

# [Oral hernández-palacios et al. (2015) (25) in mexico](https://assignbuster.com/oral-hernndez-palacios-et-al-2015-25-in-mexico/)

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Oral health is a critical component of everyindividual’s general health and wellbeing.

The World Health Organizationrecognizes oral health as an integral part of general health and a basic humanright. Poor oral health and untreated oral diseases and conditions usually havea significant impact on the quality of life. Oral disease is common in advancedage. The most common oral health problems encountered by the elderly are teethloss, dental caries, gingivitis, peridontitis, xerostomia, oral lesions, anddental problems (7). Concerning demographic characteristics, themean age of the elderly in the present study was 69. 25 ± 7. 53 which is close tothe mean reported by Ibrahim et al. (2010) among elderly in Egypt (66.

08 years). Similarly, in Brazil (69. 5years) (Ulinski et al., 2013) (20) and in (Ibadan)Nigeria (69. 7 years) (Taiwo et al.

, 2012) (21). The samepoint is confirmed by Dable et al. (2013) (22) in westernIndia who mentioned that the age range was between 60-82 years and the mean agewas 69. 4 years.

The present study revealed that the pluralitywas to the women among the study sample. The higher percentages of women mayreflect that attendants of the geriatric social club were commonly women, andreflect the higher life expectancy of women in general, and in Egypt as wasreported by the Central Intelligence Agency (CIA) where the life expectancy was70. 8 years for male and 76.

2 years for female people (23). The  finding  is in  congruence  with many  similar previous  studies such  as, Christensen et al.(2011) (24) in Copenhagen City, Hernández-Palacios et al.

(2015) (25) in Mexico City , Denmark, and Jang et al.(2015)(13) in Korea. The current study findings revealed thatslightly less than three quarters of the studied elderly were living withfamily, while one-quarter of them were living alone. It might be due to thatslightly more than half of them were still married and living with theirspouses. Moreover, Middle-Eastern cultures are considered to possess morecollectivist values where societies tend to encourage interdependence andtherefore traditionally provide support and care for older people within theirfamilies. In the same context, the results of study conducted in Brazil by Alvesda Silva et al. (2016) (26) who reported that more than half ofthe elderly were still married and more than three quarters of them were livingwith family                   Thefindings revealed very deficient knowledge among studied elderly before theprogram.

This was noticed in all the tested knowledge areas such as the changesassociated with aging, oral cancer, and the most common oral problems. The onlyexception was the part related to the preventive measures, which was known bymore than one third of them. This could be explained by the specificinstructions on media (TV & Radio) regarding tooth brushing and mouthcleanliness that still, perceived its importance was inconsistent with theirdemonstrated effectiveness. In support of this, the study results demonstratedthat more than half of the studied elderly were depending on TV assources of their oral health knowledge. Inagreement with the present study finding, a study in Egypt by Al Imam (2014)(17) who found that very deficient knowledge among the studysubjects before the program. The author attributed this poor knowledge to theeducational level of the study sample where the majority of them wereilliterate.

Similarly, another study in USA by McQuistan et al. (2015) (27)revealed that many participants were familiar with basic dentaldisease prevention and treatment; however, the most participants wereunfamiliar with concepts pertaining to periodontal disease, oral cancer, andoral health.  The deficient pre-program knowledge depictedamong the elderly in the present study might be attributed to the low level ofeducation among some of them as well as their mental abilities, which could beaffected by the aging process.

In support of this, the study resultsdemonstrated significantly higher scores of knowledge among those in the youngerage group, less than 70 years, those educated and female gender. Moreover, agewas negatively correlated to knowledge score, while the educational level waspositively correlated to it. The same findings were revealed in logisticregression analysis. In congruence with this, the study of Al-Sharbatti andSadek (2014) (28) in Ajman, United Arab Emirates UAEidentified a significant association between elderly’s knowledge and their ageas well as educational level. On contrast with these findings, a study inAustralia revealed that the total oral health knowledge score was examined inrelation to the various socio-demographic and oral health. None of thesevariables yielded a statistically effect on the overall knowledge score(Marino et al., 2015a) (29). After implementation of the current studyeducational program, there were statistically significant improvements inelderly’s knowledge.

This indicates the effectiveness of the program in leadinga positive change in their knowledge. Additionally, the educational level ofthe majority of the studied elderly was high or moderate as well as themajority of them were in 60-69 age group and these factors might play animportant role in improving their oral health knowledge. This improvement wasaccompanied with little declines at the follow-up phase. This is expected giventhe effect of old age on memory, especially the short-memory.             Similarly, a study in Melbourne, Australia where participants showed statisticallysignificant improvements in participants oral health knowledge (18. 4 vs. 23.

3; p <0. 001) (Marino et al., 2015b) (30).

In agreement withthis result, Albrecht et al. (2013) (31) in Germany concludedthat oral health knowledge of elderly improved by one or more oral healtheducational interventions.       Regarding the oral self-care practicesobservation checklists, the findings revealed inadequate practice among thestudied elderly before the program. This was noticed in all the observedprocedures where  all of them were unableto manage oral cancer self-examination procedure, the majority of them wereunable to manage teeth flossing procedure, about two thirds of  them were unable to manage teeth brushingprocedure, and one third of them was able to manage only part of denture careprocedure. This could be partly due to low knowledge and motivation regardingoral hygiene practices. On the same line, Al-Sharbatti and Sadek (2014) (28)in Ajman, UAE, who found that the majority of elderly had inadequate oralself-care practices. The inadequate pre-program practices shownamong the elderly in the present study might be attributed to that the majorityof elderly had more than one chronic disease which take the priority in carerather than the oral health.

Additionally, the low level of education, insufficientincome among some of them as well as their inadequate knowledge regarding theimportance of oral health to body health. This finding might be  due to that elderly with high level ofeducation are more likely to have sufficient income that enable them to get better access to dental care. In support of this, the study results demonstrated that the score of oralself-care practice had statistically significant positive correlations withelderly’s educational level, income and oral health knowledge. In congruence with this, the study of AlImam (2014) (17) in Egypt identified a significant associationbetween elderly’s oral self- care practices and their educational level as wellas income. Additionally, Skorupka et al. (2012) (32) inSouthern Poland revealed that the most frequent cause of oral hygiene neglectin the elderly could be the socio-economic conditions, and lack of sufficienthealth education.

After implementation of the current studyeducational program, there were statistically significant improvements inelderly oral self-care practices with some declines were revealed at thefollow-up phase. This indicates the effectiveness of the program in leading apositive change in their practices. This finding was expected since theprocedures were explained in the oral health education program included in thebooklet that the researcher distributed it to all of the studied elderly andeach procedure was applied individually. Additionally, the educational programwas considered as a start point and motivation for the elderly to take care oftheir oral health like other health concerns. In the same line, Mariñoet al.

(2015a) (29) in Australia found that theparticipants showed significant improvements in self-care oral hygienepractices (p < 0. 05).  Moreover, Zini et al. (2013) (33) in Thailand demonstrated that there werestatistically significant improvements in elderly's practices total mean scoreof teeth brushing , teeth flossing, denture care and  oral cancer self-examination with some declineswere revealed at the follow-up phase.    Before the program, lips, gums and tissueschanged in less than half of the studied elderly, while tongue, saliva, andoral cleanliness changed in more than half of them. Ultimately, natural teethand denture changed in the majority of studied elderly and dental pain changedin the minority of them. This can be explained by that, the inadequateknowledge as well as inadequate practice and limited dentist visiting among themajority of studied elderly, predict the changing in oral health status. Also, the majority of them were suffering from comorbidity and were depending onmultiple medication that affect negatively on oral health.

These findings go in line with that of Comptonand Kline (2015)(34) in Edmonton, Canada who found that very fewelderly had good oral health, where one fifth had healthy oral cleanliness, more than one tenth had healthy tongues; and around two fifth had healthy gumsand tissues. On the other hand, categories on the OHAT in which a majority ofelderly were deemed healthy were lips, saliva, and pain.  After implementation of the current studyeducational program, there were statistically significant improvements inelderly oral examination findings with some declines were revealed at thefollow-up phase. This indicates the effectiveness of the program in leading apositive change in their oral health status.

This finding was expected sincethe knowledge of oral health and oral self-care practices were improved amongthe studied elderly which act as a positive predictors for improved oral healthstatus. In support of this, the high score of oral examination findingsindicate poor oral health status so, the study results demonstrated that thescore of oral examination findings had statistically significant negativecorrelations with elderly oral health knowledge. Similarly, Komulainen (2013) (35)in Kuopio, Eastern Finland found that oral health status improved in boththe intervention group during the study, and especially the positive changes inperiodontal health can be considered to be clinically substantial.

In agreement with this result, Albrecht etal. (2013) (31) in Germany concluded that oral health status ofelderly was improved by one or more oral health educational interventions.  It was hypothesizedthat after implementation of the educational program, OHRQoL among the elderlywill be improved.

This hypothesis was supported by the current study findingswhich revealed that educational program had an effect on OHRQoL domains scoreswhen comparing pre-program mean scores with post-program mean scores and followup mean scores, which indicated significant improvement in the elderly oralhealth related quality of life. The findings demonstrated generally poorlevels of OHRQoL among these elderly before the program. This was especiallynoticed in the physical pain domain followed by psychological discomfort domainthen, physical disability domain.

The findings are expected given the negativeimpact of these three domains on daily life. In agreement with this, a study inBrazil (Ulinski et al., 2013) (20) reported that thehighest means were registered for physical pain and psychological discomfort. On the same line, a study in Bengaluru, India found that among the sevendomains of OHIP, the greatest impact was on physical pain (painful aching, discomfort while eating) (Pushpanjali et al., 2013) (36).  After   the    implementation    of   the    current    study program, a statistically significantimprovements were shown in all areas of elderly OHRQoL. However, there weresome declines at the follow-up phase.

This indicates the success of theprogram, and leads to acceptance of the research hypothesis. In agreement withthis finding, a similar effectiveness of an interventional study in improvingthe OHRQoL of elderly was reported in Egypt (Al Imam, 2014) (17). On the same line, a study in Korea found a statistically significantimprovements in the oral health related quality of life score between theelderly (P <. 05) (Kim et al., 2016) (37).       Regarding the correlations between elderly'soral health knowledge and oral self-care practices, the findings of the currentstudy indicated statistically significant positive correlations between thescore of OHK and OSCP before and after the implementation of the study program. These findings suggested that the higher oral health knowledge has adirect impact on oral self-care practices by improving the individual'sself-awareness, self-protection, and personal hygiene performances. These findingsare consistent with a study conducted in Saudi Arabia by Baseer et al.

(2016) (38) which showed that there was a significant positivecorrelation between the subjects’ knowledge and practice. Also in agreementwith the foregoing present study findings, Wahengbam et al. (2016) (39)conducted a study in India to evaluate Knowledge, Attitude and Practice(KAP) towards oral health.

The findings of this study indicated significantpositive correlation between knowledge and practice (r= 0. 405, p <0. 01).

Thepositive correlation reaffirms that better knowledge can lead to goodpractices. Concerning the correlations between elderlyoral health knowledge and oral examination findings (oral health status), thefindings of the current study showed statistically significant negativecorrelations between oral health knowledge, and oral examination findings, where the total mean score of elderly OHK is inversely proportional with theirOEF {the higher OHK score, the lower (better) OEF score}. In agreement with this, the study conducted in India by Chowdary et al. (2015) (40) revealedthat Oral health literacy scores showed a statistically significant negativecorrelation with oral hygiene status, dental caries prevalence, periodontalstatus and prosthetic needs. So, subjects with low oral health literacy had apoor oral hygiene status, high dental caries prevalence, periodontitis, andthey were in need for a prosthesis.

Concerning the correlations between elderly’soral health knowledge and their oral health related quality of life, thefindings of the current study demonstrated that statistically significantstrong negative correlations between oral health related quality of life andoral health knowledge, where the total mean score of elderly OHRQoL isinversely proportional with their OHK {the higher (adequate) OHK score, thelower (good) OHRQoL score}. This result is incongruent with Dahl et al.(2011) (41) in Norway who reported that the elderly with higherliteracy levels had more natural teeth and better quality of life. Furthermore, a review study by Cunha et al. (2014) (42) reported thateleven primary studies were analyzed and showed that poor literacy isassociated with poor oral quality of life and in order to promote it, bothliteracy and oral health should be included in nursing education, research andpractice. Regarding the correlations between elderlyoral self-care practice (observation checklist) and their oral health relatedquality of life, the findings of the current study demonstrated at statisticallysignificant negative correlation between oral health related quality of lifeand oral self-care practice, where the total mean score of elderly’s OHRQoL isinversely proportional with their OSCP {the higher (adequate) OSCP score, thelower (good) OHRQoL score}. In agreement with this present study finding, astudy in Kuwait by Alsumait et al. (2016) (43) whofound significant correlations between oral self-care practices and OHRQoL (p < 0.

05). As regard for the correlation between elderlyoral examination findings and their oral health related quality of life, thefindings of the current study demonstrated that oral health related quality oflife had statistically significant positive correlations with the oralexamination findings. In agreement with this present study finding, a study inGreece by Papaioannou et al. (2015) (44) clarified thatdental and oral health conditions have a measurable impact on the quality oflife of senior citizens.

According to the present study findings, theelderly OHRQoL was influenced by many of their personal as well as their healthand disease characteristics. The personal factors with positive impact wereyounger age, female gender, higher education, as well as employee. All thesefactors indicated better socioeconomic and psychological status. Moreover, theeffects of age, gender, and education were confirmed in correlation analysis. In agreement with this, a study in Babol, Iran reported that subjects withacademic educations also had a better oral health status due to the highercultural level and better care of oral health (Motallebnejad et al., 2015)45.