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Oral health care: the knowledge and work of the community health agent

Atenção à saúde bucal: o saber e o trabalho do agente comunitário de saúde

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Resumo

Introdução: Com a reorganização da política de saúde bucal em 2004, o agente comunitário de saúde passa a ser considerado como um facilitador das ações de saúde bucal em sua área de atuação. **Objetivo**: Identificar conhecimento e prática do agente comunitário de saúde sobre atenção em saúde bucal. **Material e método**: Este estudo é uma pesquisa qualitativa baseada na Teoria das Representações sociais, cujos dados foram coletados através de entrevista semi-estruturada, tendo como técnica de tabulação e análise de dados o discurso do sujeito coletivo. A amostra foi composta por 11 entrevistas, delimitada por saturação. A coleta de dados realizada no período de abril a junho de 2010, em Dourados-Mato Grosso do Sul. **Resultado**: Os resultados apontam que os entrevistados apresentam entendimento do é saúde bucal, percebem a influência da saúde bucal sobre a saúde geral, na sua pratica de trabalho orientam a comunidade sobre saúde bucal, funcionamento e atendimento na unidade básica de saúde, entretanto não passaram por curso de formador. **Conclusão**: Os agentes comunitários de saúde apresentam conhecimentos de saúde bucal de senso comum, adquiridos pelo individuo a partir de experiências, vivências e observação do mundo, mas demonstram certa insegurança por falta de formação, apontando para necessidade de investimento na educação continuada desses profissionais para que possam continuamente auxiliar a população no processo do empoderamento dos saberes sobre saúde.

Descritores: Agentes comunitários de saúde; saúde bucal; promoção da saúde.

Abstract

Introduction: With the reorganization of oral health policy in 2004, the community health agent is regarded as a facilitator of oral health practices in her area. **Objective**: To identify knowledge and practice of community health agents in oral health care. **Material and method**: This is a qualitative study, based on the theory of social representations, and the data were collected through semi-structured interviews, using the collective subject discourse as the technique of tabulation and analysis of data. The sample consisted of 11 interviews, delimited by saturation. Data collection was conducted during the period April-June 2010, in Dourados, Mato Grosso do Sul. **Result:** The results indicate that respondents understand what oral health is, realize the impact of oral health on overall health, guide the community regarding oral health carein their work practices, operate and provide care in the basic health unit, but have not been trained to act as instructors. **Conclusion:** The community health workers have knowledge of common sense oral health, acquired through their own life experiences and observation of the world, but show some uncertainty due to lack of training.This points to the need for investment in ongoing education for these professionals so that they can continuously assist the population in the process of empowerment of knowledge about health.

Descriptors: Community health workers; oral health; health promotion.

INTRODUCTION

The 1988 Federal Constitution established that public health practices and services should integrate a regionalized and hierarchical network into a single system, organized according to the guidelines of decentralization, comprehensive care and community participation. A new model of health care appeared, oriented toward the community with a focus on the promotion of health and prevention of disease.

The health care system, based on primary care, aims to:

> […] optimize the health of the population through the use of the most advanced state of knowledge about the cause of illnesses, management of diseases and the maximization of health, minimizing disparities among populational subgroups such that certain groups not be at a systematic disadvantage in relation to their access to health services and attaining an optimal level of health[1].

The path outlined to improve this model was the implementation of the Program of Community Health Agents (PCHA) in 1991which, in its development and evolution, showed positive results. The family health program was initiatedin 1994, known today as the Family Health Strategy (FHS), with themain objective of reducing the differences in the state of health and the assurance of equal opportunities, allowing the maximum development of the health potential of individuals and families in a complete and continuous way through practices of health promotion, protection, control and maintenance[2].

The changes in primary care triggered a process of adapting the work to the proposed model of care, actively pursuing interdisciplinarity and comprehensive care[3,4].

In the search for expanding access to oral health, the Ministry of Health created the regulation and financing of practices and the insertion of dental professionals into family health through Administrative Rule nº 1.444/GM, on December 28, 2000[5].

The reorganization of the national oral health policy occurred in 2004, the guiding principle of which is:

> To expand the access of the population to Oral Health practices, including them in the set of activities developed by the Family Health Program (FHP), respecting its organizational and operational principles, thereby stimulating the reorganization of Oral Health in primary care[6].

The introduction of oral health professionals into the FHS brought the need to expand access to the service, with the intention of surpassing the model of care that focused only on the treatment of disease. Practices to promote oral health and prevent oral disease can and should be developed in all stages of life, with the intention of qualifying individuals with the aim of empowering the pursuit of autonomy, allowing them to become actors in the transformation of the condition of their own oral health and that of their families.

Given the need for a multidisciplinary profile of the CHA, the importance of a comprehensive and organized teaching process with training programs that provide these workers with critical, reflexive training, capable of recognizing the political, technological and scientific changes related to health and to popular knowledge in the day-to-day reality of the practice is evident. This training ensures mastery of the knowledge and skills specific to the performance of their functions[7,8].

In this way, the CHA is an important actorin the network formed within the FHS, it connects the community to health professionals. They have the potential to act for change in the prevention of disease and the promotion of oral health. Thus, they have the possibility of contributing to the solution of the oral health problem of the population, education, and guidance in the demystification of possible barriers to oral health services[9].

Thus, the purpose of this study was to understand the perception and the practice of the community health agent (CHA) regarding oral health care.

MATERIAL AND METHOD

This is a descriptive study with a qualitative focus. Qualitative research works with personal concepts, values, myths, representations, life style and customs in such a way as to include and understand a specific group. Clearly, it does notintend to arrive at the truth as to what is right or wrong[9].

This study was performed in the city of Dourados, in the state of Mato Grosso do Sul, a health referencehub for the 38 cities in the region. It has a population of about 186 thousand inhabitants, with the family health strategy covering 64% of the population.

In Mato Grosso do Sul, Decree N° 11.684 of 8 September, 2004, sets forth the condition that every health team formed must, necessarily, have an oral health team. Dourados has 34 family health teams, and each one contains an average of 5 community health agents (CHA).

The population of the study comprised 150 community health agents who work in the family health strategy. The respondents worked in three family health teams that assisted in coverage areas having very specificsocioeconomic characteristics.

The sample was formed by convenience, comprising 11 interviews, delimited by saturation of the responses. This process is defined operationally with the suspension of adding new participants when the responses obtained began to reach a certain redundancy or repetition, in the researcher's evaluation, such that it is not considered meaningful to continue the data collection[10].

The technique of Collective Subject Discourse (CSD), according to Lefrève, Lefrève[11], was used to analyze the data. CSD is a technique for tabulating and organizing qualitative data presented through a speech synthesis written in the first person singular. It is developed with the most significant statements from the depositions having similar meaning. It provides an understanding of the life experiences, gleaned through the eye of the researcher, and it translates into the capture of fragments of the life-world, or part of a reality of the person as constructed and lived by him. "It works with values, beliefs, representations, habits, attitudes and opinions" in such a way as tocomprehend the specific group thoroughly[9-11].

Three methodological figures were used for this study: the key expression (KE), the central idea (CI) and the Collective Subject Discourse (CSD).

For Lefrève, Lefrève[11] the key expression is the methodological figure that reveals the essence of the deposition; it is what the subject said about a particular topic. The central idea is the description of the meaning present in the key expression.

The Theory of Social Representations (TSR) consists of analyzing central ideas, anchors and similar key expressions present in the individual discourses, expressing the opinion or the collective thinking, considering the collective opinion to be empirical fact. For Moscovici[12], the theory of social representations is a system of interpretation of reality, formulated from the experiences by which the subject attributed meaning to a given object and a "form of socially developed and shared knowledge, with a practical range that contributes to the construction of a reality common to the social set"[13].

DATA COLLECTION

The data were collected in the workplace, in an environment that allows privacy, comfort and confidentiality of information so as to minimize the possibility of intimidation bias due to the fact that the interviewer is a dentist. A semi-structured guide, which contained the identity of the subject and the guiding question, was used to collect the data. The guiding question was: How do you approach the topic of oral health in the community where you work?

The interviews were scheduled by telephone, according to the availability of the participants. The objective of the research and the free and informed consent form were presented to the respondent at the beginning of the interview. After reading the form, the respondent signed it. The interviews averaged 45 minutes and were recorded and transcribed during the period from April to June of 2010.

ETHICAL PRINCIPALS

The present study follows the Guidelines and Norms for Research Involving Human Beings (Ministry of Health, 1996). The research protocol was evaluated by the Committee for Ethics in Research on Human Beings, University Center of Greater Dourados, as protocol Nº 356/2009.

RESULT AND DISCUSSION

The majority of the Community Health Agentsinterviewed in this study are female, with mean age of 38 years and length of service ranging from 5 to 12 years. Most of the agents worked in this position for more than 7 years.

The results obtained were divided into Central Ideas (CI) that depict the perception and practice of the CHA in oral health care, from which the CSD was built, as:

I - Community health agents (CHA) knowledge about oral health;
II - Influence of oral health on the general health of the individual;
III - Guidelines offered to the community regarding oral health care;
IV - Training of the CHA in oral health care.

CI I - Community health agents (CHA) knowledge about oral health

CSD: "*It is with the mouth protected, the teeth all cared for. It is to havea healthy mouth, good hygiene and daily care. It is the prevention from the teeth to the rest of the mouth. It is the person being aware that all the health problems, or most of them, come through the mouth, being concerned with the importance of brushing. It is having healthy habits regarding hygiene, brushing the teeth at least 2 times a day, when getting up in the morning and going to sleep at night, using dental floss after meals and before going to bed. As for prevention, it is going to the dentist at least every 6 months, 1 or 2 times a year, in order not to allow caries to develop before going to the dentist. It is not giving a pacifier to children; and, those who use a prosthetic, it is taking the prosthetic out every night when sleeping so that the blood can circulate in the mouth. If the teeth are not dealt with, if nothing is done, certainly other diseases, besides oral ones, will be acquired.*"

In the discussion, the respondents showed knowledge of the importance of periodic examinations with the dentist, including children, as a means of early intervention and prevention of oral diseases. An expanded notion of oral health was observed, from the perspective of the health-illness process and oral health, as a determining factor for the equilibriumand general health of the individual.

The CHA decribe oral health as a consequence of daily care with brushing and the use of dental floss, as well as periodic checkups with the dentist, watching out for bad habits, the use of a prosthesis and looking for change in the self-care behavior of the individual through the transmission of information. Similar findings were observed by Koyashiki et al.[14] and Mialhe et al.[15].

A significant percentage of people was observed to consider that dental caries may be avoided by self-care and visits to the dentist. This shows that the understanding that the onset of disease and the search for health are influenced only by these two conditions[16].

Koyashiki et al.[14] obtained similar accounts, enabling the understanding that a sense of prevention of dental caries and diseases of the mouth are attributed to "oral health", and that oral health care is a consequence of the habit of dental hygiene and brushing, from childhood to adulthood.

However, the maintenance of oral health goes beyond brushing the teeth, using dental floss and having periodic dental checkups. The time dedicated to cleaning, the interval between meals, the type of food and toothbrush, the techniques of brushing and the use of dental floss are essential information for individuals to be able to maintain oral health. Therefore, the health agents must be prepared to deal with guidelines for health, including oral health, to avoid having information being passed vertically.

CI II – The influence of oral health on the general health of the individual

CSD: *Oral health is important, it is part of our life, it interferes with eating habits as well asin the general health of the patient. It is through the mouth that many diseases areacquired, sometimes a headache is related to the mouth, poor chewing damages the stomach, there are several factors. Sometimes it is not just a toothache that showsthe lack of oral health, it can lead to heart problems and even heart attacks. The mouth is the entry point for bacteria, and so other diseases of the body can appear through poor oral hygiene. If this is not treated, itcan end up causing more serious disease in the future. A healthy mouth has major influences onthe individual: if there are not good, well cared-for teeth, the person will not relate well with others.*

The respondents related cardiac and gastric problems to terrible oral conditions: however, without showing scientific basis, this knowledge could be based on knowledge acquired from work experience. Nevertheless, this perception is consistent with the literature that describes the possibility of microorganism entry from the oral microbiota in the bloodstream during invasive dental procedures. Streptococcus, the microorganism isolated most frequently in bacteria of dental origin, may trigger bacterial atherosclerosis to endocarditis[17].

The discussion shows the strengthening of the perception of oral health care as an investment in quality of life, making vital the understanding that the oral cavity is an extension of everything, and not just a part of the body. This perception was also noted by Koyashiki et al.[14].

Vargas, Paixão[18] claim that individuals associate the absence of dental elements and oral prosthetics with digestive problems. These come from inadequate chewing and grinding of the food, consequently impairing the absorption of the nutrients and may also trigger stomach problems such as gastritis and ulcers.

In the discourse, there was a direct relation among the condition of oral health, quality of life, general health and self-esteem of the individual. Tooth loss was correlated with lack of care and the negative influence of oral esthetics on social interaction.

The perception of the CHA regardingthe relationship between appearance and health is evident in their interpretation of tooth loss as a socially unfavorable esthetic condition, capable of excluding people from social interaction. The importance of good appearance is considered a facilitating issue for the acceptance of the individual by the social group, highlighting the smile and healthy teeth asimportant symbols of presentation and appearance[18,19].

CI III – Guidelines offered to the community about oral health care

CSD: "*During office visits, I provide guidance as to dental care, how the office works, and the hours. If, by chance, some problem arises and it is urgent, there is pain, I will take a look and schedule an appointment. I provide guidance in oral hygiene in order not to have dental problems, and that they see the dentist regularly for follow-ups, even if they think everything is OK and they have or feel nothing, even the young ones! Even if we try to look in the mirror to see if there are cavities, only the professional, in an office visit, sees if everything is well and if cleaning is necessary. The agent has to guide the mother of the baby, even before the teeth appear, to wipe the baby's mouth with acloth after breast feeding. How to brush when the first teeth appear in order to have good teeth, to teach how to brush! To have correct hygiene, and not touse the same toothbrush! I guide them to eatvegetables, not to eat a lot of junk food, especially gum, also not to eat a lot of sweets. Sugar and pasta ruin the teeth. Salty snacking also is not good because it sticks and even brushing doesn't get rid of it well. They know a little, and it helps a lot to talk with them about brushing and flossing, to keep the mouth healthy. I talk with those who don't know what good hygiene is, what a good toothbrush is, I tell them that if they eat before going to bed they have to brush, I look for correct brushing and frequency because, generally, they don't brush well! People with dentures have to remove the denture before going to bed. Until a certain time, we did not know about letting the gums breathe and to pay attention to something that appears on the gums and to go to the dentist.*"

The respondents guide the community regarding the dental care system in the family health unit, show understanding about the importance of periodic, preventive monitoring, even in the absence of painful symptoms, as well as care with oral hygiene and with feeding. The agent tries to focus on information about hygiene and eating habits, as well as focusing on groups such as children and the elderly, caring for them in all life cycles[14,15,20]. However, the information may not yield the desired effect if it is unclearand has no purpose, and may even trigger an increase in demand as a consequence of the individual's search for care due to the subjective understanding of what constitutes an urgent situation.

For Gift et al.[20], improving the knowledge, alone, does not translate into a change in behavior, but, it does help people in making decisions about their oral health because this condition is directly and simultaneously related to environmental, social and economic factors.

It was noticed that the notion of oral health emerged from the discourse with abroader view of the health-disease process. A perception also appeared of the mouth that goes beyond the anatomical/physiological, as an extension of the body with its own meaning and senses[14].

The CHA is a health professional who performs the essential function of promoting the link between the community and the health care service. She must belong to the community in which the functions are performed and may belong to the same social class and cultural level, with the role of mediating between popular and scientific knowledge, contributing to facilitating the access of the population to health service and seeking improvements in the quality of life of the community[21,22].

The agent also has the task of guiding the population about how health care is developed in the public health network, as well as offering important information about the health problems of the population to the members of the team[23,24].

Based onthe discussion, it is possible to realize that the CHA assumes the function, occupying an important position in the promotion of oral health, especially in overcoming recognized barriers to communication permeated by a conflict of values and explanatory models[14,23-27].

Unfer, Saliba[16] confirmed that the population believes that the influence of diet on the occurrence and the prevention of dental caries assumes a secondary role in the process. The agents understand that, in the process of preventing oral diseases like caries, factors like diet and hygiene habits like brushing are inseparable[28] and, therefore, should be emphasized in the guidelines for the community. Such findings were also reported by Mialhe et al.[15].

CI IV – Training of the community agent for oral health care

CSD: "*Look, what I know I learned when I was a* child.Atthe *school where I studied there wasa dentist that gave many talks and did home visits. I have my daughters there and I am always on top of things. I had to have a root canal in one tooth, and then I started to recommend [that the people care for their own oral health – author's note] because when it hurts, you learn. Some pamphlets that we received said something . . . very little, about oral cancer. In the dentist's talks in the hyptertension and diabetes program that I did on Thursdays and also when I went to see the professionals and I saw them commenting and talking. We're always together, we learn. But we never had anything specific, a course, training, never had training about oral health. I took the introductory course when I did the exam, but no specific guidance.*"

The statements in this discussion show that the community health agents were not prepared to develop the functions of promotion and prevention of oral health with the community. This is the same condition observed by Mialhe et al.[15], Moura et al.[29], who confirmed that the community health agents did not have any training or preparation to conduct educational activities in oral health.

The respondents made it clear that their knowledge was constructed through personal interest, accompanying the dentist on house calls, team lectures, reading educational pamphlets rarely offered to the community, or even from personal experiences with their children or in their own childhood.

Mialhe et al.[15], Moura et al.[29] confirmed that the CHA knowledge about oral health was constructed and grounded in educational activities performed by dentists from the public network in the health unit or from school programs.

Based on their experience, these professionals try to work in health education. However, if they were to receive appropriate training they could develop these activities in a more efficient way, empowering the population to care for theiroral health[15]. This fact is corroborated by Frazão, Marques[26] who observed that agents trained to give health education to the community were able to provide significant changes in the knowledge of oral health of women and mothers.

The discourse shows the need for investing in ongoing education for the CHA, as they show insecurity in relation to the educational activity related to oral health. Even hesitant, without specific and appropriate training, they make the effort to do their job and spread their knowledge[14,22,26,29].

As members of a health team, the CHA should be trained regularly and have access to technical information that legitimates their knowledge of the local reality and the improvement of interventions for the betterment of the current life situation. For that reason, the dentist is an important instrument for training the family health teams in educational and preventive practices in oral health[28]. This training is necessary and should be complemented with ongoing educational activities aimed at improving the oral health conditions of the population[26,27].

According to Silva, Dalmaso[22], the CHA have no instruments for the different dimensions expected intheir job and this insufficiency of resources, confirmed by the discourse, makes them end up working with their common sense, based on "beliefs rooted in the popular universe". Perceiving the need to offer basic training to these professionals, based on the need to prepare the human resources for consistent professional performance aligned with the demands expressed by the community, as well asthe guidance for a gradual expansion of knowledge[24,26].

For Koyashiki et al.[14], the training received by the CHA has mirrored the training that other members of the Family Health team received. That is, they may be reproducing social assistance principles aimed at curative practices. Another issue realized in the analysis is the lack of training processes aimed at professional qualification in oral health, in such as way as to make the practice of health care more complete and with more integrated features.

The training and qualifying processes are unstructured, fragmented and, most of the time, insufficient for developing the new skills necessary for the appropriate performance of the role.

Solla et al.[3] concluded that most CHA resent the lack of training and greater, in-depth investigation to better persuade the families. Oliveira et al.[4] observe that the CHA needs appropriate ongoing training, aimed at regional realities.

Moura et al.[29] also noticed that most of the CHA interviewed (79.8%) were not trained, and that 59.6% did not attend any type of educational lecture about oral health.

Community Health Agents (CHA) symbolize the link between the Health Institution and the community. They are seen as key pieces in the development process of primary carepractices, including oral health, because they are considered as ahealth component in its broadest sense[30]. In spite of the lack of training of the respondents in oral health, the transmission of information, even hesitatingly, about the topic seems to be adequate. However, limited knowledge was observed in relation to the subject. Despite this barrier, the agents perform the task of health education approaching oral health without great difficulties, using knowledge acquired throughout life and at work.

CONCLUSION

The results show that the community health agents realize the importance of oral health and seek, in their practice, to guide the community.

The community health agents see the oral cavity as the portal of entry of infectious agents, and understandthat oral diseases are not necessarily associated with the symptom of pain, but with the multifactorial context of oral hygiene care, healthy diet, prevention of bad habits and care of prosthetics.

The respondents show common sense knowledge of oral health since it was acquired during childhood, in dental consultations or lectures with professionals at work. They show some in security about the lack of scientific theoretical background but seek, in a unique way, to stimulate the maintenance of health through oral health education, empowering the population with knowledge about oral health, and promoting changes in the life habits and perceptions of the community.

REFERENCES

1. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO/Ministério da Saúde; 2002.
2. Brasil. Ministério da Saúde. Fundação Nacional de Saúde. Programa de Saúde da Família. Brasília; 1994.
3. Solla JJP, Medina MG, Dantas MBP. O PACS na Bahia: avaliação do trabalho dos Agentes Comunitários de Saúde. Saúde em Debate. 1994; 51:4-15.
4. Oliveira RG, Nachif MCA, Matheus MLF. O trabalho do Agente Comunitário de Saúde na percepção da comunidade de Anastácio, Estado do Mato Grosso do Sul. ActaSci Health Sci.2003; 25(1): 95-101.
5. Brasil. Ministério da Saúde. Portaria nº 1.444, de 28 dezembro de 2000. Diário Oficial [da] República Federativa do Brasil, Brasília, DF, 29 dez. 2000.
6. Brasil. Ministério da Saúde. Diretrizes da política nacional de saúde bucal. Brasília; 2004.
7. Brasil. Ministério da Saúde. Diretrizes para elaboração de programas de qualificação e requalificação dos Agentes Comunitários de Saúde. Brasília; 1999.
8. Cesar RJ, Cavaleti M, Holtahushem R, Lima LGS. Mudanças em indicadores de saúde infantil em um município com agentes comunitários: o caso de Itapirapuã Paulista, Vale do Ribeira, São Paulo, Brasil. Cad Saúde Pública. 2002; 18(6): 1647-54. http://dx.doi.org/10.1590/S0102-311X2002000600019
9. Minayo MCS, Sanches O. Quantitativo-qualitativo: oposição ou complementaridade? Cad Saúde Pública. 1993; 9(3): 239-62. http://dx.doi.org/10.1590/S0102-311X1993000300002
10. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativa em saúde. Cad Saúde Pública. 2008; 24(1): 17-27. http://dx.doi.org/10.1590/S0102-311X2008000100003
11. Lefrève F, Lefrève AMC. O discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa (desdobramentos). Caxias do Sul: EDUCS; 2003.
12. Moscovici F. Desenvolvimento interpessoal: treinamento em grupo. 13ª ed. Rio de Janeiro: José Olympo; 2003.
13. Oliveira DC, SÁ CP. Representações sociais da saúde e doença e implicações para o cuidar em enfermagem: uma análise estrutural. Rev Bras Enferm. 2001; 54(4): 608-22. PMid:12098863.
14. Koyashiki GAK, Souza RAA, Garanhani LM. O trabalho em saúde bucal do Agente Comunitário de Saúde em Unidades de Saúde da Família. Ciênc Saúde Coletiva. 2008; 13(4): 1343-54. http://dx.doi.org/10.1590/S1413-81232008000400032
15. Mialhe FL, Lefèvre F, Lefèvre AMC. O agente comunitário de saúde e suas práticas educativas em saúde bucal: uma avaliação qualiquantitativa. Ciênc Saúde Coletiva. 2011; 16(11): 4425-32. PMid:22124823.
16. Unfer B, Saliba O. Avaliação do conhecimento popular e práticas cotidianas em saúde bucal. Rev Saúde Pública. 2000;34(2): 190-5. http://dx.doi.org/10.1590/S0034-89102000000200014
17. Barros VMR, Ito IY, Azevedo RVP, Morello D, Rosatelli PA. Estudo comparativo da eficiência de três métodos de antissepsia intrabucal na redução do número de estreptococos do sulco gengival. Rev Odontol Univ São Paulo. 1998; 12(3):201-6. http://dx.doi.org/10.1590/S0103-06631998000300002
18. Vargas AMD, Paixão HH. Perda dentária e seu significado na qualidade de vida de adultos usuários de serviço público de saúde bucal no centro de saúde Boa Vista em Belo Horizonte. Ciênc Saúde Coletiva. 2005; 10(4): 1015-9. http://dx.doi.org/10.1590/S1413-81232005000400024
19. Wolf SMR. O significado psicológico da perda de dentes em sujeitos adultos. Rev Assoc Bras Odontol. 1998; 52(4): 307-16.
20. Gift HC, Corbin SB, Nowjack-Raymer RE. Public knowledge of prevention of dental disease. Public Health Rep. 1994; 109:397-404.
21. Brasil. Ministério da Saúde (MS). Política Nacional de Atenção Básica. 4ª ed. Brasília: Ministério da Saúde; 2007.
22. Silva JA, Dalmaso ASW. Agente comunitário de saúde: o ser, o saber, o fazer. Rio de Janeiro: EditoraFiocruz; 2002.
23. Nunes MO, Trad LB, Almeida BA, Homem CR, Melo MCIC. O agente comunitário de saúde: construção da identidade desse personagem híbrido e polifônico. Cad Saúde Pública. 2002; 18:1639-46. http://dx.doi.org/10.1590/S0102-311X2002000600018
24. Misrachi CL, Sáez MS. Valores, creencias y practicas populares en relación a la salud oral. Cuad Méd Soc. 1989; 30(2):27-33.
25. Moreira TP, Nuto SAS, Nations MK. Confrontação cultural entre cirurgiões-dentistas e a experiência de usuários de baixa renda em Fortaleza, Ceará. Saúde em Debate. 2004; 28(66): 58-67.
26. Frazão P, Marques DC. Influência de agentes comunitários de saúde na percepção de mulheres e mães sobre conhecimentos de saúde bucal. Ciênc Saúde Coletiva. 2006; 11(1): 131-44. http://dx.doi.org/10.1590/S1413-81232006000100021
27. Rodrigues AAAO, Santos AM, Assis MMA. Agentes comunitários de saúde: sujeito da prática em saúde bucal em Alagoinhas. Ciênc Saúde Coletiva. 2007; 15(3): 907-15. http://dx.doi.org/10.1590/S1413-81232010000300034
28. Brasil. Ministério da Saúde. Departamento de Atenção Básica. Guia prático do programa de Saúde da Família. Brasília: Ministério da Saúde; 2001.
29. Moura MS, Carvalho CJ, Amorin JTC, Marques MFSS, Moura LFAD, Mendes RF. Perfil e práticas de saúde bucal do agente comunitário de saúde em municípios piauienses de pequeno porte. Ciênc Saúde Coletiva. 2010; 15(1): 1487-95. http://dx.doi.org/10.1590/S1413-81232010000700061

30. Souza DS, Cury JA, Caminha JAN, Ferreira MA, Tomita NE, Narvai PC, et al. A Inserção da saúde bucal no Programa de Saúde da Família. Rev Bras Odontol. 2001; 2:7-29.

CONFLICTS OF INTERESTS

The authors declare no conflicts of interest.

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