

“With a toothache, everything seems to be bad in life!”: oral health in the indigenous community of Tremembé, Ceará, Brazil

“Com dor de dente, tudo é ruim nesta vida!”: saúde bucal na comunidade indígena de Tremembé, Ceará, Brasil (resumo: p. 17)

“¡Con dolor de muelas, la vida es horrible!”: salud bucal en la comunidad indígena de Tremembé, Ceará, Brasil (resumen: p. 17)

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This study aimed to analyze the importance of oral healthcare in the Tremembé indigenous community, municipality of Itarema, state of Ceará, Brazil. In this exploratory and qualitative study, semi-structured interviews were carried out with six adults considered key informants in the community. The perceptions most frequently found in the discourses indicated that the informants recognize the importance of oral healthcare and focus on dental hygiene, necessary for socialization. The discourses related valuation of healthy eating - associated with good oral health - to valuation of traditional knowledge as a care practice. However, the discourses focused on clinical care for adults at the expense of educational aspects. The perceptions showed that it is possible to integrate the care delivered by health professionals with the care provided by social actors who have a leadership role in the indigenous community.

Keywords: Indigenous peoples. Oral health. Social perception.



Introduction

Indigenous peoples underwent intense changes after surviving the violent colonialist process of European cultures, marked by environmental changes and introduction of diseases. The health situation of Indigenous communities is related to a complex framework of sociocultural, historical and environmental transformations, grounded on a continuous process of interrelation with the non-Indigenous expansion¹.

Indigenous healthcare is characterized by a long historical and social process and has been the object of Indigenous claims since the 1970s, stimulated by the First Conference on Indigenous Peoples' Health in 1986¹. With the implementation of the Indigenous Healthcare Subsystem of the Brazilian National Health System (SASISUS) in 1999, 34 Special Indigenous Health Districts were created for the organization of the healthcare network. Furthermore, the National Indigenous Healthcare Policy (PNASPI), created in 2002, aimed to promote comprehensive and differential care related to the articulation between the services of the Brazilian National Health System (SUS) and Indigenous medicine². In 2007, Indigenous oral healthcare was regulated by the Guidelines for the Oral Healthcare of Indigenous Populations, which facilitated access to free dental treatment but did not reduce access inequities based on this population's needs³.

Promoting oral healthcare to Indigenous peoples has been a challenging enterprise due to the territory extension and diversity of these populations. Globally, there are 370 million people identified as Indigenous in 90 countries⁴. According to the last census, carried out by the Brazilian Institute of Geography and Statistics in 2010, 896.9 thousand Indigenous persons were registered in Brazil, 36.2% in the urban area and 63.8% in the rural area⁵. It is estimated that they comprise 305 Indigenous ethnic groups with highly diverse sociocultural characteristics and epidemiological profiles⁶.

A review of Indigenous oral healthcare interventions has shown that the United States, Canada, Brazil, and Australia have implemented a wide range of initiatives for prevention and treatment of dental and periodontal diseases, as well as improvements in oral health knowledge, behaviors, and other associated psychosocial factors⁷; however, oral health inequalities between Indigenous and Non-indigenous persons still exist^{8,9}.

Indigenous peoples face substantial exclusion or marginalization. Their health status is worse than that of non-Indigenous populations, including worse oral health conditions and limited access to dental services⁹. Brazilian Indigenous individuals are three times more likely to never having visited a dentist's office¹⁰; furthermore, they are more likely to having experienced tooth decay and periodontal disease when compared to non-Indigenous individuals¹⁰⁻¹². In Brazil, such differences in oral health conditions may be associated with territory: ethnicities in the West region of the state of Mato Grosso do Sul (Terena and Kadiwéu) present greater evidence of tooth decay compared to those in the South region (Kaiwoá and Guarani)¹³.



Inequalities in access to oral health services clearly show the vulnerability of Indigenous populations. Health interventions introduced without adequate planning and without promoting universalization and equality have amplified health inequities^{14,15}. Furthermore, lack of knowledge about the cultural practices of these populations can prevent health professionals from understanding their methods for treating diseases by means of other rationalities or traditional medicines. The biomedical model, still in force, distances health professionals from services users, which prevents them from knowing the real problems of those communities¹⁶.

To understand the scientific impact of Indigenous health, a systematic review has shown that the knowledge produced was associated with the political, social, and scientific transformations brought by the healthcare reform and with the Indigenous agenda, from the 1950s to 2010¹⁷. After the implementation of SASISUS in 1999 and PNASPI in 2002, the number of publications about Indigenous health increased ten times between the 2000s and 2010s, and Indigenous oral health represented 7% of this scientific production¹⁷. An analysis of the profile of studies presented in the 2018 meeting of the Brazilian Society of Dental Research showed fewer studies involving Indigenous people than children, pregnant women, women, and older individuals - more prevalent specific groups¹⁸. Moreover, a greater concentration of studies in the North¹⁵ and Central-West¹³ regions reveals a lack of evidence about ethnicities living in the Northeast, Southeast and South regions of Brazil.

The epidemiological panorama and the availability of dental services require a thorough understanding of oral health as a social phenomenon. Thus, oral health promotion must transcend the restrictive curative profile that naturalizes tooth loss and emphasizes the use of dental prostheses, and go beyond the odontological clinical limit¹⁹. The concept of "buccality" proposed by Botazzo¹⁹ is a theoretical framework that is adequate to the context of the present study. It expands the perception of oral health practices beyond clinical conditions, and promotes the mouth as a bridge for affirmation of life and relationship with the world, considering the entire social potential related to this organ: chewing, eroticism, language, not to mention the multiplicity of meanings of beauty, delicacy, voracity, and power of this bodily territory¹⁹.

Thus, using this framework to understand the Indigenous community's subjectivity regarding its own oral health might subsidize the planning of tailored actions to reduce the occurrence of oral problems and improve access to the health services, based on self-perception of the mouth as a space of relationship with the world, and maintaining a health quality that favors not only physiological processes, but also human and social ones. In view of this, the present study aimed to analyze the importance of oral healthcare according to informants from the Tremembé Indigenous community, in the municipality of Itarema, state of Ceará, Brazil.



Methodological path

This qualitative research follows the requirements proposed by Tong, Sainsbury and Craig²⁰. Studies with a qualitative approach contribute to health systems due to the incorporation of practices based on cultural values of individuals, their mediators, and their ecosystems^{21,22}.

The present study investigated the Tremembé Indigenous people, who inhabit the district of Almofala, in the municipality of Itarema, one of the 12 hamlets present in the Northeastern state of Ceará²³. The municipality of Itarema had an estimated population for 2021 of 42,595 people²⁴. The Tremembé ethnicity, documented in the Brazilian coastal area from Maranhão to Ceará, descends from the Tapuia/Cariri ethnicities, and its original language does not belong to the Tupi trunk. Today, it inhabits regions in coastal and inland Ceará, in the municipalities of Itarema, Acaraú, Itapipoca, and Fortaleza. In Itarema, the ethnicity's greatest geographical representativeness is in Almofala (in the coast, to the left of the Aracati Mirim river), Varjota (on the right bank of the river), and Córrego do João Pereira (in the inland area)²⁵.

The Tremembés' survival is inseparable from nature, and the preservation of ecosystems is part of their culture, as well as a mysticism personified by *encantados* (enchanted beings), who encompass spirituality, ancestry, defense of nature, and Indigenous territoriality²⁶.

Interviews were carried out with key informants from the Tremembé people. The eligibility criteria considered individuals born and residing in the Almofala hamlet, of both sexes, aged 18 years and older, in full physical and mental conditions to provide testimonies, and who authorized the use of their recorded information. According to Tong, Sainsbury and Craig²⁰, interviews are useful tools to obtain in-depth information, insights and explanations about the ways of thinking or acting of community members, and key informants are well-informed individuals who have an active involvement in the community and can provide detailed, broad information on a system, service, or other matters of interest to the researcher.

The participants were recruited by means of the snowball sampling technique. In this technique, key informants are used as *seeds* to locate people with the desired profile in the general population. The people indicated by the seeds are asked to suggest other individuals with the desired characteristics, based on their own personal network, and so on²⁷. The chief indicated three key informants, and each one indicated one more, totaling six participants to the data collection stage.

Initially, the nurse who works in the Family Health Strategy that assists the Tremembé Indigenous community suggested that we contacted the community chief to present our proposal and obtain his authorization to conduct the research. After two initial visits to survey the empirical field, we presented the project to the chief and other community leaders in our third visit. The fact that one of the interviewers lives in Itarema and has close contact with the community's members and leaders strengthened the bond.



Between July and August 2021, two interviewers with the research team collected the data in person. They had been previously instructed by the main researcher, who has expertise in qualitative health research, about how to approach the participants, how to conduct semi-structured interviews, and about the precautions to be taken when collecting qualitative data. Due to the Covid-19 pandemic, the prevention precautions in force were adopted as biosafety measures, including use of personal protective equipment, hand sanitizer, and interviews conducted in a ventilated area, with researcher and participant distanced from each other. The individual interviews took place in the hamlet itself, at a private and safe environment, respecting the interviewees' daily activities and availability, according to a previous schedule. Each interview lasted from 10 to 30 minutes. A script with guiding topics comprised the following questions: "What is your understanding of and the importance you give to oral health?", "Talk about the experiences you had when seeking dental care", and "What is your perception of the oral health actions promoted in your community?".

The reflexivity of the data collection process provided us with sufficient grounds to perform an analysis that focused not only on biological aspects, but also on the social role that good oral health promotes to the members of the Indigenous community. After this initial contact with the empirical corpus, the interviews were fully transcribed. Subsequently, two other team researchers duly prepared for the interpretation stage analyzed the data using Bardin's Content Analysis, which has the following steps: a) organization of the analysis; b) coding; c) categorization; d) treatment of the results, inference, and interpretation of the results based on the categorizations presented in the next section of the article^{28,29}.

This is a research with human beings, without conflicts of interest, that complies with the ethical principles in force. The research conforms to the National Health Council's Resolutions no. 466/2012 (respecting non-maleficence, beneficence, autonomy, justice, and equity principles), no. 510/2016 (research in the areas of Human and Social Sciences), and no. 304/2000 (within the special theme "Indigenous populations"). It was approved by the National Council for Research Ethics (CONEP) on January 22, 2021, under opinion no. 4.507.802. All the participants were informed about the research procedures and signed two documents: an Informed Consent Form and an Audio Recording Consent Form. To ensure the confidentiality of the information and anonymity of the participants, the testimonies were coded by the symbol "#" followed by the Arabic number corresponding to the chronological order of the interviews.



Results and discussion

Six community leaders participated in the present study. A coherence of speeches was obtained from the participants, and such speeches were organized in the sub-sections below, based on the convergence of discourses.

The importance of oral health related to bodily wellbeing and socialization

We perceived a consensus in the speeches regarding the importance of oral health and dental care as an inseparable part of good general health conditions, with emphasis on the need of self-care.

And also understand that if the mouth is not ok, there's definitely a problem in the body, there's a problem elsewhere. Sometimes the person has a stomach problem, they are not taking care of themselves, and it's the mouth that responds to it. (#1)

The participants also viewed oral health not only as necessary to the physiological functioning of the human body, but also as an instrument that favors life in society and generates good physical and mental conditions for work, food consumption, and interpersonal relationships.

Without teeth, the guy can't eat, can't drink, can't do "stuff", and this gives the impression that nobody can't even talk to anybody. (#3)

If you don't have healthy teeth, if your teeth are healthy and you don't have bad teeth, you have a peaceful life. (#4)

When you have toothache you can't drink water because it hurts, you can't have lunch because it hurts, it even hurts at night, when you're sleeping. Because it grows, right, it gets really painful and then it's impossible to sleep. And with a toothache, everything seems to be bad in life... (#5)

The subjective meanings that relate oral health to the existence of toothache, speech difficulty, and loss of the capacity to perform daily activities were also reported by Indigenous persons from four ethnical groups of the Central-West region of Brazil (Kaiwoá, Kadiwéu, Terena and Guarani)¹³. Research carried out with the Xukuru do Ororubá ethnicity in Pernambuco about experience of tooth decay over two decades corroborated the association of the experience of pain and suffering due to poor oral health with a greater search for dental care, compared to esthetic complaints or preventive reasons^{30,31}. These aspects show that, although the phenomenon "oral health" contains in it the word 'health', the Indigenous perception of absence of pain and relationship with the world can result from difficulties in receiving comprehensive oral healthcare.



Focus on clinical care to the detriment of educational aspects

The problematization of comprehensive care predominated in the speeches. Even though they mentioned easy access and an apparent search for dental care in the SUS, which the Ministry of Health³² recommends should happen according to life cycles and life conditions, this seemed to be more effective when pain occurred.

I spoke to the doctor yesterday and I'm going there. This doesn't happen only with me, but the person is assisted whenever any little problem emerges. (#1)

I never went to the dentist again, I never felt anything wrong again. Before, I used to go there only when it hurt; whenever I was in pain, I scheduled an appointment. (#3)

Scheduling dental consultations based only on pain complaints could lead to care characterized by tooth extraction, a mutilating procedure, to solve the problem.

The cure for the tooth is pulling it out. I prefer to have it pulled out because when the dentist puts in the filling, on the next day it's already becoming loose, and when you pull it out, it doesn't annoy you anymore. (#2)

Although the reports expressed the presence of professional oral healthcare in the Indigenous area, it seemed that the work process was supported exclusively by the clinical model, mainly in places where there are difficulties in access to oral health services³³. There are important elements in the speeches that associate educational dental work with children and students, an action that remained from the model that incremented oral health. Thanks to the hegemony of the Incremental System, the oral health of schoolchildren was prioritized, unlike what happened with other age groups, which ended up being excluded from public dental care³⁴.

The health team works a lot, mainly with the youth, the children. (#4)

She (dental surgeon) comes to the school, we call her, sometimes, twice a year to give a lecture on the importance of oral health to the students, both to elementary and to high school students. (#5)

These speeches reveal that dental care seems to focus on preventive and educational aspects for schoolchildren, a challenge that reflects on the experience that each life cycle has with oral health. Guarani Indians in the state of Rio Grande do Sul reported dissatisfaction at dental care: 18% of adolescents compared to 7% of adults³⁵. Among Kaingang and Guarani Indians from the Guarita Indigenous Land, in Rio Grande do Sul, the older ones also reported going to the dentist when there was pain involved. The younger ones, in turn, visited the dentist because of the social and functional



importance of a good oral health³⁶. This strengthens the idea that the Indigenous concern for oral health can decrease with age, similarly to what was observed in 2000, when the Tremembé ethnicity presented indicators about the precariousness of its oral health and absence of educational actions³⁷.

Educational actions to prevent oral diseases should be associated with the availability of adequately fluoridated water for consumption, a context not found among adult Kiriri Indians in the state of Bahia, who presented a high index of dental caries³⁸. Supervised oral hygiene actions involving eating, bodily, and oral issues, taking social determinants into account and without promoting acculturation through the colonial model of care, were part of a successful experience with the Xukuru do Ororubá population in Pernambuco³⁹.

It is important to highlight that prevention workshops with Indigenous persons resulted in the production of a Tremembé oral health handbook³⁹, not reported by the informants in the present study. The failure in identifying this technology can be a result of language and/or illustrations decontextualized from the local Indigenous culture⁴⁰. Finally, a qualitative study conducted with the Tremembé people from Almofala showed that many leisure activities are practiced in the natural environment, as well as children's plays with animals. Such activities foster the feeling of belonging to a group²³ and favor collective educational actions.

Traditional knowledge associated with oral health

The speeches analyzed here reported the coexistence between cultural practices and oral hygiene habits in the Tremembé people, which strengthens the existence of ancestry in healthcare.

I used to use grated *Juá* zest, I put it in my mouth and gargled, it was very good to preserve my teeth. My grandmother died at the age of eighty-six... she didn't have any decayed teeth. And she taught me to wash my mouth with salted water and with *Juá*. (#2)

I soak *emburana* bark in water, then in the morning I gargle with it, then there is no bad breath. It's also a healing solution. (#3)

Look, I never put a toothbrush in my mouth when I was young, right? I used to wash my mouth with sand. I never washed my mouth with the top layer of sand... I always pushed it away to get the sand that was beneath it. (#4)

Sometimes I brush with toothpaste, sometimes with coal... and sometimes with sand or oyster powder. I've always taken these precautions. (#6)



These cultural practices represent traditional medicines and promote the (re)construction of knowledge through the interaction between popular and scientific knowledge in the local reality, focusing on self-care. Thus, they can be more effective than the curative pattern. The reports corroborate another study carried out with the Tremembé people from Almofala that revealed the use of leaves of different plants in rituals like baths, incense burning, blessings, healing prayers, and the use of *umburana* bark and seeds in the form of *garrafadas* to reduce inflammation and improve healing. This can offer an important contribution to the ethnobotany of Northeastern Indigenous peoples⁴¹. The Tremembés showed that they use traditional knowledge to promote physical and spiritual cure, grounded on a symbolism of their own and incremented by Umbanda signifiers, non-human *encantados* (Curupira and Caipora, protectors of forests, and Guajaras, protector of mangroves)^{23,42}, Shamanism, and popular Catholicism⁴².

A catalog of the medicinal herbs and plants used by the community in the therapeutic treatment of oral diseases was developed in 2000, aiming to revive the traditional Tremembé medicine³⁷. However, this is a pioneering and isolated experience in the thematic literature about the studied ethnicity, and it is not possible to infer its longitudinal potentialities and limitations in the contemporary scenario.

Although the discussion about traditional Indigenous oral health knowledge is recent, there have been reports on general health practices in the lower Amazon region, in the state of Pará, since the 1990s, at community venues for treatments with native plants, and bioenergetic, floral and drug therapies developed together with scientific institutions⁴³. Therefore, these traditional and alternative health practices can connect different knowledge systems.

Valuation of healthy eating associated with good oral health

An important finding was that the community members recognized that eating ultra-processed foods damages their oral health. At the same time, they automatically demonstrated the educational power that the Indigenous community has in relation to healthy eating habits.

I think that the eating part also counts a lot, because today most kids eat a lot of junk food: bonbon, xylitol, stuffed cookies. The mothers don't stimulate their children to eat fruit. (#1)

We give many lectures to the students, right, because today's youth love bonbons and bonbons are a poison. I hardly ever put a bonbon in my mouth. (#4)



These speeches showed that the subsistence agriculture of the Tremembés is not seen as a means of production; rather, it is viewed as a possibility of living without the constraint of white people⁴². On the other hand, food insecurity, verified in the tendency of high consumption of ultra-processed foods, can have an impact on the high index of tooth decay, as it was found in Kaingang adults beneficiaries of the *Bolsa Família* who live in the Guarita Indigenous Land, Rio Grande do Sul⁴⁴, and in Indigenous persons of the Xukuru do Ororubá ethnicity, in Pernambuco⁴⁵. A national study carried out in 113 Indigenous hamlets in Brazil showed a lower socioeconomic status in the North region, as well as higher overweight rates in women and malnutrition in children, with impacts on oral health quality⁴⁶.

Regular consumption of soft drinks, sweets, pasta, and canned food by Indigenous Kaingang adults from the Guarita Indigenous Land, in Rio Grande do Sul, associated with the hamlet's distance, longer time since the last visit to the dentist (three years or more), and higher number of decayed teeth, can contribute to worsen dental health indicators⁶.

Care provided with health professional-social actor integration

The present study showed that the recognition of the importance of oral health, associated with traditional care practices focusing on healthy eating, which are present in the informant's speeches, are capable of integrating the care delivered by health professionals with that provided by social actors who had a leadership role in the Indigenous community. This recognition is explicit in the speeches that mention different types of knowledge and articulate them. Some of the informants even consider themselves indirect partners of the health workers when they refer to the utilization of different therapeutic approaches that can support conventional treatments.

She (dentist) already knows about a fever that can be cured with medicine and that can be cured with tea. We, Indians, were the ones who passed it on to her. So we have this whole thing of work partnership. (#1)

When I go to the dentist, I always ask if I can chew some herb that helps to heal and he answers that I can. So, I get better quickly. He works from there and I work from here, taking care of myself with the little knowledge I have; when the two do the right thing, the person gets better quickly. (#2)

These speeches show that the Indigenous education process in the Tremembé ethnicity from Almofala is represented as a daily experience grounded on the affective relationships they establish with one another, with nature, and with society in general⁴⁷. Their women shamans are frequently asked to perform healing works and are well supported by the Indigenous group^{23,48}.



In Brazil, there was a significant increase, in the last two decades, in the Indigenous peoples' access to public health services and in the number of professionals in Indigenous healthcare teams⁴⁹. However, the high rate of health worker turnover, the non-dialogic interpersonal relationship, and lack of training and qualification are factors that hinder the improvement in Indigenous health conditions^{35,49}.

The decolonization debate and the construction of plural knowledge based on Indigenous knowledge are important in health education. Indigenous oral healthcare can be experienced since the undergraduate years, as the outreach program "Huka-Katu" ("beautiful smile" in the local language) has proved in the Xingu Indigenous Park. The program promotes visits to communities and educational actions, and encompasses values from different dental care realities, community-based teamwork, decision-making, respect for the Indigenous culture, and a holistic view of the patient⁵⁰.

Understanding political structuring models might help to neutralize social determinants and combat Indigenous inequities⁴. According to Jamieson *et al.*⁴, based on the power of ideas, increasing the importance of Indigenous representativeness might be a path worth following; based on the power of the issue, use of credible indicators; on the power of the actors, the Indigenous community's search for cohesion; and on the power of the political context, taking advantage of the governmental and economic moment for the benefit of the actors' action.

Final remarks

This study's design adopted a qualitative methodology that gives substantial importance to the empowerment of Indigenous communities and to the strengthening of health policies. The study's limitations corroborate the literature, which shows the heterogeneity of Indigenous populations, challenges faced by investigators in research implementation, and little attention given to the social determinants of health. Difficulties in the process of admission to the research field are justified by the ongoing Covid-19 pandemic, which finds in the Indigenous population people who are more vulnerable to the transmission of the virus and require special attention. Although the participants reported important experiences that strengthened the bond with the oral health team, the bilateral construction of this relationship could not be investigated more thoroughly due to the methodology that was chosen.

It is possible to conclude that the discourses converge to the need of oral healthcare beyond physiological functions and to the recognition of social action, which results from social relations, processes and productions. In addition, we found that it is necessary to amplify the meaning of oral healthcare by including preventive and damage reduction actions, and by valuing healthy habits like eating and the community's traditional practices. These actions are strategies associated with life-cycle care programs, and must include problematizing and emancipatory educational approaches in the Indigenous community.



The knowledge obtained from the analysis of the speeches is viewed as a social practice, that is, the recognition of the need for dental care, and the understanding that self-care practices that consider cultural and ancestral aspects can be articulated to professional knowledge in the qualification of oral healthcare. These social productions, which were institutionalized in the Tremembé community by means of habitual practices, are important for the management processes of SUS.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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Este estudo teve por objetivo analisar a importância do cuidado em saúde bucal de informantes da comunidade indígena Tremembé, em Itarema, Ceará, Brasil. Neste estudo exploratório de caráter qualitativo, foram realizadas entrevistas semiestruturadas com seis adultos considerados informantes-chave da comunidade. As percepções mais presentes nos discursos indicaram o reconhecimento da importância no cuidado em saúde bucal, com foco na higiene dentária, necessária para a socialização. As falas relacionaram a valorização da alimentação saudável, associada à boa qualidade da saúde bucal, com a valorização do conhecimento tradicional como prática de cuidado. No entanto, os discursos apresentaram uma focalização na assistência clínica para adultos, em detrimento de aspectos educativos. As percepções revelaram potencial para integração de cuidados dos profissionais de saúde e dos atores sociais que possuem papel de liderança na comunidade indígena.

Palavras-chave: Povos indígenas. Saúde bucal. Percepção social.

El objetivo de este estudio fue analizar la importancia del cuidado de la salud bucal de informantes de la comunidad indígena Tremembé, en Itarema, Estado de Ceará, Brasil. En este estudio exploratorio de carácter cualitativo se realizaron entrevistas semiestructuradas con seis adultos considerados informantes-clave de la comunidad. Las percepciones más presentes en los discursos indicaron el reconocimiento de la importancia del cuidado con la salud bucal, con enfoque en la higiene dental, necesaria para la socialización. Los diálogos relacionaron la valorización de la alimentación saludable, asociada a la buena calidad de la salud bucal, con la valorización del conocimiento tradicional como práctica de cuidado. Sin embargo, los discursos presentaron un enfoque en la asistencia clínica para adultos, en detrimento de aspectos educativos. Las percepciones revelaron potencial para integración de cuidados de los profesionales de salud y de los actores sociales que tienen un papel de liderazgo en la comunidad indígena.

Palabras clave: Pueblos indígenas. Salud bucal. Percepción social.