

# The work in oral health in the Family Health Strategy: is it a tough integration?

## *O trabalho em saúde bucal na Estratégia Saúde da Família: uma difícil integração?*

Charleni Inês Scherer<sup>1</sup>, Magda Duarte dos Anjos Scherer<sup>2</sup>, Sônia Cristina Lima Chaves<sup>3</sup>, Erica Lima Costa de Menezes<sup>4</sup>

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**ABSTRACT** This study analyzed the integration of the Oral Health team (eSB) to the Family Health Team (FHT) in the Federal District. It is a qualitative study where nineteen interviews, work observation and documentary analysis were conducted, and the collection and analysis, in triangulation, were based on analytical categories formulated from public policies that guide the work in oral health: teamwork, educational and intersectoral actions, bonding and reception, access and coordination of care, planning and continuing education, participation and social control, qualification of care and working conditions. The results have evidenced the integration of oral health professionals in inter-consultation, team meetings, home visits, in intersectoral actions focused on school and individual and group health education in a setting where biomedical model predominates. Community workers stand out as facilitators of the integration, while the oral health technicians remain invisible. It is concluded that the integration of eSB with the FHT is incipient and limited by conflicts of rules and the way work is organized in FHT in the context studied, constituting a difficult integration.

**KEYWORDS** Primary Health Care. Family health. Oral health. Qualitative research.

**RESUMO** *Este estudo analisou a integração da equipe de Saúde Bucal (eSB) à equipe de Saúde da Família (eSF) no Distrito Federal. Trata-se de estudo qualitativo onde dezenove entrevistas, observação do trabalho e análise documental foram conduzidas, e a coleta e a análise, em triangulação, basearam-se em categorias analíticas formuladas a partir das políticas públicas que orientam o trabalho em saúde bucal: trabalho em equipe, ações educativas e intersectoriais, vínculo e acolhimento, acesso e coordenação do cuidado, planejamento e educação permanente, participação e controle social, qualificação da assistência e condições de trabalho. Os resultados evidenciam integração dos profissionais da saúde bucal na interconsulta, nas reuniões de equipe, nas visitas domiciliares, nas ações intersectoriais focadas em escolares e de educação em saúde individual e de grupos, num meio onde predomina o modelo biomédico. Os agentes comunitários se destacam como facilitadores da integração, enquanto os técnicos de saúde bucal permanecem na invisibilidade. Conclui-se que a integração da eSB com a eSF é incipiente e limitada por conflitos de normas e pela forma como se organiza o trabalho na eSF no contexto estudado, constituindo-se em uma difícil integração.*

**PALAVRAS-CHAVE** *Atenção Primária à Saúde. Saúde da família. Saúde bucal. Pesquisa qualitativa.*

<sup>1</sup>Secretaria Municipal de Saúde de Porto Alegre, Coordenação-Geral de Atenção Primária à Saúde – Porto Alegre (RS), Brasil  
Orcid: <https://orcid.org/0000-0002-1863-4007>  
[charlenischerer@yahoo.com.br](mailto:charlenischerer@yahoo.com.br)

<sup>2</sup>Universidade de Brasília (UnB), Departamento de Saúde Coletiva – Brasília (DF), Brasil  
Orcid: <https://orcid.org/0000-0002-1465-7949>  
[magscherer@hotmail.com](mailto:magscherer@hotmail.com)

<sup>3</sup>Universidade Federal da Bahia (UFBA) – Salvador (BA), Brasil.  
Orcid: <https://orcid.org/0000-0002-1476-8649>  
[sclchaves@gmail.com](mailto:sclchaves@gmail.com)

<sup>4</sup>Secretaria de Saúde do Estado da Bahia, Diretoria de Atenção Básica, Núcleo Técnico Científico de Telessaúde – Salvador (BA), Brasil  
Orcid: <https://orcid.org/0000-0002-3966-6382>  
[ericalcenezes@gmail.com](mailto:ericalcenezes@gmail.com)



## Introduction

In Brazil, Primary Health Care (PHC) has three important characteristics that distinguish it from most models of other countries: the responsibility of multiprofessional teams for geographic territories with a population ascribed to them, the unique presence of community health workers and the inclusion of dental care in the public health system<sup>1</sup>. The strengthening of PHC has been a process of advancement and retreat, through the implementation of the Family Health Strategy (FHS), with emphasis on the reformulation of work processes according to the principles of the Unified Health System (SUS)<sup>2</sup>.

The insertion of oral health and dental practices in the SUS was done in a parallel way with the organization of other health services. Although successful local experiences of insertion of oral health in PHC have occurred since 1995, the inclusion of this team in the FHS at a national level occurred only in 2000<sup>3</sup>. In 2004, the National Oral Health Policy Guidelines (PNSB) were published, entitled Smiling Brazil Program, which reinforce the reorganization of oral health care at all levels of the SUS and the readjustment of work, through interdisciplinarity and multiprofessionalism, integrality of care, intersectoriality, extension and qualification of care and definition of standards to guide the work<sup>4</sup>.

In 2002, the population coverage of Oral Health teams (eSB) in the FHS was 15% of the Brazilian population, and, in 2017, it increased to 38%, corresponding to 77.3 million people<sup>5</sup>. In addition to the expansion of access, the inclusion of oral health in the FHS has constituted the possibility of breaking with the exclusionary, technician and biologicist dental practice, representing an opportunity for change in the work process. In this context, the integration of eSB with family health has been a gap in studies on oral health care in Brazil<sup>6,7</sup>.

The effect of the eSB on the access and type of service used was investigated by

Pereira et al.<sup>8</sup>, who pointed out paradoxes, such as the fact that this model of attention is not producing effects in the sense of a more restorative and less mutilating treatment and in the expansion of individual or collective preventive actions, or even a negative effect in seven of the twelve municipalities investigated. Other studies that have already dealt with the work process point to advances in access, reception and bonding, on the one hand, but few results in the practices of health promotion, territorialization and interdisciplinary approach<sup>6,9</sup>.

Work, when performed in a team and cooperatively, tends to be more effective in achieving the desired results, and this can be an indicator to be used in evaluating the implementation of a policy, such as oral health. In this sense, after more than a decade of implementation of the national oral health policy, this article analyzed the integration of the eSB and the Family Health team (FHT).

## Material and methods

This was a multicenter national study, with a qualitative approach, on oral health in the FHS, being a cutting of the findings in the Federal District (FD), one of the pioneers in the insertion of oral health in SUS. In August 2014, the year of this study, the DF had coverage of primary health care and oral health care in primary care of 54.4% and 26%, respectively. Oral health coverage in primary care is the sum of the estimated coverage of eSBs belonging to FHS and oral health coverage in primary care of eSB equivalent to traditional primary care. In this, every 40 hours of outpatient workload of dental surgeons (general practitioner, collective health) in primary care is equivalent to one team. The calculation is as follows: estimated population health coverage in primary care =  $(n^{\circ} \text{ eSB} \times 3.450) + (n^{\circ} \text{ eSB equivalent} \times 3.000) / \text{estimated population}$ . However, the FHS coverage was 30%, and the eSB in family health was 8.5%<sup>5</sup>.

Participants were seven Community Health Workers (CHW), four Nursing Technicians (NT), two nurses (N), two Dental Surgeons (DS), two Oral Health Technicians (OHT) and two Doctors (D) of two Basic Health Units (BHU), in two administrative regions of the FD, which would correspond, in the states, to two municipalities. The choice of study site and participants occurred based on the following inclusion criteria: a) complete family health teams with eSB, regardless of the modality; b) FHT considered to be of good performance by managers, with reference to the National Primary Care Policy and the National Oral Health Policy Guidelines; c) teams that, preferably, had as reference Dental Specialty Centers (CEO) and/or Family Health Support Center (Nasf); d) teams that participated in the 1<sup>st</sup> cycle of the National Program for Improving Access and Quality of Primary Care (PMAQ-AB).

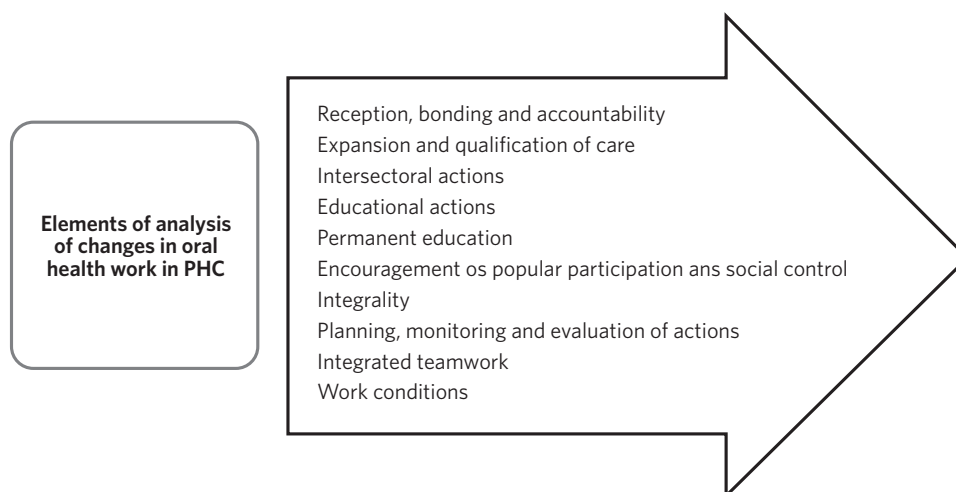
The multiprofessional character of the sample had as objective to cover different views about the object of study, considering that oral health is not restricted to the core of dentistry, but it covers the field of

competences and responsibilities of other professional areas<sup>10</sup>. The eye of the researcher turned to the oral health work of FHT and eSB professionals, without analyzing the clinical or technical procedures of care.

The data collection, guided by the script, was carried out from January to June of 2014, through 19 semi-structured interviews, observation of the work and analysis of the minutes of the meetings of the teams. The script sought to know the work routine of the teams; composition; work process; work division; decision making; flow of care and services offered by the unit and the Health Care Network; BHU organization; relationship of the manager with the teams; elements of cooperation; relationships among professionals; how eSB integrates with FHT; and to know the actions of oral health developed.

The treatment of the data, both in triangulation<sup>11</sup>, was guided by previous analytical categories, constructed by Scherer and Scherer<sup>12</sup> in order to identify how these data are integrated to realize the attention to oral health, being this the main guiding question of the study (*figure 1*).

Figure 1. Elements of analysis of change in oral health work in Primary Health Care

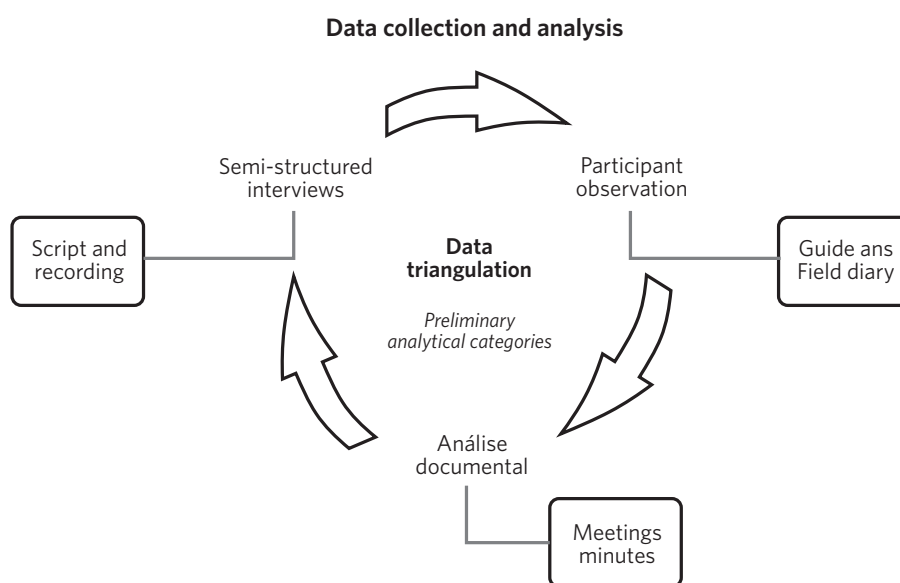


Participants were identified by letters, which correspond to their professional category (CHW: community health worker, DS: dental surgeon, N: nurse, D: doctor, NT: nursing technician, OHT: oral health technician), and by numbers, which correspond to

the number of respondents per category.

The resources available in the Atlas.ti software (Qualitative Research and Solutions), version 7.1.8, served as a tool for systematizing and categorizing the data and subsidizing the qualitative analysis (*figure 2*).

Figure 2. Synthesis of the methodological course of the field work and triangulation of the data



The research project was approved by the Research Ethics Committees of the University of Brasília (Opinion n° 491.461) and the Health Science Teaching and Research Foundation (Opinion n° 459.739) and followed the norms of Resolution n° 466/12, of the National Health Council.

## Results

The results reveal how the eSB integrates into teamwork, evidencing the presence of actions that favor integration and others that demonstrate fragmentation (*chart 1*).

Chart 1. The integration of eSB with FHT from the previous analytical categories and the actions that the teams develop in the work

Categories	Strengths	Fragilities
Team work, Intersectoral actions and Educational actions	<p>Participation and collaboration of the professionals of the team, including the doctor, highlighting the CHW in the educational activities of Oral Health (OH) (focused on prevention) carried out at the school.</p> <p>Articulation and recognition of health professionals by education professionals.</p> <p>Identification of partners and resources in the community for intersectoral actions.</p>	<p>Isolation of the OH team from the family health team is strengthened by the physical structure of the BHU.</p> <p>Professionals do not know how to organize attention to OH and the work of the other.</p>
Bonding and accountability and reception	<p>CHW as a promoter of the bond with the community and able to contribute to the autonomy and the extension of care to OH.</p> <p>Home visit of the DS as an instrument for the bonding and the accountability of the user.</p>	<p>The contact of the user with the teams at the BHU is through 'referral' of the professionals to clinical consultations in an independent and individualized way.</p> <p>Fragmentation of the reception at BHU.</p>
Access and care coordination	<p>Group activities increase access and early qualification in OH, with the participation of CHWs and, sometimes, the nurse.</p>	<p>Difficulties in the organization of supply stimulate the predominance of individual healing actions.</p> <p>Barriers in access to attention to OH, way of scheduling consultation by waiting list and unstructured reception to spontaneous demand.</p> <p>Obstacles in coordinating care in the oral health care network, with special reference to the specialties of the CEO.</p>
Planning and Permanent Education in Health (EPS)	<p>Team meeting instituted and valued by professionals for the planning of actions.</p> <p>Presence of informal spaces at work for dialogue and exchanges.</p>	<p>Predominance of offers of continuing education (courses and qualifications).</p> <p>Training of oral health professionals separated from others.</p>
Qualification of assistance and Working conditions	<p>Recognition by managers of the team's work, in particular, for the performance in the 1st cycle of the PMAQ.</p> <p>PMAQ as a strategy to redefine the scope territory according to the guidelines of the Ministry of Health.</p>	<p>Lack of clarity in the use of resources of the PMAQ discourages staff to the next accession to the program.</p> <p>The lack of some materials and support from the managers impairs the work of the teams.</p>
Participation of the community and social control	<p>PMAQ as a strategy to encourage professionals in participation and collaboration for social control.</p>	<p>Lack of professional participation in social control spaces.</p> <p>Need for a continuous work of encouragement and health education to rescue community participation.</p>

Source: Own elaboration, based on data of the fieldwork, 2014.

In a first observation, the physical distance between the FHT and the eSB, revealed due to the architectural arrangement of the BHU, suggests distance also in the way of working, which is confirmed in the interviews:

*Actually, it's us here and they, in there. So we do not have much involvement with them. We do not have much contact. We help practically nothing. (NT1).*

*[...] we kind of stay here, right? We do not have much contact with people there. (OHT2).*

*When I arrived and it was still the Health Center, the dentistry was like a service apart from the post. Get in there? We did not even go in. It was as if it was secret. The feeling I had, it was like it was just theirs. (NT3).*

*The dentist has a distinctive scheduling system. I do not know how to explain in detail how it works. (NT2).*

Moments of integration between eSB and FHT occur in discontinuous collective actions, especially in those developed by oral health team initiatives in the school environment:

*With the oral health team, every event that the dentist carries out, we are part of it. We have already done theater, we make the scheduling of consultations, the brushing in the schools. First he teaches us, and then he passes to the students along with him. (CHW4).*

*There was the dental week, and I attended it. The dentist did a good job. He did theater and everything. What we could help... not necessarily in the medical field, in the logistics itself. (D2).*

*Last year, there were two actions at school, and one of them was directed to the dental section. And I went there to collaborate. I did not participate directly, but I collaborated. (D1).*

However, the way the work is organized in the FHS invites the oral health professional to leave the isolation and seek to be a more active professional in the field of health, in the search for integrality of care.

*We try to show them that the mouth is part of the whole body. That is not to treat only the mouth. (DS2).*

*I want to be addressing this issue, not only dental, but mental health, psychological, every part that composes the needs of the human being, in general. (NT3).*

It was observed the sharing of knowledge in the clinical doubts and in the attendance to the priority groups, which can be confirmed by the interviews:

*Total freedom. Any doubt, I can get into anyone's room and ask anything, see their agenda. On the day of the pregnant women, I ask, 'let me see who the pregnant women are?'. Oh, they have already come or have not. And they do it too, 'take a look at this boy here', or 'the little mother wants to talk to you'. So, with the doctor too, sometimes preoperative medication. Especially hypertensive and diabetic, you can talk. At least, with those who passed by, there was never any restriction, no obstacle to talk to them. (DS2).*

In the work of the teams, approximations and exchanges predominate in the individual actions performed in the office:

*Always in the service of growth and development of the child, when it is the first consultation, we guide them to go to the dentist for him to give the orientations. (D1).*

*They always go to one or the other. There's been a case, but it's one case or another. There was a mouth cancer that the doctor saw and called me: 'look at this here'. So I called the specialist of the HRAN, and we sent it together. (DS2).*

*[...] I oriented, I looked if there was any deformation of the palate, some malformation in the dentition. At that, I already sent to the dentist, sometimes talked to him. If I had to send, we would send, and even older children, at the time of the physical examination, if I identified a caries or something like that, I questioned the mother why it was happening, whether he was brushing or flossing. But, anyway, I was already sending to the dentist to have an evaluation. (D1).*

That is, there is articulation, however, more focused on individual technical knowledge, to the detriment of the collective and multiprofessional approach necessary to address health problems and their determinants.

Another difficulty present were the problems of access that the population faces to oral health clinic actions. In the observation, it was possible to perceive the fragility of the scheduling strategy used by the teams, through a waiting list and by the CHW as interlocutor, which results in a big list and, according to the interviewees, in 'lack of responsibility' of the user and a certain misunderstanding of the social determinants as a barrier to access to oral health:

*Then I say to the dentist that there are people in the queue for 2 years. He had already have a case of a comrade saying that he needed to go to the dentist, then I said I was going to put his name on the list, then it took so long, but in that case the fault was his, because he was called for an appointment and did not come. Then there was another, he did not come. After a long time I went there and he said he had to find another way to fix his teeth. His teeth had already fallen, and he needed a denture. (CHW2).*

The CHW appears as a facilitator for the access of the user to oral health, especially, because he/she is the link between the team and the community. However, CHWs report difficulties in this 'gateway' function for the scheduling of oral health consultations:

*So I go through the houses and do not even ask anymore, because it's such a sensitive part to deal with. I wait for them to look for me and I explain that I'm going to put the name on the list. (CHW6).*

From the difficulty of access, different models of supply organization are created, which prioritize certain groups according to criteria of health problems (hypertension and diabetes) and life cycles, notably, children and pregnant women. There are challenges in incorporating other parts of the population:

*Usually, schoolchildren and Zero Caries we go already calling through our list. The day of the pregnant woman, for example, we pass it to the CHW. Adult, adolescent and hyperdia are with the CHW as well. Then we pass the spots, and they say 'oh, there are so many spots for pregnant women tomorrow', for example. Then they send them to us. In case, we do not know who will come. (OHT2).*

Health professionals face obstacles both structuring the scheduling of dental consultations and the realization of the spontaneous demand in oral health, which, during the observation, proved to be poorly structured and fragmented, suggesting a low integration of eSB with FHT for organization of work and definition of joint strategies.

It was perceived, as well, difficulties in integrating the team in the coordination and continuity of oral health care in the care network:

*They send the monthly spots, endodontics, periodontics, surgery, patients with special needs, then they already send the code with the number of spots, and we have a list of the patients' needs, and it goes to them every end of the month. Everybody has to go on Monday mornings to the hospital to watch the lecture, everybody at the same time. Then they send the counterreference to continue the maintenance here. If you did not attend the lecture there, you lost the spot. (DS2).*



Although the traditional model remains, there are resignifications of the educational practice and its meaning among some workers:

*What theme are we going to talk about tomorrow? Oh, we're going to talk about breastfeeding, so there I was going to research on breastfeeding, see what I could say, make that language as popular as possible for mothers to understand. (CHW5).*

*I do not like to get to school and do the lecture. Every time I go to school I take something different, or it's a movie, or it's a game, or something to paint... I like that. (DS1).*

Apart from the clinic, disease prevention and health promotion are among the tasks common to all team members. For them to be effective, the identification of partners and resources in the community is recommended as a way to enhance intersectoral actions and integrated work:

*The CHW talked to the head of the soccer school and explained that we wanted to make a partnership, and they loved it, so we're not doing anything from top to bottom, we're doing together with the parents, because otherwise it will not work. (N2).*

*So, we went to see what we could do, then we are going to make a partnership with the soccer school project, make a union with them and see what we can offer them. So, we saw that we can offer what? The medical clinic consultations here at our health facility and dental monitoring, which for many, this is a distant dream, because they there have not the slightest chance of having. (CHW5).*

Intersectoral actions, however, were characterized by the maintenance of traditional practices, such as individual healing care. Preventive and health promotion work is centered in schools, and the matter of vulnerability is a difficulty for professionals:

*Outside the unit, we have the HSP, Health in School Program. But, this HSP is more a matter of health education, in relation to washing hands, brushing teeth, lice issue. You do not have that part of vulnerability. Although we know by the teachers if the child has any vulnerability. In this part, it is even difficult to intervene. (D2).*

Promoting community mobilization and participation for social control is among the common actions to family health professionals. The minutes of the team meetings record moments of encouragement of managers to make this directive effective, however, professionals feel under-supported and unmotivated to participate and foster these processes, evidencing limits to comply with the prescribed:

*We don't have a health council that brings the community together with the team to hear the suggestions. Because most of the suggestions of the community are more to complain than to help. (DS2).*

*With the community, we have never had a partnership, to call the community, like: ah, we're going to do an event, and what do you guys think of us doing it? Can you help with what? We have never had. (CHW4).*

*I've already received several invitations to attend, because I think that, if the person takes on something like that, he has to take responsibility, and I do not see myself with the time and responsibility to take on something like that. (CHW3).*

The difficulty in 'what to do' and 'how to do' to mobilize the community to participate in collective oral health activities in the basic health unit is expressed by the workers:

*You almost have to beg them to get in here at BHU to attend a lecture. They only come because they win a consultation. Here, even giving a toothbrush is not a motivation. (DS1).*



*People, sometimes, are not so receptive when we give the lectures. But, the few, bring good things and are very participative. And I think it's an ant job because it's not easy to change people. (NT4).*

The planning process occurs in the regular meetings of the team.

*We have a meeting period, where all staff are present. At this meeting, we put what we have accomplished, the difficulty we had in the week, we seek answers, seek joint solutions and plan what we can do. (CHW4).*

*In team meetings, it is where we plan, discuss, evaluate actions taken. (N2).*

It was verified that other spaces, besides the team meeting, are used to plan the actions:

*We go there on that little table (BHU scullery) and make a plan. Then, our team plans saying that there's gonna have something on such day. (CHW2).*

*Usually, it's in the scullery. Some simpler things are talked about during office hours. If it is something more complicated, it is left to when the team meetings are held. (CHW7).*

There is fragility in planning common team actions that include oral health care, such as, for example, the creation of criteria for defining home visits, whose periodicity is hampered by the lack of logistics:

*Look, I'll be honest, it's the dentist who do that. So, I still don't know to tell you the method he uses to do it. (OHT2).*

*Unfortunately, not always on the days of the visits we go out to visit, which I don't object to, because they do not always have a car available. (D2).*

In the observation, it was noticed that the eSB organizes actions using results of epidemiological surveys. Children and school-children are classified by risk condition for

clinical care and also by register in minute and division by micro-area of the CHW. This is carried out in isolation from FHT, so that this informations are not used for the planning, monitoring and evaluation of other actions, such as health promotion.

The educational offerings for oral health professionals, of technical and superior level, are punctual and, when they happen, are isolated from the whole FHT:

*Once a year, all of dentistry get together. There is no other oral health movement. They address humanized care, procedures, how to act in emergency... They are more basic things of dentistry, aimed at the same humanized care. (OHT1).*

*What I realize, in fact, is that when they (management) are going to do these refresher courses, it's like this: they call the doctor and the nurse. This is typical of the the secretary. (D2).*

*I miss those trainings, because I think it would be interesting, we could go deeper, learn more. (OHT1).*

In the team meeting registers, professionals report that experiences of approximation with teaching institutions strengthen them and propitiate transformations in their practices, such as the partnership with undergraduate nursing students to assist intersectoral activities through the Health in School Program (PSE).

In understanding the work process, it is essential to know the working conditions. In the context studied, professionals report that they are not always adequate for the accomplishment of a service with quality. They mention the lack of materials, equipment and support of managers for work in the daily health service:

*A greater support of management with regard to small things, sometimes, the lack of material or, sometimes, the lack of even support, baking that you do not have. (CHW5).*

*Extractions are left for the teams, and no dentist wants to do extraction, because everyone claims they do not have a vacuum pump; offices are not ready. (DS1).*

However, it was verified in the documentary analysis that the managers recognize the team work and its performance in the 1<sup>st</sup> cycle of the PMAQ, and emphasize the conquest of new technologies, such as matrix support and the telehealth tool for the expansion of the actions and qualification of the team, as well as to foster possible advances in the organization and working conditions, issues not mentioned by the interviewees.

## Discussion

This study revealed that the integration between eSB and FHT is still a challenge for professionals, where the biomedical model is hegemonic. The joint development of common actions, which demand greater contact and engagement, is still incipient among the teams. The eSB is basically involved in clinical consultations, with no space to act with the territory, the family and the community in an integrated way with the FHT. Other studies have already indicated that DS work is rarely inserted in practices shared with professionals from other areas, since their actions are developed in an autonomous, independent and individualized manner<sup>13-15</sup>. The same happens with FHT, which develops health actions in an isolated and fragmented way, with difficulties of inventing new ways to relate in a team so as to interrogate places, knowledge and practices<sup>16,17</sup>.

The isolation of the eSB appears mainly in the statements of the technicians, when they reveal the ignorance of the work of the others, signaling the isolation of themselves in the context of the teams. There are few published works on the actuation, qualification and labor insertion of technical professionals of oral health, which is an important gap to understand eSB<sup>17</sup>.

In the research, the manifestations of integration come mainly from the CHW and the higher level professionals.

In a convergent way with other findings<sup>16</sup>, the study shows that the CHW are fundamental to generate a relationship of trust and complicity that extends to other workers, enhancing the reception, bonding and accountability of users. The CHW, because of his/her proximity to the community, sometimes took on the role of interlocutor to the arrangement of consultations, which places him/her in an uncomfortable position both because the organization of supply is a critical node of services and because of the complexity that this function often presents<sup>6</sup>.

It should be noted that the work is the result of a discussion of norms and values of the worker/professional with himself/herself, of how to use himself/herself and how to manage the complexity of issues related to collective work<sup>18</sup>. The research pointed to the presence of a paradox experienced by eSB and FHT professionals, that hampers integration. There is a conflict of norms where they are oriented to perform comprehensive care, organizing the service according to health needs, but, at the same time, they must organize the service in a fragmented way, by life cycles and grievances<sup>2,4</sup>. Professionals work in the midst of prescriptions, which present contradictions that limit the integrated action of the eSB with that of family health: on the one hand, common duties are prescribed for all team professionals, and, at the same time, they constitute two two different teams, that is, according to the normatives, oral health professionals do not make up the FHT, and may or may not be included according to the decision of the local managers.

The professionals who work at the FHS experience attempts to share knowledge and to move between the multiprofessional and the interdisciplinary<sup>19</sup>. The existence of a multiprofessional teamwork, which is integrated, is considered a basic issue for

the exercise of interdisciplinarity<sup>20</sup>. The difficulties for integration presented coexist with approximations among professionals, evidenced through the collective activities coordinated by the eSB and the interconsultations with individual and care and at the office. Interconsultation is a strategy capable both of qualifying clinical care to the user and of improving the performance of the health professional, by strengthening and exercising more integrated health practices. By using interconsultation, health and management teams use a permanent education tool that considers the pedagogical aspect of health work<sup>21</sup>.

Literature review carried out by Soares et al.<sup>22</sup>, which discussed the performance of the eSB in the FHS, points out that for an action consistent with the principles and guidelines of the FHS, training qualification actions are required, as well as training of oral health professionals. On the other hand, studies in the state of Minas Gerais indicate that there is 'sufficient' training, with access to permanent qualification, and that most of them carry out preventative/collective rather than assistential activities<sup>17,23</sup>.

The way of organization of referral of users to specialties is also one of the challenges that need to be addressed<sup>24,25</sup>, because the existence of bureaucratic flows and limitations for the care provided to users submitted by BHU shows obstacles to the coordination and integrality of care, as found of the present study and research developed in Natal (RN)<sup>26</sup>. Knowing the itinerary of users and the reasons for 'choices' and 'possibilities' can be a way to reorient services and expand access.

In the present research, it was evidenced that DS do not perform systematic planning of oral health activities, converging with the results of Pimentel et al.<sup>13</sup>, in a study carried out in Pernambuco, which has made it difficult to obtain adequate dental care for the population. The difficulty of changing the work process may be related to the

adjustments of these professionals to the public health system, which is considered a problematic issue, since public dental care demands other skills and competences of integration, planning and programming in health, still little incorporated into the market expectations of dental surgeons<sup>14</sup>.

Knowing the work of the other is one of the conditions for the integration of the team and for the joint construction of an agenda, enabling moments that, when articulated, have the power to promote the integrality of health care. The FHT work routine should include the knowledge of the territory and the population, which constitute subsidies for the planning, monitoring and evaluation of actions<sup>13</sup>.

Popular participation and social control in the health sector constitute one of the fundamental principles for improving the quality of life of society, but a challenge to its implementation<sup>3</sup>. The appropriation of oral health themes through the spaces of social control can contribute to the effective implementation of oral health services in SUS<sup>15</sup>.

Some factors contribute to an organization of the work process with predominance of curative actions by DS, in an isolated and fragmented way of the team, such as the historical process of insertion of oral health in the FHS, the hegemony of the market dentistry, difficulties of adjusting these professionals to the public health system and their conceptions of the health-disease process<sup>6,9</sup>. In addition, the model of attention of the FHS itself is still little focused on the health needs of the territory, on community participation and on addressing social determinants in an intersectoral way<sup>2</sup>. The identification in the community of other social devices to potentialize and promote their actions with an expanded view on the health-disease process and the integrality of care is also recommended<sup>27</sup>.

For advancements in oral health work at the FHS and an integrated performance of the entire team, it is necessary that the professionals seek the exchange of knowledge,

recognize the skills and competences of each member and have attitudes for the collective construction of interventions. The values and the way each professional understands the norms guide their choices and the way they act, with consequences in the collective work<sup>18</sup>. In addition, local health management may or may not enhance this process of integration and improvement of collective work.

The present study pointed to strengths and fragilities present in the daily work of the teams, either revealing the integration, or revealing the fragmentation, corroborating the typology of the work in Peduzzi's multiprofessional team<sup>28</sup>, acting at certain moments as 'grouping team', in which the juxtaposition occurs of actions and the grouping of the agents, sometimes as 'integration team', in which the articulation of the actions and the interaction of the agents takes place. However, the emphasis on individual curative actions coexists with the characteristics of the work advocated by the policies, pointing to the transition of the care model through the integration interface.

Integration is fundamentally effected through the participation and collaboration of team professionals. The eSB, in the study, has demonstrated the ability to coordinate collective actions, which, although they happen in a little systematized way, call for the health team to act in a shared way.

The way in which FHT is structured has encouraged dentists to look more comprehensively at the health-disease process and to experiment with integrated work with the other professionals of the team, especially the consultation with doctors and nurses and the work done with the CHW. They appear as important facilitators for access to oral health actions, despite the difficulties related to the incipient organization of the services offer.

Also as potentialities for integration, we can

highlight participation in groups that increase access and early qualification in oral health, team meetings and the existence of informal spaces at work for dialogue and exchanges. These findings suggest the existence of characteristics of an integrated team<sup>29</sup>.

As fragilities, the physical isolation of the eSB within the structure of the health unit was observed, which reflects and is a reflection of the distancing in the planning and organization of work, producing different ways of thinking about the organization of service provision and access by the population<sup>29</sup>. Problems in integration are also present to ensure the coordination of care in the relationship with CEOs that reproduce bureaucratic flows and access limiters<sup>26,27</sup>.

As a gap in this study, one can point to the fact that it was local, focusing on a specific reality. However, the scientific production on the subject brings indications of the permanence of these findings in other municipalities of the Country<sup>13,14,30</sup>.

It is concluded that the integration of oral health in the FHT is incipient, limited by conflicts of norms and by the way in which the work in the FHS is organized in the studied context, being, therefore, an integration under construction.

## Collaborators

Scherer CI participated in the conception, collection and data analysis, wording and approval of the final version. Scherer MDA participated in the conception, data analysis, wording and approval of the final version. Chaves SCL participated in the data analysis, wording and approval of the final version. Menezes ELC participated in the collection and analysis of the data, wording and approval of the final version. ■

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