



SOS CHILDREN'S
VILLAGES
GHANA

ACTIVITY REPORT

WRIGLEY ORAL HEALTH PROJECT GHANA



Organization: SOS Children's Villages Ghana

Report By: Naa Bruce-Konuah

Reporting On: Upper East Region

Reporting Period: October ~ November 2016



INTRODUCTION

With your continuous support and also as part of our commitment to Goal 3 of the Sustainable Development Goals (SDGs) that seeks to *promote good health*, the Oral Health Project has successfully extended its activities to children at Bolgatanga and its surrounding villages in the Upper East Region of Ghana.

This was in collaboration with the Bolgatanga Municipal Education Office of the Ghana Education Service, the Bolgatanga Municipal Assembly, community leaders and basic school teachers.

This time around, our services extended to ten (10) circuits within in the Bolgatanga Municipality of the Upper East Region and these include: South East, South West, Central A, Central B, North West, North East, West A, West B, Zuarungu East and Zuarungu West.

In all, 100 public basic schools (Kindergarten & Primary) were visited within the above mentioned ten (10) circuits and two other major surrounding towns (Bawku and Paga). A total number of thirty five thousand and thirty four (35,034) children were reached during the exercise.

BACKGROUND OF THE BOLGATANGA MUNICIPALITY

The Bolgatanga Municipality is one of the nine (9) districts in the Upper East Region of Ghana.

According to the Ghana Statistical Survey, the Bolgatanga Municipality has a total population of 131,550. Although urbanization seems to be on the rise, the rural population still account for more than half of the population. The Bolgatanga Municipality has an average household size of five persons per household which is highly associated to most rural areas. Children, however, make up a larger portion of each household.

Agriculture is the main occupation for most households, as many families are engaged in crop farming and tree planting. A lower percentage of inhabitants are engaged in weaving of baskets, hats and other traditional accessories.

Some of the communities visited by our team include: Tindonsobulugu, Tindonmolgo, Zuarungu, Gambibigo-Azuabisi, Bukere, Yikine, Sumbrungu, Yorogo, Bawku and Paga.



REPORT ON ACTIVITIES

Below is a vivid interpretation of schools visited and the number of children reached out to in all the various locations. As shown in the tables below, a circuit could boast of not less than 5 schools and 1464 children.

No	WEST 'B'	TOTAL		
		BOYS	GIRLS	OVERALL
1	Anateem KG & Primary	189	210	399
2	Yebongo KG & Primary School	234	205	439
3	Kulbia KG & Primary	268	235	503
4	Dazongo KG & Primary School	232	207	439
5	St. Charles Lwanga KG & Primary	228	223	451
6	Asoegoom KG & Primary School	173	116	289
7	Aguusi KG & Primary School	142	133	275
8	Azorebisi KG & Primary School	169	178	347
9	Atampuurum 'A'	142	118	260
10	Atampuurum 'B'	206	222	428
11	Atulisum Primary School	102	85	187
		2,085	1,932	4,017

No	WEST 'A'	TOTAL		
		BOYS	GIRLS	OVERALL
1	Apasinaba KG & Primary School	270	271	541
2	Azaalonge KG & Primary School	159	163	322
3	Sumbrungu KG & Primary School	257	249	506
4	Sherigu KG & Primary School	167	170	337
5	Dorongo KG & Primary School	443	388	831
6	Yikene KG & Primary School	176	168	344
7	Nyorkorkor KG & Primary School	215	160	375
8	Sokabisi KG & Primary	181	182	363
		1,868	1,751	3,619



No	ZUARUNGU EAST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Zuarungu Moshie KG & Primary	170	166	336
2	Nimolgo KG & Primary	28	26	54
3	Dubila KG & Primary	134	124	258
4	Ayeltige KG & Primary	165	143	308
5	Dachio KG & Primary	157	155	312
6	Animoah KG & Primary	85	76	161
7	Abolato KG & Primary	106	113	219
8	Afeghera KG & Primary School	130	118	248
9	Katanga KG & Primary School	182	183	365
10	Maurice Brown KG & Primary Sch	166	149	315
		1,323	1,253	2,576

No	ZUARUNGU WEST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Dulugu KG & Primary	367	372	739
2	Gambibgo KG & Primary	423	422	845
3	Kantia KG & Primary School	149	160	309
4	Zuarungu KG & Primary	287	286	573
5	Kumbosigo KG & Primary	198	196	394
6	Yarigabisi KG & Primary School	136	151	287
7	Pologo KG & Primary School	63	64	127
8	Grace Preparatory School	154	104	258
		1,777	1,755	3,532

No	NORTH WEST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Zorbisi	33	33	66
2	Akantome Primary School	197	215	412
3	Preparatory Model	621	589	1210
4	Zaare English Arabic	176	161	337
5	Zaare Experimental	177	170	347
6	Yorogo Kunkua	31	35	66
7	Yorogo Asorogobisi	174	172	346
8	Bolga Nyariga	175	157	332
9	Nyariga Doone Girls	39	262	301
		1623	1794	3,417



No	NORTH EAST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Awogeya KG & Primary	148	153	301
2	Bukere D/A KG & Primary School	186	192	378
3	St. Joseph KG & Primary School	222	179	401
4	St. Paul KG & Primary School	119	176	295
5	Yorogo KG & Primary School	204	203	407
6	Akakia KG & Primary	221	189	410
7	Failiya Madina KG & Primary School	160	135	295
8	Yipaala KG & Primary School	60	62	122
		1320	1289	2,609

No	SOUTH EAST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Aningazanga KG & Primary School	59	60	119
2	Adabase KG & Primary School	135	137	272
3	Aswaj KG & Primary School	89	77	166
4	Anglican KG & Primary School	369	445	814
5	Bolga Experimental KG & Primary	99	114	213
6	Tahiriya KG & Primary	88	62	150
7	Rashadiya KG & Primary	30	31	61
8	31st December KG	25	10	35
		894	936	1,830

No	SOUTH WEST	TOTAL		
		BOYS	GIRLS	OVERALL
1	Ola KG & Primary	185	172	357
2	SDA KG & Primary School	247	194	441
3	Ayuusi - Yine KG & Primary School	406	380	786
4	Kalbeo Tindon Sobligo	281	268	549
5	Tindaa Yamga Primary School	36	43	79
		1155	1057	2,212



No	CENTRAL A	TOTAL		
		BOYS	GIRLS	OVERALL
1	Rev. FR. Ken Memorial KG	77	65	142
2	Sacred Heart KG	104	101	205
3	St. Charles KG & Primary School	328	319	647
4	Atulba Daboo KG & Primary	148	145	293
5	Queen Elizabeth KG	72	71	143
6	TI Ahmadiyya KG & Primary School	134	123	257
7	St. Charles Special School	30	19	49
8	St. Georges Primary	198	212	410
9	St. Clements Primary School	207	260	467
		1298	1315	2,613

No	CENTRAL B	TOTAL		
		BOYS	GIRLS	OVERALL
1	Presby KG & Primary School	190	205	395
2	Umaria KG & Primary School	62	72	134
3	Nurul - Islam KG & Primary	69	64	133
4	Watania KG & Primary	39	51	90
5	Methodist KG & Primary	214	253	467
6	Baptist Primary	122	135	257
		696	780	1,476

The two tables below are representative of the 2 major surrounding towns (Paga & Bawku) as mentioned earlier in the introduction above.

No	PAGA, UPPER EAST REGION	TOTAL		
		BOYS	GIRLS	OVERALL
1	St. Oscars KG and Primary School	223	203	426
2	Paga E/A Primary School	202	219	421
3	Nakolo-God's Glory School	49	34	83
4	Frontiers	114	115	229
5	Northern Educational Complex	142	163	305
		730	734	1464



BAWKU, UPPER EAST REGION				
No		TOTAL		
		BOYS	GIRLS	OVERALL
1	Bazua R/C Primary School	249	323	572
2	Yalugu E/A Primary School	229	235	464
3	Benguri Primary School	233	199	432
4	Kuloko Primary School	119	117	236
5	Azum Sapeliga Primary School	229	274	503
6	Sakpari Primary School	228	211	439
7	Gum Yoko Primary School	382	342	724
8	Bazua D/A Primary School	146	149	295
9	Kpalugu Primary School	236	229	465
10	Boko KG & Primary School	235	217	452
11	Nayoko #1 KG & Primary School	131	143	274
12	Nayoko #2 KG & Primary School	271	242	513
13	St. Timothy's KG & Primary School	141	137	278
	Children not enrolled in school	10	12	22
		2,839	2,830	5,669

OUR APPROACH

Haven decided that the project was targeted at schools within the Bolgatanga Municipality, SOS Children's Villages Ghana first contacted the Director of Education for the Bolgatanga Municipality and later followed up on the Deputy Upper East Regional Minister for formal introduction and presentation of the Oral Health Project initiative designed for children within the target location.

Other officials and stakeholders contacted were the Coordinator of the Bolgatanga Municipality, Circuit Supervisors from the Ghana Education Service, School Health Educational Project (SHEP) Coordinator, the Assembly Members, and Heads of Schools among others.

Next, our team engaged Circuit Supervisors of the Ghana Education Service in a training workshop to present activities outlined for the Oral Health Project for their respective schools.

Participants were first sensitized on oral health related topics and open demonstrations.

Bearing in mind that these Circuit Supervisors were directly in charge of schools to be visited, the team deemed it relevant to engage them in a collaborative exchange of ideas on the best approaches to adapt for the purpose of school visitations.

At the end of the workshop, both the Oral Health Team and Circuit Supervisors had agreed on scheduled timetable for the school visitations and appropriate methods for the distribution of toothbrushes and toothpastes to suit all ages of children.



It was decided that due to the large number of schools intended to be visited under each of the ten (10) circuits, it was ideal to limit school visitations to two (2) circuits per week.

The project also recruited some community volunteers to assist in bridging the anticipated language barrier that could have been a challenge in sending across messages intended for children especially those in Kindergarten and lower primary.

METHODOLOGY

Bearing in mind that children are best taught through active child participatory methods, especially when they are still at their young and receptive stages in life, the Oral Health team utilized demonstrative teaching methods at the schools.



Dental manikins and pictorial charts were used to demonstrate how children should properly brush their teeth to avoid teeth discoloration and the accumulation of plaque.

Children were also given an opportunity to demonstrate how they had been brushing their teeth prior to the team visit and how they would be brushing their teeth after the exercise.

Also as part of instilling a regular habit of twice brushing of teeth as a lifestyle, facilitators taught these children songs with lyrics that advocated for proper dental care.

However, due to some deplorable infrastructure conditions of the classrooms, warm weather conditions, language barrier and limited classroom spaces to accumulate the large numbers of children that were regrouped, the Oral Health Project facilitators organized student gatherings under trees in some schools.



Volunteers also played active roles in taking turns to teach the children 'how', 'when', 'why' and the number of times they needed to brush their teeth with recommended toothbrushes and toothpastes.

Active participation of the children proved very effective and fun for these children as they openly voiced out some concerns and posed questions relating to dental care practices.

Distribution of recommended tooth brushes and tooth pastes took place only after all the children; ranging from Kindergarten to Primary six (6) had been regrouped.

This is because, facilitators had to properly identify suitable recommended tooth brushes and tooth pastes for all ages.



Another reason for the regrouping was to distribute distinct tooth brush colours to children who lived in the same household, more especially, siblings, twins and triplets.

This is because the facilitators wanted to prevent the situation whereby siblings could easily exchange tooth brushes due to similarity in colours which is a prerequisite for gum infections.

OBSERVATIONS



It was observed that majority of children visited suffered from tooth decay (cavities), with a few at its chronic stages and this often caused severe pains as its infectious stages. While some experienced bleeding gums, other children had tooth discoloration, bad breath, sores in the mouth and plaque buildup, among others.

Interactions with community members indicated that the three major reasons contributing to the spate of bad dental practices in most communities visited were sheer parental negligence, ignorance and unaffordability of treatment of dental infections for the larger portion of the society.

A survey by the team showed that the percentage of children aged between four (4) and twelve (12) years in low income families with symptoms of tooth decay was twice as high as compared to those from middle income earning households.



Majority of the children our team interacted with, exhibited ignorance on the proper conventional usage of toothbrushes and tooth pastes. Common practice was the use of chewing sticks made from Nim tree or the stem of plantain, while a few admitted they had never used toothbrushes or tooth paste. The residue from the chewing sticks are dipped in ashes from charcoal, sand, salt, lime and other unidentified substances in cleaning their teeth.

Teachers attributed this to parental ignorance, sheer negligence, native beliefs, generational inherited practices and inability of parents to secure toothbrushes and pastes due to economic hardship.

The facilitators highlighted the dangers of improper brushing of teeth and cited that the buildup of plaque on the teeth was a prerequisite for tooth decay; as the plaque eats away the enamel to cause cavities.





Again, a visit to most schools showed children sharing streams, wells and manual borehole water with farm animals even at schools. Some children had to queue with community members during school hours to manually pump water to drink.

As evident in the picture, a donkey is seen drinking water from the channel point of the manual bore hole as it is being pumped for water by one of the children.

This is a clear case of several instances where animals

share limited water sources with children even at the schools.

Animal presence on school premises exposes children to flies and some insects that wove around their open sores and in some instances breed over stagnant water.



This is because, most schools did not have pipe borne water and this is a major challenge being faced at most schools.

Water from unrecognizable sources are often contaminated and are detrimental to their teeth.

CHALLENGES

Even with the positive outcome of this two (2) month intensive oral health campaign, some challenges were recorded and are worth expatiating for future planning and execution of similar campaigns.

To begin with, was the issue of student absenteeism at some schools visited during school session. When our team contacted the heads of schools concerning this issue, information relayed to facilitators was that some parents send off their children to assist in farm work while others sold on market days. This was prevalent in the farming communities and with households of single parenting.



Another challenge identified was economic hardship which was a hindrance to the consistent purchase of tooth brushes and tooth pastes on the part of some caregivers. The cheapest method of keeping teeth clean was the use of 'chewing stick' and ashes from charcoal or sand and lime in a paste form.

Also, in some schools visited, teacher cooperation was low and facilitators had to go the extra mile of personally taking charge of regrouping children for the exercise. This was time consuming and delayed the process to some extent. A few teachers we interacted with also showed some level of ignorance on the recommended way of brushing teeth.



In some schools, students were seen loitering on the compound during class hours due to teacher absence at the time of our visit. Facilitators had to go round the compound and organize students into the classrooms before commencement of intended activities for the day.

Bad road network within the locality was also a hindrance to smooth journey to some schools. The facilitators were left with no other choice than to walk some short distances with learning materials and packages of tooth brushes and pastes to be distributed to children on the school premises.

CONCLUSION

Teachers and some heads of schools who were sensitized in proper oral health practices expressed the willingness to impart their knowledge by way of introducing school clubs.

Educational materials on dental care such as posters, charts and booklets were distributed to schools as a way of rekindling knowledge impacted after the campaign visit.

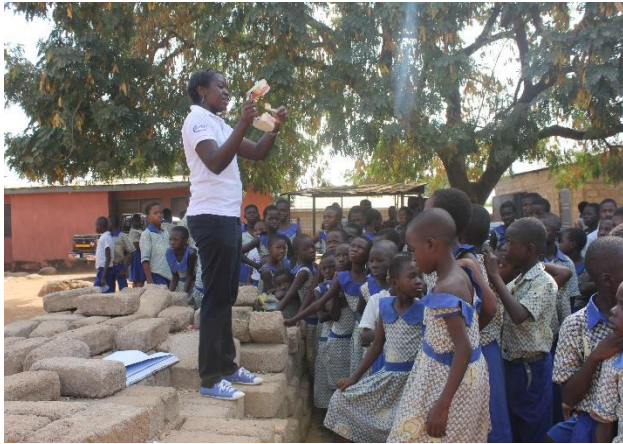
Facilitators played a key role in the success of the just ended two month oral health campaign as they offered selfless efforts and time in ensuring that all the set objectives were achieved in a timely and professional manner.

This was essential, as language barrier was also not a challenge at any point in time.



PHOTO GALLERY OF THE ORAL HEALTH PROGRAMME IN BOLGATANGA

CHILD CENTERED ACTIVITIES WERE HELD TO FACILITATE CHILD PARTICIPATION



Facilitators went the extra mile to teach children the recommended way of brushing teeth



Oral Health Facilitators sensitized children on 'how', 'when' and 'why' to brush teeth properly



CHILDREN WERE ALSO GIVEN THE OPPORTUNITY TO FREELY PARTICIPATE AND PRACTICE WHAT THEY HAD LEARNT



Children had fun showing us what they knew



Every child learnt something new



Indeed, child participation was very impactful



Time to brush the right way



CHILDREN WERE EXCITED TO RECEIVE THEIR VERY OWN TOOTH BRUSHES AND TOOTH PASTES



Each child received a new toothbrush & paste



Children could not hide their joy



Hurray! New brushes for everyone



Facilitators giving out the toothbrushes



WATER SOURCES IN THE COMMUNITY

In most schools visited, animals like pigs, goats, cows and donkeys could be seen loitering on school premises and at some point joined students to drink water from the manual boreholes whenever the opportunity presented itself.



Some animals sighted on the school compound Children drinking water from manual boreholes



Picture of a donkey drinking some water at a manual borehole



