

**Knowledge, attitudes, and practices towards Oral healthcare-seeking behaviours among dental Patients aged 15-45 years in Kayunga Regional Referral Hospital, Kayunga District.
A cross-sectional.**

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Page | 1

Abstract.

Background

Oral health is a vital component of overall well-being, affecting nutrition, communication, and quality of life. This study assesses the knowledge, attitudes, and practices regarding oral health care-seeking behaviors among dental patients aged 15–45 years who attend Tororo General Hospital, Tororo District.

Methodology.

A descriptive cross-sectional study design was employed involving 50 respondents selected using convenient sampling methods. Data were collected using a structured self-administered questionnaire and analyzed using descriptive statistics such as frequencies and percentages.

Results.

The majority (52%) of respondents were aged 15–25 years, and most (56%) were males. 80% of respondents had adequate knowledge about oral health care-seeking behaviors, with 70% obtaining information from schools. However, 72% and 52% were unaware of the effects of cold soft drinks and sugary diets on dental health, respectively; 84% knew that smoking affects oral health, and 68% identified irregular brushing as the main cause of oral problems. Attitudes were generally poor; 82% of respondents visited the dentist only when in pain, and an equal percentage cited fear as a major reason for avoiding dental visits. 84% acknowledged that regular dental checkups are necessary. In practice, 74% used a toothbrush and paste for cleaning, 70% brushed once daily, and 56.5% used the combined brushing technique.

Conclusion.

Although respondents demonstrated good knowledge and fair practices regarding oral health, their negative attitudes hinder regular oral health care-seeking behavior.

Recommendations.

The Ministry of Health should intensify oral health education and community outreach programs. Dental services should be made more accessible and affordable to encourage preventive dental visits.

Keywords: Oral health, knowledge, attitude, practices, dental care, Tororo General Hospital.

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Background.

Oral health refers to the overall condition of the mouth, teeth, and oral–facial structures that enable individuals to perform essential functions such as eating, breathing, and speaking. It also encompasses psychosocial aspects such as self-confidence, emotional well-being, and the ability to socialize and work without pain, discomfort, or embarrassment (Sfeatcu, 2022). Good oral health is a cornerstone of general health and well-being, as it predicts nutritional status, systemic health, and overall quality of life. Ideally, an individual should be free from oral cancers, infections, periodontal diseases, tooth decay, and facial deformities that impair one’s ability to bite, chew, or speak.

Oral health care seeking behavior (OHSB) refers to the actions individuals take when they perceive a problem with their oral health, or when they seek to maintain good oral health and prevent disease. It includes efforts to maintain oral hygiene, make healthy nutritional choices, and utilize dental services appropriately. OHSB is influenced not only by personal knowledge, attitudes, and beliefs but also by broader social, economic, and cultural factors that determine access to oral health information and services. The social structure of a community plays a major role in determining how individuals perceive oral health, their awareness of available dental services, and their ability to afford and access these services.

According to the World Health Organization (WHO), oral health problems remain inadequately controlled worldwide, despite significant improvements in oral health interventions in recent decades. This persistence is largely attributed to limited knowledge, negative attitudes, and poor oral health practices, which in turn influence people's oral health care-seeking behaviors. In Africa, the prevalence of oral diseases is approximately 47%, affecting around 480 million of the continent's 1.3 billion people (WHO, 2017). Evidence from several East African countries shows an upward trend in oral and periodontal diseases, driven by increased sugar consumption, lack of oral health awareness, and inadequate access to dental care.

These findings underscore the widespread knowledge and attitude gaps that hinder appropriate oral health care-seeking behavior in Uganda. Overall, despite global and regional efforts to promote oral health, significant challenges persist in developing countries, including Uganda. Poor awareness, cultural beliefs, limited accessibility to dental facilities, and economic constraints continue to affect people's oral health care-seeking behavior, contributing to the high burden of preventable oral diseases. This study assesses the Knowledge, attitudes, and practices towards Oral healthcare-seeking behaviours among dental Patients aged 15-45 years in Kayunga Regional Referral Hospital, Kayunga District.

Methodology.

Study area.

The study was conducted at Kayunga regional referral hospital in Kayunga town. The hospital was established by the government of Uganda and is in full operation. The hospital has departments and clinics which include OPD, dental clinic, eye clinic, orthopedic department, and laboratory. There are also medical and surgical wards, which include a minor and main operating theatre, male medical ward, male surgical ward, female surgical ward, female medical ward, Pediatric ward, obstetrics, and gynecology ward.

Study design.

The study was descriptive and cross-sectional. This was because the study was done in a short time and never involved following up with respondents.

Study population.

The study population was adults aged 15 to 45 years attending the dental clinic in Kayunga regional referral hospital, since the prevalence of periodontal diseases was more common in that age group.

Sample size determination.

The sample size was determined using Burton's formula (1965). Sample size (n) = QR/O , where Total number of days

taken for data collection, A, maximum number of respondents who were interviewed per day, O- Maximum time taken on each respondent per day. Values: Q= 10 days, R=5 respondents. O=1 hour. Therefore, $n = QR/O = (10 \times 5)/1 = 50$. Respondents. Therefore, 50 respondents were involved in the study.

Sampling technique.

A simple random sampling technique was used to choose the participants for the study. Simple random sampling was a non-biased probability sampling technique and ensured that everyone had an equal opportunity of participating in the study.

Dependent variable.

The dependent variable was oral healthcare-seeking behaviors.

Independent variable.

The independent variables were knowledge, attitude, and practices.

Data collection tool.

Data were collected using structured questionnaires. These were predetermined written lists of questions that will be answered by the respondents without supervision and with minimal or no explanation from the interviewer. This, therefore, helped to reduce bias from the respondents and the researcher; it also enabled the researcher to collect data from a large number of respondents within a short period.

Data collection procedure.

The introductory letter was obtained from Kampala School of Health Sciences and was then taken to the Medical Director of Kayunga Regional Referral Hospital. The researcher was then granted permission to collect data from the facility.

Piloting the study

The study area was pre-visited for mobilization a day before data collection commenced. The questionnaires were pre-tested among 5 respondents at the KRRH dental clinic for clarity, acceptability, and to assess whether they meet the stated specific objectives of the study before carrying out the main study, and necessary adjustments were made. This was all aimed at providing valid and reliable data.

Quality control.

The research tool (questionnaire) was pre-tested as stated in the pilot study above. The questions of the questionnaire were structured understandably so as to enable the respondents to interpret the questions without bias in order to attain responses that answer the research questions, and a

research assistant was trained and closely supervised on how to correctly administer the data collection tools to enhance the validity of the data collected. The questionnaires were screened for completeness and legibility, and the standard operating procedures will be strictly maintained during the data collection period.

Data was tallied using a pen and A4 sheets of paper, and analyzed manually. Summarizing the key findings, explanations, and quantitative data were presented in frequency distribution tables, graphs, and pie charts using Microsoft Excel for easy analysis.

Page | 3

Data management procedure

After data collection, the questionnaires were checked for completeness and accuracy. The questionnaires that were not completed or correctly filled out were completed before the respondent left the facility. The forms were then kept in a locked cupboard to maximize confidentiality and ensure access to the research team only.

Ethical approval.

The topic, purpose, and significance of the study were introduced to the respondents. The respondents were assured confidentiality in the study as no names were used, and thereafter were asked to sign a consent form. No respondent was forced to participate in the study. Each respondent was interviewed alone, and information obtained from any respondent was not shared with other colleagues. The data collected was kept in a locked cupboard.

Data analysis.

STUDY FINDINGS.

Demographic data

Table 1 shows the demographic data of respondents.

AGE (YEARS)	FREQUENCY (F)	PERCENTAGE (%)
15-25	26	52
26-30	10	20
31-36	8	16
37-45	6	12
GENDER		
Male	28	56
Female	22	44
RELIGION		
Catholic	16	32
Protestant	24	48
Moslems	8	16
SDA		24
LEVEL OF EDUCATION		
Primary	18	36
Secondary	26	52
Tertiary	6	12
Never went to school	0	0
OCCUPATION		
Peasant	23	46
Civil servant	6	12
Student	17	34
Unemployed	4	8
MARITAL STATUS		
Single	27	54

Married	20	40
Separated/divorced	0	0
Widow	3	6

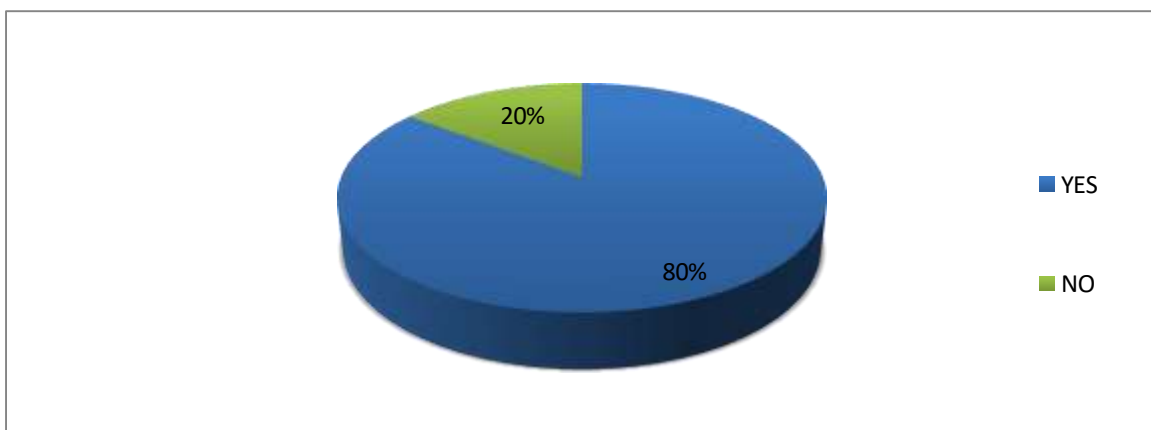
Page | 4

From table 1, the majority (52%) of the respondents were within the age bracket of 15- 25years of age, whereas the minorities (12%) were within the age bracket of 37-45 years of age. From the table, most (56%) of the respondents were males, whereas the least (44%) were females. From table 1 above, most (48%) of the respondents were Protestants, whereas the least (4%) were SDA. From the table above,

most (52%) of the respondents had attained a secondary level of education and none of the respondents (0%) lacked formal education, most (46%) of the respondents were peasants whereas the least (8%) were unemployed, more than half (54%) of the respondents were single whereas none of the respondents (0%) were widowed or separated.

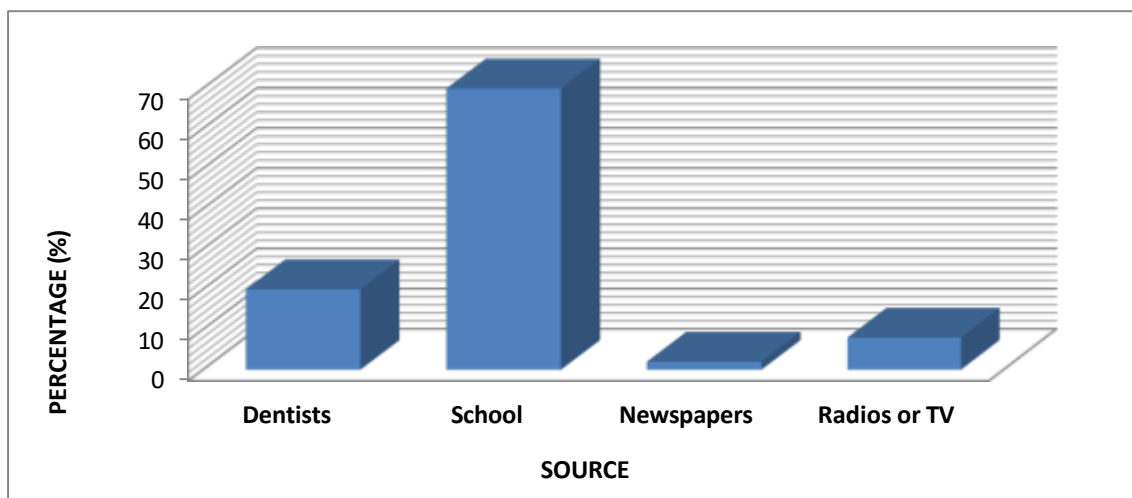
Knowledge towards oral health care seeking behaviors among dental patients aged 15- 45 years.

Figure 1: Shows the distribution of respondents according to whether they knew about oral healthcare-seeking behaviors. (N=50)



From Figure 1, most (80%) of the respondents knew about oral health care-seeking behaviors, whereas the least (20%) did not know about oral health care-seeking behaviors.

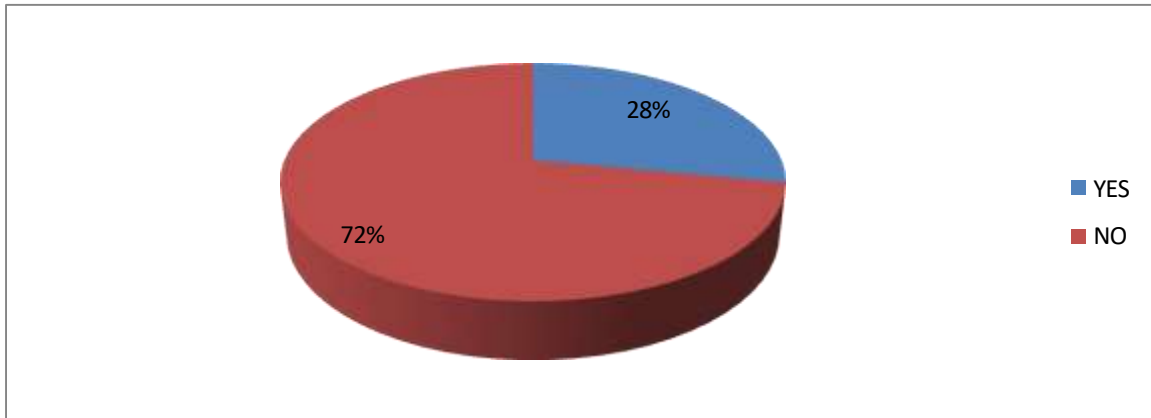
Figure 2: Shows the distribution of respondents according to where they obtained information about oral health care-seeking behaviors. (N=50).



From figure 2, 70% (28) of the respondents who knew about oral healthcare seeking behaviors obtained information from the school, whereas the least 10 % (4) reported that they obtained information from the newspapers.

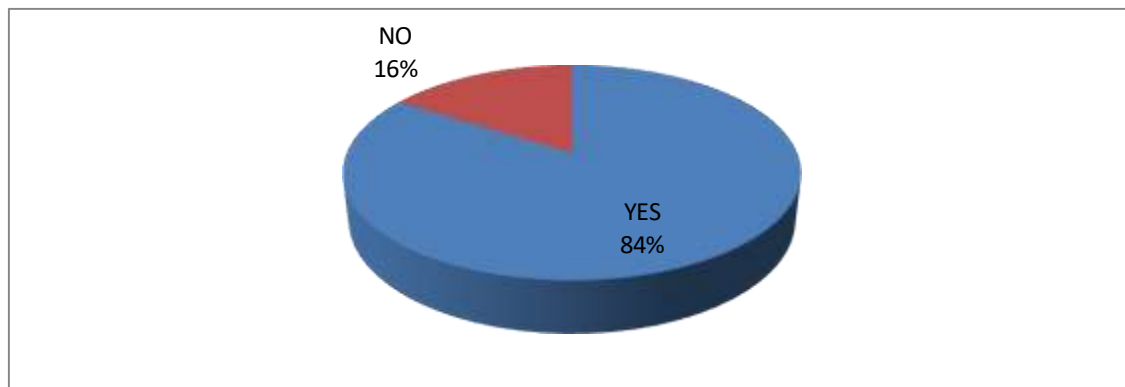
Figure 3: Shows the distribution of respondents according to whether they knew that cold soft drinks affect dental health. (N=50).

Page | 5



From figure 3, 36 (72%) of the respondents never knew that cold soft drinks affect dental health, whereas the least 14 (28%) knew that cold soft drinks affect dental health.

Figure 4: Shows the distribution of respondents according to whether they knew that smoking affects oral health. (N=50).



From Figure 4, most of the respondents (84%) knew that smoking affects oral health, whereas 16% did not know that smoking affects oral health.

Table 2: Shows the distribution of respondents according to whether they knew that a sugary diet causes dental decay. (N=50).

RESPONSE	FREQUENCY	PERCENTAGE (%)
Yes	14	28
No	26	52
Don't know	10	20

From table 2, most 26(52%) did not agree that a sugary diet causes dental decay, ay whereas the least 10(20%) did not know whether a sugary diet causes dental decay or not.

Table 3: Shows the distribution of respondents according to whether they knew the indication of bleeding from the gums (N=50).

RESPONSE	FREQUENCY	PERCENTAGE (%)
Gum disease due to poor oral hygiene	37	74
General illness	2	4
Don't know	11	22

Page | 6

Table 3 shows that the highest percentage of the respondents (74%) knew that bleeding from the gum was due to poor oral hygiene, and the least number of the respondents (4%) knew that bleeding from the gums was due to general illness.

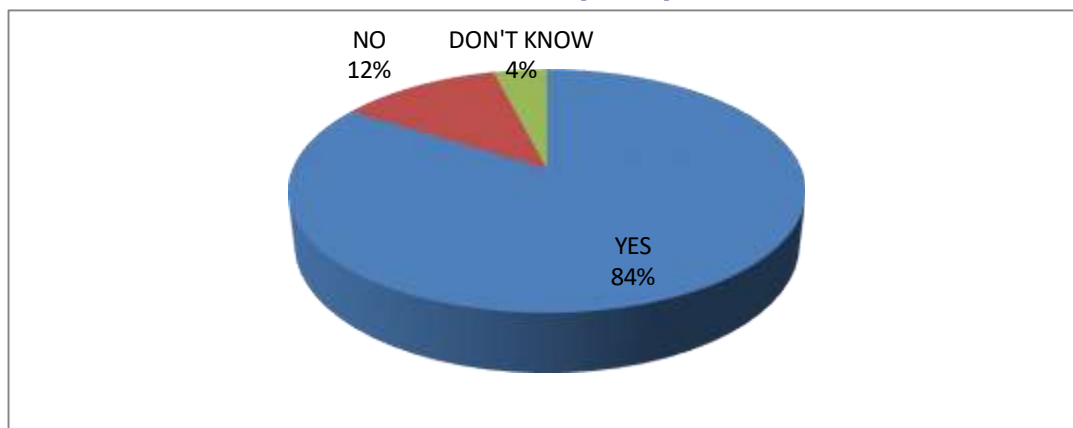
Attitudes towards oral health care seeking behaviors among dental patients aged 15-45years.

Table 4 shows the distribution of respondents according to how often they visit the dentist (N=50).

RESPONSE	FREQUENCY	PERCENTAGE (%)
Regularly/once in 6 months	3	6
When in pain	41	82
Never	6	12

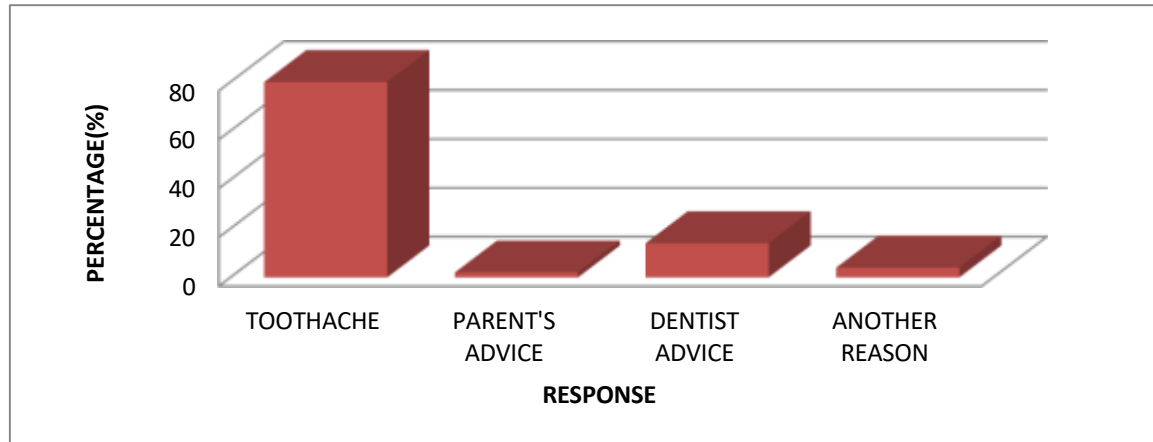
Table 4 shows that most of the respondents (82%) visited the dentist when in pain, and the lowest percentage (6%) visited the dentist.

Figure 5 shows the distribution of respondents according to the necessity of regular visiting the dentist (N=50)



According to Figure 5, the majority (84%) found it necessary to visit the dentist regularly, and the least (4%) found it unnecessary to visit the dentist regularly.

Figure 6: Shows the distribution of respondents according to the reasons for their last dental visit (N=50).



From figure 6, the majority of the respondents (80%) visited the dentist due to a toothache, and the least respondents (2%) visited the dentist following their parents' advice.

Table 5: Shows the distribution of respondents according to the reasons for not visiting the dentist (N=50)

RESPONSE	FREQUENCY	PERCENTAGE (%)
Fear	41	82s
No dental clinic nearby	8	16
No specific reasons	1	2

From Table 5, the majority of respondents (82%) never visited the dentist due to fear, and the least percentage of respondents (2%) had no specific reasons for not visiting the dentist.

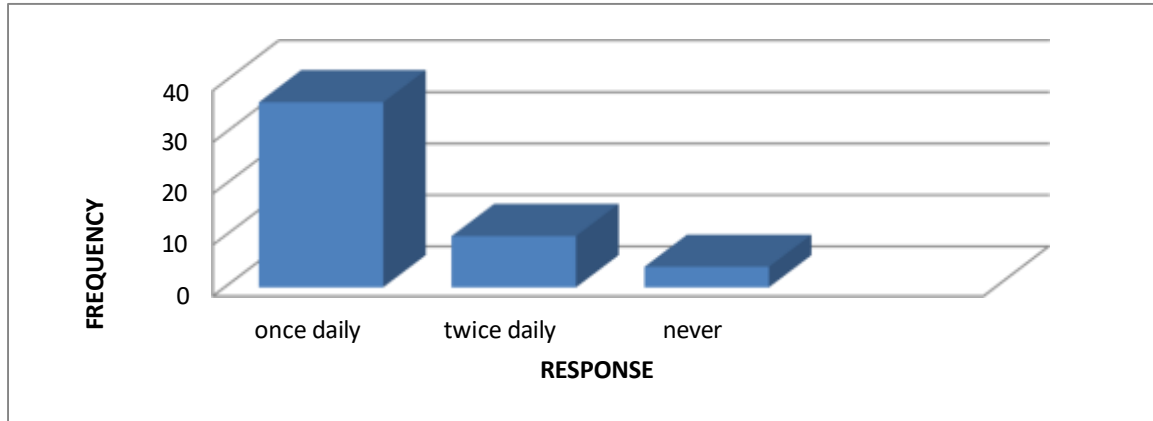
Oral health care seeking practices

Table 6 shows the distribution of respondents according to their primary tooth cleaning aids. (N=50)

RESPONSE	FREQUENCY	PERCENTAGE
Toothbrush and paste	37	74
Miswak (wooden cleaning sticks	10	20
Dental floss	0	0
Toothpicks	3	6

According to Table 6, most of the respondents (74%) used toothbrush and paste as their primary tooth cleaning aid, and the least respondents (6%) used toothpicks as their primary tooth cleaning aid; however, no respondent used dental floss.

Figure 7 shows the distribution of respondents according to how often they brush their teeth in a day. (N=50)



From Figure 7, the majority of the respondents (35) brushed their teeth once daily, and the least number of respondents never brushed their teeth.

Table 7 shows the distribution of the respondents according to the brushing technique they use while brushing their teeth (n=46).

VARIABLE	FREQUENCY	PERCENTAGE
Horizontal	14	30.5
Vertical	4	8.7
Circular	2	4.3
Combined	26	56.5

From Table 7, the majority of the respondents (56.5%) followed the combined technique, whereas the smallest number of respondents (4.3%) followed the circular technique.

Discussion.

Knowledge towards Oral Health Care Seeking Behaviors among Dental Patients Aged 15–45 Years

The findings of this study revealed that a majority (80%) of respondents possessed adequate knowledge about oral health care-seeking behaviors. This relatively good knowledge level can be attributed to the fact that most respondents had attained at least primary education, while others obtained oral health information through their school-going children, churches, communities, and health centers. However, these findings contrast with those from a study conducted in Western Sydney by Shalinie King et al. (2023), which reported poor understanding of oral health care-seeking behaviors and limited awareness of the link between oral health and general well-being.

Regarding sources of oral health information, the study found that 70% of respondents acquired their knowledge from schools. This may be because oral health is often

taught at the elementary level as part of personal hygiene education. The finding aligns with the respondents' educational backgrounds, where the majority had attained primary education.

When examining knowledge about the effects of cold soft drinks and sugary diets on oral health, 72% and 52% of respondents, respectively, did not associate these with oral health problems. This indicates limited awareness about dietary contributors to dental diseases. Many respondents believed that failure to brush was the only cause of dental problems, reflecting a narrow understanding of oral health risk factors. These results agree with those of Akinyamoju et al. (2018), who found that only 37% of respondents recognized sugar-containing foods as a cause of tooth decay. Conversely, knowledge about the effects of smoking on oral health was strong, with 84% acknowledging that smoking harms oral tissues. This finding corresponds with the study by Arzu Beklen et al. (2021) in Turkey, where 84.5% of participants were aware of the oral health risks of smoking. Similarly, 68% of respondents in this study recognized irregular tooth brushing as the main cause of oral health problems, consistent with the findings of Ocwiea et al. (2021) in Nebbi District, Uganda. Furthermore, most respondents (74%) correctly identified gum bleeding as a sign of poor

oral hygiene, a finding comparable to Tsz Yung Wong's (2022) study in Hong Kong, where 91.3% of participants reported a similar understanding.

Attitude towards Oral Health Care Seeking Behaviors

Despite adequate knowledge, the study revealed that 82% of respondents visited a dentist only when they experienced pain, indicating a poor attitude towards preventive oral health care. This finding is consistent with Zarina Waheed et al. (2018), who found that 64% of Malaysian university students visited a dentist only when in pain. However, 84% of respondents in the current study acknowledged the importance of regular dental visits but cited barriers such as poverty, distance to dental clinics, and lack of time.

Fear was another major deterrent to dental visits, reported by 82% of respondents. This fear was linked to anxiety about pain and possible tooth extraction, especially of the incisors, which could cause social discomfort. This level of fear is higher than the 39.6% reported by Masoud Saatchi (2015) in Iran, suggesting greater psychological barriers among the Ugandan respondents.

Practices towards Oral Health Care Seeking Behaviors

In terms of oral health practices, most respondents (74%) reported using a toothbrush and toothpaste as their primary cleaning aids. This demonstrates generally good oral hygiene practices, consistent with the findings of Desalegn Humna Beyen (2018), who found that 76.8% of dental patients in Southern Ethiopia used toothpaste for cleaning. However, 70% of respondents brushed their teeth only once daily, citing time constraints, busy schedules, and limited access to cleaning materials.

Regarding brushing techniques, 56.5% of respondents used the combined brushing technique, indicating an understanding of effective oral hygiene practices. This result corresponds with Rugaia Eltayeb Hag et al. (2019), who found that 42% of schoolchildren in Omdurman used the same technique.

Conclusion

The study revealed that while the respondents demonstrated good knowledge of oral health and hygiene practices, such as awareness of smoking risks and the importance of regular brushing, their attitudes and practices toward oral health care seeking were generally poor. Most respondents only sought dental care when in pain, and fear, financial constraints, and distance to clinics were major barriers. Although oral health knowledge was adequate, negative attitudes and inconsistent practices, such as infrequent brushing and irregular dental visits, compromise overall oral health outcomes. Therefore, improving awareness alone is insufficient; interventions must also address behavioral

change and accessibility to encourage preventive oral health care.

Recommendations

Strengthen oral health education programs in schools, health facilities, and communities through health camps and public outreach to enhance awareness of oral hygiene and preventive care.

Increase accessibility to oral health services by establishing or integrating dental care units within existing health centers and subsidizing the cost of basic oral hygiene materials like toothpaste and toothbrushes.

Conduct regular oral health sensitization campaigns and community outreaches to promote early detection and treatment. Screening for oral health problems should be integrated into general outpatient services to identify and manage conditions early.

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ACRONYMS/ABBREVIATIONS

BMC:	BioMed Central
HSB:	Healthcare Seeking Behaviors
KAP:	Knowledge, Attitude, and Practice
KRRH:	Kayunga Regional Referral Hospital
MOH:	Ministry of Health
NCCDPHP:	National Center for Chronic Disease Prevention and Health Promotion.

NGOHSR: New Global Oral Health Status Report
WHA: World Health Assembly
WHO: World Health Organization.

Source of funding

The study was not funded

Conflict of interest.

There is no conflict of interest.

Availability of data.

Data used in this study are available upon request from the corresponding author.

Author's contribution.

TM designed the study, conducted data collection, cleaned and analyzed data, drafted the manuscript, and CA supervised all stages of the study from conceptualization of the topic to manuscript writing and submission.

Authors biography

Ronald Tamale is a student of a diploma in clinical medicine and community health at Kampala School of Health Sciences.

Cliffe Atukuuma is a research supervisor at Kampala School of Health Sciences.

References

1. Arzu Beklen, B. G. (2021). Arzu Beklen, Burak G. Yildirim, Meh. The impact of smoking on oral health and assessment of tobacco cessation support from Turkish dentists in Turkey. National Library of Medicine. <https://doi.org/10.18332/tid/136418>
2. C.A. Akinyamoju, J. T. (2018). Oral health knowledge and practice among traders in Ibada. Annals of Ibadan Postgraduate Medicine, 50-156.
3. Dagnew. (2020). Nurses' attitude towards oral care and their practice level for hospitalized patients in Orotta National Referral Hospital, Asmara, Eritrea. Journal of oral health sciences. <https://doi.org/10.1186/s12912-020-00457-3>
4. Juliet Ocwia, R. O. (2021). Oral health seeking behaviors of adults in Nebbi District, Uganda: a community-based survey. BMC Oral Health. <https://doi.org/10.1186/s12903-021-01824-5>
5. Masoud Saatchi, M. A. (2015). Prevalence of dental anxiety and fear in patients referred to Isfahan Dental School, Iran. Dental Research Journal, 248-253.Organisation.
6. Rugaia Eltayeb Hag Maki Ibrahim, M. O. (2021). Assessment of Brushing Techniques in School Children and Its Association with Dental Caries, Omdurman. International Journal of Dentistry. <https://doi.org/10.1155/2021/4383418>
7. Sfeatcu, R. (2022). Global Oral Report. Romanian Journal of Dental Medicine, 189-201.
8. Shalinie King, A. T. (2023). oral health literacy, knowledge, and perception in a socially and culturally diverse population. BMC Public Health. <https://doi.org/10.21203/rs.3.rs-2715927/v1>
9. Tsz Yung Wong, Y. C. (2022). o Self-Reported Gum Bleeding, Perception, Knowledge, and Behavior in Working Age Hong Kong, China. International Journal of Environmental Research and Public Health. <https://doi.org/10.3390/ijerph19095749>
10. Waheed, Z. (2018). Awareness and Practices of Oral Hygiene among Female Undergraduates in a Malaysian University. Journal of Education and Educational Development, 2. <https://doi.org/10.22555/joeed.v4i2.1321>

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Page | 11

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