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ORAL HEALTH IN BRAZIL – HISTORICAL DIMENSION

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Abstract: Oral health is directly related to social inclusion and human dignity. The article aims to identify the historical dimension of oral health in Brazil. The study methodology is qualitative, analytical, deductive research. It was adopted to carry out an integrative bibliographical review. The results prove that promoting oral health is the duty of the State and represents a rescue of dignity and citizenship. Dentistry can contribute to an increase in social inclusion; therefore, it is necessary to use methods that prevent and combat oral diseases, especially dental caries. The conclusion of the study reports that poorly conducted oral health produces low self-esteem and poor quality of life in citizens. Poor oral health, therefore, represents a clear sign of a precarious living condition, as well as discrimination and social exclusion.
Keywords: Oral health. Brazil. Historicity.

INTRODUCTION

This work adopts the heuristic problem, consistent with the formalization of a historical approach to the development of oral health in Brazil.

Oral health qualifies the oral cavity and contributes to the overall health of the individual. The most prevalent oral diseases, such as tooth decay and periodontal disease, are prevented by applying oral hygiene measures and other preventive actions, such as the use of mouthwashes (rinses) and fluorides, thus preventing the individual loses oral function. Another oral health problem, which is quite common, is cancer of the lips and oral cavity. According to the World Health Organization, these are among the 15 most common types of cancer worldwide, causing about 180,000 deaths each year. Problems related to oral diseases affect 3.5 billion people worldwide. (CISION, 2021).

The data collected by the International Dental Federation (FDI), highlights that 90% of the world's population must suffer some injury or disease related to oral health. The cause is related to the inadequate daily routine of hygiene and care, causing loss of teeth and even oral cancer (tongue, palate, among others). (QUEIROZ *et al.*, 2018).

Worldwide, the quality of oral health is related to the socioeconomic and cultural conditions of the population. In Brazil, the scenario is no different, the population has the same problems in relation to lack of knowledge about preventive actions and difficulty in accessing oral health services in the public network of Primary Health Care. (QUEIROZ *et al.*, 2018).

The country is in third place regarding the incidence of oral cancer, behind India, the country that occupies the first place, in second place is Czechoslovakia. (SICIDETO, 2021; BRASIL, 2020).

Until 2003, Brazil offered health services in parallel with other services of the Unified Health System (SUS). In 2004, with the implementation of the National Oral Health Policy – Brasil Sorridente, oral health began to be offered to the population in an integral way, providing more complex services and composing a network of oral health care services in the SUS. (BRASIL, 2012).

The historian seeks to understand the fact in a certain period of time, however a sequence of historical facts obeys multiple temporal rhythms, as it also happens in the evolution of public policies in oral health in Brazil. When the historical rescue is done from the individual or a group of individuals, it needs to be contextualized in time and space, so that the experiences and multiple experiences of those involved are rescued. (SANTOS *et al.*, 2021*)*.

SANTOS *et al.*, (2021) reinforces that "history can be understood as a science not in the sense of a laboratory science that follows rigid experimental methods, but as a critical

investigation about historical facts", knowing the historical facts linked to the The process of oral history, using history among the social sciences, will make it possible to understand the environment for the construction of Brazilian public policies aimed at oral health. (BARROS, 2017).

Therefore, as a research question: How has the historical dimension influenced oral health in Brazil?

The purely scientific story excludes many facts, as they are not within scientific rigor. The historical study allows building a conception of human societies as full, organized and complex compositions, with unique historicities, possible to be known by researchers of history. (SANTOS *et al.,* 2021). The historian's role is to study and present clippings of past events, since it is impossible to know all the facts and the exact way in which they occurred. (AVEAL *et al.,* 2017).

In view of the above, the article aims to identify the historical dimension of oral health in Brazil.

The study methodology is qualitative, analytical, deductive research. The procedure adopted in the research was to carry out an integrative bibliographical review.

Qualitative research studies a "phenomenon" from the perspective of the people involved, considering all the points of view of those involved. It can also include the study of documents (medical records, articles, databases, among others), considered a rich and important source of information about the object of study, as they are considered permanent information over the years. (GODOY, 1995).

In the analytical method, the historian starts his study of internal and external elements, seeking a cause and effect relationship between the nature of the object of study. In the analysis of the study, the researcher seeks to produce a knowledge base, contributing to general knowledge. (BORBA *et al.,* 2004).

In the deductive method, the researcher submits the research material to the questions of a previously formalized theory, trying to answer the historical process of study or questions referring to specific social aspects. The method has a formal interest in the generality of the theoretical explanation, going from the general to the particular study. (TEIXEIRA *et al.,* 2014).

Google Scholar, Latin American and Caribbean Literature in Health Sciences (Lilacs) and *Scientific Electronic Library* databases. *Online* (SciELO), based on the keywords: oral health; Brazil; story.

The results are presented in descriptive form, based on the discussion with the literature.

DEVELOPMENT

The model of dental care in Brazil has undergone many changes and transformations when assuming the role of caring for the population's teeth, being influenced by models adopted in other countries and by disastrous public policies.

Brazil adopts the first dental model between 1534 and 1536. The years correspond to the founding of the first villages in the hereditary Brazilian captaincies. With the population of Brazilian lands, surgeons, bleeders and barbers also arrived in the country, with the task of taking care of the mouths of the colonizers. (MARTINS *et al,* 2018).

The barbers were more skilled professionals, their role was to perform dental extractions, performing the procedures with improvised materials and without the minimum hygiene conditions. The bleeders used leeches for bleeding and extracted teeth. (MARTINS *et al,* 2018).

Many of the settlers who arrived to occupy Brazilian territory were artisans without much education, looking for new opportunities. Barbers and bleeders had the same profile, they learned the activity from someone more experienced, being known for being cruel, having little knowledge and low opinion by society. (MARTINS *et al,* 2018).

In the 17th century, Portugal approved the Royal Charter of Portugal on November 9, 1629, regulating the practice of dental art. Barbers to perform dental extractions need a license, without the document they are subject to fines in the amount of two thousand réis. Another document from the period is the Regiment to the Substitute Surgeon of Minas Gerais, approved by the administrator of Minas Gerais, the Portuguese military and nobleman Gomes Freire de Andrade Bobadela. (SILVA; SALES-PERES, 2007).

Until the 18th century, oral health in Brazil changed little, based on the premise of tooth extraction. The pilots (manumitted slaves or slaves) had little social recognition, mainly by the Portuguese, being responsible for the task. The population had little choice, including post-extraction treatment consisting of the use of medicinal herbs. Two diseases stand out for oral health: scurvy (lack of vitamin C) and tartar, formed from bacterial plaque or dental biofilm. (SILVA; SALES-PERES, 2007).

With the arrival of the Portuguese royal family to Brazil on January 22, 1808, King D. João VI promoted:

> - On February 18, 1808, the Bahia School of Surgery is created at the São José Hospital;
>
> - The extinction of the Real Junta do Protomedicato, on January 7, 1809, returning control of licenses to the Chief Physician and Chief Surgeon;
>
> - Issuance, on February 15, 1811, of the first Dentist's Charter in Brazil in the name of Pedro Martins de Moura (Portuguese) and, on July 23, 1811, in the name of a Brazilian, Sebastian Fernandez. (SILVA; SALES-PERES, 2007, p. 9).

The fight for the monopoly of Dentistry begins, from the Savoy Reform, institutionalizing the Dentistry Courses attached to the Medicine Courses on October 25, 1884. The day that the Dental Surgeon is celebrated in Brazil. (SILVA; SALES-PERES, 2007).

Dental care models in Brazil are greatly influenced by the United States of America, many dentists fleeing the Civil War (1861-1865) such as *Samuel I. Rambo, Carlos Koth, Witt Clinton Green, Preston A. Rambo, John William Coachman, William B. Keys, Carlos Keys,* etc., move to Brazil. The *Coachman and Keys* families, constituting until today the largest contingent of American dentists established in Brazil. (ROSENTHAL, 1995).

The United States of America leads the technical evolution and world science, due to the fact that this nation became a world power in the beginning of the 20th century. Many Brazilians interested in the Dentistry Course migrate there, seeking improvement in the area. The standard of dentistry initially found in Brazil was predominantly aimed at private practice, essentially curative and tending towards specialization, thus dividing knowledge. (ROSENTHAL, 1995; BRASIL, 2006).

Following the American model, a history of public assistance begins in 1912, with the entry of dental care in schools, with the inauguration of the first school office in official primary education in the city of São Paulo. Other school offices were created in the states of Rio Grande do Sul, Minas Gerais, Paraíba, Pernambuco, Rio de Janeiro, Bahia and Sergipe. (OLIVEIRA; MATOS, 2018).

Other strategies were implemented seeking the quality of oral health in Brazil, such as competitions for good teeth, multiplication

of dental offices and school dental education campaigns. The dentist held the knowledge, disseminated the standards of beauty associated with the body, citing the values of responsibility, discipline, regularity and rationality in relation to the body and health, establishing the use of toothbrush, toothpaste and mouthwash. The child equipped with objects for oral hygiene responded to the family, specifically the mother figure, aware of her role in the formation of healthy citizens. (OLIVEIRA; MATOS, 2018).

In the 1950s, the incremental system was implemented in 1951, again imported from the United States and, once again, aimed mainly at students aged between six and 14 years, therefore, it does not present a strategy that would reach the population as a whole. It is shown to be an ineffective system in terms of health issues and extremely exclusive, as only a small part of the population would have access to dental care. (LIMA, 2017).

Adults and the elderly receive only one emergency service which, most of the time, was mutilating, hence the reason for so many total or partial toothless patients in the country between the 50's and the 80's. (BRASIL, 2006; LIMA, 2017). School attendance was predominantly guided by a practice similar to that developed in private practices, that is, private curative dentistry. (BRASIL, 2006).

In 1968, Brazilian dentistry, based on **the medical teaching model of the** *Flexner* Report, adopted the suggestions of mechanism, biologicism, curative, technocratic and specialized. Despite all the technical-scientific development, the objective is curativism, not meeting the needs of the population, in addition to being a high-cost dentistry. (LIMA, 2017).

In 1974, the federal government sanctioned Law No. 6050/74, which regulated Decree No. 76872/75, releasing funding and credits for states to implement water fluoridation in local water supply systems. The legislation changed the Dentistry workspaces and the expansion of auxiliary personnel, promoting the collective, the educational, the approach and the community participation. However, dentistry actions continue to promote the hegemony of the biomedical model, serving a specific group of the population (6 to 14 years old), creating at the other extreme the "toothless group". (BRASIL, 2008; LIMA, 2017).

The Sanitary Reform Movement of the 1st National Conference on Oral Health in 1986 expressed the need for changes in school curricula, insertion of health in the political field as a collective actor in the process of changing the liberal-privatist model and maintenance of the medical-industrial model. The model for dentistry intended to serve the younger population, without a caries process, to prevent carious lesions in permanent molars, an advance in traditional dentistry. (LIMA, 2017).

In Brazil, before the 1988 Federal Constitution and the creation of the Unified Health System (SUS), only workers enrolled in the National Institute of Medical Assistance and Social Assistance (INAMPS) had the right and access to health services, including dental services). With the creation of SUS, there is the possibility of access to health services by all Brazilians, preventing any type of restriction or exclusion of population care. (MATTOS *et al.,* 2014).

From the 1990s onwards, "the school space began to be questioned as an exclusive place for oral health care". (BRASIL, 2006, p. 21). Several action programs then followed, in a line of work aimed at the universalization of dental care.

The first of these programs was centered on the adequacy model in **basic health units,** through dental clinics in health units. (BRASIL, 2008).

The second program, called **the Attention Inversion Program (PIA),** combines preventive and curative methods, thus removing infectious processes in order to promote a better biological condition of the oral environment, thus improving the effectiveness of the prevention. (MORAIS *et al.*, 2020).

The third program was characterized by the development of **promotional oral health and prevention programs within homes,** configuring an attempt to insert collective oral health within the Family Health Programs (PSF) in Basic Care or Primary Health Care. The health programs seek with the Oral Health Team (ESD) to develop individual and collective actions, focusing on the promotion of oral health, prevention of injuries/diseases, treatment, rehabilitation and health maintenance. (BRASIL, 2008). The Oral Health Team (eSB) has a Dental Surgeon (CD), an Oral Hygiene Technician (THD) and/or Oral Health Assistant (ASB), articulated with the family health teams (Doctor, Nurse, Nursing Technician or Nursing Assistant and Community Health Agents (CHAs) (CAYETANO *et al.*, 2019).

The planning of Oral Health actions in Primary Care starts to use information from Epidemiology, recognizing the main oral diseases in the territory of the health team, carrying out monitoring, evaluation of the actions developed and resource estimates, in addition to producing important health information. (BRASIL, 2008).

Subsequently, the strengthening **of surveillance programs for the quality of fluoridation of public supply water,** combating smoking, healthy diets, access to basic sanitation, among others, were established. (BRASIL, 2006).

In 2003, the elaboration of a National Oral Health Policy began, designed to reach the various age groups (children, adolescents, adults and the elderly), aiming to rescue the citizen's right to adequate dental care. The policy is completely intertwined with the SUS (unified health system), therefore, in line with the constitutional provisions related to health in a broader sense. (SIQUEIRA; ACOSTA, 2015).

The Brazilian State currently exercises the National Oral Health Policy through the **''Brasil Sorridente" Program,** which corresponds to a strategy inserted in a larger context of health programs developed by the Ministry of Health through the SUS. (BRASIL, 2006; CAYETANO *et al.*, 2019).

The Brasil Sorridente Program "comprises a set of actions at the individual and collective levels that encompasses health promotion, disease prevention, diagnosis, treatment and rehabilitation". (BRASIL, 2006, p. 42). Its main actions are focused on three directions: basic oral health care; specialized care; and the feasibility of adding fluoride in public water supply treatment stations.

Primary Oral Health Care is developed through the Family Health Strategy (ESF), reaffirming the priority strategy of reorganizing health services, the values of health promotion and the identification of health vulnerabilities in the population. Specialized care is developed through Dental Specialty Centers (CEOs) and Regional Dental Prosthesis Laboratories. The teams are structured in: Modality I - Dental Surgeon (CD) and Dental Assistant (ACD), currently Oral Health Assistant (ASB) and Modality II - Dental Surgeon (CD); Oral Health Assistant (ASB) and Dental Hygiene Technician (THD), currently Oral Health Technician (TSB). (MATTOS *et al.,* 2014).

As the concept of Primary Care underwent expansion, including a greater number of procedures, there was, consequently, the need to expand and qualify the offer of specialized dental services. The third line

of action of the Brasil Sorridente Program is exactly the focus of this work, that is, the fluoridation of public water supply. (BRASIL, 2006; FREIRE, 2011).

The portrait of the oral health condition of Brazilians was drawn from several epidemiological surveys, including from the DMFT marker index proposed in 1937 by Klein and Palmer, and in dentistry it represents the number of Decayed, Lost and Filled Teeth restored). (AGNELLI, 2015).

The **first National Survey of Oral Health** in Brazil was carried out in 1986, in 16 capitals of the five Brazilian regions, data related to caries, periodontal diseases, use and need for complete dentures, access to dental services and socioeconomic assessment were obtained. Four age groups were analyzed: 12 years old; 15 to 19 years old; 35 to 44 years old; and 50 to 59 years old. The DMFT index for the 12-year-old group was **6.65** on average. Those analyzed with a salary of less than five minimum wages have the worst CPO-D index. (BRASIL, 2006; AGNELLI, 2015).

The standard for international comparison is the DMFT/CEO-D index (decayed, lost and filled) at 12 years of age. The index at this age is especially representative, as it indicates the degree of teeth affected at the beginning of the permanent dentition. (BRASIL, 2012).

The **second survey** was concluded in 1996, encompassing 27 capitals and carried out only with children between 6 and 12 years of age from public and private schools, producing data on dental caries. For the 12-year-old group, the DMFT index obtained was **3.06** on average. (BRASIL, 2006; AGNELLI, 2015).

The **third survey** took place in 2003, 250 municipalities were surveyed, 50 from each Brazilian region (North, Northeast, Midwest, Southeast and South). In this study, six age groups were analyzed: 18 to 36 months; 5 years; 12 years; 15 to 19 years old; 35 to 44 years old; and 65 to 74 years old. For the 12-year-old group, the DMFT index found was **2.8** on average. (BRASIL, 2006).

The results of the third survey, when analyzed more meticulously, end up revealing discrepancies between Brazilian regions. It is observed that, despite the national average of the DMFT index for 12-year-old children being **2.8,** a better oral reality can only be found in the South and Southeast regions, where the DMFT index revolved around of **2.3.** In the North and Northeast regions, the index found was almost **3.2.** (BRASIL, 2006; AGNELLI, 2015).

Note that this index is much higher than that found in southern Brazil, remembering that it represents a greater number of decayed, lost and filled (restored) teeth. It is also observed that in the South and Southeast regions the percentage of teeth that have already been treated (filled) is much higher than the rate of teeth restored in the North and Northeast regions. (BRASIL, 2004).

The data obtained in the survey, when compared to the goals of the World Health Organization (W.H.O.) for the year 2000, show a worrying scenario. (TABLE 1). Brazil reached only the target for the age group of 12 years, the result may have been obtained due to the oral condition achieved by children in the South and Southeast regions. The goals proposed for the other ages were not achieved by the stipulated deadline. (BRASIL, 2004).

AGE	WHOGOAL FOR 2000 _	ORAL HEALTH BRAZIL 2003
5 to 6 years	50% no caries experience	40% no caries experience
12 years	DMF ≤ 3.0	DMFT-D = 2.78
18 years	80% with all teeth	55% with all teeth
35 to 44 years old	75% with 20 or more teeth	54% with 20 or more teeth
65 to 74 years old	50% with 20 or more teeth	10% with 20 or more teeth

Table 1 - WHO DMFT targets for Brazil in 2000 and the results obtained in the Brazilian Oral Health Program. Brazil, 2003. Source: Brazil, 2006.

The **fourth National Oral Health Survey of 2010,** carried out in 177 municipalities (26 capitals and the Federal District, in addition to 30 municipalities in each region of the country), examined 38 thousand people from five age groups: 5 years old; 12 years; 15 to 19 years old; 35 to 44 years old; and 65 to 74 years old. The national average obtained from the CPO-D index in the 2010 survey, for the age of 12 years, was approximately **2.1.** The index reveals a good evolution in the oral condition of Brazilian children, for the same age group, when compared to the **2.8 index of** the survey in 2003, placing Brazil in the group of countries with low prevalence of caries. (BRASIL, 2010; AGNELLI, 2015).

An improvement in the oral condition of Brazilians was also achieved in the other age groups surveyed, with a reduction in the DMFT index in all of them. What can be observed, however, when analyzing by region, is the fact that, while the DMFT index fell, mainly in the Southeast region (DMFT = **1.7**), it increased in the North Region going from **3.1** in the 2003 survey to **3.2** in the 2010 survey. (BRASIL, 2010; AGNELLI, 2015).

The analysis of the results confirms the inequalities between the North, South and Southeast regions. The third epidemiological survey identifies the increase in CDO-D in the North Region, which may indicate an increase in socioeconomic and cultural inequalities, lack of knowledge and difficulty in accessing oral health services by the population.

FINAL CONSIDERATIONS

The Dental Care model in Brazil was initially influenced by other countries, mainly by the models adopted by the United States of America. It underwent many changes and transformations when it assumed the role of caring for the population's teeth, focusing on preventive care for the school group, leaving other citizens on the margins of oral health.

Prior to the implementation of the SUS, only workers enrolled in the National Institute of Pensions and Health (INAMPS) were assisted in the public health system, and the oral health system remained restricted to school groups.

The implementation of the Family Health Strategy (ESF), advancing with the work of Oral Health in Primary Health Care, enabled the reorganization of the health system serving all citizens, as the principles of the SUS (Unified Health System) with equity, integrality and universality are valued. The ''Brasil Sorridente" Program is a strategy adopted in Brazil, in the area of oral health, for health promotion, disease prevention, diagnosis, treatment and rehabilitation. It even provides for the addition of fluoride in public water supply treatment plants.

The Brazilian State is currently facing a crisis of legitimacy caused by numerous social problems, such as poverty and unemployment. Other problems are present, related to the area of oral health, which is the focus of this work, where the government has undoubtedly shown inefficiency, which generates social inequality.

For a change to occur in the current situation, aiming at increasing governance, there is a need to face social inequalities, which prevent people from accessing citizenship and compromise the democratic project. Social policies must be created and implemented, in an equitable manner, so that the population can fully enjoy all their rights.

When analyzing the Brazilian history related to health, especially oral health, one can see the wealth of legislation that provides for and guarantees countless rights. There is, however, an abyss between legality and social reality, which needs to be approximated.

It is therefore necessary to provide the conditions for citizens to fully enjoy their rights provided for by law. The State needs

to seek innovative alternatives in order to minimize the crisis of legitimacy and enhance the construction of democracy, allowing individuals universality and equal access to their rights.

A state of exclusion from access to basic social rights, such as, for example, employment, decent wage income, housing, health, adequate education and security, has repercussions on the population in a poor quality of life.

Poor quality of life produces a totally negative result on oral health. Poor oral health, therefore, represents a clear sign of a precarious living condition, as well as social exclusion.

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