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Original Article

Experiences of Family Members Regarding the Oral Health Care of Children[1]

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The aim of this study was to comprehend the experiences of family members regarding the oral health care of children. This was a qualitative study, conducted in 2007, in the health district of Ribeirão Preto, with 12 caregivers. The theoretical framework of vulnerability and the hermeneutical perspective were used. Three empirical categories were established: the meanings of oral health care, in search of the causes and prevention of oral diseases, and the reality of oral health services. Among other potentiating factors of infantile vulnerability to oral diseases, the overvaluation of biological causality, of high complexity care and of esthetic dentistry emerged, and among the protective factors, the valorization of popular knowledge and the integration of professional actions and knowledge were observed. This study indicates the necessity for a review of prevention and oral health promotion strategies and provides elements to assist health services to reorganize oral health care for children.

Descriptors: Oral Health; Vulnerability; Child.

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Experiências do familiar em relação ao cuidado com a saúde bucal de crianças

Este estudo objetivou verificar a compreensão das experiências dos familiares em relação ao cuidado com a saúde bucal das crianças. É estudo qualitativo, realizado em 2007, em distrito de saúde do município de Ribeirão Preto, SP, com 12 cuidadores. Utilizou-se referencial teórico da vulnerabilidade e a perspectiva hermenêutica. Três categorias empíricas foram elaboradas: os significados do cuidado com a saúde bucal, em busca das causas e da prevenção de agravos bucais e a realidade dos serviços de saúde bucal. Entre outros elementos potencializadores da vulnerabilidade infantil aos agravos bucais, emergiu a supervalorização da causalidade biológica, do atendimento de alta complexidade e da odontologia estética e, entre os protetores, a valorização do saber popular e a integração de ações e conhecimentos profissionais. Aponta-se para a revisão das estratégias de prevenção e promoção de saúde bucal, fornecendo elementos para auxiliar os serviços de saúde a reorganizarem o cuidado com a saúde bucal de crianças.

Descritores: Saúde Bucal; Vulnerabilidade; Criança.

Experiencias del familiar en relación al cuidado con la salud bucal de niños

Este estudio objetivó verificar la comprensión de las experiencias de los familiares en relación al cuidado con la salud bucal de los niños. Es un estudio cualitativo, realizado en 2007, en un distrito de salud del municipio de Ribeirao Preto-SP, con 12 cuidadores. Se utilizó el referencial teórico de la vulnerabilidad y la perspectiva hermenéutica. Tres categorías empíricas fueron elaboradas: los significados del cuidado con la salud bucal, en busca de las causas y de la prevención de daños bucales, y la realidad de los servicios de salud bucal. Entre otros elementos potencializadores de la vulnerabilidad infantil a los daños bucales, emergieron la supervalorización de la causalidad biológica, la atención de alta complejidad y la odontología estética; y, entre los protectores, la valorización de la sabiduría popular y la integración de acciones y conocimientos profesionales. Se señala que debe ser efectuada la revisión de las estrategias de prevención y promoción de la salud bucal, ofreciendo elementos para auxiliar a los servicios de salud a reorganizar el cuidado con la salud bucal de niños.

Descriptores: Salud Bucal; Vulnerabilidad; Niño.

Introduction

The child, due to the characteristics of their stage of development, depends on the care and support of the family and/or caregivers, with the care they receive during this period having an influence throughout their life[1]. In this instance, parents and caregivers are essential for taking the quotidian decisions relating to nutrition, education and health, among others. Among the actions directed toward the welfare of the child, caregivers also assume responsibility for oral health care[1-2].

The promotion of oral health includes the early initiation of the development of good dietary and oral hygiene habits, as well as collective actions through effective social policies[2]. Among the oral health problems affecting children in early infancy, gingival alterations, malocclusion and dental caries are the most frequent[3].

Dental caries is the oral disease of greatest epidemiological impact and constitutes a public health problem. It presents a high prevalence in most countries

with high financial and social costs for health care institutions and society and has its prevention related to a series of general and individual factors[2,4].

When considering that, in Odontology, preventive activities that have centered on the concept of risk - factors and behavior - have been insufficient to alter the current condition of oral health of children[5], there is need to broaden the comprehension of these determinants.

The concept of risk, developed by epidemiology, was conformed as an instrument for quantifying the possibilities of developing disease for individuals or populations, from the identification of casually related associations between events or pathological conditions and other events and non-pathological conditions[6]. Translated as the probability of occurrence, such cause-effect relationships provide partial explanations regarding the chances of contracting disease. Thus, it is necessary to attempt for the limits of the use of "risk" in prevention and health promotion actions, because this concept cannot always grasp the complexity of the health phenomena, leaving values, health needs and cultural meanings hidden[6].

To better comprehend the complexity of the phenomena related to the occurrence of dental diseases in children, the concept of vulnerability was adopted in this study. The construction of the conceptual framework of vulnerability in the field of health is relatively recent and is closely related to the effort of overcoming the preventive practices based on the concept of risk[6-8]. This concept refers to the chance of exposing people to diseases, as a result of a set of, not only individual, aspects, but also collective and contextual ones, which cause increased susceptibility to the occurrence of pathologies and, inseparably, a greater or lesser availability of resources of all orders that protect against disease. Vulnerability analysis involves the articulated evaluation of three main interlinked points: the individual, the social, and the programmatic[6,8].

Among the numerous possibilities for discussion of the topic, this study aimed to comprehend the experiences of family members regarding the oral health care of children. It was expected, from listening to the caregiver residents of the East Ribeirao Preto Health District, to comprehend their perspective of care, as a way to subsidize the reorganization of the health services and expand their scope of action.

Method

A qualitative methodology was chosen, as the interpretive character searched for meanings attributed to concepts and practices of health, produced by certain social subjects. The support of the Philosophical Hermeneutics of Hans-Georg Gadamer was sought, which provided the premise for a more adequate approximation of the interpretative nature of empirical production[9]. Thus, the interpretation respected the hermeneutic rule, in which the comprehension of the whole is based on the singular, and the singular, based on the whole, through extensive and repeated readings that aimed to enrich the unity of meaning by the agreement of all singular parts with the totality of the results. Conversely, aiming to overcome the concept of risk as the only perspective from which to think about the actions of promotion and prevention in oral health alluded to the conceptual framework of vulnerability.

The study was conducted in the catchment area of a health district, with the understanding that this may be representative of the municipality as a whole. Although the central focus was the oral health of children, the empirical data was obtained from interviews with family caregivers. Children at the end of early childhood, between five and five years and 11 months were chosen for study. Considering the demand for treatment, information on all children in this age group attended within two months of 2007 at the six Health Units in the Eastern District was obtained from the information system of the Municipal Health Department and totaled 198 children. Two children were selected from each Health Unit with distinct oral health conditions, i.e. one that only had preventive dental care and the other dental care for curative reasons. The selection was initiated with the last child on the list and, from there, the family caregiver was sought, such as the mother, father or grandparent, giving a total of 12 people, the research subjects. This number of participants was defined, initially, with the possibility of increasing it if necessary. However, in the course of the study, this was shown to be sufficient since the empirical material obtained allowed a comprehensive picture of the matter investigated to be outlined[8].

Collection of empirical material

The semistructured interview was used and, for this, a script was elaborated aimed at identifying individual aspects (cognition, knowledge, behavior, attitudes, values, desires, interests, skills and beliefs), social aspects (access to social networks, to education and to culture; political participation and socioeconomic status) and programmatic aspects (access, type of care, programmatic actions, professional development,

intersectoral collaboration and integrality) in order to provide support for the analysis of the vulnerability of children to the occurrence of dental disease.

The collection of empirical material was performed at the domicile of the caregiver, after signing of Free Prior Informed Consent form. The interviews took place in a single meeting that lasted for, on average, two hours and were tape recorded and later transcribed in full. The interview script was subordinate to the dynamics that the interviewee gave in their narrative, thereby offering the possibility that they would discourse freely about the proposed topic.

The results are presented in the form of excerpts from the statements of caregivers. At the beginning of the excerpt the degree of relatedness with the child is specified, in parentheses and, at the end, the fictitious surname of the caregiver. The presentation of the transcribed statements respected the linguistic variety used by the participants. The project was approved by the Ethics Committee of the School of Nursing of Ribeirão Preto-USP (Protocol nº 0152/2005).

Results

From the analysis of vulnerabilities, three empirical categories were identified: the meanings of oral health care, in search of the causes and prevention of dental diseases, and the reality of oral health services.

The meaning of oral health care

The representation that individuals have regarding oral health is determinant for the actions they perform in their quotidian life and configures their practices. The comprehension of what the caregivers consider as care and as oral health care is evidenced in the statements below:

(mother) *I'm caring, I do not want my child to be sick, when he coughs slightly and I see that there is catarrh, I say: I'm going to give you an inhalation [...] And there are so many times that I give home remedies, because I know it's bad, but it is better than the injection* (Figueiredo family).

(mother) *my mother, she would always do these things, cotton wool with medicine, put I do not know what on the tooth, garlic with hot oil, she would also make a poultice with plants, she made lots of things from the garden, she would mash up some green things and that would solve it, seems not, but me and my brothers, we could sleep* (Santana family).

Good oral health appeared idealized in the good aesthetic appearance, overlying the functional issues, as illustrated by the following reports:

(mother) *[...] I have a tooth, I treated it a little while ago, but this tooth is rotten [...] in me, I wanted to do whitening for my teeth to stay white, that are yellowing with time, lack of care, I know. And in them* (children) *the same thing too* (Vetorazo family).

(mother) *[...] N.* (son) *I need to see if he needs a brace in his mouth* (Nogueira family).

(grandfather) *[...] of course, the first thing I would do is implant a tooth* (Reparate family).

In search of the causes and prevention of oral disease

Several factors are determinants for the development of oral diseases, particularly dental caries. In this study, it was observed that caregivers associated oral diseases, often with the biological dimension, which induces the understanding that people get sick due to their own carelessness, causing them feelings of guilt. For example:

(mother) *[...] sweet things, because sweet things destroy the teeth, what barbarity! Chewing gum, candy [...] I think it may also be my fault, understand? If I was on her case more* (daughter)*, on top of her, because she is terrible for brushing her teeth* (Galante family).

(mother) *[...] for not brushing the teeth after meals, because I also, sometimes, I'm in a rush ... so I think that this could have led to it* (Figueiredo family).

The prevention of oral diseases was often associated with the care practices, especially those related to diet (sugar control), to oral hygiene (practice of brushing and use of dental floss) and regular visits to the dentist, as in the following reports:

(mother) *Ah! Yes, I changed the diet a lot, the nutrition re-education, the habits that we have more towards health now, the part of the mouth, greatly improved* (Figueiredo family).

(mother) *[...] trying to brush more often, because before not, what we understood when I lived in the countryside was that you brush your teeth only in the morning when you get up [...] That's what we knew* (Mendonca family).

(grandfather) *[...] you professionals (dentists) have all the equipment, you see things in minute detail, we use the naked eye and it is very difficult, so if the child went to the dentist more often, for certain this would help more* (Reparate family).

The reality of the oral health services

Oral health care was seen as inextricably linked to the system of public and private health services. For the caregivers, the oral health status of individuals depends directly on the accessibility to health services and the availability of treatment. Difficult access to

dental services, the absence of follow up consultations for monitoring, lack of resolvability of actions, difficult access to services of greater complexity and the lack of multidisciplinary care were situations reported by caregivers as potentially harmful, which may compromise the integrality of attention, as in the following:

(father) *[...] in the Center there is a huge waiting list that takes more than a year* (Perez family).

(mother) *[...] about referral, I think it takes a long time, because I´m waiting for over a year* (Martins family).

(mother) *[...] the pediatrician should look at the mouth when they look at the throat and say: look mom, now you have to start caring because the tooth is like this, like that. No, never, never has a doctor said that to me* (Santana family).

(father) *[...] the nurse could do this role, teaching how to brush the teeth, but they do not* (Perez family).

(mother) *[...] I think every school, at least in the preschool, the teachers should have an orientation within the school, it should start there* (Vetorazo family).

Discussion

The focus on the child exposes its dependence in relation to health care, as well as its integration into a family and social context. Child, caregiver and family group usually live in the same environment and follow the same traditions and customs related to health care. Thus, a therapeutic project should incorporate actions of health care that transcend the clinical that are limited to the cure of disease and should valorize the context, the social determinants, the subjectivity of the health-disease process, as well as the inclusion of users as active, autonomous and participatory beings[10].

In this way, to comprehend, accept and reflect on the practical knowledge permits the child to be taken care of in the context of the family and in their relationships with the health services, community, school and other social sectors. The attention directed towards the interests and singularities of children and their families brings the essential elements for the construction of spaces of care and the expanding of horizons[11].

Confirming this concept, in the discourses of the caregivers, health care appeared rooted both in scientific knowledge (inhalation/injection) as well as in the empirical (home remedies). Thus, the need for an odontological practice supported by the composition of knowledge can be understood, because only then is it possible to reach a clinical practice that reflects real life, with therapeutic capacity[12]. However, health education projects in Brazil, still continue to be mostly inscribed in the perspective of transmission of scientific and specialized knowledge to a lay population, whose lived knowledge is little valued and/or ignored[13]. A study conducted in rural community in the State of Minas Gerais, using social representations of the oral health-disease process of mothers of students, identified the use of home remedies to try to solve problems in oral health, a common practice among the rural population[14]. As with this author, the procedures reported here may also be related to historically constructed cultural values and the lack of access to the Health System, as verified in the reports.

The representation of oral health appeared idealized in good aesthetic appearance, reflecting the behavior of the current society. The aesthetic appearance has a strong influence on the formation of self esteem of individuals and is determinant in the development of positive interpersonal relationships and for conveying a professional image of success and competence[15].

The caregivers reported that good oral health is achieved primarily through attendance in the high level of complexity, which exposes the seductive power of technology, leading people to believe that oral health is obtained from this. In this sense, the caregivers understand that they and the children need, primarily, dental whitening, odontic braces and implants. The increase in the commercialization of the health services and the placement of advertisements in the media, which offer the emerging cosmetic odontology for those who can pay, have obscured the distinction between health and aesthetics[2].

Regarding determinants for the occurrence of dental diseases, the caregivers indicated that these relate particularly to biological factors and to individual responsibility. They mentioned the consumption of sweet things as one of the major causes for the development of dental caries. Hygiene practices were also related to dental caries, and the focus was their carelessness. Therefore, the recognition, by caregivers, of the association between poor oral hygiene and dental caries triggered in them a mixture of embarrassment and guilt. Moralistic practices are still common in the health field and particularly in odontology. Thus, the person who presents some preventable health problem, such as in the case of dental caries, is now seen as if they had done something wrong. This 'doing something wrong' ends up being judged both from a biological standpoint and from a moral one[16]. However, when the moral judgment of certain health practices is examined, the possibilities of care are expanded.

When the phenomena of health-disease-care is conceptualized with complex and uncertain socio-historical processes, the causal models, meaning structures of effect-specific determination, show that they are not the most appropriate heuristic devices to reference such phenomena. Conversely, multi-causality, recognized as the etiology of dental caries by many, also does not indicate any substantial increase in the level of complexity. Multiply causes and/or effects of explanatory models do not solve the fundamental limitations of causality; this approach ends up with referring particularly to the complication and not the complexity of the phenomenon[17].

The statements of the caregivers regarding prevention of oral diseases, particularly dental caries, were often associated with the care practices, especially those related to diet (sugar control), to oral hygiene (practice of brushing and use of dental floss) and regular visits to the dentist. In this sense, the dominant discourse among the caregivers related prevention to the dietary and hygiene standards, or, dental health for them came down to the activity of caring for the body, not recognizing the influence of psychosocial, socioeconomic and cultural issues, both in the genesis as well as in the possibility of response to dental disease. One of the major barriers to ensure oral health care for all children is the tendency to structure health problems in terms of parental responsibility rather than social policies[2].

There was reference to the performance of the dental surgeon being essential for good oral health. The relationship between oral health status and contact with the professional, either with informative, preventive or curative purposes, reveals the dependence that the caregivers identified between oral health status and consulting the dental surgeon. It is likely that the search for assistance is the result of what is advocated by common sense, since the biomedical model has, over the years, emphasized this need. However, this does not match what the literature has postulated. It is known that odontological care has contributed little to improvements in the oral health status of populations. Research that analyzed data from 18 industrialized countries revealed that the contribution of odontological services in reducing dental caries in children, 12 years of age, was only 3%, while socioeconomic aspects contributed between 35 and 50%[18].

To expand and improve prevention, there is a need to go beyond the biological and individual aspects, identified by caregivers as the only factors associated with the occurrence of dental problems and move toward the collective issues, linking these determinants to the programmatic and social dimension which, being inter-related, condition the vulnerability of the child to the occurrence of oral diseases.

In relation to the situation of oral health services, the statements of the caregivers indicated that the programmatic vulnerability of the children to the occurrence of dental diseases appeared reflected in the difficulty of access to odontological services, in the fragmentation of health care and in the lack of multi-professional care.

Regarding access, the parameters for healthcare coverage of the Unified National Health System (SUS), used by the Ministry of Health for the planning of odontological resources, are a consultation every two years and up to two odontological consultations per annum[19], being that entry into the health system should take place, at the latest, from six months of age[20]. However, approximately 15% of the Brazilian population have never had access to odontological treatment; only 33.2% of Brazilians have consulted a dental surgeon in the last year and, among children under five years of age, 81.8% of the children have never consulted a dental surgeon[21]. Thus, the results of this study regarding the access of children and family members to odontological services in the municipality are in agreement with the Brazilian data.

Historically, oral health in Brazil has not been satisfactorily addressed. However, at the moment the new national oral health policy, "Smiling Brazil", is being introduced as an initiative that can modify this reality, with the injection of specific resources into this area. It is the first time the federal government has proposed the development of a national oral health policy, i.e. a set of actions that go beyond isolated incentives in this area. In addition to basic care, the policy recommends that the population also has access to specialized treatment in the public network, through Odontological Specialty Centers[22].

The caregivers reported that there are several spaces and professionals who can share oral health care with the dentist. They recognized the importance of the pediatrician, nursing professional and teacher as collaborators in the oral health care of the child. Conceptually, the approach to issues relating to oral health constitutes a field of responsibilities and knowledge common or confluent to the various professions or specialties. Thus, the various professionals involved in child care, when they observe the presence of caries injuries or in the oral soft tissues during examination,

should make the formal referral to the odontological service, enabling the specific care of the dental surgeon - core competence[23]. However, some studies highlight deficiencies in the knowledge of professionals of different areas in relation to oral health, which limits their performance in promoting the integral health of children[24]. Greater integration is necessary between health and education professionals, and dental surgeons, as well as between their areas of expertise.

Final considerations

The reports of the caregivers portrayed the complexity that is the care related to oral health and, at the same time, allowed the identification of numerous elements that interfere in this.

When focusing only on the oral health of the child, the care is shown to be limited, since the health of the child is intertwined with that of the caregiver and of other family members. This situation leads to the need to act together with the family, with a view to diminishing their vulnerability, through interventions that promote their strengthening and the Family Health Strategy points in this direction.

In order to expand the possibilities of oral health care for the child, it is necessary to go beyond the preventive actions that extrapolate the biological risk, contextualizing it in a more comprehensive and complex perspective. As a vital issue, there is the recognition of the other in their singularity, respecting their experiences, beliefs and values and seeking, through shared and responsible choices, the real meeting that is the basis of care. For this, the professional qualification is essential for the viability of practices based on those assumptions.

However, it is understood that the oral health care of the child, shared by different professionals - pediatricians, nurses, teachers, community health agents and day care attendants - favors integral attention to health in the different stages of development. Thus, the integration of actions and knowledge among the different professionals should be a guideline fixed in the health and education services, so that each professional assumes their responsibility in caring for the health of the child. It is believed that the establishment of such partnerships will open up new possibilities of action for the professionals and lead to the expansion of infantile care.

Finally, it is considered that the vulnerability of the child to dental diseases results from a set of characteristics of the political, economic and sociocultural contexts, which increase or reduce their individual risk. Thus, when working in social vulnerability, the challenge remains to invest in programs of promotion, prevention and care, opening up spaces for dialogue and the comprehension of structural obstacles. This challenge contemplates the overcoming of programmatic vulnerability, with the aims of universal access to oral health services, of overcoming the fragmentation of health care, of investing in multidisciplinary and interdisciplinary work and of professional training, so that personnel practices, beliefs and values may in fact protect the child from dental diseases.

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