

From incremental dentistry to the health at school program – the participation of the dental surgeon in the health promotion of schools in the municipality of Fortaleza – Ceará

Da odontologia incremental ao programa saúde na escola – a participação do cirurgião-dentista na promoção à saúde dos escolares no município de Fortaleza – Ceará

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ABSTRACT

The School Health Program (PSE) appears as a way of working on the importance of self-care, disseminating information related to health, through a strategy of integration and permanent articulation between education and health policies and actions, with the participation of the community intersectionally involving the family health and basic education teams. The objective of this research was to analyze and verify the participation of dentists in the PSE in Fortaleza-CE. This is a quantitative, descriptive, observational, and cross-sectional study. The target population was dentists from the Family Health Strategy of the Primary Health Care Units in Fortaleza. Data collection was carried out from March to April 2021 through a structured questionnaire sent via the internet to research participants. Data were tabulated in Microsoft Excel and exported to the Statistical Package for the Social Sciences (SPSS) software, version 20.0 for Windows, in which the analyzes were performed adopting a 95% confidence level. As a result, it was found that of the professionals who were interviewed 80.4% (n=45) were female, 98.2% (n=55) knew about the health program at school, and 57.1% (n=32) carry out the activity of surveying the number of students identified with oral health needs. The planning was carried out by 87.1% (n=49) of the participants. It is concluded that professionals have adequate knowledge about the PSE and that the vast majority carry out activities in the program, especially dentists, nurses, oral health assistants, and community health agents. Thus, strengthening the PSE becomes an excellent strategy for working with children and adolescents, seeking to implement healthy habits.

Keywords: health education dental, oral health, adolescent.

RESUMO

O Programa Saúde na Escola (PSE) surge como uma forma de trabalhar a importância do autocuidado, divulgando informações relacionadas à saúde, através de estratégia de integração e articulação permanente entre as políticas e ações de educação e de saúde, com a participação da comunidade escolar, envolvendo intersetorialmente as equipes de saúde da família e da educação básica. O objetivo desta pesquisa foi analisar e verificar a participação do cirurgião-dentista no PSE no município de Fortaleza-CE. Trata-se de um estudo do tipo quantitativo, descritivo, observacional e transversal. A população alvo foram os cirurgiões-dentistas da Estratégia Saúde da Família das Unidades de Atenção Primária à Saúde de Fortaleza. A coleta de dados foi realizada no período de março-abril de 2021, através de um questionário estruturado, enviado via internet para os participantes da pesquisa. Os dados foram tabulados no Microsoft Excel e exportados para o software Statistical Package for the Social Sciences (SPSS) versão 20,0 para Windows no qual as análises foram realizadas adotando uma confiança de 95%. Como resultado obteve-se que dos profissionais que foram entrevistados 80,4% (n=45) eram do sexo feminino, 98,2% (n=55) conhecem o programa saúde na escola e 57,1% (n=32) realizam a atividade de levantamento do número de escolares identificados com necessidade de saúde bucal. O planejamento era realizado por 87,1% (n=49) dos participantes. Conclui-se que os profissionais apresentam o conhecimento adequado sobre o PSE e que a grande maioria realiza atividades no programa 98,2% (n=55) destacando-se os cirurgiões-dentistas, enfermeiros, auxiliar de saúde bucal e agente comunitário de saúde. Assim, fortalecer o PSE torna-se uma excelente estratégia para trabalhar com crianças e adolescentes, buscando a implementação de hábitos saudáveis.

Palavras-chave: educação em saúde odontológica, saúde bucal, adolescente.

1 INTRODUCTION

The determining factors of health are social, economic, cultural, ethnic/racial, psychological, and behavioral conditions, and these influence the occurrence of health problems and risk factors for the population, such as housing, food, education, income, and employment. When evaluating health conditions, access to essential goods and services must be observed, guaranteeing, for people and the community, conditions of physical, mental, and social well-being. Thus, talking about health involves a series of tools that make the man a being that suffers and interacts with his environment, which is directly responsible for his health determinants. Therefore, working on health and education become of fundamental importance for the quality of life of individuals (BUSS, 2007).

In Brazil, public health services are organized through the regulations of the Unified Health System (SUS), which has specific characteristics with a focus on universality, equity, and integrality and aims at a better organization of services develops actions through hierarchy, according to the complexity of the situations. In the meantime, the SUS comprises three levels of care: Primary Care, which encompasses care and actions for the promotion, prevention, and recovery of the state of health, including actions such as consultations and vaccination. Secondary Care requires specialized monitoring, and Tertiary Care, which monitors patients with more severe conditions who need hospitalization for better monitoring. Rehabilitation consists of a phase in which the patient was discharged but still requires further follow-up (SILVA, 2011).

In the field of Primary Care, it is important to highlight the implementation of Health Promotion and Health Education actions aimed at the production of care. Health promotion is defined by the World Health Organization in the Ottawa Charter (1986) as "the process of enabling the community to act to improve their quality of life and health, including greater participation in the control of this process" and education in health, through pedagogical processes that adopt participatory methodologies, consists of a practice that promotes changes in habits, in the way of seeing the world, feeling and acting. According to FADEL et al. (2013), "health education should promote, on the one hand, a sense of individual identity, dignity and responsibility for self-care and, on the other hand, solidarity and community responsibilities."

Candeias, 1997, signals the principles and concepts that underlie the practice of health education and health promotion, where health education seeks to trigger changes

in individual behavior, while health promotion, although it always includes health education, it aims to provoke changes in organizational behavior, capable of benefiting the health of broader sections of the population (VITALI, PAULA. ET AL 1997).

With regard to actions related to oral health in Brazil, it is important to note that public dental care began in 1929 in the state of São Paulo when dental surgeons became part of the School Medical Inspection team of the Secretary of the Interior. Three years later, actions aimed at schoolchildren in the state public network began to be carried out when the Inspectorate of Hygiene and Dental Care in the Sanitary Service was implemented. The dental care service started to be formed in health centers in other states besides São Paulo after 1947 with the creation of the State Health Department. Paulista (VASCONCELLOS, 1984 apud NARVAL. 2006).

Throughout the history of public health in Brazil, several initiatives and approaches have been identified that intended to focus the school space from a health perspective. Most of these experiences were intended to convey information on first aid, hygiene, and guaranteeing medical and dental care. The initiative was centered on biological paradigms, which advocated that students' bodies should be healthy (MINISTÉRIO DA SAÚDE, 2009).

In this context, in the 1950s, in the field of oral health, the implementation of a proposal by the Special Public Health Service (SESP) to work with Oral Health Programs in Schools stands out, this being the first experience of health care oral hygiene in schoolchildren, in the school environment. In this proposal, the incremental system methodology was used, which consisted of a program with a curative and repairing focus, which prioritized public school students from 6 to 14 years old to treat the accumulated needs of the defined population until the complete treatment for later treatment control (SCHIO, GIONE ANDRE, 2018).

According to Graciano (2015), the field of Dentistry in Brazil used for 50 years the assistance model of American origin called the Incremental System, which organized oral health care exclusively for schoolchildren and was characterized by the predominance of assistance to prevention and health education. With the conquest of the SUS, the implementation of the PSF (Family Health Program), and the linking of oral health teams to the PSF in 2000, the actions developed began to incorporate the concept of health promotion.

In the historical course of public health, the Health at School Program (PSE) emerged in 2007, created through Presidential Decree n° 6,286, proposed by SUS and MEC, based on the need to work effectively with the actions of health promotion. The PSE aims to build intersectoral policies to improve the quality of life of the Brazilian population, facilitate the work dynamics of health and education teams, promote the integration of students, and carry out broad training for citizenship and full enjoyment of human rights (BRASIL, 2007).

It is noteworthy that as of 2017, the PSE will work under the regime of Ordinance No. 1055 of 04/25/2017, which redefines the rules and criteria for joining the PSE (Brasil, 2017). In this scenario, the PSE is configured with the proposal of working on the importance of self-care and disseminating information related to health, through a strategy of integration and permanent articulation between education and health policies and actions, with the participation of the school community, involving intersectionally the family health and basic education teams. The idea is to promote the full development of schoolchildren through health and education policies aimed at children, adolescents, youth, and adults in Brazilian public education (BRASIL, 2009).

The PSE, concerning oral health, consists of an assessment whose objective is to:

It is to minimize the possible risks to which children and adolescents are exposed in the school environment and in the territory in which they live, seeking both individual and collective coping strategies through intersectoral work that includes the participation of education professionals and health (in the planning, execution, monitoring, and evaluation of actions). The active participation of students and families throughout the process is also essential for the production of health and comprehensive education (BRASIL, 2016).

This program showed significant capillarity in Brazilian municipalities, and in this scenario, it is important to highlight this process in the municipality of Fortaleza, the capital of the state of Ceará, whose adherence to the aforementioned program took place in 2010, when the municipality started to serve 248 schools reaching the number of 168,135 students able to attend, linked to 260 Family Health Teams (ESF) distributed in 93 Primary Health Care Units (UAPS). Currently, Fortaleza serves 104,699 students, linked to 158 ESF distributed in 116 UAPS (BRASIL, 2021).

Considering that the city of Fortaleza, with an estimated population of 2,703,391 people (IBGE, 2022), is the fifth largest capital in Brazil and understanding the

importance of the PSE for the development of actions that contribute to the health of schoolchildren, as well as, considering the absence of studies that evaluate the participation of the dentist in the program in question, it is justified to carry out this research, whose objective was to analyze the participation of the dentist in the Programa de Saúde na Escola (PSE) in the city from Fortaleza-CE.

2 MATERIAL AND METHODS

This is a quantitative, descriptive, observational, and cross-sectional study carried out in the city of Fortaleza-CE. The target population was dental surgeons (DC) of the Family Health Strategy (ESF), with a total population of 306 CD, whose sample (n) was composed of 56.

The inclusion criterion used was the professional working in the FHS in Fortaleza for at least two years. Professionals on vacation, leave or working in management at the time of data collection.

Data collection was carried out from March to April 2021 through a structured questionnaire sent via the internet to the research participants. The questionnaire underwent an initial face validation in which the instrument was built with 15 questions and initially submitted for evaluation by scholars in the area of public health, who made the suggestions for necessary adjustments to the instrument, then a pilot test was performed applying the questionnaire to 4 professionals who tested the instrument and through their notes, the final adjustments of the research instrument were made. The questionnaires applied in the pilot test were not considered in the research.

Data were tabulated in Microsoft Excel and exported to the Statistical Package for the Social Sciences (SPSS) software, version 20.0 for Windows, in which the analyzes were performed using a confidence level of 95%.

The absolute and percentage frequencies of each variable were expressed and crossed with the planning of activities using Fisher's exact test or chi-square test.

The research complied with all ethical aspects according to Resolution No. 466 of December 12, 2012, having been approved by the Research Ethics Committee of Centro Universitário Christus through opinion No. 4,450,645.

3 RESULTS

The research was carried out with 56 dentists from the Family Health Strategy (ESF) who participate in the school health program (PSE), in which 80.4% (n=45) were female and 19.6% (n=11) male. As for age, 73.2% (n=41) were over 40 years old.

The time working in the FHS was longer than 15 years for 51.8% (n=29) of the interviewees. It was observed that 98.2% (n=55) were familiar with the School Health Program (PSE) (Table 1).

When evaluating the professionals who work in the PSE, it was observed that 8.9% (n=5) participate in medical activities, 57.1% (n=32) nurses, and 100% (n=56) dentists. nursing technicians 30% (n=17), oral health assistants 89.3% (n=50), community health agents 62.5% (35) and another 10.7% (n=6). (Table 1)

Table 1: Socio-demographic characterization and participation of dentists in the Family Health Strategy of Fortaleza-CE in the Saúde na Escola Program, Fortaleza-2020.

	n	%
Sex		
Feminine	45	80,4
Male	11	19,6
Age		
Up to 40 years	15	26,8
>40 years	41	73,2
Time working in the ESF		
<15 years	27	48,2
15+ years	29	51,8
Know the PSE		
Yes	55	98,2
No	1	1,8
Carry out activities in the PSE		
Yes	55	98,2
No	1	1,8
Professionals who carry out activities at school		
Doctor	5	8,9
Nurse	32	57,1
Dentist	56	100,0
Tenho, nursing	17	30,4
Oral health assistant	50	89,3
Community health agent	35	62,5
Others	6	10,7

Data expressed as absolute frequency and percentage absoluta e percentual

Evaluating the performance of dentists, it was observed that 96.4% (n=54) recorded the activities performed by the team and 57.1% (n=32) carried out the activity of surveying the number of students identified with health oral needs. (Table 2)

The planning of activities is carried out by 87.1% (n=49), among the clinical actions performed, the update of the vaccination schedule was 46.4% (n=26), and the oral

health assessment was 94.6% stood out (n=43). Regarding the promotion and prevention activities carried out, educational activities on promoting healthy eating and lifestyles stood out at 96.4% (n=54), and actions to prevent alcohol use, tobacco, and drug use were 46.4 % (26). (Table 2)

Table 2 Monitoring of activities carried out in the PSE in the municipality of Fortaleza-CE, Fortaleza, 2020.

	n	%
Register of the activities		
Yes	54	96,4
No	2	3,6
Number of students with needs oral health		
Yes	32	57,1
No	24	42,9
Plan the activities		
Yes	49	87,5
No	7	12,5
Clinical Assessment Activities		
Vaccination Update	26	46,4
Early detection of hypertension	0	0,0
Neglected health problems.	4	7,1
Anthropological Assessment	19	33,9
Ophthalmological Evaluation	18	32,1
Hearing Assessment	5	8,9
Nutritional Assessment	5	8,9
Oral Health Assessment	43	94,6
Prevention and Promotion Activities		
Healthy food and lifestyles	54	96,4
Physical activities	12	21,4
sexual health	22	39,3
Alcohol, Tobacco and other drugs	26	46,4

Data expressed as absolute and percentage frequency

Regarding participation in training processes, the majority, 78.6% (n=44), stated that they did not participate in activities to work with health education. (Table 3)

Although the questionnaire does not show whether the planning is carried out with the school or not, the data point to reduced participation of the DCs in the school's actions, such as in the parents' meeting (never + rarely = 69.7% - table 3). The data denote a fragmented process, that is, dentistry performs the actions, but the dentists are not included in the other actions of the program.

Regarding the frequency of participation in activities developed in the PSE, 35.7% (n=20) stated that they participate sometimes, and 28.6% (n=16) participate in the

organization of these activities. It is noteworthy that 39.3% (n=22) never participated in any parent meetings at PSE schools. (Table 3)

Table 3: Participation in activities carried out in the PSE in the city of Fortaleza-CE, Fortaleza, 2020.

	n	%
Capacity to work with Health education		
Yes	12	21,4
No	44	78,6
Frequency of participation in PSE activities		
Never	1	1,8
Rarely	10	17,9
Sometimes	20	35,7
Frequently	12	21,4
All time	13	23,2
Organization of PSE activities		
Never	6	10,7
Rarely	8	14,3
Sometimes	12	21,4
Frequently	16	28,6
All time	14	25,0
Parent meetings at schools PSE		
Never	22	39,3
Rarely	17	30,4
Frequently	15	26,8
All time	2	3,6

Data expressed as absolute and percentage frequency

By correlating the planning of PSE activities with the other variables, it was possible to verify that there was no statistically significant correlation.

Table 4: Correlation between the planning of PSE activities and the other variables, Fortaleza, 2020.

	Total	Plan the activities of PSE		p-Value
		Yes	No	
Sex				
Feminine	45 (80.4%)	39 (79.6%)	6 (85.7%)	0,703
Male	11 (19.6%)	10 (20.4%)	1 (14.3%)	
Age				
up to 40	15 (26.8%)	13 (26.5%)	2 (28.6%)	0,909
>40	41 (73.2%)	36 (73.5%)	5 (71.4%)	
Time working in the ESF				
<15	27 (48.2%)	25 (51.0%)	2 (28.6%)	0,266
15+	29 (51.8%)	24 (49.0%)	5 (71.4%)	
Know the PSE				
Yes	55 (98.2%)	48 (98.0%)	7 (100.0%)	0,703
No	1 (1.8%)	1 (2.0%)	0 (0.0%)	
Carry out activities in the PSE				

Yes	55 (98.2%)	48 (98.0%)	7 (100.0%)	0,703
No	1 (1.8%)	1 (2.0%)	0 (0.0%)	
Register the activities				
Yes	54 (96.4%)	47 (95.9%)	7 (100.0%)	0,586
No	2 (3.6%)	2 (4.1%)	0 (0.0%)	
Number of students with oral health needs				
Yes	32 (57.1%)	29 (59.2%)	3 (42.9%)	0,414
No	24 (42.9%)	20 (40.8%)	4 (57.1%)	
Training to work with health education				
Yes	12 (21.4%)	10 (20.4%)	2 (28.6%)	0,622
No	44 (78.6%)	39 (79.6%)	5 (71.4%)	
Frequency of participation in PSE activities				
Never	1 (1.8%)	1 (2.0%)	0 (0.0%)	0,135
Rarely	10 (17.9%)	7 (14.3%)	3 (42.9%)	
Sometimes	20 (35.7%)	19 (38.8%)	1 (14.3%)	
Frequently	12 (21.4%)	12 (24.5%)	0 (0.0%)	
All time	13 (23.2%)	10 (20.4%)	3 (42.9%)	
Organization of PSE activities				
Never	6 (10.7%)	4 (8.2%)	2 (28.6%)	0,568
Rarely	8 (14.3%)	7 (14.3%)	1 (14.3%)	
Sometimes	12 (21.4%)	11 (22.4%)	1 (14.3%)	
Frequently	16 (28.6%)	14 (28.6%)	2 (28.6%)	
All time	14 (25.0%)	13 (26.5%)	1 (14.3%)	
Parents' meetings at schools				
Never	22 (39.3%)	19 (38.8%)	3 (42.9%)	0,954
Rarely	17 (30.4%)	15 (30.6%)	2 (28.6%)	
Sometimes	15 (26.8%)	13 (26.5%)	2 (28.6%)	
Frequently	2 (3.6%)	2 (4.1%)	0 (0.0%)	

*p<0.05, Fisher's exact test or Pearson's chi-square (n, %). absolute and percentage.

4 DISCUSSION

Some characteristics in the profile of dentists were observed and deserve to be highlighted, such as the predominance of females among the participants. Studies show a "feminization" in health courses, with a growing number of women, especially in dentistry courses (COSTA, DURÃES, ABREU, 2010).

ESF professionals must take ownership of the PSE proposal, whose target audience is children, adolescents, and young people, filling the void existing in primary care that refers to the health support of this population exposed to social vulnerabilities and inserted in the school, providing for the articulation of several actions with thematic areas, passing through assistance, educational, preventive and promotional modules (ALMEIDA, 2013).

The PSE provides for the articulation of several health actions in the school that must occur concomitantly. These actions are organized into three components, namely:

Component I, tests as the main tool for clinical and psychosocial assessment, which aims to assess the health of students and thus allow them to be referred for care in the health network when necessary, carrying out the actions of anthropometric assessment, updating the calendar vaccine; early detection of Systemic Arterial Hypertension; early detection of neglected health problems; ophthalmological assessment: hearing assessment: nutritional assessment, oral health assessment and psychosocial assessment (BRASIL, 2011).

Component II aims to carry out health promotion and prevention activities that aim to guarantee the opportunity for all students to make choices that are more favorable to health and to be, therefore, protagonists in the process of producing their health, seeking to improve their quality of life. The actions will be addressed from the themes highlighted as priorities for the implementation of health promotion and prevention of diseases and injuries in the territory (BRASIL, 2011).

Component III works on the training of PSE participants to guarantee the training of managers and of the education and health teams that work in the PSE. The strategies pointed out to be contemplated are the training of management, technology, and innovation; training young protagonists; training of Education and Health professionals in themes related to the PSE: conducting distance education courses, strengthening, even more, when the training is integrated into health and education (BRASIL, 2011).

Regarding the assessment of bacterial health in the school environment, initially, it is important to recognize the capacities of the health team, education professionals, and of the school structure, including the preparation and availability of the team, the prior organization of safe space, and environment for driving, which must be done jointly by the health and education team. A lighted environment, with good ventilation, with the availability of a sink for brushing, for washing hands and instruments used, as well as disposable materials and documents for recording information, are aspects and important inputs to be contemplated (BRASIL, 2016).

In the case of adolescents and children under 18 years of age authorization from parents or guardians must be obtained by signing a comment term before carrying out the oral health assessment, the dentist can observe whether schoolchildren report an annual history of toothache, fractured restorations, teeth with caries, and visible changes in the soft tissues of the mouth, among other aggravations. With this, professionals can develop individual strategies for each student. Those who need dental treatment must have a

defined therapeutic plan for continuity of care, which must be articulated, scheduled, and follow-up in the health network (BRASIL, 2016).

As for the development of PSE actions, we saw that the dental surgeons who participated in this study and who work in the School Health Program have the support of Oral Health Assistants, Nurses, and Community Health Agents in the vast majority of cases, but a small number of doctors usually participates in the development of PSE activities. The literature shows that, in many cases, the planning and execution of activities with schoolchildren are carried out alone by the oral health teams, without the participation of the other members of the ESE, due to the historical insertion of these professionals at school (MORETTI et al., 2010).

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The lack of material resources, especially for educational actions in the PSE, was revealed by studies carried out in the municipality of Fortaleza, in which difficulties related to the implementation of the PSE in the municipality were highlighted, among them, the lack of knowledge of the program on the part of professionals and managers, the lack of planning and interaction between the health and education sectors, in addition to different demarcations in the territory that involves the Primary Health Care Unit and the School. Such difficulties contribute to the fact that actions within the scope of the PSE happen in a discontinuous and disjointed way, without planning and involvement of professionals and management, being regulated by higher bodies, and still not contemplating the principles of health promotion (PAIVA, 2021; SILNA, 2020).

The study presented showed a high degree of knowledge of the PSE and realization of the activities by the dentists, however, 12.5% still do not plan activities that will be carried out, which can make it difficult to carry out the actions proposed by the PSE.

In this context, it is noteworthy that the study highlights the difficulty of articulating health and education, although the situation presents improvements, it remains a great challenge that needs to be faced. It is reiterated with the study that it is opportune to revisit the strategies of dialogue between the teams of primary health care and schools, aiming at the development of health actions with schoolchildren aimed at children, adolescents, young people, and adults in public education and that is based on the participation of the subjects involved in the process.

Given the complexity of the PSE proposal, it is noteworthy that the National Oral Health Policy requires dentists with an expanded view of health, with the ability to understand individuals, families, and the community in a systemic way, and with skills and abilities that support the development of actions that fully address the health of schoolchildren, based on intersectoral planning anchored in the diagnosis of the health needs of the territory where the students live (BRASIL, 2013).

In the meantime, it is important to highlight the essentiality of education in the process of school care, as indicated by Francisco and Da Silva (2019);

Education is an essential point of any health program. Its results are significant when they succeed in promoting positive changes in people's behavior. The implementation of oral health education programs in schools provides children with knowledge about the effective means to prevent oral diseases. Motivation is also an indispensable requirement for learning. It is a personal, internal process that determines the direction and intensity of human behavior.

5 CONCLUSION

The study indicates that the professional and member of the PSE is mostly female, over 40 years of age, and among the most performed activities, vaccination, assessment of oral health, nutrition, and healthy lifestyles stand out.

It was observed that professionals have adequate knowledge about the PSE and that the vast majority carry out activities in the program, especially dental surgeons, nurses, dental health assistants, and community health agents. However, it is important to strengthen the participation of dentists in planning actions for PSE activities, as well as in meetings with parents held in schools.

The actions developed by the PSE, in an integrated way, considering the three components, contribute to the development of autonomy/protagonism of children/adolescents, as well as to the co-responsibility of the parents and guardians with their health.

Strengthening the PSE becomes a powerful strategy to work with children and adolescents, emphasizing, in this process, the need to overcome the biomedical model, inter-sectoral/interprofessional approach, participation of various actors in school-health environments, adoption of strategies to strengthen bonds, monitoring and evaluation of actions, and investment in permanent education for teams. In this way, the empowerment and social participation of schoolchildren will contribute to citizenship.

However, for the development of this program, the involvement of qualified professionals is necessary, capable of articulating in the exercise of their work the specific knowledge built throughout their professional training, with collective knowledge, in the direction of a social practice, which transcends the fragmentation and specialization characteristic of health actions in the country (BRASIL, 2009).

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