Perspective of users, residents and workers on a community-based oral health intervention in the rural FHS

Daniela Maria Cruz Ferreira de Carvalho*; Tainá Faustino Mafra*; Delâine Cavalcanti Santana de Melo; Ive da Silva Monteiro***; Márcia Maria Dantas Cabral de Melo******

* Specialist in Family Health with emphasis on the Health of Rural Populations
** Adjunct Professor, Department of Social Work, Center for Social and Applied Sciences, Federal University of Pernambuco
*** Professor of the Residency Program in Dentistry in Public Health.
**** Associate Professor, Department of Clinical and Preventive Dentistry, Center for Health Sciences, Federal University of Pernambuco
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ABSTRACT

The aim of this study was to analyze a comprehensive community-based oral health care intervention carried out by residents of Dentistry in Family Health inserted in two health units in the rural area of the municipality of Caruaru/PE, according to the perspective of professionals, residents and users. The intervention included diagnosis and assessment of dental needs, collective actions in oral health and actions for caries treatment with atraumatic restorative treatment. Target groups were composed of schoolchildren and users from more remote areas included in the health units of Lagoa de Pedra and Xicuru. The qualitative study used the focus group technique for data collection. Three groups were formed: nine professionals, six residents and eight users. Interviews followed a script with open questions about oral health care and technologies used in the context of rural populations and access/accessibility to health units. Data were submitted to content analysis. Two thematic categories emerged: difficulties in accessing oral health care and satisfaction with implemented actions. Participants in the three groups positively evaluated the initiative of establishing a participatory educational/care relationship by opening up to community spaces and valued the approach adopted by the oral health intervention in dealing with problems that limit access to dental services and the reported collective actions. However, lack of interest in the continuity of actions carried out and contrary to community practices in oral health were reported in the focus group of professionals. There is persistent presence of professional and structural factors that limit the guarantee of access to health of users from more remote areas included in health units.

Descriptors: Rural Health. Family Health. Oral Health. Comprehensive Dental Care.

1 INTRODUCTION

Rural populations are characterized by peoples and communities whose ways of life, social reproduction and production are mainly related to land and water[1]. It is undeniable to affirm that this rural space is traditionally a place with little government action in the implementation of public policies related to health promotion and social assistance[2]. Historically, when compared to urban populations, these populations have faced a series of social inequities in their daily lives, which directly impact their quality of life and must be analyzed in the light of understanding the socioeconomic determinants and the government guidance to guarantee rights[3,4]. This reality is reflected in the oral health indicators that inform greater intensification of the impact of these determinants in the unfavorable health standards that affect rural populations with greater severity and which are also expressed by differences in availability and quality of health care[5,6].

In addition, access and accessibility to Primary Health Care (PHC) services are not always guaranteed, and explanations are found in the long distances between rural communities and Family Health Units (FHU) and their respective support points, which are places used by professionals to decentralize the care offer from the reference FHU to other more distant micro-areas belonging to the territory[2,7].

Under these circumstances, the Multiprofessional Residency in Family Health, University of Pernambuco (RMSFC-UPE), created in 2015, in line with the guidelines of the National Policy for the Comprehensive Health of Rural, Forest and Water Populations[8], being a result of the articulation of this university with the Movements of Landless and *Quilombola* Rural Workers, and the municipalities of Caruaru and Garanhuns – which has among its purposes to promote the capacity of critical analysis and evaluation of residents to enable the performance of comprehensive health care for rural populations.

In areas where RMSFC-UPE operates, there is an expressive contingent of rural families in areas far from health services and they are those with greater socioeconomic vulnerabilities. Such families have difficult access to services provided by FHUs due to the scarcity of public transport, in addition to the physical and symbolic barriers of the training and organizational process of workers of Family Health Strategy (FHS) teams that maintain the logic of work in the urban context, without considering the specificities of life in rural areas.

In Brazil, the guidelines of the National Oral Health Policy (PNSB)[9] were launched in 2004 with the aim of expanding access, equitably facing the prevailing epidemiological situation and promoting greater allocation of financial resources to structure a network of oral health services, with national capillarity, coordinated by PHC[10]. Since then, the oral health scenario in the Unified Health System (SUS) has been of continuous growth to promote comprehensive care to users in order to overcome previous and little resolving care models[11].

However, studies on the work process of oral health teams (eqSB) have shown a legacy of the biomedical model, with persistence of professional action focused on care activities, little focus on community actions, lack of action planning and low interaction of eqSB with other PHC workers[12,13]. In a study with qualitative approach, it was found that only the minority of eqSB respondents are aware of the limited impact of their practices, demonstrating restricted understanding of their potential in the production of health care in the FHS[14]

It is noteworthy that, among care strategies recommended by PNSB, atraumatic

restorative treatment (ART) stands out, which eqSB can perform to increase the population's access to dental services and enable treatment, control and prevention of dental caries[15,16]. This strategy must be carried out integrated with programmatic actions of family and community approach in order to promote the integrality of oral health care practices[17], humanization of these practices and user satisfaction with public health services[18]. Thus, this care technology becomes essential to the work of eqSB, as it is a technique for minimally invasive and low-cost caries treatment, which does not require dental equipment and can be widely used for curative and preventive purposes at individual and collective level[19].

Despite evidence on the effectiveness of ART and its benefits for populations in socially vulnerable contexts, where the network of oral health services is precarious and access is difficult[20], there is some opposition to the incorporation of this oral health care technology. Studies have indicated ART underutilization by the public health care network, involving issues such as lack of knowledge of the technique, professional barriers related to lack of training, difficulty in handling the material, preference for conventional restorations, among others[21–23]. There is also lack of studies presenting experiences and results of comprehensive oral health interventions in rural areas[24,25].

In the RMSFC-UPE context, the interpretation of the reality carried out by residents of the Department of Dentistry on the oral health conditions and access to dental services at FHU in rural areas of Caruaru, pointed out the importance of the effective incorporation of ART in the community work process of eqSB to respond to the accumulated treatment needs, to promote improvements in oral health and to face the physical barriers of the great territorial extensions of microareas that impair access to FHU in rural regions.

This study aimed to analyze, from the perspective of workers, residents and users, a comprehensive community-based oral health care intervention, which incorporated ART and was carried out by Dentistry residents in family health inserted in territories of two health units covered by RMSFC-UPE in the FHS of Campo de Caruaru, ‘Agreste Pernambucano’ region, with the intention of producing health and facing barriers of access to oral health.

2 METHOD

The intervention under analysis considered the importance of knowing the perspective of the different actors who participated or followed its development (professionals, residents, users). This intentionality requires approximation with the subjective contents of these social actors in order to know their perspectives, opinions, feelings and knowledge about the proposal, as well as knowing resources and difficulties of users to access health care in FHS and of professionals and residents in promoting health to the population under their health responsibility. It was considered pertinent to carry out a qualitative research because it was considered adequate to reveal these issues. Among procedures for this type of study, the focus group technique was chosen to obtain data through discussions[26], which allow subjects to freely express their opinions on a given subject[27].

The study was carried out at the FHU of Lagoa de Pedra and Xicuru, rural area of Health District IV, Municipal Health Department of Caruaru, in community spaces in areas assigned to the FHU, which cover, respectively, a population of 2,737 and 1,811 inhabitants. In each FHU, the is an eqSF composed of a doctor, a nurse, a nursing technician, in addition to seven and eight community health agents (CHA) and an eqSB composed of a dentist and an oral health

assistant. During the period defined for the practical activities of residents, the dental office at FHU Lagoa de Pedra was unable to operate due to structural reasons. In the areas covered to these two FHUs, collective intersectoral actions were carried out by the reference oral health team punctually in municipal schools and individual care, focused on clinical-assistance actions, carried out in the form of spontaneous demand. In this space, only supervised brushing activities with fluoride application were carried out, although there are materials available in the municipality for carrying out ART.

In the municipality, urban population prevails, with 85,821 households, with 10,489 rural households. The Human Development Index in 2010 was 0.677, and the *per capita* income was R$ 553,99, higher than the state of Pernambuco (R$ 525.64) [28].

The health care network consists of 73 units of the federal Family Health Strategy program, with 55 units in the urban area and 18 in the rural area. In addition, it has 01 school unit, 04 health centers, 01 city gym, 02 health gym and 01 medical clinic, totaling 77 BHU (Basic Health Units), with 65 eqSB, all of type I. Primary Care cover in the city is 73.91% and oral health cover in primary care is 66.03% [29].

The intervention was proposed by two residents of the Department of Dentistry inserted in these FHU from June 2018 to July 2019, having been validated by eqSB dental preceptors of the aforementioned FHU and tutors indicated by RMSFC-UPE, who offered continued supervision during intervention. There was also collaboration of nutrition, social service, pharmacy and psychology residents in health education actions, as facilitators of conversation circles and in logistical support for care actions.

The intervention plan adopted theoretical-methodological and interventionist references based on health concepts, health care and surveillance models, in addition to participatory management adopted for SUS[18,30,31]; as well as on guidelines to carry out interprofessional work[32], on Popular Health Education[15] and on studies on technologies appropriate to the contexts and realities of the populations covered by FHS[20,33]. Thus, in the light of integrality, promotional, preventive and dental treatment actions were articulated and implemented with participatory and community practices.

The actions defined for the intervention include three moments: I) diagnosis of the reality with survey of dental needs; II) planning and carrying out collective actions to promote oral health using participatory methodologies of popular education and pedagogical strategies that included playfulness, games and dynamics[34]; III) care actions for the treatment of dental caries with ART technology, which were followed up on return visits to schoolchildren and at participants' households

Previously, visits were made to schools and households of families in the areas indicated by the FHU for intervention, in addition to articulation with CHAs in the assigned area. Subsequently, conversation circles were held with community members, directors and school teachers to share about the proposed actions, find out about their interest in participating, obtain suggestions and build a work agenda.

A total of 210 individuals participated in the intervention in both territories, 44 in the Xicuru territory and 166 in the Lagoa de Pedra territory. The age of participants ranged from 1 to 43 years and the mean age was 10.5 years. In Lagoa de Pedra, data from the clinical caries exam showed that 130 people had untreated caries. In Xicuru, 36 had untreated caries at the time of examination. Schoolchildren and residents with caries treatment needs who were indicated for ART were scheduled and treated. The others were referred to the FHU or to

specialized care, in order to have their caries treatment needs met.

Participants were professionals working at two FHUs, residents of the 2018-2020 class and users participating in the intervention and/or those responsible for underage participants. They were organized into three groups according to the following selection criteria: Group I – professionals from the two FHUs who were familiar with the intervention proposal, including preceptors, and who were working after residents entered the activities of these FHUs in March 2018; Group II – RMSFC-UPE residents who participated in the intervention with residents of the Department of Dentistry; Group III - users/community participants, beneficiaries of the intervention plan actions (promotional/preventive and ART) or those responsible for underage participants.

To approach groups, the researcher in charge individually invited participants of this research through the delivery of an Invitation Letter and the Free and Informed Consent Form (FICF), including the Informed Assent Term (IAT) for underage participants, and reading and clarification of doubts were carried out before signing and accepting to participate in the study.

After this stage, the three focus groups were formed and then meetings were scheduled from August to November 2019, with average duration of 90 minutes, according to recommendations of the technique[35,36]. Nine professionals participated in group 1 (02 nurses from the two reference FHUs, 01 doctor, 01 dentist from the eqSB and 05 community health agents from the two reference FHUs); in group 2, six residents participated (speech therapist, physiotherapist, pharmacist, sanitarian, psychologist and nutritionist); and in group 3, eight users participated (5 adult women and 3 adolescents over 18 years of age, who directly participated in the organization and care or who had a family member who received ART treatment during actions).

A moderator, represented by the researcher herself, conducted the group meetings and interviews were guided by a guide-script composed of open questions. Care was taken not to induce responses or interfere with speeches, encouraging the participation of all. A research assistant was responsible for recording from the beginning of each speech to help identify participants at the time of transcription of speeches. In this identification, the letter "P" was adopted to refer to professionals (P1, P2, P3...), "R" for residents (R1, R2, R3...) and "U" for users (U1, U2, U3...) as they are the initial letters of the word of each group of participants, preserving the identity of each one of them.

The formulation of questions considered aspects related to comprehensive oral health care, the incorporation of ART into the work process as a care technology appropriate for rural populations, the issue of access and accessibility to general and oral health services in the rural environment as a condition of citizenship for rural populations, in addition to participants' perceptions about the intervention carried out. Debates and reflections were conducted through a guiding question common to the three focus groups “What are the perceptions of the group about the comprehensive care actions in oral health with the incorporation of ART in community spaces of FHU territories carried out by dentistry residents?”

During interviews, questions were adjusted to the language of each group for better understanding. All material from speeches was transcribed, systematized and categorized to be submitted to the categorical thematic content analysis proposed by Bardin[37].

This technique proposes three steps to approximate results: pre-analysis, material

exploration and interpretation. In summary, several readings were initially carried out to identify the significant recording units in order to meet the research objectives. Subsequently, an in-depth analysis was carried out in which units were grouped by similarities and divergences, forming themes that led the inferences, thus establishing the thematic categories of the study, which were not pre-determined, but defined according to participants' speeches to be discussed with a theoretical and reflective basis.

The study was approved by the Research Ethics Committee of the University of Pernambuco, under CAAE: 24012619.1.0000.5207 and No. 3.748.534.

3 RESULTS AND DISCUSSION

The speeches of the collected material allowed systematizing the results of the study into categories according to themes that most appeared during the phases of exploration, interpretation and analytical deepening of the material. Two thematic categories emerged: i) difficulties in accessing oral health care and ii) satisfaction with innovative oral health care actions.

Difficulties in accessing oral health care

From the diagnosis of the socio-epidemiological conditions of populations covered by FHUs, the need to face difficulties of dental access was problematized by dentistry residents. From this perspective, the proposed care plan was conceived and implemented in the search to expand the right of access to oral health as a citizenship condition[3]. It is emphasized that the analysis of reports on “access and accessibility” to PHC strategies planned by FHUs should consider the determinants of socioeconomic order, as well as inflections of the chronic SUS underfunding, which has recently become worse with the advance of ultra-liberal policies imposed on the country. This fact has strong impact on the living conditions of the population, on SUS and on the fragile and precarious working health relationships[38–40].

In the group of users, the recurrence of arguments about difficulties in accessing FHUs related to structure, accessibility and differential access to oral health according to the area of origin was identified:

> *“...is the renovation of this health unit over yet? This renovation has been going on for 4 years, then they said that only electricity was required to turn it on [the dental office]... Only electricity to turn it on! [...] We used to go from five o'clock in the morning to queue for the dentist, when it was possible [...] Then, leaving here at five o'clock in the morning is dangerous and going to that health unit... and getting there too late to queue for the dentist because it is only useful for people who are already there. Those who live nearby go early. We cannot go early because we live far away” (U4).*

> *“Grandpa said he's been there for don't know how many years, just waiting for the unit to work...” “The dentist was great! The treatment of J. [U3’s son] I had started to do, then after she left... then the health unit underwent renovation and it is going on until today, right?” (U6).*

> *“The luck of us is that you are coming here, because if not... we just have to thank you, because if it were not for you, it was bad” (U3).*

Repeatedly, the literature addresses the socioeconomic and political determinations that impact the ability to provide oral health care to populations covered by the FHS[5,7,10]. The reports above show difficulties in the local health system to ensure structure and accessibility, with the availability of transport

to facilitate access for users from more distant areas to the oral health services of FHU. This fact is also experienced by residents, who move around the territories of these FHUs on their own to reach the most remote areas, which compromises continued care in the rural context.

The turnover of FHS professionals is another barrier, reported by participant "U6", which is a consequence of the growing instability of labor ties, explained, among other reasons, by the political dispute of health private sectors, determining the direction of the type of labor relationships observed in the public SUS network[40,41].

It should be highlighted that the precarious labor relationships observed in the public health care network constitute an obstacle to the SUS development, by compromising the relationship of workers with the health system and users, impairing the quality and continuity of the essential services [42,43]. In addition, the high turnover of committed and trained managers, for purely political reasons, hinders the continuity of good practices and the provision of better quality services by health professionals[44]

The group of professionals, on the other hand, focused their discussions around the actions that were carried out by residents, in order to make it possible for users from the most remote areas of FHU territories to have access to oral health care:

> *"It was very good [the oral health action] right? because of the difficulty of people in the rural area to have access to the unit. For example, the 'Sítio de Medeiros'... it's too far away! ... this made it a lot easier, especially for children with special needs [P8] ... so, it was very good. Everyone liked it a lot" (P4).*

> *"I also thought it was very important because, in addition to access being difficult, there are also many mothers who do not take their children, and you managed to reach them. Sometimes we advise, we send [forwarding them to the FHU], and they say: "I'm going", and they don't go. Then you two [residents] got together and got there... Then you went to them, these more difficult people" (P7).*

> *"Besides the issue of distance, what I saw positively was the way you improvised, in a certain sense, the issue of working in the most adverse conditions, without a dental chair, without certain equipment, but even so you managed to make the service possible" (P5).*

From these speeches, the recognition of the strategies adopted by residents to face the barriers of access are perceived, considering the decentralization of oral health care beyond the walls of the FHU and the use of care technologies appropriate to the context of life and culture of rural populations. This health action is in line with the discussions on the relevance of the community and family approach, providing professionals with a better knowledge of the relationships of users with the family and the community, in addition to allowing the deepening of links between professionals, families and the communities[41,45]. In this study, the discussions held in the focus groups on participants' impressions about the intervention generated reflections that identified the relevance of actions carried out in community spaces to promote oral health care to community groups with greater difficulties in accessing FHU, in addition to inquiries on the feasibility of these actions being permanently incorporated into the list of collective activities of eqSB.

Despite this recognition, critical reflections on health practices carried out by FHU teams were not identified, whose work

process in oral health has predominantly curative and health care characteristics, differing from what is required from FHS teams to develop health actions of individual and collective scope with the adoption of family and community approaches subsidized by context analyses carried out in a multiprofessional way[10,16]. At the same time, lack of knowledge and resistance of some professionals to the action of eqSBs outside the FHU involving the performance of dental treatments were revealed:

> *“I think it really only works if it's a separate service [...] only if it's done by other professionals, you know? Not the basic team... like, the dentist and her assistant... If there are other people who come to add, because we can’t handle everything” (P4).*

Furthermore, although P7 considered that the intervention was 'important', her opinion about the mothers' non-compliance with guidelines given denotes lack of knowledge about the possible reasons involved in this maternal behavior. This issue must be analyzed considering the professional, social, cultural and subjective determinants that may be interfering with the low use of health services by children from lower classes living in rural areas.

At the same time, difficulties related to interprofessional work were also observed among the interviewed professionals:

> *“I had never known this system [ART]. I didn't know that the dentist could attend at the patient’s household! I thought that there was only fluoride application... I didn't know that this whole process existed, of improvising as if it was really an office and doing it... I found it interesting” (P1).*

These identified professional difficulties are also evidenced by other studies[12,41]. In contrast, the experience of dentistry residents, based on the interpretation of objective reality, bet on the tensioning of what was instituted to carry out changes in the work processes of eqSB, in the establishment of practices coherent with the analyzed context in dialogic and participatory communication, in the Freirean perspective[46].

According to the residents' perception, oral health actions carried out were able not only to increase users' access to treatment through ART, but also to implement promotional and preventive actions planned from the perspective of integrality and interprofessional action:

> *“[The oral health action] has expanded multiprofessional access. When you did this process with physiotherapy, with speech therapy, which is very important for those who have some limitations... there was a child who needed surgery and you managed to do this multi work... I think it involved other professionals, the way you did, it also expanded this multi work service to the community” (R4).*

> *“So, it is in this perspective of democratization and expansion of access that the ART, in this innovative form, and so horizontal, managed to guarantee [access] in rural territories. These people not only have access, they have the right to participate, together with dentists, to define the day, the time, the best shift, the place... organize the space, right? So, people have the right to access, to participate and have the right to knowledge itself” (R5).*

> *“...It brings up the issue of health promotion, guidance and also considering the issue very focused on prevention, ART favors prevention, because [the dentist] goes there and performs the care...” (R6).*

From these reports, there is a direction

and intention towards a praxis of residents in favor of the most vulnerable social groups, which must be approached as subjects of rights, consistent with the theoretical-methodological assumptions proposed by RMSFC-UPE, adopted to guide the formative and interventionist process involved with the construction of humanized health care and education practices, which consider the sociocultural context and popular knowledge of CHAs in territories where residents operate[47].

Satisfaction with innovative oral health care actions

It is considered relevant to know the speeches of beneficiary subjects on the evaluation of user satisfaction and quality of care provided, which are important indicators to be incorporated into the planning of FHS teams, since in this context, community participation is recommended in all decision making instances; as well as in the construction of innovative, creative and appropriate practices to the local context to face health problems. Furthermore, from the implementation of the National Humanization Policy[18], the valorization of the participation of users, professionals and managers took on new contours with a view to the protagonist, shared and co-responsible inclusion of these actors and to improve the ways of acting of health services and their teams[48]. It was found, in general, that users were satisfied when their oral health demands were met:

> *"...It was good. Say U6 [U5's daughter], that you loved it, that your teeth are beautiful! If the girls didn't have it here, teeth would start to spoil..." (U5).*
>
> *"It is very much in the interest of people who work, like you... We see that you have the greatest pleasure of coming, of attending... The service is very good!" (U3).*

These reports highlighted aspects related to the humanization of health practices and the empathic attitude of professionals performing the action. Such attributes are pillars of PHC, which requires action to establish strong community links, which is committed to improving the health and living conditions of populations on the health responsibility of health teams[26,49].

Thus, these results suggest that the action proposed by residents was correct and coherent with the model of action focused on the territory and on the health needs of the population[50].

The satisfaction shown by users with the action taken was also identified among reports of the group of residents:

> *"In general, there is a report of people's satisfaction, right, and then it's the mother who is satisfied because they were able to provide care at her home because of such a demand or because she couldn't go to the unit, it's the child who insists on showing the restored tooth, opening his/her mouth and show it to us" (R5).*

On the other hand, although eqSB professionals did not develop collective activities with the same approach adopted by the intervention under analysis, there were positive reports that valued the work proposed by residents:

> *"In my area, I heard very good things about you [resident dentists] ... about the office at 'Sítio Medeiros' that you set up at the user's home [U3]" (P8).*
>
> *"I heard that user, who has a daughter with microcephaly, saying that she was seen at the support point... saying that she liked it" (P4).*

A similar study found that the impact of oral health actions on the community was perceived as not expressive by participating

dentists, who also observed higher prevalence of curative actions and other factors limiting the eqSB performance[27].

It should also be noted that the limit of action for meeting all dental treatment needs of users was also perceived, and the referral guidelines of users with dental treatment needs not resolved by the ART of FHU or others points of the municipal oral health care network were valued:

> *"... there are materials that you cannot bring [on home visits] to perform a filling... there is no equipment... not everything can be done outside the dental office. There are some teeth that are more damaged, right? Others are less, and restoration can last longer... Others need to be referred to extraction" (U5).*
>
> *"... I think the service here is very good, because, well, there are also referrals, you know?... The dentist refers to another professional you and you just have to go there..." (U3).*

However, due to weaknesses in communication and care regulation existing in rural areas of Caruaru, it was not always possible to monitor, through ViConSUS - Regulation application for consultations in secondary and tertiary care of the City Hall of Caruaru - the route of action users in the care network, with a view to guaranteeing access and obtaining dental treatment in specialized care. This issue must be analyzed in the light of factors that enhance or hinder the establishment of comprehensive care and the regulation of the local system of reference and counter-reference to guarantee the path of users in the care network, which must be carried out under the coordination of the FHU reference healthcare team[51].

For there to be assimilation of the principle of integrality in the relationship between professionals and users, health intervention beyond the disease is necessary, with apprehension of broader needs of subjects. It is necessary to overcome one more of the modalities of fragmentation in the health field: the "self-other split", that is, to overcome the "monopoly of the diagnosis of needs" and to integrate the "voice of the other" in this process[52]. These issues were pursued by the developed action.

As a probable limitation of the present study, the fact that it was conducted by resident professionals under local preceptorship is highlighted, which may have implications for results due to the influence of the FHS context on the development of experiences on the social researcher, as well as its personal life history, professional and cultural background. On the other hand, the methodological care adopted for conducting data collection and the contribution of the qualitative methodology in health research to qualify assessments subsidized by indicators and quantitative data are strengths.

Further studies are needed to deepen these discussions and provide more support for the planning of health work in rural areas, with a view to operating changes that result in the expansion of access with equity and in the qualification of comprehensive oral health care, which incorporates new care technologies. appropriate to the context of rural populations. Furthermore, transformation of management plans is necessary, and investments in effective and specific policies must be guaranteed, avoiding the transfer of management plans oriented to the reality of urban centers.

4 CONCLUSION

The participants of this study perceived the oral health care initiative proposed to face the difficulties of access to oral health actions by groups of rural users as innovative in order to have their health and guidance needs met.

However, the lack of interest in the continuity about the actions implemented was identified in the meanings attributed by professionals who bring perception supported by the understanding of actions in the FHS restricted and contrary to health practices based on community approach.

RESUMO

O olhar de usuários, residentes e trabalhadores sobre uma intervenção em saúde bucal de abordagem comunitária na ESF do campo

Objetivou-se analisar uma intervenção de cuidado integral em saúde bucal de abordagem comunitária protagonizada por residentes de Odontologia em Saúde da Família inseridos em duas unidades de saúde do campo de Caruaru/PE, segundo o olhar de profissionais, residentes e usuários. A intervenção englobou diagnóstico e levantamento das necessidades odontológicas, ações coletivas em saúde bucal e ações assistenciais para cárie com tratamento restaurador atraumático. Os grupos-alvo formam escolares e moradores de áreas mais remotas nas unidades de Lagoa de Pedra e de Xicuru. O estudo qualitativo utilizou técnica do grupo focal para coleta dos dados. Três grupos foram constituídos: nove profissionais, seis residentes e oito usuários. As entrevistas seguiram um roteiro com perguntas abertas sobre o cuidado e as tecnologias em saúde bucal empregadas no contexto das populações campesinas e acesso/acessibilidade às unidades de saúde. Os dados foram submetidos à análise de conteúdo. Emergiram duas categorias temáticas: dificuldades de acesso aos cuidados em saúde bucal e satisfação com as ações implementadas. Os participantes dos três grupos avaliaram positivamente a iniciativa de estabelecer relação educativa/assistencial participativa abrindo-se a espaços comunitários e valorizaram o enfoque adotado pela intervenção de saúde bucal no enfrentamento dos problemas limitadores do acesso aos serviços odontológicos e às ações coletivas que relataram. Contudo, desinteresse na continuidade das ações realizadas e contrários às práticas comunitárias em saúde bucal foram relatadas no grupo focal dos profissionais. Considera-se persistir fatores profissionais e de estrutura limitadores à garantia dos direitos de acesso à saúde aos usuários de áreas mais remotas às unidades de saúde.

Descritores: Saúde da População Rural. Saúde da Família. Saúde Bucal. Assistência Odontológica Integral.

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Correspondence to:
Márcia Maria Dantas Cabral de Melo
e-mail: marciamdcm@hotmail.com
Av. Prof. Artur de Sá, 329/481
Cidade Universitária
50670-420 Recife/PE Brazil