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# ANALYSIS OF HEALTH EDUCATION ACTIVITIES PERFORMED BY ORAL HEALTH TEAMS

## *Análise das atividades de educação em saúde realizadas pelas equipes de saúde bucal*

## *Análisis de las actividades de educación en salud realizadas por los equipos de salud bucal*

**Janice Dávila Rodrigues Mendes**
Public Health Consortium of Sobral Microregion (*Consórcio Público de Saúde da Microrregião de Sobral - CPSMS*) - Sobral (CE) - Brazil

**Cibelly Aliny Siqueira Lima Freitas**
Vale do Acaraú State University (*Universidade Estadual Vale do Acaraú - UVA*) - Sobral (CE) - Brazil

**Maria Socorro de Araújo Dias**
Vale do Acaraú State University (*Universidade Estadual Vale do Acaraú - UVA*) - Sobral (CE) - Brazil

**Mirna Marques Bezerra**
Federal University of Ceará (*Universidade Federal do Ceará - UFC*) - Sobral (CE) - Brazil

**José Jeová Mourão Netto**
North Regional Hospital (*Hospital Regional Norte - HRN*) - Sobral (CE) - Brazil

**Daniel Rodrigues Fernandes**
North Regional Hospital (*Hospital Regional Norte - HRN*) - Sobral (CE) - Brazil

**ABSTRACT**

***Objective*:** To analyze the health education activities carried out by the oral health teams comprised in the Family Health Strategy (FHS). **Methods***:* The research was classified as exploratory and descriptive, with a qualitative approach. Popular Education was adopted as the theoretical framework of Health Education. The study was performed at Family Health Centers, the Reference Center on Social Assistance (Centro de Referência em Assistência Social - CRAS) and schools in the municipality of Sobral, Ceará, Brazil, between November 2013 and January 2014. Seventeen professionals working in the oral health teams took part in the study. Data was collected through an interview with guiding questions and simple observation, and was processed through Discourse Analysis. **Results***:* The conception of Health Education mostly referred to by the professionals is related to the traditional model. The educational activities carried out are not systematized for the whole municipality and are subject to ministerial programs. The integration between the oral health teams and the family health teams, with regard to activities for schoolchildren, is a process still under construction, not yet consolidated in the FHS. **Conclusion:** The development of more intensive policies for the training of health professionals, which consider Popular Education and the use of active teaching methodologies as method in their formation, is necessary. This study may contribute to a reflection regarding the theme in practice, thus enabling the construction of a new approach to Health Education.

**Descriptors*:*** Health Education; Family Health Strategy; Oral Health; Health Education Dental.

***RESUMO***

**Objetivo***: Analisar as atividades de Educação em Saúde realizadas pelas equipes de saúde bucal que estão inseridas na Estratégia Saúde da Família (ESF).* **Métodos***: A pesquisa classificou-se em exploratória e descritiva, com abordagem qualitativa. O referencial teórico de Educação em Saúde utilizado foi a Educação Popular. O estudo foi realizado em Centros de Saúde da Família, Centro de Referência em Assistência Social (CRAS) e escolas no município de Sobral, Ceará, Brasil, entre os meses de novembro de 2013 e janeiro de 2014. Participaram do estudo 17 profissionais das equipes de saúde bucal. Os dados foram coletados por meio de entrevista contendo questões norteadoras e observação simples, sendo processados por meio da Análise do Discurso.* **Resultados:** *A concepção de Educação em Saúde referida majoritariamente pelos profissionais relaciona-se com o modelo tradicional. As atividades educativas realizadas não são sistematizadas para todo o município e estão condicionadas a programas ministeriais. A integração entre as equipes de saúde bucal e as equipes de saúde da família, no que diz respeito às atividades para escolares, é um processo ainda em construção, não estando consolidado na ESF.* **Conclusão***: É necessário o desenvolvimento de políticas mais intensivas de formação de profissionais de saúde, que considerem a Educação Popular e o uso de metodologias ativas de ensino como método nas suas formações. Este estudo poderá contribuir para uma reflexão a respeito do tema na prática, podendo, assim, possibilitar a construção de um novo olhar sobre a Educação em Saúde.*

**Descritores:** *Educação em Saúde; Estratégia Saúde da Família; Saúde Bucal; Educação em Saúde Bucal.*



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***RESUMEN***

***Objetivo****: Analizar las actividades de educación en salud realizadas por los equipos de salud bucal inseridas en la Estrategia Salud de la Familia (ESF).* ***Métodos****: Se clasificó la investigación en exploratoria y descriptiva de abordaje cualitativo. El referencial teórico de educación en salud utilizado fue lo de Educación Popular. El estudio fue realizado en Centros de Salud de la Familia, Centro de Referencia en Asistencia Social (CRAS) y escuelas del municipio de Sobral, Ceará, Brasil entre los meses de noviembre de 2013 y enero de 2014. Participaron del estudio 17 profesionales del Equipo de Salud Bucal. Se recogieron los datos a través de entrevista con preguntas norteadoras y observación simples siendo procesados a través del Análisis del Discurso.* ***Resultados:*** *La concepción de Educación en Salud relatada por la mayoría de los profesionales se relaciona con el Modelo Tradicional de Educación en Salud. Las actividades educativas realizadas no son sistematizadas para todo el municipio y dependen de los programas ministeriales. Respecto las actividades para los escolares, la integración entre el Equipo de Salud Bucal y el Equipo de Salud de la Familia es un proceso todavía en construcción y no está consolidada en la ESF.* ***Conclusión****: Es necesario el desarrollo de políticas de formación de profesionales sanitarios más intensas que consideren la educación popular y el uso de las metodologías activas de enseñanza como método en sus formaciones. Ese estudio podrá contribuir para una reflexión sobre el tema en la práctica y así posibilitar la construcción de una nueva mirada sobre la Educación en Salud.*

***Descriptores:*** *Educación en Salud; Estrategia de Salud Familiar; Salud Bucal; Educación en Salud Dental.*

## INTRODUCTION

Oral health care is comprised in the actions advocated by international institutions of the Health for All goal, which was created in 1977 and confirmed in 1978 in the Alma Ata International Declaration on Health Care. This goal has been successively updated, culminating recently in the Millennium Development Goals, established in 2000. However, the World Health Organization (WHO) published a wordwide review on oral health emphasizing that, despite great improvements in the oral health of populations in several countries, persistent problems are still serious, particularly in low-income groups, whether in developing and developed countries[1].

With regarding to the social organization of oral health care, specifically in the European continent, in countries such as Germany, dental care is part of the catalogue of social health insurance services. Nonetheless, this is the care sector with incidence of the highest copayment fees. Accredited dentists provide care to policyholders in their private offices. Private schemes predominate, with payments made by users by means of direct disbursement or copayment schemes for some procedures covered by the Sickness Fund. Copayment waivers have a long tradition in German social health insurance and are awarded to specific population groups, such as low-income or unemployed people, people with special needs, children and adolescents up to the age of 18, and pregnant women[3].

In Oceania, Australia adopts a health system whose fundamental principle is the universal access for the majority of the population, regardless of ability to pay. However, dental services in general are not covered by the public sector, except for children and low-income people. The dramatic improvement in oral health in this country, with the decrease in the index that stands for permanent decayed, missing and filled teeths (CPO-D), has been attributed to the addition of fluoride to water supplies and to other education and health promotion programs[3].

In the Americas, Cuba is a country with a completely state-owned health system, where health is everyone's right and the State's duty. In the 1980s, with the introduction of the primary care model, based on family medicine, the family dentists became linked to this care team. The actions are centered on health promotion and prevention of oral diseases, aiming to form healthy habits and lifestyles. In the United States of America, the model for provision of dental services is essentially based on the individual private practice, and the professional receives their fees directly from the patient. A wide variety of pre- and post-payment forms proliferate in the country, and the participation of the public sector remains restricted[2].

Considering that oral health is a vital component of health, which contributes to the well-being and quality of life, and can have strong biological, psychological and social projections[4], there has been a reorganization of the oral health actions in Brazil, so that the oral health teams (OHTs) have come to integrate the Family Health Strategy (FHS) from the 2000s, with the objective of improving health care and expanding the access to oral health actions, endorsing comprehensive attention to individuals and families. It was regulated through Ordinance no. 1444, of December 2000[2].

In 2003, a National Oral Health Policy was conceived, called Brasil Sorridente, with the purpose of establishing the Brazilian citizens' right to oral health care. It encompasses individual and collective actions for health promotion, disease prevention, diagnosis, treatment and rehabilitation. Actions for health promotion and protection aim to minimize risk factors that threaten people's health and might lead to disabilities and diseases. They involve preventive-curative actions, water fluoridation, Health Education, supervised oral hygiene, and topical application of fluoride[5].

Health Education encompasses actions that focus on knowledge of the health-disease process, covering risk factors and factors related to oral health protection, thus allowing the population to change habits and achieve autonomy. The health team should stimulate self-care practices on the part of patients, families and communities[5].

However, Health Education actions require an expanded understanding of health care, requiring the user's participation in the mobilization, training and development of individual and social learning skills to deal with the health-disease processes[6].

Studies show that, with regard to oral health, the role of the individual is decisive, and they are able to face the various conditions that can affect his health only as far as they hold a health culture that allows them to practice self-care and self-accountability[7].

Therefore, the educational activities should consider the influence of social, economic, political and cultural determinants on the living and health conditions of the population. Despite this, studies show that health promotion actions are still used through traditional paradigms of educational-preventive interventions in the school environment, with focus on supervised oral hygiene, lectures and fluoride applications[8].

In addition to this issue, Oral Health Education has been poorly described in studies with an isolated approach, having as the most evaluated practices the fluoride in dentifrices and mouthwashes, as well as occlusal sealants. The preventive studies are also focused on specific groups, especially schoolchildren. The regularity and frequency of the preventive procedure, as well as actions aimed at several oral conditions and other age groups, still constitute scarce information[9].

Given that, the work of one of the authors of this study as a FHS surgeon-dentist for almost 10 years, experience as a resident in the Multi-professional Family Health Residency (RMSF) program, run by the Visconde de Saboia Family Health Training School (*Escola de Formação em Saúde da Família Visconde de Saboia - EFSFVS*), and her performance as a preceptor in the city of Sobral, have aroused interest in practices of promotion and prevention in dentistry, mainly in the area of Health Education, either because of the lack of studies addressing these practices, or lack of proper records of these actions, which hinder their longitudinal monitoring and cannot manage to evaluate the actual impact on the oral health of the population.

In an attempt to overcome the paradigm traditionally adopted, which is based on the technical and biomedical model, historically determined in the training of the majority of health professionals, the Popular Education in Health strategy[10] can contribute to health promotion and to the qualification of Health Education, strengthening emancipatory bonds so that the individual manages to achieve autonomy in self-care. With a view to strengthen the change in the disease-centered model of attention, the integration between Primary Health Care services and popular practices of care is relevant, since these provide a vision of the world and health that approaches the principles that need to be reinforced, such as integrality, humanization and embracement[11].

Popular Education in Health[10] aims, through the acquisition of knowledge, a way to overcome the conflicting vertical relations and mechanistic models of appreciation of the social reality and implementation of new proposals recommending the need for change. Therefore, once health promotion encompasses the pillars of the FHS, recognizing the way it is being worked within the scope of the oral health teams (OHTs) can facilitate the identification of fragilities and potentialities, and help in the improvement of the care provided.

Thus, the present study was aimed at analyzing the Health Education activities carried out by the oral health teams comprised in the Family Health Strategy (FHS).

## METHODS

Based on its objectives, this research was classified as exploratory and descriptive, with a qualitative approach. The study scenario was settled in Sobral (Ceará), Brazil, which integrates a hierarchical and regionalized healthcare network of the Unified Health System (*Sistema Único de Saúde - SUS*), with an installed capacity to perform services at different levels of complexity, which makes this municipality the host city for Sobral microregion and the pole of the macroregion North of Ceará[13]. There are currently 57 FHS units with 39 OHTs, composed of 39 dental surgeons (DSs) and 39 dental assistants (DAs) [13].

The municipality of Sobral was one of the first to implement the OHT in the FHS, in 1998, giving continuity to Dental Actions Restructuring Project, presented in 1997 by the Secretariat of Social Development and Health. That was a first step in obtaining a situational diagnosis, pointing out needs and propositions in the area of oral health[14].

The Sobral School Health System, through the EFSFVS, contributes to the construction of new technologies in primary care and to the systematization of practices of several professional categories, providing greater problem-solving ability at the primary care level and, consequently, favoring the population's well-being. Nonetheless, Sobral has a twelve-year history of investing in this type of education within the service[15]. Many dental surgeons in the municipality have attended the RMSF program, therefore, there is a remarkable evolution of the oral health service, and many successful experiences have already occurred throughout this period, as described in experiences systematized by former students of the RMSF program[16,17].

The study settings consisted of family health basic units (FHBUs) that have OHTs registered, in addition to other sites where the participants perform Health Education activities, such as the Reference Center on Social Assistance (*Centro de Referência em Assistência Social - CRAS*) and schools. The period of data collection lasted from November 2013 to January 2014.

The research universe consisted of DSs and DAs, which were part of the family health teams in the municipality of Sobral. The inclusion criteria for DS participation in the research were: have been working in the municipality's FHS for more than

one year, restricted to only one representative from each FHBU, work settled at the municipality's headquarters or in the three districts located closer to the headquarters, and with greater number of inhabitants. For DAs, in addition to the same criteria mentioned for the DSs, the inclusion criteria consisted of: having completed, or being then attending the DA course, and being the assistant of a DS participating in the research. According to these criteria, 9 DSs and 9 DAs should participate but, since one of the DAs was on vacation during the data collection period, 9 DSs and 8 DAs were assessed, making up the sample of 17 participants.

All study participants were previously contacted by the researchers, who put over the objectives and the importance of the research. After the invitation, for acceptance by the parties, the date and time for data collection were agreed with all the representatives of the sample. To conduct the collection, interviews with the following guiding questions were used: what is your perception of Health Education? And how are the health education activities planned? The instruments used in the simple observation technique were a field diary and a checklist, which helped to produce a thorough report of the observations concerning the educational activities.

The theoretical framework adopted was Paulo Freire's Popular Education[10], a strategy that should be used to train professionals committed to social issues, by changing behaviors and promoting the claim for rights and commitments, with welcoming attitudes for development of autonomy of individuals and social groups[11].

The author[10] left as a legacy important reflections on marginalized subjects, making clear the importance of constructing an education with the people and based on the people's knowledge, considering the reading of reality from the oppressed subject's view, which is formed within the historical and social relations. In this sense, the oppressed must reflect and come out of the condition of being exploited, starting from the stimulation of awareness on being the oppressed class.

In this way, in the Popular Education method, the teaching contents are denominated "generating themes", being extracted from the problematization of the educatees' life practice. The traditional contents are rejected, because each person, each group involved in the pedagogical action has in itself, even in a rudimentary way, the necessary contents from which one sets forth. The important thing is not the transmission of specific contents, but rather the awakening of a new form of relating to the lived experience. The transmission of structured contents from the outside is considered "cultural invasion" or "deposition of information", because it does not emerge from the popular knowledge[18].

The interviews were carried out at the FHBUs, according to prior scheduling, inside the dental offices, as a way of guaranteeing non-disclosure and confidentiality on the part of the professionals, and according to each one's availability. The interviews had their duration set apart according to the participants' needs, being recorded and subsequently transcribed. The interviewed professionals were identified in their statements by means of the initial letters of their profession followed by numbers (DS1, DS2, DA1, DA2), as a way to guarantee their anonymity.

The phase of simple observations occurred during the interviews with the oral health professionals, totaling five observations of educational activities developed in several spaces: at municipal schools, which had children in the age group of 4 to 7 years as target audience; at the FHBUs, with pregnant women and adults as audience; and at the Reference Center on Social Assistance (CRAS), with pre-adolescents and adolescents aged 8 to 12 years. Two observations of the Health Education practices were made at schools, two at FHBUs and one at the CRAS.

In the checklist used, it was observed whether the participants used dialogic and participatory approaches, whether they encouraged the population to reflect critically on reality, and whether there was a shared construction of knowledge, allowing the interface with popular and scientific culture, according to the theoretical framework adopted[10].

The data was organized through the categorization process, using the Discourse Analysis method[19], from which two categories emerged: the first one, the theoretical framework of Health Education present in the oral health professionals' perception, with its subcategories: traditional model of Health Education and educational practices that resemble the Popular Education; and the second category, Health Education, with focus on the activities of the oral health team. These categories served to guide the analysis, having been defined after the pre-reading of the interviews and following the guidance by the Discourse Analysis reference author.

The research was developed according to Resolution no. 466/12 of the National Health Council[20], complying with its ethical aspects, and after approval by the Local Research Ethics Committee of Vale do Acaraú State University (UVA), under opinion number 470,588. All participants completed the Free and Informed Consent Form prior to the conduction of this research.

## RESULTS AND DISCUSSION

The thematic categories and their respective subcategories, which have emerged from the study, are presented in this section.

**Theoretical framework of Health Education present in the oral health professionals' perception**

**Traditional model of Health Education**

This subcategory, according to the professionals' statements, points out that the predominant conception of Health Education in the interviews refers to the traditional model of Health Education or banking education[10], in which the professional transmits the content, seen as the truth to be absorbed; the user becomes a depository of information, and a number of recommendations on "right" and "wrong" behaviors are given, as well as oral hygiene instructions, thus characterizing a vertical transmission of knowledge, reflecting the authoritarianism between educator and educatee[21], as can be seen from the following speeches:

> *"For me, Education means trying to make people aware. If the person is conscious, the treatment is much easier [...] As for me, I would brush everyone's teeth, kind of, would mahe them aware, open everybody's mind and put this [...]". (DS 5)*
>
> *"Health education, for me, is to try to pass a little piece on, isn't it, for people, about how they get prevention in relation to health. To pass a little piece of the basics [...], to transmit a little piece of what I know to those people, so that they can get prevention [...]". (DS 4)*
>
> *"It means passing on a little piece of what we know to someone that does not know of it [...] So, I am promoting health, isn't it so? I think that this is a way of educating the patient towards their oral health." (DA 4)*

Educational activities carried out by other health professionals, such as community health workers (CHWs), are also performed according to this vertical model of information transmission[22].

Other studies have also found the traditional education, in which nurses demonstrate some features of the hegemonic pattern, regulated by the prescriptive health model, with a focus on disease control and intervention and influence on people's behavior[23].

Thus, since the 1970s, Health Education has been strongly thought over, and a certain distance from the imposed actions, attributes of the hygienist discourse, has been observed. An increase is evidenced in the knowledge of the health-disease process, which, starting from the restricted conception of biologicism, begins to be seen as a consequence of the causal interrelationship between social, economic and cultural factors. At this moment, the persuasive pedagogical practices and the vertical transmission of knowledge, allowing the educator's authoritarianism towards the educatee and the denial of subjectivity in the educational processes, are subject to questioning. Then, in this context, the concern for the development of autonomy arises, causing the social subjects to awake in search of their interests[24].

Therefore, the educational interventions should not be targeted only at the individuals, but should rather verify factors that interfere with health behavior and interpersonal relationships, the organizational and environmental factors[25]. The effective awareness of a change in health behavior is very complex and encompasses several actions and adjustments over time[25].

During the simple observations, it is evidenced that the main theme of all the activities refers to oral hygiene instruction, characterizing a mere transfer of information to the population. Therefore, there is no stimulus for construction of the subjects' autonomy, nor is there support for co-responsibility of those subjects. Research has shown that educational interventions based on traditional methods, such as the simple transmission of knowledge without addressing the social determinants of behavior and the health-disease process, are relevant, but a few of them lead to behavioral changes[25].

It was also observed that the methods and instructions taught are not appropriate to the reality of each group, being the same for the entire target audience. The population that takes part in the educational approaches is capable of intervening in the learning process, and should be considered influential and holder of its own attributes. Thus, teaching methodologies must be adapted to each reality[26].

In this sense, the banking vision of teaching hinders one's own thinking. Educating is not the same as training, instead it means learning as a critical, epistemologically curious subject, who builds knowledge or participates in its construction. It is necessary not to use the banking transfer of knowledge and, instead, to be aware that the learner has experiences that must be considered[10].

The professional training process for working with family health, by means of several undergraduate or continuing education programs, still have ascendancy of the Flexnerian teaching paradigm, incompatible with the purpose of Health Education in the context of the FHS[27].

Educational approaches with the use of peer groups trained by the team can often stimulate the improvement of the oral health behavior, with better results than demonstrations run by professionals[28].

**Educational practices that resemble the Popular Education**

In this subcategory, the study participants expressed an understanding of Health Education in a more comprehensive way, resembling the Popular Education strategy:

> *"My perception of Health Education is not just like passing information on, but rather being attentive to exchanging ideas, exchanging information between us and the community." (DS1)*

> *"I think it's time for you to be sharing something with someone who, in our work, would be our community, our schoolchildren, our groups. Thus, you are sharing what you have with other people, and it is not enough for you to be just passing it on to the person, because, from that moment on, that's when you also gain knowledge [...]." (DS 7)*

A survey held in the city of Sobral, Ceará, Brazil, evidenced that dialogic educational practices were found in the approaches performed by nurses, despite being of limited significance. It also proved that certain professionals, when addressing the guidelines, were based on the users' needs and reality, avoiding a vertical conduct[29].

In a study carried out with professionals of the family health teams acting in the municipality of Santa Marina, Paraná, Brazil, aiming to analyze their perceptions of Health Education, it was found that some of those participants adopt an educational approach based on reflection, dialogue and problematization[30].

Health education should be approached aiming at the habitual problematization, considering the participants' experience, as individuals, in social groups and in the contextualisation of the different realities. As a social practice, Health Education has come to be seen as a strategy that leads people to the reflection and critical awareness about the origins of their health problems, emphasizing the educational process based on dialogue, so that work is conducted with the people, and not for people as before[31].

It was also noticed, from the participants' speeches, that the implementation of Health Education activities is a challenging process for the teams, as can be verified through this statement:

> *"I am completely in favor of Health Education. I like what I do. I am discouraged, I recognize that, but I love my profession and I also love public health, despite this being a very difficult area, which you have to love fivefold as much to get your work done." (DS 5)*

During the Health Education activities carried out by these professionals, a combination of the two educational models was observed: the traditional model and the one based on Popular Education, in an attempt to overcome the former, since it was still strongly embedded in their professional practices.

As a way of defeating the decontextualization of pedagogical practices, the educatees must have space to learn about Health Education in a dialogical and critical way, according to the especifications for formation of the professional profile, essential for the care practices in force in the FHS. Moreover, the pedagogical strategies based on transdisciplinarity and multiprofessional work promote the production of novel knowledge, considering the social context of the promotion-health-disease-care complex[32].

The National Policy on Continuing Health Education (*Política Nacional de Educação Permanente em Saúde - PNEPS*) establishes that the formation and qualification of health professionals, in response to SUS demands, should occur in a decentralized, upward and transdisciplinary way, comprising all places and knowledge, giving access to the democratization of the workplaces[33].

In this sense, it is important to emphasize that such reflections should not be restricted to the academic environment. Health professionals need to be prepared to overcome their limitations and to improve and upgrade their skills through lifelong education, which suggests a new way for health professionals to produce knowledge and consider education and work[34].

**Health Education: focus on the activities of the oral health team**

In this category, OHT professionals, when asked about the planning of Health Education activities, reported that student-centered activities are planned with necessary adjustments; and are also comprised in the activities of the School Health Program (SHP). This program provides the strengthening of actions envisioning the integral development. It also gives the school community the opportunity to participate in projects that articulate health and education[34].

> *"The schoolchildren, we always plan at the beginning of the semester to convey the guidelines, delivery of toothbrushes and toothpastes, then, according to the programs, for example the SHP [...]. It is semiannual and, after that, it goes according to the SHP." (DS 1)*

Regarding the frequency of these activities for schoolchildren, they are done systematically, aiming at the SHP goal, that is, a certain number of oral exams and educational activities must be performed in each school:

> *"In schools, there was a period when we would go there up to three times a week, aiming to conclude the SHP, but after it was finished, then it's done, it's once a month [...] Now, in November, we didn't do it". (DA 7)*

However, it was verified from the speeches that the activities are carried out according to the planning made by each team. There is not a planning for the municipality, so that each team performs it in the way it considers most appropriate, being conditioned to the SHP goals and occurring with greater intensity during the months of this program. Thus, these are not routine practices, but should be comprised in the work process of the OHTs on a daily basis.

In the interviewees' discourse, it is emphasized that the obstacles faced by the family health team in carrying out the routine practices of educational activities are great, since their work is mainly performed in groups with pregnant women, hypertensive or diabetic individuals, being the Health Education activities conducted according to the ongoing program or epidemic[11].

As for the planning of activities for schoolchildren, most stated that it is operated only within the OHT:

> *"Not the activities for schoolchildren, this duty (the planning) is ours only. We get in touch with the management just to inform the days on which we are going to the schools." (DS 4)*

The difficulty in performing integrated actions involving the FHS and the OHT often occurs because of problems related to scheduling separately, OHT's inexperience in dealing with the way the FHS works, or even lack of agreement between both, as emphasized in the following statement:

> *"The greatest difficulty in the operation of these educational activities is the lack of support on the part of the team (family health). Here it's "each one to his own field", no one in unit helps. I feel like doing more activities, planning together, but we do not have support, we are always left aside." (DA 2)*

In a research aimed at the analysis of oral health care in the FHS of the VI Health District in Recife, Pernambuco, Brazil, the interviewed professionals answered that some educational activities involving the OHT and the FHS are punctual, such as those with pregnant women, hypertensive and diabetic individuals, otherwise being totally unrelated, as a general rule[35]. Other authors have also emphasized that integrating the OHT with the family health team to accomplish a work together has been one of the major challenges for the oral health within the FHS[36].

In addition to that, the teams have little training in the context of oral health problems[37], a matter of concern, since oral health is part of integral care for the users. Moreover, the pedagogical projects should increasingly reinforce the integration among teams, aiming at service excellence[38].

With regard to the evaluation of educational actions, more relevant than the development of collective actions on prevention and Oral Health Education, it is their execution with periodic evaluations, in order to verify their effectiveness, rather than instituting a "preventive package", which has been implemented without critical evaluation by most OHTs[36].

From the speeches, it is concluded that the evaluation was not mentioned as one of the stages in the process of developing educational activities; thus, these activities are planned and executed in a similar way to the methodology of the traditional model of Health Education, in which the evaluations are not recognized as a surveillance and monitoring instrument for the improvement of the performance of actions.

In view of the scenario described so far, the need for further research on Oral Health Education is evident, since the literature points out the existence of gaps in relation to the theme. It is noteworthy the need for more studies on the subject that could deepen and support the discussion and analysis of the results, as well as contribute to the consolidation of the oral health promotion in the FHS.

## FINAL CONSIDERATIONS

The theoretical framework of Health Education perceived by the professionals participating in this research is related to the traditional model of Health Education, aiming mainly at individual behavior changes, which methodologically guides their practices. Conversely, however, there is also a perception of Health Education that is closer to the dialogic or Popular Education model, involving dialogue, exchange of experiences and "learning/being with the other". It was observed that applying the principles of Popular Education in Health can represent a great challenge for the OHT, since professionals may not have knowledge of this model and might not have experienced educational moments based on this methodology.

Regarding the planning and development process, the activities targeting schoolchildren are planned only within the OHT. There is no systematization for the whole municipality, and they are conditioned and guided by a program of the Ministry of Health, in partnership with the Ministry of Education, the School Health Program. It is observed that the integration between the OHT and the family health team, regarding the activities directed at schoolchildren, is a process still under construction, not consolidated yet in the FHS.

The historical process of insertion of oral health into the FHT, the academic training of the professionals, the ministerial programs, with their protocols and goals, the structural aspects and the conceptions of Health Education converge towards the organization of a work process that privileges the traditional model of education, which renders it still hegemonic in the current practices.

For the construction of a new perspective on Health Education, it is necessary to develop more intensive policies for the training of health professionals, starting from the undergraduate level, as well as at the technical level, considering the Popular Education and the use of other active teaching methodologies as a method in their qualification. In order to enable the use of Popular Education by the OHT for the encouragement of the population's empowerment, its autonomy to make decisions regarding its life and health, it is important to use it as guidance in the workers' continuing education.

## REFERENCES


1. Petersen PE, Bourgeois D, Ogawa H, Estupinan-Day S, Ndiaye C. The global burden of oral diseases and risks to oral health. Bull World Health Organ. 2005;83(9):661-9.
2. Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI. Políticas e Sistema de Saúde no Brasil. 2ª ed. Rio de Janeiro: Fiocruz; 2012.
3. Malmö University. Oral Health Country / Area Profile Project [Internet]. Malmö; 2011 [accessed on 2016 May 22]. Available from: http://www.mah.se/CAPP/
4. Relwani AH, Kiran S, Bhatt R, Patel M. Impact of dental health education on "Specific Learning Needs" Children. Int J Clin Pediatr Dent [Internet]. 2016 [accessed on 2016 May 27];9(1):31-4. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4890059/
5. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Coordenação Nacional de Saúde Bucal. Diretrizes da Política Nacional de Saúde Bucal. Brasília: Ministério da Saúde; 2004.
6. Machado MFAS, Vieira NFC. Educação em Saúde: O olhar da Equipe de Saúde da Família e a participação do usuário. Rev Latinoam Enferm. 2009;17(2):174-9.
7. Angulo EL, Cabrera LG, Fernández CG, Gross SC, Lugo FS. La cultura en salud bucal como problema actual de la sociedade. MEDISAN. 2013;17(4):677-85.
8. Matos CV, Gondinho BVC, Ferreira DLA. A Educação em Saúde Bucal e suas representações na Atenção Primária á Saúde. Rev Elet Gestão & Saúde [Internet]. 2015 [accessed on 2016 May 27];6 (1):845-55. Available from: http://gestaoesaude.unb.br/index.php/gestaoesaude/article/view/1246
9. Almeida GCM, Ferreira MAF. Saúde Bucal no contexto do Programa Saúde da Família: práticas de prevenção orientadas ao individual e ao coletivo. Cad Saúde Publica. 2008;24(9):2131-40.
10. Freire P. Pedagogia do oprimido. Rio de Janeiro: Paz e Terra; 1987.
11. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa. Caderno de Educação Popular em Saúde. Brasília: Ministério da Saúde; 2014.
12. Governo do Estado do Ceará, Secretaria da Saúde. Coordenadorias Regionais de Saúde [Internet]. Fortaleza; 2010 [accessed on 2016 June 02]. Available from: http://www.saude.ce.gov.br/index.php/regionalizacao
13. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, DATASUS- Departamento de Informática do SUS. CNES Net-Cadastro Nacional de Estabelecimentos de Saúde. 2013 [accessed on 2013 Aug 03]. Available from: http://cnes2.datasus.gov.br/Lista_Es_Nome.asp?VTipo=0
14. Mendes FIR, Viana RS. A Percepção dos gerentes das unidades básicas de saúde sobre a inserção da equipe de saúde bucal na Estratégia de Saúde da Família em Sobral-CE. Sanare (Sobral). 2005;6(1):19-28.
15. Melo CNM, Chagas MIO, Feijão JRP, Dias MSA. Programa de Residência Multiprofissional em Saúde da Família de Sobral: uma avaliação de egressos a partir da inserção no mercado de trabalho. Sanare (Sobral). 2012;11(1):18-25.
16. Paresque MAC, Aragão DS, Fernandes MBL, Santos MLMF, Mendes JDR, Pereira PM. A atenção em saúde bucal e a operacionalização das suas práticas na Estratégia em Saúde da Família a partir da Residência Multiprofissional no município de Sobral- CE. Sanare (Sobral). 2009;8(2):73-82.
17. Paresque MAC, Taboza Z, Dias C, Francelino R. Ressignificando as práticas na atenção em saúde bucal aos escolares. Sanare (Sobral). 2011;10(1):49-53.
18. Luckesi CC. Filosofia da Educação. 3ª ed. São Paulo: Cortez; 2011.
19. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13ª ed. São Paulo: Hucitec; 2013.
20. Ministério da Saúde (BR), Conselho Nacional de Saúde, Comissão Nacional de Ética em Pesquisa. Normas regulamentadoras de pesquisa envolvendo seres humanos**.** Resolução nº 196/96- versão 2012. Brasília: Ministério da Saúde; 2012.
21. Cervera DPP, Parreira BDM, Goulart BF. Educação em saúde: percepção dos enfermeiros da atenção básica em Uberaba (MG). Ciênc Saúde Coletiva. 2011;16(Supl 1):1547-54.
22. Mialhe FL, Lefèvre F, Lefèvre AMC. O agente comunitário de saúde e suas práticas educativas em saúde bucal: uma avaliação qualiquantitativa. Ciênc Saúde Coletiva. 2011;16(11):4425-32.

23. Figueira MCS, Leite TMC, Silva EM. Educação em saúde no trabalho de enfermeiras em Santarém do Pará, Brasil. Rev Bras Enferm. 2012;65(3):414-9.

24. Vernon LT, Howard AR. Advancing Health Promotion in Dentistry: Articulating an Integrative Approach to Coaching Oral Health Behavior Change in the Dental Setting. Curr Oral Health Rep [Internet]. 2015 [accessed on 2016 June 02];2(3):111-2. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4596064/

25. Lemkuhl I, Souza MVC, Cascaes AM, Bastos JL. A efetividade das intervenções educativas em saúde bucal: revisão de literatura. Cad Saúde Colet (Rio J). 2015;23(3):336-46.

26. Inocente-Díaz ME, Pachas-Barrionuevo F. Educación para la Salud em Odontología. Rev Estomatol Hered. 2012;22(4):232-41.

27. Mendes EV. O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família. Brasília: Organização Pan-Americana da Saúde; 2012.

28. Vangipuram S, Jha A, Raju R, Bashyam M. Effectiveness of peer group and conventional method (dentist) of oral health education programme among 12-15 year old school children - a randomized controlled trial. J Clin Diagn Res [Internet]. 2016 [accessed on 2016 June 02];10 (5):152-9. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4948521/

29. Silva CP, Dias MAS, Rodrigues AB. Práxis educativa em saúde dos enfermeiros da Estratégia Saúde da Família. Ciênc Saúde Coletiva. 2009;14(Supl 1):1453-62.

30. Pinafo E, Nunes EFPA, González AD, Garanhani ML. Relações entre concepções e práticas de educação em saúde na visão de uma equipe de saúde da família. Trab Educ Saúde. 2011;9(2):201-21.

31. Alves GG, Aerts D. As práticas educativas em saúde e a Estratégia Saúde da Família. Ciênc Saúde Coletiva. 2011;16(1):319-25.

32. Mialhe FL, Silva CMC. A educação em saúde e suas representações entre alunos de um curso de odontologia. Ciênc Saúde Coletiva. 2011;16 (Supl 1):1555-61.

33. Ministério da Saúde (BR), Ministério da Educação. Passo a Passo- PSE- Programa Saúde na Escola: tecendo caminhos da intersetorialidade. Brasília: Ministério da Saúde; 2011.

34. Silva CT, Terra MG, Kruse MHL, Camponogara S, Xavier MS. Residência Multiprofissional como espaço intercessor para a Educação Permanente em Saúde. Texto & Contexto Enferm. 2016;25(1):1-9.

35. Pimentel FC, Martelli PJL, Araújo JLAC Júnior, Acioli RML, Macedo CLSV. Análise da atenção à saúde bucal na Estratégia de Saúde da Família do Distrito Sanitário VI, Recife (PE). Ciênc Saúde Coletiva. 2010;15(4):2189-96.

36. Souza TMS, Roncalli AG. Saúde bucal no Programa Saúde da Família: uma avaliação do modelo assistencial. Cad Saúde Publica. 2007;23(11):2727-39.

37. Cohen LA. Expanding the physician's role in addressing the oral health of adults. Am J Public Health. 2013;103(3):408-12.

38. Park SE, Donoff RB, Saldana F. The impact of integrating oral health education into a medical curriculum. Med Princ Pract [Internet]. 2017 [accessed on 2016 Aug 03];26:61-5. Available from: https://www.karger.com/Article/FullText/452275#

**Mailing address:**
Janice Dávila Rodrigues Mendes
Consórcio Público de Saúde da Microrregião de Sobral - CPSMS
Rua Padre Antônio Ibiapina, 170
Bairro: Centro
CEP: 62010-750 - Sobral - CE - Brasil
E-mail: janicedavila34@gmail.com