



Education Program for Oral Health:

Differences and meetings values, knowledge and care.



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Health Education (HE) as a social practice directed to the population represents an important possibility to extend the landscape of the promotion of the health practice in the community.

The HE includes two specific areas that are the health and the education, which fulfill an important role in relation with the society structure and its bases are, principally, on the processes of health and disease, therefore, the comprehension of these processes and their evolution determine the orientation that it is going to have.

The HE's concept, where everybody is recognized as carriers of knowledge and, therefore allowed to liberate these potentials, supports that this type of practices should find the need for horizontality of the health programs, being opposed to the fragmentary and individual reductionist approach, generating integrity principles between health professionals and patients. Texeira⁽²⁰⁰³⁾ argues that it is about the need to overcome the "monopoly of the diagnosis of needs" and of the integration of the "voice of the other" in this process.

The description and explanation of health is not independent of whom and from what position it described and explained. The processes of health- sickness-care are considered social, structural events, articulators of knowledge, practices and actors, and the product of sociocultural representations.⁽¹⁾

According to Menéndez, referring to knowledge we mean the representations and practices organized as a knowledge which operated through curators or subjects and lay groups.⁽²⁾

In planning education programs for oral health is essential to have relevant information of the population we are going to be working on.

Inglehart and col⁽²⁰⁰²⁾ stated that since children do not make decisions about issues related to the adoption of healthy living styles, the responsibility to fulfill those needs rests on their caretaker; these become important when studying the health state in relation with the quality of life⁽³⁾.

The family plays an important role in informal care of members. Researches over the past 25 years emphasize the fundamental role that families and social networks have in health attention and promotion. In the models of care coexist, implicitly, conceptions of the person and their rights, of professional ethics, of subject participation, of *Health / Disease / Care* processes explanatory models, of cure, lifestyles and decisions over the body of persons and groups.⁽⁴⁾

The fact of referring the disease, and especially the health, to the social constraints that operate on them is the initial possibility of defining a policy for health and not only for disease. It implies the assumption that health and disease are emerging of life style, that the health / disease process is not only a problem confined to the professional area, but it also involves social groups, that in the fight against the disease there are processes that are not "delegable" or at least that should not be delegated. ⁽⁵⁾

Despite the constant changes in the conception of health and disease, in practice, it seems to predominate, with some degree of generality, the biomedical model. However, this model is, now, in crisis, since the criticism to its dehumanization and its purely technical-instrumental rationality. In any case, the scientific rationality concept, which gives more emphasis on biological factors and is more interested in disease and rehabilitation, is still predominant. This rationality assumes that both health and disease are involved in the body objective reality, while ignores the cultural and social mediation that involves human suffering ⁽⁶⁾

It is necessary to discuss the aims and objectives of each possible program with those to whom it is addressed and are going to participate in it. Only in this way it is possible to know how certain values which are supposed to be universal are understood. That is to say, it is necessary to take into account the community cultural and historical vision. ⁽⁷⁾

The oral health implied in the overall health, is related to the socioeconomic and cultural conditions of the population. As Porto ⁽²⁰⁰²⁾ noted, oral health is directly related to feeding conditions, housing and employment, income, transport, the accessibility to health services and information. Education and information about oral health care have been highlighted by several researchers. The ignorance about oral hygiene proper care is a factor to be taken into account. Although the information is largely available it fails to reach all layers of the population in the same way and it is hardly apprehended in order to produce knowledge and autonomy with health care. ⁽⁸⁾

The purpose of this study is to know about the care forms on the oral component of the health existing in student's parents who could participate in an education program in relation to the selected sociodemographic variables.

For the purposes of planning oral health education programs is essential to have reference information of the population to be working on. The aim was to describe and analyze the answers given by a group of school children parents about the difficulties in sustaining the oral health of their family in relation with the educational level and the referred health coverage.

Methodology

Cross section epidemiologic Study. The information was obtained through self-given anonymous, voluntary, without gender discrimination questionnaires. There were sent out 200, 150, 100 and 150 questionnaires for each school along with the authorization to participate in a program of oral HE. They were sent to school parents before starting the implementation of the program in four schools, 3 of public management (schools I, II and III) and one of private management (IV). I and II schools are located downtown, the III school in the Northern District and the IV school in the Southern District of the city of Rosario, province of Santa Fe.

The questionnaire consisted of eight open questions, the first three ones referring to the evaluation of the oral health education program which was going to be implemented. The remaining questions analyzed in this study were related to: ways of the oral care component of health, who taught them, what difficulties they took into account to maintain or sustain their health, which oral diseases they known and why they believed they occurred.

Statistical significance (SE) was assessed using the chi-squared Irving Fisher test. The data were processed with SAS 9.1 V system.

Comparisons were made taking into account Education Level (EL) and Occupations. In each question, the most frequent response was chosen and the proportions were compared in relation to the variables.

The fulfillment of the objectives could be reached at the end of the research through the following results:

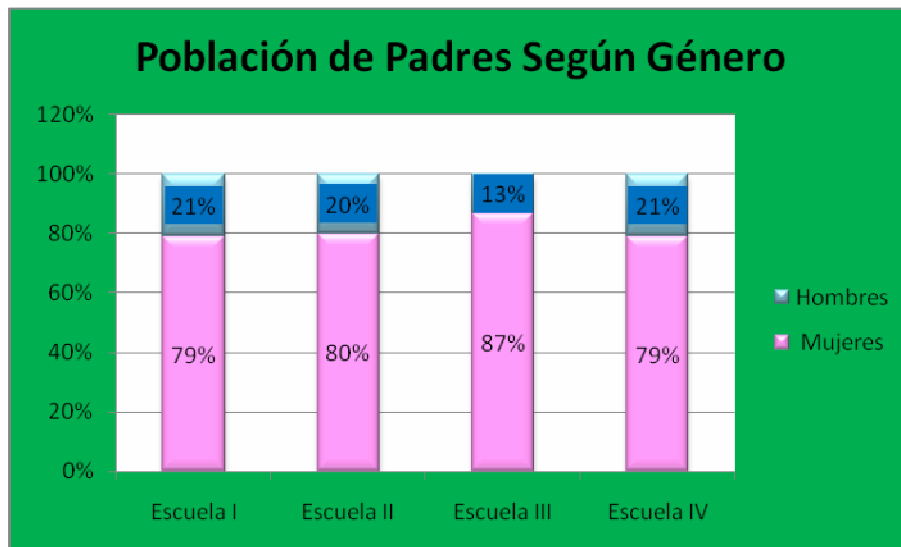
In descriptive terms we summarize some relevant features of the studied sets.

Results

In I, II and III schools of public management, although some children live in the school neighborhood, the majority come from other nearby districts of the city. The reason, according to key informants, the teachers, this happened as a result of the wide range of private education services offered in the 90's, raising a disqualification of the public education and achieving a displacement of the children of these schools towards the private sphere. While the hierarchical ranking of these schools reached by their traditional educational level, make the parents who were searching for a better education for their children to choose these schools even from different districts.

In the private management IV school, the student population is constituted mainly by children of the south neighborhood of the city.

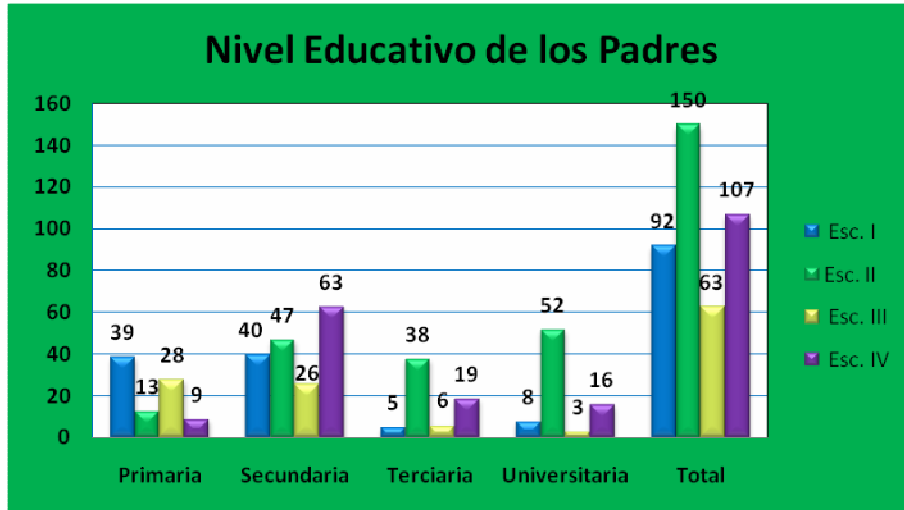
The results may support that the 79.35%, 80%, 87% and 79% respectively at each school are female.



Graphic N° 1.
Parental population per school.

The age range presents a greater emphasis between 30 and 49 years old.

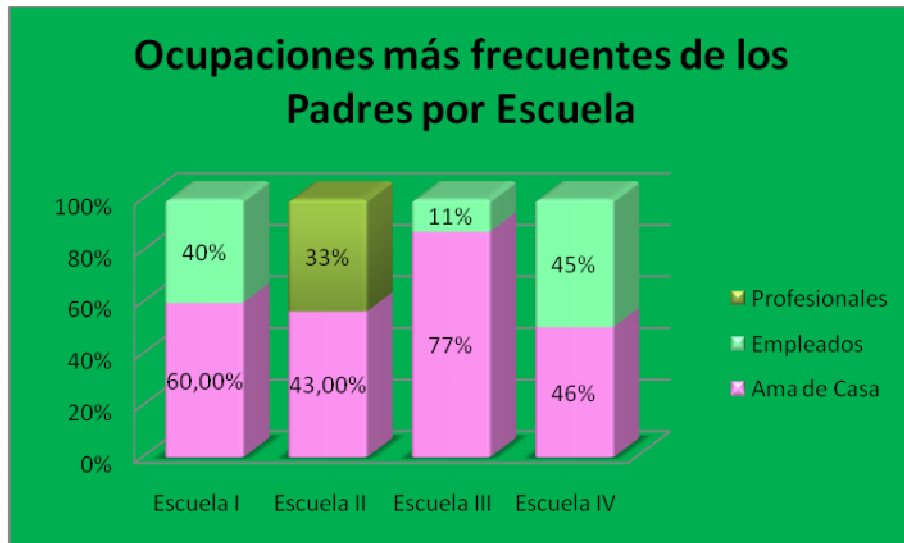
The maximum level of educational attainment is primary and secondary in I and III schools, secondary and university in II school and secondary and tertiary in IV school.



Graphic N° 2.
Educational attainment level.

The groups most representative occupations were housewives (HW), employees (E) and professionals (P).

Corresponding to a 66.67% (HW), 40% (E) at I school, 42.55% (HW) and 33% (P) in II school, 77% (HW) and 11% (E) III school, 46% (HW) and 45% (E) IV school.



Graphic N° 3
Parental occupation per school.

414 questionnaires were retrieved, most of them answered by the mothers.

The evaluation on the implementation of the program was positive. It was based on the learning processes and collaboration, "help" towards the parents in supporting their children's health. The groups who had attained higher Education Levels, (EL), marked as an obstacle, the possible lack of implementation of biosecurity measures.

To make the comparisons secondary EL groups were selected. This EL was chosen because there was the only one comparable in all schools, being the components of the other groups so dissimilar that made the statistical evaluation more difficult. Statistical difference was not found (SD) in relation to the proportion of Parents who reported that the form of care is through "Brushed", "Dentist visit, toothpaste and brush change every 3 months", "To go to the odontologist", "To make checks once a year", "To do what the odontologist teaches us", "To brush the gums, fluoride use, flossing, cariostatic and regular visits to the dentist" ($P \Rightarrow 0.05$)

The study of the information about who/whom had received knowledge about taking care, make the Hegemonic Medical Guidelines (HMG) profound. A forceful response was obtained from the groups, pointing the dentist as the main issuer. In the II School, some answers listed the family as the information issuer. In this sense, the family/domestic group is the micro structure that has more weight in the constitution of the subject's representations and practices on the process of s/e/a. While, at IV school, the "no answer" highlights.

The parent population of the four schools recognized as oral diseases the most prevalent (caries and periodontal disease) and awarding the etiology to "carelessness and poor brushing ($p \Rightarrow 0.05$).

The differences in the answers appeared in relation with the "Difficulties in maintaining oral health" indicated by the groups of I and III schools that expressed to have more difficult to sustain the health due to "lack of time", "lack of money," "lack of social health service" ($p = <0.05$). When the variable occupation was analyzed the housewives (HW) appeared with more frequency.

The HW who reported having fewer difficulties in maintaining their and their family group oral health are those who belong to II and IV schools. They recognize a variety of oral diseases which implies this knowledge allow them to demand response to these problems ($p = <0.05$).

Discussion

The possibilities of perceiving a health problem are diverse and are socio-cultural conditioned, factors such as responsibility or the family role the person plays as well as the priorities on the daily errands and the everyday activities, make it to be perceived in a different way in each case.

Health is a way of life, not a purpose in itself; therefore, health care is something developed into everyday life as natural, not an object of constant concern. The conception of health and disease depends on the definitions that ordinary people have about their suffering, and these will determine the types of assistance to search. There is a complex world of beliefs and values, norms, knowledge and behavior explicitly linked to health which permanently interact with conventional medicine and that account not only the management arrangements for health, but also the relationship that subject has with his body, feeding, habits of life, with free time and with all sanitary services, among other aspects.

The role of health care has been assumed by women (mothers, daughters, grandmothers) who are responsible for assessing the problem severity or lightness, and to make the first treatment before taking the decision to seek or not the healthcare system help. This is usually an enclosed space of decision, in which men are not usually involved. The answers led us to agree with Menendez "In almost every society, disease and disorders are treated by a variety of forms of attention, although from biomedical perspective, the treatment of the disease has been considered to belong, exclusively to medical knowledge.

According to this author, the Hegemonic Medical Model (HMM) is understood as a set of practices, knowledge and theories generated by the development of what is known as scientific medicine, which since the late XVIII century has been managing to establish as subordinate the set of practices, knowledge and theoretical ideologies that, until then, were dominant in the social groups, to achieve an identity as the only way of treating the disease legitimized both by scientific criteria and by the State.

The main structural features of this model are: biologism, individualism, historicity, sociability, mercantilism, pragmatic efficacy, asymmetry, authoritarianism, subordinate and passive patient participation, exclusion of consumer knowledge, juridical legitimization, formalized professionalization, identification with scientific rationality, inductive trends to the medical consumption.

It is important to emphasize that the biologism articulated the set of mentioned features and allows the exclusion of social and economic conditions in the explanation of the causality and development of the diseases. (9)

Biologism makes it possible to propose a disease natural history in which the suffering social history is excluded or turned into bio-ecological variables.

In some of the answers of II School the family appears as the information transmitter. In this sense, the family/domestic group constitutes the microstructure that would have the most weight in the constitution of the representations and practices of the subjects on the process of H/D/C (Menéndez, 1992) In the same line and with reference to oral health specifically, it was noted that self-care processes supposed an accumulated historical knowledge transmitted from generation to generation through family and social networks.⁽¹⁰⁾ That is why the importance of relieving the individual and family previous experiences, perceptions and knowledge relating to oral health care.

Meanwhile, at IV school, the "no response" highlights. According to JC Passeron (1982), the no response or more specifically, all abstention provides a range of information; also they are no more equivocal than the abstentions or silences that occur in the daily disorder of social life. (11)

With mothers of I and IV school differences in relation to known diseases were also showed, only "caries" as point out by Kornblit and Mendes Diz the *disease* phenomenon involves different aspects, it is not limited to being sick because of suffering some kind of alteration. The perception of illness is not only the possibility of identifying the problem but also and very especially by the possibility of being sick. This last aspect depends primarily on the social roles that the subject plays, as well as the *place* the health has in his daily live. The social representation of the problem that the patient has will determine the actions and procedures he will performed. This representation is socio-culturally constructed and has not only cognitive or rational implications but also of values and attitudes.

After the HW, employees were the occupation that most frequently answered on the etiology of oral diseases, the answer "Carelessness, bad brushed" made the difference in this group. We believe that there is a naturalization of the meaning of the word care. We understand the dimension of care in health as a possibility of identifying the meanings that allow to open the manners of daily appropriation of self-care practices due to the fact that the above mentioned meanings constitute the configuration of attitudes to assume the own existence considering the heterogeneity of worlds and visions of life.

The fact that mothers admitted that the economic situation is an obstacle, either by the cost and the impossibility to fulfill the treatment; Rita Barata (1999) argues that inequalities in living conditions will have repercussions on the health situation, so they will be identified as inequalities (12). The concept of health and disease depends on the definitions that ordinary people have about their illness which will condition the kinds of help to seek. There is a complex world of beliefs and values, norms, knowledge and behavior explicitly linked to health which interact permanently with conventional medicine and that account not only the management arrangements of health management, but also of the relationship that subject has with his body, food, habits of life, with free time and with all sanitary services, among other aspects.

Parents of I school could, probably, not recognize that they have difficulties. The evaluation on the implementation of the program was positive; they believe that the benefits are obtained by the learning and the teaching of the care ways. When we mention the care ways we refer to the experiences used by subjects and groups, and how the interest is in obtaining their development to build the different social spaces. Menendez 2009 (13)

Conclusion

Despite the intention raised from curriculum changes in the various degrees in the area of health, to incorporate a distance from the vision of the HMM, this is apparent in the health knowledge of the studied population.

The response analysis indicates the socio-cultural and subjective components of these groups. The differences given by the variables were not sufficiently decisive regarding the answers, because marked differences were not found, instead other approaches appeared, probably related to the health care model, built to take care of disease, submit to professional power, without taking into account the people participation in attending their health.

The educational level, which enables certain occupations, drew differences in protection references representations, making parents with more EL worrying about the application of the biosecurity measures that would be implemented in the program. The differences were shown in the minor EL groups in reference to the difficulties to support their and their family oral health.

The access to the representations is from its cognitive content and they must be understood from its production context. They contribute to the construction of a common reality that enables the communication to consolidate some changes and achieve the incorporation of new initiatives in relation to the health care of the population.

The educational attitude the graduate professional should have learned must be ruled by interaction, by the recognition of others, the respect for cultural differences and diversity among others.

It could contribute to the make the trainees pupils to have a constructive and creative knowledge look based on our reality, with critical, proactive and transformative attitude, with the ability to act between different logics, with a view that points to the proposal and the implementation of models of care, education, prevention, health promotion and research, according to the needs of changing of a country with a multicultural population.

Understanding human resource RRHH training as constructive and recreative knowledge activity regarding the population health situation, the different levels of social responses to confront the H/D/C problems and the health knowledge, which promotes systematic thought, theory/empiricism confrontation, ethical strengthening, the interdisciplinary and the social commitment. ⁽¹⁴⁾

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