

## Oral health and the care of pregnant women: workshops as a strategy to problematize practices in basic health care in residents living in the peripheral areas of the hills in the city of Santos

### Saúde bucal e o cuidado da gestante: oficinas como estratégia de problematização de práticas na atenção básica nos morros de Santos

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#### ABSTRACT

**Objective:** the aim of this study is to question Primary Health Care (PHC) concerning oral health during prenatal care in facilities of primary health care in the residents living in the hills peripheral areas of the city of Santos, São Paulo. **Methods:** Using a qualitative approach, workshops on PHC concerning oral health were held in three primary care units which present different forms of organization. The transcribed material was analyzed using thematic analysis. **Results:** the teams have been trying to organize dental agendas giving priority to pregnant women, however difficulties in monitoring attendance commitment have been found. Therefore the use of protocols and the approach to oral health theme during the educational groups have been used as strategies for improving treatment commitment. Regardless of the organization of the PHC unit, the teams have claimed the search for pregnant women care merely in acute painful situations as well as the fear of harming the fetus caused by dental treatment as the main cause of treatment dropout. Some professionals had doubts about the use of local anesthetics in pregnant women. **Conclusions:** The valorization of oral health care during prenatal care was not unanimous among the professionals and the use of the permanent education strategy applied in the services led the teams to carefully question their practice as well as search for practice integrality.

**Indexing terms:** Health personnel. Oral Health. Pregnancy. Primary health care.

#### RESUMO

**Objetivo:** problematizar a atenção à SB durante o pré-natal na ABS na região dos Morros de Santos, São Paulo. **Métodos:** Com abordagem qualitativa, realizaram-se oficinas de problematização da atenção à SB com as equipes de três serviços de ABS com diferentes

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formas de organização. As oficinas foram gravadas, transcritas e analisadas por meio de análise temática. Resultados: As equipes tentam organizar as agendas da odontologia com prioridade às gestantes, mas apontam dificuldades na adesão e acompanhamento, identificando a vigilância, o uso de protocolos e a abordagem da temática de SB nos grupos educativos como estratégias para melhoria da adesão. Independente da organização da unidade de ABS, as equipes atribuem a busca de atendimento, pela gestante, em situações agudas de dor, bem como o medo de danos ao feto causados pelo tratamento odontológico como causas de abandono do acompanhamento. Alguns profissionais apresentaram dúvidas quanto ao uso de anestésicos locais pelas gestantes. Conclusão: Não foi unânime, entre os profissionais, a valorização do acompanhamento da SB durante o pré-natal e a utilização da estratégia de oficinas de educação permanente em saúde, aplicadas nos serviços, mostrou ser capaz de levar as equipes a problematizar sua prática, criando possibilidades de reflexão de práticas na busca da integralidade.

**Termos de indexação:** Pessoal de saúde. Saúde bucal. Gravidez. Atenção primária à saúde.

## INTRODUCTION

Among the specific actions of oral health in Primary Health Care, (PHC), the pregnant women's oral health has been highlighted once the relationship between oral diseases, mainly periodontal disease, prematurity and low birth weight is well known. Dental treatment during pregnancy is generally safe, and in addition to avoiding complications during pregnancy, it also enhances pregnant women's quality of life while reducing oral pathogens transmission risk from the mother to the children [1,2]. During pregnancy periodontal disease and dental caries can increase and oral changes are more common. Throughout prenatal care, pregnant women have many physicians and nursing staff appointments, however rarely with professionals in the oral health team – OHT which impairs their history of oral health, as well as oral examination in search of gingiva bleeding and other signs of oral diseases [3].

Frequently these women are not treated by OHT and resist or do not commit to the dental treatment, which usually occurs due to lack of information or distorted information, such as the fear that it may pose a risk of gestation [4]. Lack or distorted information such as fear that the dental treatment may bring risk to the pregnancy can be the main cause for resisting the treatment. Moreover health care professionals, including physicians, nurses, dentists, and community health agents are also often misinformed concerning oral health knowledge and practice during pregnancy in different Brazilian regions [4-7].

The Ministry of Health, in the Primary Care Report No. 17 on Oral Health [1], as well as in the Primary Care Report No. 32 on Low Risk Prenatal Care [2] has recognized that the pregnant woman's oral health is related to her general health condition and can influence the baby's oral and general health, as well. Therefore, every health service

should routinely carry out the active search of pregnant women in order to include them in prenatal care, promoting integrated actions among oral health professionals and other members of the health team. Nonetheless, the pregnant woman's oral health is not even mentioned in the Prenatal and Puerperium Technical Manual [8].

The Municipal health Department of the city of Santos, through the "Mãe Santista Program" (Mother Program), Protocol of Women's Health of the Municipality of Santos, in the chapter on prenatal care states that the altered odontological examination as a risk factor for prematurity, emphasizing that every pregnant woman should be referred for dental evaluation at the first prenatal visit and that the dentistry agenda should be prioritized for them. Nonetheless this protocol does not bring further explanations about dental guidelines on scheduling, consultation and follow-up.

It should be noted that the Municipality of Santos has been facing difficulties in reducing maternal and infant mortality rates over the years and actions which improve pregnant women's oral health and their life quality, the fetus and the newborn as well have remained separate and disjointed from other health measures.

From the perspective of oral health in prenatal care, how can the oral teams be summoned in order to emphasize oral care during pregnancy? How can actions interfere in order to help professionals better focus on the organization of oral health actions aimed at prenatal care? In this context, this manuscript has aimed at questioning Primary Care concerning Oral Health Care throughout the prenatal, in the peripheral area of the hills of the city of Santos, São Paulo State.

## METHODS

In the present study the Primary Care Unit is where professionals perform their daily tasks and relate to

service users, colleagues and management. It is the place of political disputes where questioning the team practice can be empowered.

In order to promote knowledge focused on practical actions, workshops were held with health professionals. According to Paviani and Fontana [9], workshops can provide concrete, meaningful, pedagogical daily life situations in the health units, without losing sight of the theoretical basis as well as strengthen interprofessional work.

Designed to function as intervention tools in health care, the workshops can provide potential knowledge and meanings that the participants attribute to a given theme, which can be shared and problematized. In order to maximize the discussions, contents are offered during the educational process, to provide horizontal knowledge, enhancing the participation of all. A prior planning with a delimited theme is necessary, following a series of strategically defined steps [10].

The health teams of three basic care units in the peripheral area of the hills in the city of Santos, defined by the Coordination of Primary Care in the region, were the subjects of the study, according to the singularities of the team organization, which allowed different problematizations about the understanding of oral health care during prenatal care.

The 3 units facilities chosen for the sample study were as follows: 1) a Family Health Unit presenting a health team and the absence of Oral Health Team (OHT)- once oral health assistance for this population is provided by the Primary Health Unit near to the Family Health Unit; 2) A FHU composed of 3 health teams and two OHT which work together with the health teams; 3) A traditional FHT with dental care professional.

These three primary care study samples were called, FHU, FHU-OHT, PCU, respectively. (Family Health Unit – FHU/ Family health Unit/Oral Health Team-/Primary care unit- PCU)

The data were produced from July to December of 2015 from two workshops in each of the units, based on concepts, knowledge and concrete teamwork tasks, which for Paviani and Fontana [9] can lead to collective knowledge.

In the first workshop the professionals of the health teams were invited to a discussion about the relationship between OHT professionals with other members of the

health team and how the oral health care of pregnant women have been carried out in each unit, attempting to provide issues and everyday situations which are often not perceived by the team itself. All the professionals of the teams studied were invited to participate.

In the second workshop, the discussion was resumed from problem situations brought by the team itself. The reading of papers found in the current literature about the relationship between oral health and prenatal care was used as starting points for the discussion. The choice of articles used to produce the files was based on doubts brought by the professionals during the first workshop, as well as the interaction with the professionals of the FHU, where the researcher is based, and who helped to raise the most frequent doubts in the team about the relationship between oral health and pregnancy.

The workshops were recorded and the transcribed material was analyzed using one of the techniques of content analysis, called thematic analysis, in which the reference values and behavior models present in the discourse are characterized by the presence of certain themes [11]. Once the workshops allow meetings and can therefore produce training and care, the research tried to empower the health professional, revealing their understanding and gaps regarding oral health during pregnancy. The theoretical reference guide for the professional's discourse analysis was the concept of buccality as the expression of the social work that the human mouth performs [12].

This work was approved by the Research Ethics Committee of the Federal University of São Paulo, on 07/15/2015, under no. 1,163,765 and the data were produced after signing the Free and Informed Consent Term. The lines were identified with color names in order to keep the identity of the people confidential.

## RESULTS AND DISCUSSION

The professionals who participated in the workshops came from seven categories: nurses, dentists, physicians, nursing technicians and auxiliaries, community health agents (CHA), oral health aides (OHA) and receptionists. Social workers, psychologists and speech therapists from the NASF (Núcleo de Apoio à Saúde da Família), (*Family Health Support Center- FHSC*)- who were present at the units facilities, on the day of the workshops, have also attended.

## Workshop statements:

### “They have priority attendance”

The Health Department of the city of Santos (HDS) has been advocating the dental care of pregnant women in prenatal care since 2014, as part of the protocol of the *Mãe Santista Program* (Mother Program) and this standardization reflects in the organization of the agendas of the studied units, since all seek some way to prioritize the pregnant women in the scheduling of the oral health team appointments:

“[the oral health care] of the pregnant woman is differentiated because we do not refer them for the waiting queue, we send the names of the pregnant women to the head of the sector who promptly schedules this pregnant woman and finally she gives me the appointment date and time and who will attend her” (Esmeralda)

“They have priority service. They come to the prenatal clinic and then the nurse already refers her for clinical examination. She does not queue. She arrives here for clinical examination and is scheduled for treatment”. (Coper)

Although the teams seek to facilitate OHT follow-up, the literature shows that many pregnant women still have difficulties in obtaining the consultation for several reasons, such as: the lack of information about oral health care in prenatal care, delay in care since many professionals still schedule all the pregnant women for the same time, attending on a first-come as well as difficulty in arriving at the unit [13].

As in the units studied the service is organized to offer the vacancies preferentially to the pregnant women, access impairment was not perceived by the teams. However, we cannot say that there are no access difficulties, since the pregnant women were not heard and their perceptions could come from a professionals' different angle view.

A repeated question by professionals is that although pregnant women have priority in scheduling, there is not always adequate monitoring, often due to lack of communication between professionals and services. Monitoring is usually restricted to the presence of the pregnant woman at the first visit while their oral health follow-up occurs predominantly by single initiatives of some professionals and less by a service organization for this purpose.

“They come back if they had missed the first consultation, now whether or not they adhered to the treatment we do not know”. (Ocre)

The lack of more effective communication between professionals and pregnant women about the need to follow up their oral health in prenatal care may lead to the follow-up dropout [4].

“Although they have schedule priority with the dentists, often the pregnant women do not continue the treatment, missing the consultations: *“they even schedule but they miss the appointment, right?”* (Amarelo)”.

According to Feldens et al. [6], in a study with obstetricians in the State of Rio Grande do Sul, approximately half of the interviewees did not usually advise pregnant women about oral health, nor did they seek dental care, which means an opportunity loss to provide guidelines and conversations on the oral health of these women.

For Botazzo [12], these actions should take into account the needs of pregnant women, and conversations about oral health should not be based on the logic of caries prevention through brushing techniques and dietary guidelines. There is much more to be said about the mouth.

Correia and Silveira [14] understand that as oral health care is still very much based on the restorative surgical paradigm, professionals stop talking to pregnant women about the health-disease process, excluding other approaches which may be educational or preventive and focus only in the office procedures causing these women to be eventually removed from oral health care because they believe that treatment at this stage of life entails risks that must be avoided.

Dentistry hegemony - is the dentist's territory. However oral health, is also the territory of other health professionals, mainly the user, owner of his/her own body and when only the vision of the dentist, inside the office is valued, care completeness is impaired as well as collective and creative actions which can help to meet people's oral health needs. When only the clinic in the office is seen, no other action possibilities are envisaged [15].

The oral health actions prevalent in services today are not only due to structural problems, but also to public policies and the care model. The incorporation of new professionals and equipment, and the improvement in working conditions are positive actions however unsatisfactory in order to change work streamlines. A new

way of thinking about oral health, which takes into account the subjects and the subjectivities must be implemented. The concept of buccality - understood as the expression of the social work that the human mouth performs - can help in this task by reconciling the tooth-centered dental view with a broader view, which concerns the subjects. In this way health professionals can counteract on what is protocol and what is unique in each appointment so that more humane and resolute actions [16] can be offered.

In order to favor the participation of the user during the health acts, bonds can be a very effective tool however they can not be built if the user is not recognized as a subject, with his/her own desires and ideas. This gaze on the other opens up possibilities of apprehending their health needs, within the context of each appointment. Care must be provided by different professionals, operating through guidelines such as the warm reception and the bond, where the team is responsible for the health needs of the clientele.

Buccality- a possibility that opens to all professionals, not only dentists- would be to talk with the pregnant women so that they can express what sensations they experience during pregnancy in relation to their mouths. Has something changed? What have you experienced? This may open ways in order to build bonds towards this aspect of women's lives [17].

### **“Only when it is painful, do you understand?”**

Trevisan and Pinto [13] argue that professionals play an important role in deconstructing negative and / or incorrect understandings about oral health care in gestation, and a calm and quiet conversation during appointments in order to clarify the service for users, may increase pregnant women's commitment to their oral healthcare. Although pregnant women constitute a more vulnerable group to oral diseases, most health services still do not see oral health as part of general health, neglecting it during prenatal care [18]. One of the professionals recognizes the 'lack of attention to oral health' in the organization of work in his unit:

“We have not yet given attention to oral health as it deserved, and it is not only with the pregnant women, there are several diseases of the body that begin or become worse due to problems in the mouth, and these things

are still not very talked about, people do not care much”. (Ocre)

Regarding the relationship of the mouth to the rest of the body, Botazzo states that “Dentistry should be seen as an integrating issue which does not separate prevention from cure and considers that the oral cavity and its structures have important relations with other components of the organism, which should not be disregarded for the understanding of clinical actions”.

For Poletto et al. [19], a small number of pregnant women spontaneously go to the dentist, without any referral from other professionals, a fact that can be caused by fear and insecurity regarding the damages that dental treatment can offer, and also by finding care admittance difficult, since a part of the pregnant women may not know that health units prioritize this group in the OHT appointments.

Some professionals of the teams studied report that pregnant women do not want to take care of themselves, seeking care in the OHT only when they have pain or perceive a problem:

“When she starts to feel pain, in the tooth right? Then they come, but otherwise ... (Terracota)”

“A blood test is more important, do you understand, they consider the dentist, how important is it go to the dentist? (Escarlata)”

The following statement reinforces the view that the pregnant woman does not value her own oral health, which she understands only as another task during her prenatal care and her own responsibility herself:

“Nowaday, the dental care, within the prenatal, as protocol is new, how long has it been? A year and a half. And the pregnant woman has not yet incorporated its importance, so it's one more thing, it's an extra schedule, I think this education is in the process. I think the dental protocol has not been incorporated by the pregnant woman yet. (Sepia)”

Santos Neto et al. [20] understand that the greatest difficulties for the access and follow-up of pregnant women by OHT are their low perception about the need to monitor their oral health, the fear of pain or the consequences of the treatment and the admittance difficulty at the public service.

Regarding oral health, according to Botazzo [12], people are still not aware of the importance of teeth, caries

prevention, what happens when they are decayed, and it is essential to inform and guide them through teeth brushing lectures and dietary counseling, usually with paucy results.

If on the one hand many pregnant women believe that they can not be assisted by OHT, on the other hand many professionals, including dentists, are also afraid to attend these women [20]. The professionals reiterate that questions about the risk of the pregnant woman or the baby having problems resulting from dental treatment, often come from more experienced family member and community, or yet from some health professional, can impair oral health actions in the pre -natal, since the professionals themselves have difficulties in dealing with these issues, with both the users and the teams, as well:

“They are afraid, I feel that still, the patients are afraid. That myth that pregnant women can not. We have to deconstruct, but they do not believe. That it’s okay to receive anesthesia, you feel that despite being guided, they still have a little fear”. (Escarlate)

In order to overcome this issue the team needs to know what the pregnant women think about dental treatment during pregnancy and about the follow-up of their oral health, and for this, the health professional should interact in the community, understanding the language and the meanings about the buccality of that population, and apply them, trying to reinvent the practice according to the situations presented to it, instead of being protocol-oriented.

These professionals’ challenges include knowing and understanding these communities and their subjects and which meaningful information can be used in order to subsidize health action planning, including Oral Health. For Mesquita et al. [18], the dental treatment perception during pregnancy can bring negative images and be a cause of fear and insecurity in pregnant women and health professionals, including dentists, who often advise women against treatment during gestation. They also argue that most pregnant women believe that gestation causes dental problems, most commonly caries and the idea that the fetus removes calcium from the mother’s teeth. At the same time, even though they are aware of the possibility of having dental problems, many believe they can not undergo dental treatment and oral health follow-up. Among the excluding factors which prevent pregnant women from OHT follow-up, the literature points out the discomfort of the body on the dentist’s chair, during treatment, the

smells of the products used, the fear of feeling bad during the consultation or even the fear of feeling pain at a this very specific moment in which they are more sensitive, but mainly they fear that some harm can be caused to the child [4].

Pregnant women are also afraid of being reprimanded by dentists due to their oral condition, because of their authoritarian behavior [13]. To approach the pregnant women trying to understand how they feel about the daily performance of their mouth work, without rigid behaviour boundaries may be an alternative [12].

Zanata et al. [21] studies have shown that although 73% of dentists stated to be confident to attend pregnant women, approximately 40% would like to talk to their gynecologist before any intervention or to prescribe systemic drugs. Among obstetrician physicians, 79% would like to be consulted prior to procedures that may cause bacteremia, and only 9% would like to be consulted prior to any procedure. It is interesting to observe that even simple prophylaxis can cause bacteremia, demonstrating that knowledge in this specific area of care is not well disseminated, with many doubts, including coming from the professionals studied.

“We see in this work that the fear comes from the pregnant woman, but in fact it is the professional’s, the dental professional’s, right? And of the others too, it’s the doctor’s, the nurse’s. In fact, everyone feels a little insecure about it, so it is left aside”. (Sepia)

In a study with doctors, dentists and pregnant women about dental care during prenatal care, the authors have verified that dentists have shown the greatest prejudice regarding the dental care of pregnant women [22]. Nevertheless, during the workshops held at the health units, the dentists showed concern about the treatment and monitoring of the oral health of pregnant women. One practitioner said that the treatment was performed with few restrictions:

“Yes, of course, you have to treat, you should use the right anesthetic, and generally we recommend treating when the third pregnancy month is complete, because before they have a lot of nausea/ (Sepia)”

However, another dentist stated that despite performing the necessary treatments, he/she prefers to wait for the child to be born when possible:

“So here we assist them, routinely. The only thing I sometimes see is a case, I prefer, for example, an extraction,

if nothing is urgent, a root which has been there for a long time. I prefer to wait for the baby's birth not to go through a stressful situation. If it is an endodontic treatment for example, I give medicine for the pain, use a bandage. I do the follow-up, she comes back in other appointments. Are you alright? No pain? ... Let's wait for the baby's birth? The endodontic treatment is longer, the patient has to lie down, it's all a nuisance for her. If it is not an emergency or cause any harm to the patient, I would rather wait. For all other procedures I do everything: restoration, periodontics, but many women ask if there is any risk". (Cobre)

It should be emphasized that the doctors were absent from the workshops or remained in the room with little participation compared to other professionals. A doctor presented many conflicting doubts while understanding that the pregnant woman can be attended by the dentist. In case of not understanding the need for this care, the doctor referred the patient to a dentist does not feel safe to give answers:

"If I do not know anymore I refer the patient to another professional. Why do we refer her to another professional? What for? Why is it important?" (Violeta)

The oral health care valorization of pregnant women as an essential part of prenatal care is not yet completely integrated in the health units routine care. The health professionals and the social network of these women often bring negative perceptions about oral health follow-up: "thinking about the problems, I find it difficult to inform the families. There are some myths that are difficult to overthrow" (Dourado), which ends up discouraging pregnant women to seek care, or to commit to the proposed follow-ups.

Frequently professionals do not feel comfortable about oral health and the consequences of the mouth diseases on the gestation, as well as doubts about the use of medications, mainly local anesthetics, as in the speeches of some professionals below:

"I say to use without vasoconstrictor, but some treatments do not allow that right? [...] And what is prilocaine? Why can not it be used in pregnant women? [...] what local anesthetic can she take? Sorry for my lack of knowledge. I do not know why I get a letter from a dentist asking whether I can use anesthetic?" (Violet)

In the present study, the professionals have brought to light several daily issues that could be discussed in the workshops while showing their uncertainties, over

and above protocols and programmatic guidelines. The main difficulties pointed out by the professionals in their practices were related to the use of anesthetics, also shared by pregnant women who, according to workshop participants, are afraid of these procedures. The workers also emphasize that pregnant women's seeking for care in acute painful situations, indicate that the presence of remedial actions is predominant in the services studied.

In this context, buccality may be an important tool for expanding oral health practices, insofar as:

"Buccality is a concept and it is also a way of looking at mouths and teeth thus making it possible to think about the organization of oral health clinical work. With this concept, or way of looking, one can think of the physiology of the place, which means buccal functions, and this makes it possible to reflect on impairment or incapacity to perform such functions, enhancing the stomatology clinic." 1

**"We are still looking for strategies to make sure the treatment happens".**

The teams try to create strategies in order to increase the pregnant women's commitment to OHT follow-up "we are still finding strategies to make sure the treatment happens. Because if the treatment depended on the pregnant women ..." (Lima).

One of the strategies cited is the participation of OHT professionals or the oral health approach in pregnant women's educational groups, according to the statements:

"The group of pregnant women including the dentist, too". (Sepia)

"The specific counseling groups for pregnant women, and oral health may be a theme within the group of pregnant women. (Conclusion of the group)"

The groups can be strategies of the utmost importance for the discussion of pregnant women's oral health issues. Santos and Penna [23] discuss how groups can empower health promotion by increasing decision-making resources about the users' own health. Educational groups, designed with population participation in a co-responsible action where cultural aspects of the subjects and the health attributed meanings, these groups can articulate a variety of professional in order to integrate several areas of knowledge, provided that everyone has an open dialogic attitude and not oppressive.

Campos [24] understands that the organization of knowledge in health practices happens through the

concept blending of nucleus and field. Nucleus- the agglutination of knowledge which delimits an area of professional knowledge identity and practice, and field, as a space of imprecise limits where each discipline and profession would seek in others the necessary support for theory or action.

Taking into consideration that all professionals involved are part of health care as well, with their specific cores - it must be emphasized that there is a common field which belongs to all these professions, which would be an empowered place ready to overcome the care fragmentation [24].

This new field of knowledge presupposes the intersection of knowledge, skills and practices of each category, breaking with the isolation of health workers, escaping from the traditional multiprofessional model. This does not mean leaving aside the specific core of each profession, but rather an exercise in humility, respect and scientific team of the various professionals. Although the field is a place which privileges interprofessional work, it also influences the professionals' privacy, that is, the nuclei, because when teams can all together build dialogue, problematization, mutual aid, understanding of the health-disease process and actions, the professional's performance in their specific area is also modified [25]. The teams studied have recognized the existence of this field, and the possibility of the OHT actions with the other professionals of the team, as stated:

"We were also able to understand that a complete prenatal can have a dentist in the team, one more professional taking care of the pregnant woman". (Group Conclusion)

"A good and integrated prenatal care not only with each one doing his own task but I think of an integrated care with every single one carefully talking, a network care". (Group Conclusion)

The teams emphasize that the pregnant woman's follow-up is fundamental and that there are situations in which it may be safer to postpone dental treatment, once this decision comes after a team evaluation.

"Sometimes there are procedures that can be postponed, right? You are avoiding it, but these procedures were previously evaluated, and then the option for postponement was made. But they were at least evaluated, so avoid treatment, but not evaluation". (Conclusion of the group)

Regarding the follow-up of oral health issues, information and educational actions can be performed by several professionals, not only restricted to the OHT members, nonetheless not all the members of the health teams always share this opinion. In general, during pregnant women follow-up, physicians do not provide oral health guidelines. Dentists, in turn, only concentrate on the technical aspects inside the mouth, on the teeth, with little interaction and exchange with other professionals, which does not contribute to an interprofessional articulation [14].

The literature discusses how, historically, dentistry has chosen caries as the full oral disease manifestation which requires restorative or surgical procedures. The dentist's clinical horizon discourse is based on caries and that everything is caries or its consequence constitutes the a priori odontological, which is shared with other health professionals. Thus, if the possibilities of dentistry are limited to the restorative or surgical treatment of caries, which are exclusive dentists' attributions there is a withdrawing from other health professions in this area [12]. Some professionals recognize this distance:

"Our doctor does not do follow-up, dental evaluation on anyone". (Esmeralda)

Another issue refers to educational actions in oral health still restricted to the dentist himself. Among the professionals who participated in the study, only one of the dentists stated having performed oral health educational actions with the pregnant women in prenatal care, weakening actions that could have been planned and performed by the entire team. The speeches point to individual actions in the office, still focused on the teaching of brushing and flossing techniques:

"In the first appointment we reinforce, teach to brush, to floss, and treat all that needs to be treated, restoration, extraction, everything, all treatment is done here. But the issue of gum care, we need to put a greater emphasis on it, from the beginning". (Sepia)

Oliveira et al. [26] studies are concerned with those educational oral health activities, generally restricted to brushing lectures, still based on the vertical knowledge which shows the knowledgeable dentist in front of the ignorant user who needs to be saved by the knowledge he/she will receive. The idea that the disease is caused by lack of care, by the patient's lack of health care, and that the simple knowledge is enough to solve this issue



ends up reinforcing authoritarian, prescriptive and coercive practices of a low resolvability. Many professionals believe that the population does not provide good care of themselves, taking risky behaviors, a biased view of health professionals about people who get sick. The approachment of professionals and the search for an understanding of the meanings the community attributes to the health-disease process are fundamental steps in the production of educational health actions which do not have a bias of domination, presenting more humanized and resolute actions [27].

The workshops carried out in this research led to the discussion of impairing as well as facilitating oral health care issues during pregnancy, in the features of each team, each territory, which highlights the transformative potential of these meetings

“The lack of information, both of the team as well as the pregnant women and families; work discontinuity within the unit for health promotion - there is no such flow in public service; the very professional’s behaviour who does not want to treat the pregnant women, of course that sometimes there are some exceptions, like a risky pregnancy, so then we really wait a little to see if we can treat it after pregnancy. Of course we advise concerning oral hygiene and things like that which have to be done in the dental chair, but they’re exceptions”. (Conclusion of the group)

“We have good information here, also groups of pregnant women, information disseminated throughout the team, the presence of a dental professional within the team, the offer of vacancies for dental treatment already at the beginning of prenatal appointments, admittance to special services , because if the person needs it he or she has this as a guaranteed service, the priority admittance of the pregnant women who do not have to queue, they have priority, and the improvement of the equipment of our offices”. (Conclusion of the group)

These issues, pointed out with strengths or weaknesses by the teams, show the potential of workshops to discuss practices, based on theory and local reality, for the collective construction of care strategies.

### **“But if things are not working out, we need to talk”.**

Due to the unstable indicators of maternal and

infant mortality in the city of Santos, there is a broad investment in training, meetings and programs. This commitment of management can lead to the increase of specific actions for the maternal child group in the services, but it can also intimidate the professionals as they have to justify their actions, they withdraw and perform the minimum of interventions in pregnant women for fear of possible problems.

“Most dentists do not want to treat pregnant women because they are afraid, right? Yes, a lot”. (Cobre)

“Yes, but if the baby is born with something, she’s going to sue him and he’s going to have an annoyance. He’s going to have to prove it. He’s going to have to show his studies, sometimes the guy knows he will not do it, but he does not even want to go through it. Oh, I will not do it because if the baby has a problem you will blame me and then I will have to respond”. (Violeta)

Although the monitoring of the oral health of pregnant women appears as a source of fear and concern to the professionals, there are speech lines which demonstrate that the discussion in the team, with the agreement of actions among the professionals, may be a way to face this situation and not neglect the oral health of pregnant women’s oral health.

“You do not have a rule, right? But I think it depends a lot on the team that the dentist has with him, from the team support he has”. (Roxo)

The workshops can be resources for these deficiencies, once the problems are part of a collective issue regarding the whole health team, observing different ways of dealing with an issue is created as well as the reasons that lead decision-making, thus responding collectively to the users’ demands, create new solutions to the problems faced and deal with the problems of the teams [28].

In this sense, the studied professionals point out, first and foremost, the lack of communication between the FHT and the oral health team, which is kept apart from other professionals. Dentists also have a unique kind of working, as stated:

“The oral health team seems to be a team apart from PCU”. (Roxo)

“It’s as if they worked their way off the beaten track. It’s not like the section wants, either”. (Jade)

The statements of the professionals reinforce the idea that the separation between dentistry and other health professions is an anchored question based in the

knowledge and practices that result from disputes in diverse social and cultural contexts and so they can be questioned, revised and modified, as Meyer et al. [28] points out.

According to Rocha and Warmling [16], the fragmentation of work processes, with practices centered on the production of procedures within each core of knowledge, is not exclusive to OHT, but the dental training of oral health professionals, which isolates the mouth from the rest of the body also strengthens the OHT isolation.

In addition to training in dentistry, Oliveira et al. [26] argue that dentists are rarely invited to the planning processes, as well as to discussions and training on subjects that are not restricted to the field of dentistry, and similarly, occasions when doctors, nurses, and other health professionals attend oral health meetings or training. This contributes to the low degree of interaction among professionals, emphasizing the compartmentalization of care, driving away from integrality.

Regarding the team composition, it should be highlighted that FHU professionals who do not count on OHT in their units, understand that the physical absence of oral health professionals is an impairing fact regarding this aspect of care:

“Our unit does not have the dental service, so it is very difficult to have a good follow-up during pregnancy”. (Grená)

FHU- OHT emphasize the importance of OHT participation in the discussions during team meetings and they can foresee the potential for permanent educational actions in the Family Health Team, improving communication between professionals of different areas and problematization of care actions that enable the construction of new knowledge and strategies in order to face the of daily work issues.

“Since we became Family Health a year ago, and the dentist is part of the team, I can always give an answer. Those who have the most access to pregnant women are the health care takers. The team accompanies them, but they are the ones who get an adequate follow-up, so they did not know that either, and now that we’re always with the dentist attending the meeting, they’re not afraid of the team anymore. So for that part we managed to deconstruct the myth” (Lima)

“That’s why we explain this to the nurses, because when the test is positive they already invite the pregnant

woman to attend with us, to be receiving all this guidance in relation to this in the first trimester”. (Sepia)

The integration among different professionals is part of the main FHT challenges concerning horizontal communication actions which enhanced meetings for case discussion, the dynamics of health unit functions and the performance of permanent education activities [26]. The workshops can improve communication among professionals, exposing their daily work, as well as allowing them to problematize the practice and to create joint strategies to face difficulties, as the statement:

“But if things are not working out I think it’s worth a talk. I think you have to try to approach work processes”. (Marrom)

“One thing that has a lot of power is this conversation that we are trying to approach so that they complete what we do not have, which is dental care, not just for pregnant women”. (Conclusion of the group)

Merhy [29] proposes reminding us when we, health workers, stand in the position of health users, requiring actions and services produced on us by other health professionals, pointing out that we would be invaded by thoughts about what level of implication the other produces in our lives, which for us is valuable and deserves to be defended. Thus, the health team would have the perspective of an agent-user, imperative for the life other’s defense, individual or collective.

The workshops applied in this research did not aim to solve all the problems of the pregnant women’s oral health care, but rather, trigger processes, in which the professional could face the theme and therefore give chance for problematization.

It can be concluded from this this manuscript data production the request of, at least one prenatal dental consultation, has produced an increase in the access of pregnant women to OHT consultations however not enough for their follow up, nor for the health team professionals involved and the community either in the search for improvement of the pregnant women’s oral health conditions.

The difficulty of pregnant women’s OHT follow-up has been attributed to the lack of interest and importance concerning users’ dental treatment, as well as fear of fetus’ damages, showing users’ prejudice and ignorance. Misinformation about the follow-up need and the anesthetics use seems to be a difficulty among professionals

despite recognizing the importance of monitoring the Oral Health of pregnant women.

Dentists were the group who presented the greatest prejudice regarding the dental care of pregnant women, although concerned with the treatment and follow-up of these women. Despite dentists also fear the oral health of pregnant women's monitoring they recognize the need for team discussion and action agreement as a strategy to face oral health care of pregnant women's challenges.

Pain is cited by professionals as a commonly leading factor for pregnant women to seek care in OHT. At the same time, some workers recognize that the lack of educational actions for the population, by the team itself, can be a determining factor for pregnant women's treatment distance.

Comparing the three basic health care facilities, the FHU-OHT was the one which presented the least doubts about these issues, and professionals have admitted that the OHT presence in the team meeting has contributed to the discussion of oral health issues, deconstructing some myths. The OHT participation in team meetings, discussing not only oral health but work processes as well, seems to have brought great actions contributions among the three units studied.

Despite reaffirming that the OHT operates apart from the rest of the unit, the professionals describe attempts in order to approach strategies between FHT and OHT, aiming at increasing the pregnant women's commitment to oral health care, such as watching over for their missed appointments and dentists's participation in the educational groups of pregnant women.

During the workshops, professionals have acknowledged that new information was addressed and discussed among them, encompassing many difficulties in providing comprehensive prenatal care, as well as attitudes, which enhance oral health care. The study has shown the essential contribution the workshops performed as they are constituted as collective chances of practice problematization and a powerful tool for health future actions of permanent education, in the region.

#### Collaborators

All authors participated in all phases of the research article.

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