findings.</b>	<b>September-October 2004</b>	<b>Lisa Fingleton.</b>
<b>Development of SOPs</b>	<b>October 2004</b>	
<b>Cultural Awareness Day and allocation of register.</b>	<b>October 2004</b>	<b>Co. Offaly Dental Staff, Fergal Fox, PHCP, Dr. Olivia Murray, Dr. Maria Kenny.</b>
<b>Oral Health Presentations to CHWs</b>	<b>November 2004/June 2005</b>	<b>Eileen Lee, OHP and CHWs</b>
<b>Oral Health Presentations to adult Travellers and preschool traveller Parents</b>	<b>January-June 2005</b>	
<b>Commencement of clinical programme</b>	<b>January 2005</b>	
<b>Completion of Clinical Programme</b>	<b>July 2005</b>	
<b>Clinical Audit of charts</b>	<b>September</b>	

	<b>2005/April 2006</b>	
<b>Post-questionnaire administered</b>	<b>March 2006</b>	
<b>Data from post-questionnaire inputted and evaluated</b>		<b>Clinical Audit &amp; Research Service</b>
<b>Evaluation Report</b>	<b>February 2007</b>	<b>Clinical Audit &amp; Research Service</b>

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