COMMUNITY ODONTOLOGY AND FAMILY HEALTH STRATEGY IN DISCUSSION: Contributions and Challenges

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Abstract

This article discusses the way how members of a family, living in a socially vulnerable community, perceive their own health and the community dental practices performed by the Family Health Strategy. The context of the study is the axis on the condition of life of the care model, as recommended by the National Policy of Buccal Health that foresees the approach of the population from their familiar universe and from the social relations experienced in the territory. It is a social study of qualitative, exploratory and descriptive approach carried out in a municipality of Santa Catarina by means of collective interview and adjusted thematic analysis. By means of the category "Bonds in a community cultural reality", the data analysis revealed that both health and community dental practices are perceived through relations that express the subalternity, the intersubjectivity, the willingness to work, the bond with the evangelical church, life through arts, and sexual violence. The conclusion drawn is that materialization of the model of care, through the axis life conditions of the communities, requires the problematization of professional certainties generated by the hegemonic production of a technical scientism detached from the real life of vulnerable families.

Keywords: Education in Health; Community Odontology; Community-Institution Relations; Family Health Strategy.

1. Introduction

Over the course of the second half of the 20th century, public health services coexisted with several "Odontology Alternatives" to guarantee dental practices (SOARES *et al.*, 2017). A few historic and care models competed for the social space of the public odontology, by composing peculiar strands for the field, such as "Sanitary Odontology, Preventive and Social Odontology, Simplified Odontology, Integral Odontology (NARVAI, 1994; NARVAI, FRAZÃO, 2008; LIMA, 2017). These movements (LIMA, 2017) represented an advancement in the sector as far as they crossed the hegemony relations (MENDES, 1994) of the liberal and privatization model, in force since de 1920 decade (LIMA, 2017).

However, the historical moment of fighting for re-democratization required a broader movement with the purpose of operating a care model for buccal health in dialogue with the social health determinants: then, in the late 1980`s, the movement of Collective Buccal Health (SBC) was born at the initiative of a collective of dentists who defended the inclusion of Odontology in the health policy arena. Since it also represented

the theoretical anchor for the practices in the context of the Brazilian Unified Health System (SUS), the SBC enters the 21st century like it did when it was established, that is, still disputing the "moral and intellectual direction" (GRAMSCI, 2007) of the dental practices with the private strand of odontology (SOARES *et al.*, 2017) in substantial expansion[7] guided by a mostly technicality and a-historic care model (TESSER, PEZZATO, SILVA, 2015).

A new movement emerged in 2003, this time at government level, as one of the most inclusive policies of the Brazilian public health history: the Brazilian Smiling Program. Designed by the government of Luiz Inácio Lula da Silva, the program achieved the policy status the following year, by establishing the organization of the practices by means of the three levels of the SUS care: Primary Health Care, mean complexity and high complexity. The premises of this national policy were: qualification of the primary health care actions, guarantee of the integralities of the actions, performance according with the health vigilance, planning linked to epidemiology and to the territory information and stimulation to funding an agenda of researches grounded on scientific evidences (BRASIL, 2004).

Two years later, the Ministry of Health (MS) edited the National Policy of Primary Health Care (PNAB/2006), stating that the Family Health Strategy (ESF), established as the main operational modality of primary health care, could incorporate a buccal health staff to operate the expansion of the dental practices which till then were of care nature, towards the integral care of the individuals, families and communities. According with the PNAB/2006, the ESF buccal health staff is composed by a dental surgeon (C-D, preferably a specialist in family health), assistant and technician in buccal health, with a labor load of 40 weekly hours for all of them (BRASIL, 2006).

In 2008, the Department of Primary Health Care of the MS (DAB/MS) launched the Booklet of Primary Health Care of no. 17, as a guidance instrument of the dental practices. The Booklet described the life condition axis as a care basic axis because it was linked directly to the production of health and sickness. From then on, the need of odontology professionals to know their performance territory in the perspective of the historicity of their institutional arrangements, by taking into consideration its peculiarities and the relations between the people and the local institutions of cultural, religious, political and economic nature (BRASIL, 2008).

Fifteen years after the issue of the PNSB, a large part of the Brazilian communities have not won the right to the dental practices within the ESF yet due to several reasons, to mention a few of them:

* The ESF itself does not have a national and universal character because it is invested of an inductive mode since its origin, by means of incentives from the federal government, being dependent on the willingness of city mayors. In 2016, the coverage of the Family Health Strategy was of 64%; 14 states showed a coverage between 75% and 100%, while 11 states, between 50% and 74.9%; São Paulo and the Federal District showed coverages lower than 50% (NEVES *et al.*, 2018). It is worth pointing out that 100% coverage in a state does not mean that all the communities of all municipalities are covered.

* The adhesion to the ESF with buccal health may exist in several municipalities since the incentives are always attractive but adhering does not mean betting in fact in this operative care modality for and with the territory;

* The absence of an effective pact of accountability among the federal entities to promote the sector based on universality and equality (RIBEIRO, MOREIRA, 2016);
* The unequal conditions among the 5,570 subnational governments in terms of fiscal, government and resources capacity (RIBEIRO, MOREIRA, 2016); and
* the lack of institutional information and communication about the won right.

To these reasons, there is the addition of the austerity measures taken in 2016 and 2017 that designed new configurations for the execution of the primary health care.

The new Fiscal Regime, within the context of the Fiscal and Social Security Budgets of the Union, established by the Constitutional Amendment nº 95/2016 reduced the social expenses per capita until 2036 (BRASIL, 2016). Over 20 years, the MS budget will be readjusted only by the inflation calculation (measured by the National Index of Prices to the Broad Consumer).

The recently approved Labor Reform has established new labor relations where it is worth mentioning the legitimization of outsourced work for core end-activities of the State and the flexibilization of the working day hours through the creation of the intermittent contract (BRASIL, 2017b).

In fine tune with the Labor Reform, the second revision of the PNAB/2006, provided by Ordinance no. 2436 of 2017, recognized the strategies for the AB compatible with the flexibilization of the working day hours; it has rendered the municipal induction of the ESF difficult by opening space for the mayors to choose strategies that do not require 40 daily hours from the professionals; and, it has conditioned the implementation of enlarged standards of care to the willingness of the municipal managers, among others (BRASIL, 2017a).

The new text favors the return to the care odontology because the labor force may be guaranteed by intermittent contracts. Upon aligning itself with the New Fiscal Regime and the Labor Reform, the PNAB/2017 opened the doors to the possibility of returning the packages of selective public services, poor services for poor people and, in effect, to the possibility of increasing the distributive inequality of actions and services in the Country. The product may be a deep reversal of the right to health, in the field of practices.

These historical and conjunctural facts point out to the need of discussing community odontology within the ESF by taking into consideration the perception of the individuals, families and communities about their own health and the practices offered to them.

This article discusses the way how members of a socially violated family living in an occupation zone of a municipality from Santa Catarina perceive their own health and the dental practices offered by the community dental services performed by dentists of the ESF program. The context of the study is the life condition axis of the care model, as recommended by the National Policy of Buccal Health.

2. Methodology

It is a study of qualitative, exploratory and descriptive approach carried out in accordance with Resolution 466/12 and approved by the Ethics Committee of *Vale do Itajaí* University, SC, by means of the CAAE 76930417.9.0000.0120.

The empirical *corpus* comprised a family dwelling in a violated territory of a big-sized municipality of Santa Catarina. The choice of this territory type derived from the fact that the people who constitute it are inscribed, from the perspective of the Protection Bioethics, in a "broad context that can be qualified as that one of shortage situations – which are those where, indeed, the "susceptible" and "violated" ones must live (SCHRAMM, 2017).

Two instruments have been utilized to collect the data: field diary and collective interview. The first aimed at registering the methodological path and the non-verbal manifestations expressed by the participants (MINAYO, 2014). The second was applied with the objective of giving the opportunity to the collective expression of thoughts by the people who live in similar material conditions of existence (ZANETTE, 2017).

In order to establish the strategies of entrance in the territory, a meeting was scheduled with the coordinator of Buccal Health of the municipality when he was requested to suggest the indication of a violated neighborhood. The coordinator indicated an area where there was an occupation zone and informed the telephone number of the health community agent (ACS) responsible for the respective area. The ACS was invited to participate of the visit and she promptly accepted the invitation.

Next week, the field work took place. The occupation zone was composed mostly by wooden houses without basic sanitation. The main street was not paved, there were many holes with rain and sewage standing water where several bare feet children played flying kite. Many dogs were around and at this occasion a campaign of free castration was taking place in the neighborhood. At the end of the street, there was a deposit full of garbage with houses nearby. As per the ACS, most of the occupation zone dwellers worked with a cooperative of informal garbage collectors from the area.

The family appointed by the ACS lives in a lot where there are two houses: one in the front, a single room dwelling and another in the back, a wide home with living room, bedroom, kitchen and bathroom. The backyard house is inhabited by an elderly woman (P1), her daughter (P2) with her son (P3), his wife (P4), three school-aged children and a baby. The front single room house apparently without bathroom is occupied by P5, the second daughter of P1.

In the meeting, women P1, P4, P5 and the children were present. The interview was made in the backyard house after the signature of the free and informed consent. It lasted 50 minutes and was registered in audio and transcribed afterwards.

The data were analyzed by means of the content analysis of the adapted thematic type, guided by the meaning of the apprehended arguments and ideas, independent of the number of times when they manifested themselves (MINAYO, 2014).

At first, attentive readings have been carried out aiming at the certification of the representativeness of the content. Once it has been proven, free readings were made with the objective of getting hold of the gross material (MINAYO, 214). Next, the units of register and context were selected for further attribution of codes. Once the material has been coded by use of semantic criterium, one reached the step of grouping per analogy (MORAES, 1999). Finally, the material was explored from a transversal point of view in order to categorize it (MINAYO, 2014).

From this process, emerged the analysis category: "Bonds in a community cultural reality".

3. Results/Discussion

Based on the category: "Bonds in a community cultural reality", the results are introduced and discussed afterwards by exhibiting the selected register units in dialogue with the theoretical framework and related currents of thought.

The interview was opened with the question that is the basis of the instrument: How is your life going?

P4 answered it promptly with another question: *May one complain?* Among laughs and looking at the ACS, she added: *[...] oh yeah, it´s good [...] but I have to make an appointment for Alex, he has high blood pressure [...] (P4).*

The answer of P4, although apparently simple, seems to carry a complex social representation: that, before the health professional, the answers about life not rarely address issues regarding diseases; in this case, the problem of hypertension of the son.

In an essay about the development of an individual in the social relations, Pierre Janet is mentioned, whose conception of language has, at the same time, "a representative function […] and a stronger status […] for the participation in the planning of individual actions; [through] language, the individual prepares an act to be consummated" (GOES, 2000). From this perspective, it can be that at the moment of elaborating a thought to answer the question "how is your life going?", there was a representation in the imaginary of P4 previous to the one that she executes in the daily life: the representation of the need to take her son to the UBS.

This answer can also be interpreted in the perspective of its subjective character, of a subjectivity dialectically tied to the experience of the real world (SEPPILLI, 2011). Of a world that more and more distributes less its richness (SHORROCKS, DAVIES, LLUBERAS, 2014), where "the cultural patrimony of the subaltern strata results strongly determined "by the top", based on the role that they have to perform in the `perfect´ reproduction of the social system inside which they must continue to be subordinate" (SEPPILLI, 2011, p. 906).

Over the two first decades of the 21st century, almost at the end, the biggest and the most progressive distinction among the individuals of a same society is the gap of wealth distribution imposed by the capital accumulation of a few ones (SHORROCKS, DAVIES, LLUBERAS, 2014).

A study carried out in Aveiro, Portugal, with the objective of learning the perception of poor families on which solutions were scheduled that foresaw reaching their life targets, has signaled that these targets are focused in the improvement of dwelling and health conditions (SOUSA, RIBEIRO, 2005). In other words, life conditions do not depend of efforts by the involved subjects, but of the country policy. In the most developed European countries, the social democratic capitalist ideology nourishes the Social Welfare State and, indeed, the dream of improving dwelling and health conditions. As to countries of neoliberal ideology, like Brazil since the 1990`s, where "the economic elites identify themselves with international elites, and not with the people" (BRESSER-PEREIRA, 2018, p. 27), the dream for such improvements are in the horizon line.

A study on health and quality of life, carried out with 150 low-income adults, out of which 84.7% were Afro-Americans and 15.4% belonged to other race or minority ethnicity, has shown that "subjective perceptions of health in low-income individuals might be a better indicator of the quality of life than the

presence of systemic alterations" (SCHULER, 2015, p. 225). In this regard, being able "to complain", laughing and looking at the ACS, may be signaling to life, interaction, inter-subjectivity within the care micro policy, considering that the ACS has power of dialogue in a territory with high vulnerability.

When questioned about things of the day-to-day life that made them to feel sad, P4 said that, in principle, […] *nothing*; but, afterwards, she mentioned *[...] lack of money*. This speech was uttered with the eyes turned towards the ACS, as if calling her to participate of the talk. After a symbolic silence, ACS expressed herself; it seemed however that she wanted to say other thing: *[...] yeah, I know, lack of money makes you feel sad, doesn`t it?* (ACS). From this moment on, ACS became integrated into the family, by reaffirming that it is in the setting process that the qualitative research effectively develops.

After ACS has entered the conversation, P4 added:

[...] if Alex will feel well in the nursery, I think I will be able to work next year […] yes, I will be able to work […] oh, I loved it, I did not go through what I am facing now […] oh, I could unwind and clear my mind, I left in the morning and came back in the evening, I had peace in my life when I worked. I used to work, nothing lacked for my son, and now I face difficulties, you see [ACS]? (P4)

At the transversal analytical level, in the above speech, it is possible to recognize the response to the previous question, "how is your life going?". Willingness to work, succeeding in the job, providing conditions of life to the children; it seems this is how life goes for P4. P4 demonstrates in the intonation of her language that she had life peace when she worked and that nowadays peace is not a reality when she stresses how important it is to work. It should be highlighted that this statement only took place after the ACS intervention.

Regarding the ACS role, it is worth emphasizing that a research-intervention carried out in a Family Health Unit of a small-sized city from the south of Brazil discussed the possibilities and challenges of the ACS`s performance, by taking as basis the National Policy of Popular Education in Health. The authors point out that the ACS`s job maximizes the actions of the Popular Education in Health because it lies between the popular knowledge and the technical expertise (MACIAZEKI-GOMES *et al.*, 2016). That is, the shine of the ACS`s job is in its ability to respect and to unveil the people`s knowledge because the ACS`s are genuine people and, in the dialogue with such knowledge, it is possible to operationalize the technical expertise in a community context.

When asked if they had the habit of getting together with the neighbors, P1 said: *[...] I talk with the pastor […] Here in this area, the rule is every man for himself and God for all […] Each one manages as he can.* And P4 stated*: […] I never got together with the neighbors […] with my mother, yeah.*

The above question aimed to know if they, to some extent, talk about their problems and/or the community problems, if they participate of a resident`s association or of a local health council. The answer allows perceiving that the dialogue takes place with the *pastor* or with the *mother* showing that the religious and the maternal bonds are the ones that bloom in the interviewees` life to discuss problems; that the cultural reality does not contemplate the debate on community problems neither the solutions for the improvement of the community life conditions.

The analysis of the two case studies about the power of faith and the miracle of power signals that the Pentecostal movements have won the popular grassroots extensively to their churches through the evangelic mediators and their sermons and dogmas. The central core of this achievement at present seems to be in the capacity of the mediators and pastors to transform and to displace borders in their eagerness to reach what could be named as a "sensitive key […] the assessment of the political leadership of the "men of God", in specific social contexts – because they are subaltern -, where they warn that "they condemn the lack of horizons of those who practice blindly the obedience to the laws of men" (BIRMAN, 2012, p. 135). It might be that the experience with the pastors works as a constraint of health and disease of subaltern individuals to some extent.

It is worth mentioning that the transversal analysis of the material allowed recognizing another community connection of P1, besides the bond with the *pastor*: the CRAS, the Reference Center of Social Care, the entrance door into the Social and Care Network, located in areas of higher social vulnerability and responsible for the execution of services, programs and social projects developed by the Union, the States and the Municipalities. While a public space of territorial basis, the CRAS works as a basic unit of the Unified System of Social Care – SUAS. Its objective is working on the reduction of social risk in the territories, by stimulating the strengthening of the family and community bonds besides the expansion and the guarantee of access to the citizenship rights (SÃO PAULO, 2019): *When one has some problem or one needs help, the CRAS is there […]* (P5).

The speech of P4, where the mother appears as partner to discuss problems, was completed with the following statement: *Oh, on Thursdays I attend the handicraft course when I enjoy myself, I laugh, I play […] oh, we enjoy ourselves there*.

The above statement exhibits life through arts; arts while a space of expressing feelings, freedom, promotion of bonds and health. A study carried out with a handicraft group of a Health Primary Unit of Maringá, Paraná, made in 2009, searched to understand the users` motivation to participate of the mentioned group. The women unveiled a daily routine crossed by various needs, i.e.: of having somebody to share pains, flavors, anguishes, experiences, fears; of interacting and feeling herself valued in the relation with the other side of herself. Belonging to this group represents escaping from the routine, sometimes, tiresome and gloomy (SCARDOELLI, WAIDMAN, 2011).

The meeting of P4 with laughing, having fun, playing through the handicraft course, seems to convey her to a space of right, although not with her recognition. And the labor force of a UBS has an important role in supporting the recognition of this space: how can the UBS workers contribute? A fertile path is the one of politicization of the daily work: with political will, the dentist, for example, can produce historical consciousness (BERLINGUER, 2012), in the work relations; in this case, promoting in P4 the recognition of the space of handicraft meeting as a potential space to discuss issues about the neighborhood, to foster the debate on social rights, and among these, the community participation in local decisions.

When asked how they perceive the UBS services, P1 reported: *[…] look, they have helped me, me particularly whenever I needed support, I always received help from the health care service […]*.

The speech reveals welcome from the UBS, but in the sense of help, and it maybe signals that P1 did not know that once she belongs to the territory where she lives, the Unit is hers, it belongs to the community and being welcome is a right of hers.

A report on the experience about the implementation of welcoming in an ESF staff of a UBS from a municipality of Santa Catarina (VIANA, LIMA, 2018) told about the place that the welcoming act occupies today within the Strategy: welcoming has been constituted of a programmatic action guided by procedural steps in view of the progressive increase of needs and demands.

When asked if it has been easy to obtain treatment with the dentist in the health care "service", P4 said:

Yes, when I was dying of pain, I needed it and I was attended very well thanks God. The dentist said that I had to have the tooth pulled out because I had not finished the treatment of the root canal that I started long ago. He is going to make the appointment to pull it out and I will have to put another one (tooth) because I do not want to become toothless, can you imagine it. It´s the one in the front, woman, how can I become toothless? My children will not even look at me, I am not beautiful and how can I become toothless? (smiles) It is not possible, isn`t it? […] I know that in that other place [CEO] they make those dentures, full bridgework, for elderly people.

Again, P4 resorts to laughing to manifest pain. A pain which is generated by excluding macro-economic policies, by lack of life conditions, by unfair and avoidable inequalities, by government neglect, by lack of work, by lack of opportunity to succeed in life, by low self-esteem, by seeing the hungry children, by the dentist, by the health system, by the capital force.

The Brazilian society has won the SUS, but the great society mass is not the owner of the System. It has won the Smiling Brazil; after 112 years of tragic slow pace, a federal government recognized the right of people to move their lives ahead with teeth. It won the National Policy of Primary Health Care (BRASIL, 2006; 2017a). It won the regulation (BRASIL, 2011) of the Health Organic Law (BRASIL, 1990), the regionalization of the System, although by decree: of no. 7,508 of June 28, 2011 (BRASIL, 2011). However, from the early Old Republic until today it has not won a Social State which treats social rights as non-negotiable and recognizes that only a healthy and fair society can produce economic wealth; that recognizes that in the poverty line and below it no person will look at himself/herself as a subject with dignity and citizenship and with conditions to get up every morning and to produce richness to the Country.

The teeth or the lack of them reflects the political economy. The Brazilian context of deep social inequalities is also expressed "in the mouth". The resource of extraction removes the local symptom, yes, sometimes unbearable, but it is also "a strategy that produces a […] condition of vulnerability: of not having teeth, as a consequence of the treatment plan of dentists". Upon producing violated individuals, the resource of extraction produces "a false expression of the political economy in the subject and it creates the illusion of re-establishing the health" (COSTA *et al.,* 2013, p. 466). It only lacks [to place] *another tooth, or* [a] *denture.*

When asked about the access to the dentist over their lives, P1 answers with a report of violence:

The first time I went to the dentist […] he wanted to abuse me and my minor sister there, we never went there again […] I was 13 and she was 10 […] he wanted to kiss us in the mouth […] he touched our breast with his hand […] then we did not go there anymore […] we had the trauma of going to the dentist, you understand? Then, when I went there, I wanted to pull 4, 5, out once so that I did not have to go there often […] I was 25 when I had my first denture […].

In the search for the perception of their own health and dental practices, sexual abuse has been evidenced. The relationship between the interviewers and the report showed that P1 had already overcome, to some extent, the episodes of violence, experienced in the early years of adolescence. Her understanding that it was violence occurred in the same time when the episodes took place because she states that: *[…] I have had sexual education at school […] they (the teachers) also taught it*. The sexual education was probably of great value because notwithstanding the unsurmountable fractures in her intimate tissue, she could recognize that the way of attending was configured as abuse. She could protect herself and her younger sister, when she decided to extract all her teeth at once to expel the need of returning to the dentist.

A review of 2015 about sexual violence practiced against children and adolescents systematized technical contributions from several researchers who study the theme. The author`s objective was to shed some light on the possible consequences of this form of violence. Findings signal that the consequences of sexual abuse are "extensive and diverse to the victims"; that especially doctors, psychiatrists, psychologists and sociologists have made efforts to gather elements that might outline intervention proposals by respecting each one`s singularities. The author comments, yet, that "it is not possible to generalize or to delimitate the effects of sexual abuse perfectly once the gravity and the extension of the consequences depend on the particularities of each victim`s experience" (FLORENTINO, 2015, p. 144).

Finally, new qualitative studies with families undergoing vulnerability are recommended as a way of understanding life mechanisms and movements in subaltern classes that are apart from the right condition of having rights.

4. Considerations

The article identifies and discusses the way how the members of a socially violated family, living in an occupation zone of a city in Santa Catarina perceive their own health and the dental practices of the ESF.

Grounded on the category "Bonds in a community cultural reality", the data analysis revealed that both health and dental practices are perceived through relations that express the subalternity, the intersubjectivity, the willingness to work, the bond with the evangelical church, life through arts, and sexual violence.

The conclusion drawn is that the materialization of the care model, through the axis of life conditions of the communities, requires the problematization of professional certainties generated by the hegemonic production of a technical scientism detached from the real life of violated families.

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