
Oral Hygiene Knowledge and Practices among School Age Children: an Assessment Study

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ABSTRACT

Background: Oral hygiene is the practice of keeping the mouth and teeth clean to prevent dental problems, especially dental caries, gingivitis and bad breath. The purpose of maintaining oral hygiene is to prevent the build-up of plaque. **Aim of this study was to** assess the oral hygiene knowledge and practices among school age children. **The research design was a** descriptive. It was carried out at 5 governmental primary schools representing Port-Said City. **The study subjects** consisted of 202 school age children in the age group of 10-12 years, regardless their gender and residence. The data was collected using an interview questionnaire sheet and observational checklist to assess the study subjects' knowledge and reported practices related to oral hygiene. **The results of the study** revealed that one third of the studied children were at the age group of 11 years, more than half were females. Moreover, less than half and more than one third of studied children had unsatisfactory total knowledge and reported practices respectively regarding oral hygiene. In addition to more than half of studied children's don't follow up about their teeth. **It was concluded that** knowledge and reported practices of the studied children regarding oral hygiene practice was satisfactory by more than half of them. **The study recommended** raising awareness of school age children about oral health and hygiene through oral health education sessions and community outreach programs in children's school settings.

Key words: Oral hygiene, school age children, pediatric nursing, knowledge and reported practice.

INTRODUCTION

Oral health plays an important role in the overall health of the body and the quality of life of individuals (Hashemian et al., 2012; Pakpour et al., 2012 and Fallahi et al., 2013). Oral health is a fundamental component of health and well-being. The oral health is a state that contributes positively to one's physical, mental and social well-being by allowing the individual to speak, eat and socialize unhindered by pain, discomfort or embarrassment (Canadian Dental Association, 2015d). This includes being free from oral and facial pain, oral and throat cancer, oral infection, gum disease, tooth decay, tooth loss and other oral-associated diseases (World Health Organization, 2012). Oral hygiene is most important for good health in general. Poor oral hygiene can be a source of many diseases. By maintaining good oral hygiene, the occurrence of many diseases can be prevented. Unfortunately, oral hygiene practice is very low in our society. Dental caries and periodontal problems are due to poor oral hygiene practices (Morenike et al., 2007). Oral hygiene, including twice daily tooth brushing, is critical in preventing gum disease and maintaining good oral health (Hassijaand Sridhar, 2014). Dental caries is a multi-factorial, irreversible microbial disease of the calcified tissues of the teeth, characterized by demineralization of the inorganic portion and destruction of the organic substance of the tooth, which often leads to cavitations (Lato et al., 2009). A large number of school-aged students in developing countries suffer from tooth decay and have limited access to oral health care services. Dental caries affects 60-90% of school-age children and most of the adults. Periodontal disease is prevalent in 50-90% of school age children, and is severe in 10-15% of them, while gingival diseases occur in the majority of children and adolescents (Al-Mutawa et al., 2011). Oral disease burden is significantly higher among poor and disadvantaged populations with an increase in developing countries. Globally, poor oral hygiene occurring due to increasing plaque and calculus deposits with increasing age has been reported among children and adolescents (Saied-Moallemi et al., 2009 and Mbawalla et al., 2010). A recent publication by Folayan et al. (2012) also showed that the incidence for caries was 9.9% in a population of primary school children, with a higher incidence in primary teeth than in the permanent dentition. Understanding caries pattern, its epidemiology and how the epidemiologic profile changes over time is important because caries is the primary pathological cause of tooth loss in children in many African countries. Also, an understanding of the caries profile, that is, where new caries emerges, can be useful in proper planning for the utilization of scarce resources. It

also helps to maximize the potential outcome of resources available for preventive programs, including oral health prevention programs (Ashiwaju et al., 2011). Pediatric nurses are on the front lines of children's health care delivery. They can play an important role in providing oral health screening, early risk assessment and preventive services to children who are at the highest risk for developing early childhood caries. In addition to advising families of proper oral health, fluoride supplementation, prevention of damaging oral health habits and tooth decay and the need for referrals to pediatric dentists for anticipatory guidance (Donna and Donna, 2009).

AIM OF STUDY:

Assess the oral hygiene knowledge and practices among school age children.

SUBJECTS AND METHODS:

A descriptive research design was used to conduct the current study at governmental primary schools at Port-Said city which is divided into five sectors. Representative schools were randomly selected from a list of primary schools in Port-Said Directorate of Education for the study purpose. One school from each sector was included namely: Safia Zaghoul, Kasim Amin, Abbas El-Akkad, Omar Ibn El-Khatib and Maka El-Mokarama. The sample for the present study was collected and its size was determined using *Kish and Leslie, 1965* formula, $n = P (100 - P) * Z^2 / E^2$ where n is the sample size, Z is a percentile of the standard normal distribution by 95% confidence level = 1.96. , P= Prevalence of school age children at Port-Said City =31.08% E= Percentage of standard error. Using this formula, a sample of 202 was obtained *to* satisfy a predetermined inclusion criteria (age group of 10-12 years regardless their gender and residence area) this included in fourth grade, with exclusion of children with chronic diseases.

Tools of data collection: Data were collected through using two tools:

Tool (I): Structured interview questionnaire for children. Self administration the interview questionnaire was designed by the researcher after reviewing related literature, and was written in simple Arabic language, the questions were open and closed-ended to gather data in relation to:

Part (I): This part was concerned with: a - Characteristics of school age children. It contained 9 questions about children and their parents (student's age, number of siblings,

rank, living with whom, caregiver of the child, age of parents and their educational level, occupation and monthly income/LE).

b- Assessment of children's teeth condition (number and characteristics) (WHO 2007).

Part (II): It was concerned with the school age children's knowledge related to their oral health and hygiene: it is self-administered questionnaire. It contained 29 questions, (5) about mouth care, (5) about dental decay, (3) about prevention of dental decay, (6) about follow up, (5) about duration of cleaning teeth and (5) about eating.

Tool (II): Observational checklist to assess school age children's reported practices of oral hygiene. It was adopted from *Bulletin and Version (2000:2014) and Jelsoft (2011)*. It included 11 steps. This tool was concerned with assessment of school age children's reported practices such as: using soft toothbrush and toothpaste containing fluoride for dental brushing to clean the upper jaw, wash outer and inner surfaces of teeth, move the brush from the gums and downwards in the upper jaw or upward in the lower jaw and brush teeth for two minutes at least.

Scoring system of children's knowledge: Scoring system for knowledge of the school age children was estimated as follows: 38 questions. A total score of 74 was given for all questions. The school age children's answers were compared with a model key answer, where (2) scores were given for complete correct answers, (1) for incomplete correct answers and (0) for do not know or incorrect answers. The total knowledge were classified as satisfactory more than 50% and unsatisfactory less than 50%.

Scoring system of reported practices of the school age children was estimated as follows: The total scores of school age children's reported practices were 22 marks for the 11 items of oral hygiene procedure. The school age children's reported practices were classified into done scores for satisfactory and not done score for unsatisfactory. According to the children's total reported practices, their levels of total reported practice were categorized into satisfactory > 60% and unsatisfactory < 60%.

Validity and Reliability: Tool was reviewed by a panel of five experts in the field of pediatric, the opinions of the experts for each item was recorded on a 2 points scale: relevant or not relevant and clear or not clear. They were requested to express their opinions and comments on the tool and provide any suggestions for any additions or

omissions of items. Cronbach's alpha coefficient was used to assess the internal consistency of the questionnaire and its value was (0.78).

Administrative and ethical consideration: An official permission was obtained from the directors of the selected primary schools through official letters from the Dean of the Faculty of Nursing, Port-Said University. The school age children's oral consent and their parents was obtained before data collection ensuring complete privacy, confidentiality and anonymity. Children were informed about the aim of the study and were ensured that they had the right to withdraw at any time, and that the study was harmless.

Pilot study: A pilot study was carried out on 10% (20) of the studied children to test applicability, clarity, relevance and feasibility of the study tools and whether it was understandable or not, and to estimate the proper time required to fill each tool. The necessary modifications were done according to the results of the pilot study, then the children involved in the pilot the study were excluded later from the sample size.

Field of work: Data was gathered starting from the 1st of October 2014 till the end of March 2015. The researcher was available by rotation 3 days/week in each study setting for data gathering from 9.30 AM to 2 PM. The researcher started by presenting self, aim and expected outcomes of the study. Each child was interviewed individually by the researcher using the previously mentioned tools for 15 minutes in the class during break time.

Statistical analysis was performed using the Statistical Package for Social Sciences (SPSS version 16). Chi-square test was used to study the significance of association between variables of the study. "P value" of ≤ 0.05 was considered as statistically significant. The knowledge was considered satisfactory if it was 50% or more than it, and unsatisfactory less than 50%. On the other hand reported practices, was categorized into satisfactory $\geq 60\%$ and unsatisfactory $< 60\%$.

RESULTS :

The results in **table (1)**: illustrated the characteristics of the studied children. It was clear from this table that more than one third of the studied children (36.1%) were aged 11 years, while 34.7% were aged 10 years, with mean age 10.94 ± 0.80 years. In relation to their genders, it was found that more than half of the studied children (56.9%) were females and 43.1% were males. The same table showed that 43.6% of the studied children had one sibling and 32.7% had two siblings, 45.0% were ranked as first children

and 30.7% were ranked as middle ones. Also, 95.0% lived with nuclear families and majority of them 81.2% received care from both parents.

Table (2): Showed that more than half (51.5%) of the studied children didn't follow up with dentist visits. The causes of dentist visits were due to tooth ache 44.7% regular follow up 29.8% and 25.4% extract tooth. Also; more than three quarters of the studied children (76.2%) reported school absence twice a year due to teeth problems.

Table (3): Showed children's nutritional practices that affect their oral hygiene and illustrated that 80.2% of them reported once /twice intake of sweets daily, 92.1% reported eating sweets without cleaning teeth, 60.9% reported intake of carbonated water during meals, 48.0% reported intake of milk, vegetables, rice and bread and 38.6% had snacks between meals as fresh fruits.

Table (4): Describe that there are a statistically significant relation was found between children's total knowledge and their total reported practices regarding oral hygiene and there are a positive relation between total knowledge and total practice.

Table (5): Demonstrated relation between total children's knowledge and their females.

Table (6): Illustrate relation between total children's reported practice and their characteristics. It is clear from this table, there are satisfactory of practice and knowledge were significantly higher among females students.

Table (1): Number and percentage distribution of the studied children according to their characteristics (n=202).

Characteristics of Studied Children	Number (No.)	Percentage (%)
Student's age in years:		
10-	70	34.7
11-	73	36.1
12-13	59	29.2
$\bar{x} \pm SD (10.94 \pm 0.80)$		
Gender:		
Female.	118	58.4
Male.	84	41.6
Number of siblings:		
None.	46	22.8
One.	88	43.6
Two.	66	32.7
Three or more.	2	1.0
Rank:		
The first.	91	45.0
The middle.	62	30.7
The last.	49	24.3
Living with:		
Nuclear family.	192	95.0
Extended family.	10	5.0
Caregiver of the child:		
Both parents.	164	81.2
The father only.	25	12.4
The mother only.	11	5.4
The grandparent.	2	1.0

Table (2): Frequency distribution of the studied children according to their frequency of dental visits during the last six months and why in addition to school absence due to teeth problems (n=202).

	Number	Percentage
Items	(No.)	(%)
Frequency of follow-up visits to dentist:		
Yearly.	37	18.3
Monthly.	35	17.3
Every six months.	26	12.9
Don't follow up.	104	51.5
Visit the dentist during the last six months:		
Yes.	114	56.4
No.	88	43.6
If yes (n=114), why?		
Toothache.	51	44.7
Regular follow-up.	34	29.8
To extract a tooth.	29	25.4
Frequency of school absence due to teeth problems/year:		
Two times.	154	76.2
Four times.	34	16.8
Six times.	14	6.9

Table (3): Frequency distribution of the studied children according to their nutritional practices that affect their oral hygiene (n=202).

Nutritional practices about dental care	Number (No.)	Percentage (%)
Daily sweets taken:		
Once or twice a day.	162	80.2
Twice to five times a day.	22	10.9
Never.	18	8.9
Eating sweets continuously without cleaning:		92.1
Yes.	186	7.9
No.	16	
Kinds of drinks taken between meals daily:		
Sweet juices.	123	28.7
Carbonated water.	58	60.9
Tea and coffee with sugar.	21	10.4
Eating important foods for the health of the teeth:		
Milk.	60	29.7
Vegetables.	24	11.9
Rice.	13	6.4
Bread.	8	4.0
All of the above.	97	48.0
Snacks between meals every day:		
Fresh fruits.	78	38.6
Chips and carbohydrates.	63	31.2
Chocolates.	34	16.8
Biscuits and cake.	27	13.4

Table (4): Relation between children's total knowledge level and total reported practices regarding oral hygiene (n=202).

Reported Practice	Total Knowledge Level				Total		X ²	p-value
	Satisfactory		Unsatisfactory					
	N=118	%	N=84	%	No	%		
Satisfactory N=123	85	72.0	38	45.2	123	60.9	14.79	.000**
Unsatisfactory N=79	33	28.0	46	54.8	79	39.1		

χ^2 : Chi square test.

*Statistically significant at P< 0.05

Table (5): Relation between children's total knowledge regarding oral hygiene and their females of personal data (n =202).

Children's Characteristics	Total Knowledge Level				Total		X ²	P-value
	Satisfactory		Unsatisfactory					
	No.= 118	%	No.= 84	%	No.	%		
Age in years:								
10	36		34	40.5	70	34.7	2.8	.241
11	43	30.5	30	35.7	73	36.1	4	
12	39	36.4	20	23.8	59	29.2		
Gender:							Mc Ne mar Tes t	.004 **
Female	75	63.6	43	51.2	118	58.4		
Male	43	36.4	41	48.8	84	41.6		
Number of siblings:							.87 2	.704
None.	27	22.9	19	22.6	46	22.8		
One.	49	41.5	39	46.4	88	43.6		
Two.	41	34.7	25	29.8	66	32.7		
Three and more.	1	0.8	1	1.2	2	1.0		
Rank:							4.4 7	.106
The first.	48	40.7	43	51.2	91	45.0		
The middle.	43	36.4	19	22.6	62	30.7		
The last.	27	22.9	22	26.2	49	24.3		
Living with:							.01 1	.917
Nuclear family.	112	94.9	80	95.2	192	95.0		
Extended family.	6	5.1	4	4.8	10	5.0		
Care giver of the child:							9.9 7	.019
Mother only.	8	6.8	3	3.6	11	5.4		
Father only.	8	6.8	17	20.2	25	12.4		
Parent.	100	84.7	64	76.2	164	81.2		
Grandparent.	2	1.7	0	0.0	2	1.0		

 χ^2 : Chi square test.

*Statistically significant at P< 0.0

Table (6): Relation between children's total reported practices regarding oral hygiene and their characteristics (n=202).

Children's Characteristics	Total Reported Practice				Total		x ²	p-value
	Satisfactory		Unsatisfactory					
	No.= 123	%	No.= 79	%	No.	%		
Student's age in years:								
10	42	34.1	28	35.4	70	43.7	.222	.895
11	46	37.4	27	34.2	73	36.1		
12	35	28.5	24	30.4	59	29.2		
Gender:							McNemar Test	.001**
Female	80	65.0	43	54.4	123	60.9		
Male	43	35.0	36	45.6	79	39.1		
Number of siblings:							4.874	.181
None.	25	20.3	21	26.6	46	22.8		
One.	50	40.7	38	48.1	88	43.6		
Two.	46	37.4	20	25.3	66	32.7		
Three and more.	2	1.6	0	0.0	2	1.0		
Rank:							2.491	.288
The first.	55	44.7	36	45.6	91	45.0		
The middle.	42	34.1	20	25.3	62	30.7		
The last.	26	21.1	23	29.1	49	24.3		
Living with:							1.614	.204
Nuclear family.	115	93.5	77	97.5	192	95.0		
Extended family.	8	6.5	2	2.5	10	5.0		
Care giver of the child:							12.10	.007
The mother only.	5	4.1	6	7.6	11	5.4		
The father only.	8	6.5	17	21.5	25	12.4		
The parent.	109	88.6	55	69.6	164	81.2		
The grandparent.	1	0.8	1	1.3	2	1.0		

□²: Chi square test. * Statistically significant at $P \leq 0.05$

DISCUSSION:

The present study revealed that more than one third of the studied children aged were 11 years, while 34.7% were aged 10 years, the mean age 10.94 ± 0.80 years and more than half of the studied children were females. This finding was in an agreement with (American Academy of Pediatric Dentistry (2009) who found that the fifty percent of students aged were between 10-12 years of age, the mean age of student's was 10 years, and their achievement were average, while two third of them were females.

The present study revealed that the causes of dentist visits were due to toothache, regular follow up and to extract a tooth. This finding was in an agreement with Yusuf and Booyen, (2011) who found that the majority of the participants visited dental clinics only when they had dental pain. This similarity of findings could have been due to that pain was the main reason for visiting the dentist. However, there were those who still visited dentists for dental checkups, fear of injections and fear of tooth loss, while the main reason for the students not visiting dentists was lack of money.

The present study indicated that more than three quarters of the studied children reported school absence twice a year due to teeth problem. This findings in this study were attributed to the fact that if the child doesn't maintain adequate health, the benefits of education will be lost because of absenteeism or lack of attention due to ill health (Minor and Sivakumar, 2011 and Zahra, 2010).

The study revealed that the majority of the studied children eaten sweets continuously without cleaning teeth. This was in an agreement with Dhar et al., (2007) who found that the high prevalence, and consequently uptake of candy, sweetened beverages in urban areas and refined sugar in the form of sweets, biscuits and chocolates, might be raising levels of caries which are said to be associated with changes in standards of living, dietary habits, and increases in sugar consumption. This might be due to dental caries increasing over time and lack of attention of parents.

The present study indicated that there are a positive relation between total knowledge and total practice. This finding was in agreement with Shenoy and Sequeira (2013) who found that higher oral care knowledge, practice and better behavior were resulted on oral health. Because of multiple sources of knowledge from parents, school nurse, friends, computers and the media.

The study revealed that there are satisfactory of knowledge was statistically higher among females. This finding was in no agreement with Cheah et al., (2010) who found a no significant gender relation was noted in this respect, though certain international studies have reported a higher consumption of sweets amongst the female gender. This might be due to awareness of parents and concept of females about importance of oral health.

CONCLUSION:

Based on the findings of the current study, it can be concluded that the school age children of the present study had satisfactory knowledge and reported practice regarding oral hygiene with a statistically significant relation between children's females.

RECOMMENDATIONS:

Raising awareness about oral health and hygiene practices through health education programs and community outreach programs in both public and private school settings over the country for school age children, school teachers and care providers of school age children.

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معلومات وممارسات العناية الصحية للفم بين الأطفال في سن المدرسة: دراسة تقييمية

الخلاصة

نظافة الفم هي ممارسة للحفاظ على الفم والأسنان نظيفة لمنع مشاكل الأسنان، ومن أهم هذه المشاكل تسوس الأسنان، التهاب اللثة ورائحة الفم الكريهة. كما أن بقاء الفم نظيفاً يمنع تراكم الترسبات الجيرية و البكتيريا والمواد الغذائية على الأسنان بشكل دائم. وكان الهدف من الدراسة تقييم ممارسات العناية الصحية للفم بين الأطفال في سن المدرسة. أجريت هذه الدراسة الوصفية في 5 من المدارس الابتدائية الحكومية في مدينة بورسعيد، حيث تضمنت الدراسة 202 طفلاً من الجنسين في عمر 10-12 سنة وقد تم جمع البيانات باستخدام استمارة استبيان لقياس معلومات وممارسات الأطفال عن صحة الفم والأسنان. ومن أهم نتائج الدراسة أن ثلث الأطفال كانوا في الفئة العمرية 11 سنة، وأكثر من نصفهم كانوا من الإناث. علاوة على ذلك أن أكثر من نصف الأطفال لديهم معرفة وممارسات عن صحة الفم. و الخلاصة إن مستوى المعرفة والممارسات للأطفال الخاصة بصحة الفم والأسنان كانت بسيطة ومرضية وقد أوصت هذه الدراسة بضرورة تقديم برنامج تدريبي لطلاب المدارس الابتدائية وذلك من أجل الارتقاء بمعلوماتهم وأدائهم عن صحة الفم والأسنان مما سينعكس بصورة إيجابية على صحة أسنان الأطفال

الكلمات المرشدة: العناية بالفم، الأطفال في عمر المدرسة، ممرضه الأطفال، الممارسات، المعلومات.