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Therapeutic itineraries of *quilombola* adults for oral health care in a rural district of Bahia, Brazil

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Abstract *This study examined the oral health-related therapeutic itineraries of quilombola adults in a rural district of Vitória da Conquista, Bahia. This qualitative study involved ten semi-structured interviews of adult members of the quilombola community, in May 2021, which were then transcribed and analysed using content analysis. The results showed little or poor oral hygiene at some stage of life, especially in childhood and adolescence, the use of popular oral health care practices, and experiences of professional care featuring tooth extraction. Use of health services was mostly reported only in the period prior to the COVID-19 pandemic. Responses as to perceived ease of access to health services in the community varied. One common complaint as to satisfaction with oral health was the need to use or replace dental prostheses. This study concluded that oral health must be promoted jointly with disease prevention, dental rehabilitation and recognition for the knowledge and worldview of the quilombola population.*

Key words *Health knowledge, attitudes, practices, Oral health, African Continental Ancestry Group, Ethnicity and health*

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Introduction

The expression "remnants of *quilombo* communities" in Article 68 of the Transitional Constitutional Provisions Act (*Ato das Disposições Constitucionais Transitórias*, ADCT) of Brazil's 1988 Federal Constitution is associated with the struggle of parliamentarians and black militants committed to the anti-racist cause for broad rights, which go beyond the struggle for land title[1,2]. The term *quilombo* is not restricted just to an archaeological vestige of temporary occupation or biological evidence, nor to homogeneous or isolated groups, nor did its origin necessarily come from insurrectionary movements, but especially from groups that developed practices of resistance in reproducing and preserving their territories and ways of life[3].

The Organization of American States acknowledges that historical omission by the Brazilian State has allowed abuses of the rights of *quilombola* populations to take place, for lack of public policies and precarious service provision, or by violation of land rights, failure to consult these people or the nonexistence of any effective policy of reparation for the discrimination to which they have been subjected historically[4]. The Racial Equality Statute promulgated in 2010 was one of the legal frameworks sanctioned to guide the actions of the Brazilian State in combating discrimination and various forms of ethnic intolerance, guaranteeing equal opportunities for the black population and defending collective, diffuse and individual ethnic rights[5].

Brazil's National Policy for Comprehensive Health of the Black Population specified strategies to ensure improvements in *quilombola* populations' health indicators and improve access to health services[6]. The National Policy for the Comprehensive Health of Rural and Forest Populations set targets for expanding these populations' access to the Unified Health System (*Sistema* Único *de Saúde*, SUS) and stated the need to introduce specific indicators in monitoring and evaluating health measures and services for different populations, including *quilombolas*[7].

Oral health is expressed physically, psychologically, emotionally and socially and plays an essential role in overall health and quality of life. Impaired oral conditions can influence not only diseases of the mouth and other organs, but also quality of diet and nutrition, as well as mental health, thus interfering in people's social lives and in their ability to adapt, through self-care, to physiological life course changes[8-10].

Unfavourable oral health conditions in, mostly rural, *quilombo* remnant communities (QRCs), are influenced by adverse life contexts, such as poor access to education and health services[11] and less coverage by sewerage systems, treated water and fluoridation of the water supply[12]. Miranda *et al.*[13] identified a 52% prevalence of edentulism among older adults in a *quilombola* community and a need for dental prosthesis in 88%. Araújo *et al.*[14] found that 49.8% of adults in a QRC reported having extracted up to five teeth and 32.2%, more than five teeth. Souza *et al.*[15] concluded that more than 50% of older adults in a QRC were completely edentulous and only 17% wore complete dentures. Souza and Flório[16] found that, in two QRC populations, no-one in the 35-59 and over-60 year age groups was free from dental caries. Silva *et al.*[17] found that 37.9% of a group of 29 individuals over 12 years of age from a QRC had never seen a dentist.

Studies based on therapeutic itinerary analysis help investigate, analyse and understand health practices in rural *quilombola* communities, which are conditioned by worldviews, interpretations of life and available social resources and influenced by material, social and subjective determinants[18,19]. Accordingly, this study examines the oral health-related therapeutic itineraries of *quilombola* adults in a rural community in the municipality of Vitória da Conquista, Bahia.

Methodology

An exploratory qualitative analytical study was carried out as part of the dissertation project "Therapeutic itineraries in oral health of *quilombola* adults in a rural district of Vitória da Conquista - Bahia", based on semi-structured interviews ten *quilombola* adults living in the rural district of Pradoso and assisted by the Pradoso Family Health Team in the municipality of Vitória da Conquista, Bahia, Brazil.

Formulation of the interview questions drew on sociodemographic factors, narratives of oral health conditions and care experiences, health service accessibility, self-perceived oral health and the relationship between oral and overall health. This data recording instrument helped to describe events, conversations and thinking that informed the researcher's analysis and interpretations of what had been experienced[20].

Study participants were invited to take part by community health workers during home visits. Interview dates were scheduled to suit partic-

ipants' availability at home. In March 2021, six adults from the localities of Baixão and Lagoa de Maria Clemência, who were not part of the final sample, were pretested. The ten adults included in the research and interviewed in May 2021 were residents of the communities of Oiteiro, Malhada, Manoel Antônio and Saguim. Residents without at least 30 minutes available interview or who lived in a micro-area not served by a community health worker and one invitee who was not at home as scheduled were excluded from this research. Voluntary acceptance, indicated by signing a declaration of free and informed consent, was an ethical prerequisite for participant inclusion.

Determining the number of interviewees was challenging, given the comprehensive nature of the interconnections established in understanding a research object[21]. Equipment was used to record the interviews. The pre-test interviews and those of the final sample were conducted by a single researcher, who was male, a dentist and master's student in collective health. The interview audios were transcribed by a company under contract and reviewed by the researcher who had conducted the interviews. Participant anonymity was ensured by omitting names and using the expression "interviewee" followed by a number. The study's reliability was anchored in methodological transparency[22], achieved by describing in detail the empirical and theoretical procedures used in exploring the meanings[22] of the study population's oral health and recognising the limits of this research.

Interview saturation was ascertained using a model proposed by Fontanella *et al.*[22], involving immersion in, and exploration of, each interview by listening to the audios of the interviews transcribed previously and compiling the specific meanings revealed in each interview, then grouping and classifying the meanings so identified and, finally, producing a visual representation of this saturation, as shown in Chart 1.

Content analysis started with preliminary analysis, which was followed by exploration of the material, treatment of results, inference and interpretation[20]. Exploration of the material was designed to identify meanings and nuclei of meaning, while the processing of results, inference and interpretation examined for relevance with the research objectives, questions and assumptions[23].

The study was approved by the continued professional development centre of the municipality of Vitória da Conquista and the research ethics committee of the Multidisciplinary Health Institute of the Universidade Federal da Bahia.

Results and discussion

The *quilombola* adults interviewed were mostly between 40 and 59 years old and declared themselves to be black (brown in colour) and their marital status to be "in a stable union". Seven participants were female, three were illiterate, two reported not having completed lower secondary school, two had completed lower secondary school, two had not completed upper secondary school and one had completed upper secondary school. Half the group were retirees. Half the interviewees declared family income of less than one minimum salary and the other half, one minimum wage.

As regards housing, the interviews revealed that nine interviewees owned their homes and eight had running water at home. All interviewees reported that the rural community had no rainwater drainage or sewerage system. Seven interviewees reported that refuse was collected on certain days of the week, but only one revealed that collection was selective, while four interviewees revealed that burning of refuse was a frequent practice.

The socioeconomic profile of *quilombo* remnant communities populations is generally notable for a context of vulnerability, commonly featuring dependence on social cash transfer programmes, subsistence family farming and restricted access to health, education and basic sanitation services[24,25].

Oral health care

In the therapeutic itineraries mentioned in the interviews, the participants took paths that combined the use of public and private oral health services, as well as resorting to popular practices and self-medication to meet care needs. In this regard, note that, in most of the reports of oral health care strategies, oral hygiene habits were absent or precarious at various different stages of life. In combination with the sociodemographic profile, this constitutes a context of social vulnerability to be overcome by civil society and public policymakers. Contemporary evidence has shown that so-called minority racial groups generally live with a greater burden of oral diseases, which differs significantly between socially advantaged and disadvantaged racial groups, and

Chart 1. Visual representation of interview saturation.

Theme	Core meanings	Interviews										Total recurrences
			2	3	4	5	6	7	8	9	10	
Therapeutic itineraries in oral health for quilombola adults in a rural district of Vitória da Conquista, Bahia.	Oral health care	x	x	x	x	x	x	x	x	x	x	10
	Toothache as a clinical complaint at a certain point in life	x		x	x	x	x	x	x		x	8
	Accessibility of oral health services	x	x	x	x	x	x	x	x	x	x	10
	Report of poor oral health conditions at a certain stage of life	x		x	x	x		x	x		x	7
	Relationship between oral health and overall health	x	x	x	x	x	x	x	x	x	x	10
	Report of the possibility of an oral health condition adversely affecting a person's social life	x		x	x	x	x	x	x	x		8
	Popular oral health practices	x	x		x	x	x		x		x	7
	Report of gum disease	x	x	x	x		x				x	6
	Report of cavities		x		x	x	x	x				5
	Report of oral cancer		x		x						x	3
	Self-perceived oral health	x	x	x	x	x	x	x	x	x	x	10
	Report of current use of dental prosthesis		x	x					x			3
	Report of a history of support from friends or family for interviewee or someone else to access oral health services		x	x		x			x		x	5
	Regular visits to the dentist to have oral health			x		x				x	x	4
	Report of the need to use or replace a dental prosthesis				x	x		x			x	4
Frequency of appearance of new types of statement (meanings) in each interview		9	4	1	1	0	0	0	0	0	0	

Source: Authors.

that racial inequalities in oral health are observed over time in several nations through structural racism, that is, a structure produced and maintained by laws, and political and economic systems, as well as social and cultural norms[26].

Therapeutic itineraries reflect the pathways individuals take in search of health care contextualised by their worldviews, their ways of interpreting life and the health-disease-care process, the social support networks and social resources available to them[18]. Some interviewees reported precarious oral hygiene habits in childhood, whether in the family environment or at school (Chart 2). The reports revealed that health must be experienced in different social spaces. The family environment, school, health units, churches and community centres can be places for building/sharing information and strategies for promoting health. Tooth brushing, one of the strategic pillars of good oral health, was mentioned by all interviewees (Chart 2).

There was no mention of using dental floss in hygiene strategies, although such an accessory would be a desirable part of the interviewees' routine, as a complement to oral hygiene. Silva *et al.*[27], in a study that included *quilombola* and non-*quilombola* adolescents, found that 46.7% of the adolescents studied did not use dental floss and that, although they found no distinction in prevalence between *quilombolas* and non-*quilombolas*, differ-

ent factors were associated with this habit[27]. Interviewee 5 contrasted his experience of oral hygiene, based on his parents' education, with current realities, as in the account below:

There are people who don't have mouth problems. All their teeth are beautiful and they don't even go to the dentist that much. I think it's because they took good care when they were younger. [...] Brush at least two or three times a day. In my time, if you even asked your parents for a brush, your parents would beat you. "What do you want that for, boy?" Our parents were really ignorant. [...] If you asked for a toothbrush, Holy Mother! Today, our children, we give them everything, we try to keep them, because you know how things are today, too expensive. You have to take care of children, because if you leave it until they're older, it's too late (Interviewee 5).

It is reasonable to infer that, ideally, promoting oral health begins in childhood with parental encouragement/monitoring, understanding that this practice can be a determinant of good oral health at different stages of life, even without regular visits to a dentist and without minimising the importance of such monitoring. Over and above oral health care, clearly all citizens must be guaranteed good general conditions of life, such as housing, basic sanitation, transportation, food, education and so on, as basic prerequisites of human dignity.

Some interviewees highlighted the use of popular (homemade) treatments for combating dental pain or as a therapeutic resource post-operative to dental extractions or to alleviate gum inflammation (interviewees 1, 2, 4, 6, 8 and 10) (Chart 2). Oral health care practices were observed that are the result of popular knowledge and this community's way of life and shared by family and/or friends. They include the use of *mulungu* peel or cashew leaf or vinegar mouthwash as a resource to reduce gum inflammation, as well as potato leaves or pomegranate peels to combat toothache. Understanding health care in *quilombola* communities is not limited to connecting items of popular knowledge as effects of systematic exclusionary processes experienced by this population, but there are also epistemologies that link health care to a broader dimension associated with ways of life[28].

Souza *et al.*[15] identified reports of using wood stove ash and/or water, as well as tobacco chewing habits as oral hygiene strategies among nine elderly women from a QRC[15]. The use of herbal medicines, such as cloves, mallow, propolis, pomegranate, chamomile and cat's claw, in dentistry has proven to be an efficient and low-cost alternative[29,30]. Souza *et al.*[15] observed the use of acid from plants to combat dental pain among elderly *quilombolas*. Intermedicality, that is, the dialogue and intersection between academic, formal health knowledge and the knowhow produced by popular practices, can be fostered in *quilombola* communities by health policies that ensure strategies are implemented to favour such a meeting of bodies of knowledge[31].

Seven interviewees reported experiences of professional care involving numerous extractions over the course of their lives (Chart 2). Most of the stories narrated featured self-reported poor oral health conditions, particularly partial or total edentulism (tooth loss), underlining that tooth extractions predominated as a clinical dental procedure in the study group. Although this procedure is a therapeutic option, the narratives associating poor oral health conditions and tooth extractions reveal that other therapeutic options could have been implemented in a timely manner and contributed to a better oral health situation.

Araújo *et al.*[14] identified greater likelihood of tooth loss from extraction among older subjects in a QRC in the Bahia semi-arid, which can be explained as the effect of the accumulation of oral diseases not prevented nor treated in oral health services[14]. The higher prevalence of edentulism is related to situations of discrimination against subjects of low socioeconomic position and particularly black and brown people, in which situations of deprivation and social exclusion may occur, in addition to greater exposure to stressors and institutional discrimination, which can compromise both access to, and quality of, oral health services[32]. Also, oral health care is independent of the presence or absence of teeth, because in cases of edentulism, in addition to regularly checking the use, or need for use, of dental prostheses, soft tissues must also be evaluated to prevent diseases of the oral mucosa, especially precancerous or cancerous lesions[33].

Relationship between oral health and overall health

In connection with the concept of health, in some interviews, the expression "health" was associated with professional care, self-care (hygiene measures) and examinations as key factors in achieving or preserving good overall or oral health (Chart 3).

There is a recognition of the value of appointments and diagnostic tests intended to achieve or

Chart 2. Thematic category "oral health care", according to empirical data from the interviews.

Theme	**Therapeutic itineraries in oral health of quilombola adults in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Oral health care	**Interviewer:** Talk about your life story, from childhood to the present day, thinking of the condition of your mouth and teeth and oral health care. **Interviewee 01:** *"[...] So, before, it was very difficult for us to go to a dentist and when we went to the dentist, it was to have the tooth pulled out, there was no such thing as treatment".* **Interviewee 02:** *"In my day, when I was a teenager, I generally had a lot of toothache, didn't I? I would even have treatment, get a filling. Then, soon after, again I'd have to have another filling done. Now, in my adult life, it's better [...]".* **Interviewee 03:** *"From when I was ten, I already looked after my health".* **Interviewee 04:** *"[...] My mother always took care of us, didn't she? [...] There were times when we didn't even brush our teeth, back then. We'd splash some water in our mouths, go to school and 'cleaned them' [...]".* **Interviewee 05:** *"The care was very precarious, because it was up to us ourselves. [...] We used to go out to the fields, with our father, come back. [...] We'd get there (to school), the teachers didn't care either at that time, people had almost no oral hygiene. So, today I suffer the consequences. All my teeth are falling out [...]".* **Interviewee 06:** *"[...] In terms of oral care, I think that when we were children we didn't take much care, because parents used to go out to work and didn't have the time to be helping their children. [...] There was hygiene, but it wasn't like what we do today. Sometimes I would even go all day without cleaning or even more than a day [...]".* **Interviewee 07:** *"[...] And our mothers didn't care, almost didn't bother, did they? Then you'd get a toothache and we'd put some medicine on to relieve the pain. [...] Today, people are charging R$ 50.00, R$ 40.00 to pull a tooth. Money is really, really scarce. There's times when we can even pay for water, electricity, buy food at home. That's the way things are."* **Interviewee 08:** *"[..] I haven't got any teeth anymore. [...] My mother used to brush our teeth when we was little. It was our mother who brushed our teeth. Then when we started to grow up, it's us who brushed. We brushed."* **Interviewee 09:** "*When I was a child, I didn't use to go to the dentist, because there wasn't one. Then we didn't know what a dentist was. It's not long I started going to the dentist. [...] My father and mother taught us to take care of our teeth, brush our teeth well and our tongue."* **Interviewee 10:** *"She (mother) took care, because my mother bought us toothbrushes. Then I started to get old, my teeth started to go bad, so I had all my teeth out [...]".* **Interviewer:** How do you take care of your teeth or prosthesis ("plate") on a daily basis? **Interviewee 01:** *"I brush in the morning, after I get up, after breakfast I brush, I brush midday after lunch and at night, when I go to sleep [...]".* **Interviewee 02:** *"[...] Every time I eat, I brush, I take off the prosthesis, I clean it well, brush it really thoroughly, understand? Just like I brush my teeth."* **Interviewee 03:** *"[...] I brush three times a day".* **Interviewee 04:** *"[...] I brush my teeth early in the morning, brush them midday and brush them at night. Before going to sleep, I brush my teeth well. You have to brush your tongue. [...]"* **Interviewee 05:** *"[...] Just brushing, that's all".* **Interviewee 06:** *"[...] During the day, only sometimes, when I eat something that really bothers me, but really brushing properly, which I do, I try to do the way I've learned, in the morning and at night".*

it continues

Chart 2. Thematic category "oral health care", according to empirical data from the interviews.

Theme	**Therapeutic itineraries in oral health of quilombola adults in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Oral health care	**Interviewee 07:** *"I brush early, I brush midday, after lunch, I brush at night after I go in to sleep. Three times a day".* **Interviewee 08:** *"[...] I finish eating, I brush. I go to sleep at night, I brush. Early in the morning I get up, I brush. It's all brushed. I take good care of my (prosthesis).* **Interviewee 09:** *"I always brush, I use an 'oral' (mouthwash), I brush my tongue, my teeth and, every so often, I see a doctor for a cleaning, at the dentist's".* **Interviewee 10:** *"I clean. I brush everything, on my tongue, under my tongue, I brush my gums, I brush everything."* **Interviewer:** Have you ever used any tea or home remedy or charm to solve a problem in your mouth or teeth? Talk about that experience. **Interviewee 01:** *"[...] there is a little bush, with a little flower, we used to pull off that little flower, I just don't remember the name. Then, we'd take out that little piece and put it in the hole in the tooth, then you'd fall asleep. I even used it."* **Interviewee 02:** *"I remember once I had a bad toothache. They recommended making potato leaf tea and rinsing your mouth with it. I made the tea, I did. I used it [...]".* **Interviewee 04:** *"Only when we pulled off, [...] we were taught that potato leaves were good for rinsing, so as not to inflame too much. Just that. And Pedra hume [Myrcia sphaerocarpa]".* **Interviewee 05:** *"[...] I used to rinse my mouth with vinegar, salt and some leaves of a bush we have, some roots, to bring down the swelling, to rinse, stop the pain. [...] I used the "desinchadeira" [plant with anti-inflamatory properties] and [...] I was in pain, I rinsed with it. I also use that pomegranate peel."* **Interviewee 06:** *"[...] It was hurting, so I put water with salt on it, but I didn't drink it. I just put it in [my mouth]."* **Interviewee 08:** *"[...] I washed with [Erythrina] mulungu bark, which is very good for bringing down inflammation of the gums and teeth".* **Interviewee 10:** *"I remember. I remember. We used to rinse our teeth, something like that... salt water, [...]a remedy, a cashew leaf, something to reduce inflammation in our teeth".*

Source: Authors.

preserve health, even though self-care has also been mentioned. Indeed, they are important, complementary and non-exclusionary aspects, which can also dialogue with the community's traditional health practices.

Oral health is related to physical, psychological, emotional and social aspects and constitutes an important link in well-being and overall health, because it influences everyday activities, such as speaking, smiling, chewing, digestion, painless socialisation without pain, discomfort or embarrassment and reflects a person's ability to adapt to physiological changes in their life course and, through self-care, to keep teeth and mouth in healthy condition[8-10]. In a similar manner, this broad view of oral health was brought out by interviewees 5 and 6 when they mentioned the multidimensional nature of oral health and its possible impacts on overall health, such as difficulty chewing and the influence this can have on the ingestion and digestion of food:

[...] Your mouth is the most important thing. Have a nice smile. You will eat, eat well, manage to digest food, chew it well. Without teeth, all you can do is lick and you end up swallowing. And that food ends up not even doing you any good (Interviewee 5).

Because if you have a problem and don't take care of it, you have a cavity, your tooth gets infected and ends up having other types of difficulties. If your mouth is infected, you can't eat properly, [...], drink a liquid, drink water (Interview 6).

Four interviewees expressed concern about oral cancer and the repercussions it could have on a person's overall health and only interviewee 10 mentioned the habits of smoking and drink-

Chart 3. Thematic category "relating oral health and overall health", according to empirical data from the interviews.

Theme	**Therapeutic itineraries of quilombola adults for oral health in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Relationship between oral health and overall health	**Interviewer:** Comment on what it is to be healthy. **Interviewee 01:** *"I think like this, we need to take more care, we need to go to a dentist. A mouth, tooth thing brings a lot of health problems. So, I think it's good for us to go more to the dentist thing, because it's much better these day to take care of your health."* **Interviewee 02:** *"A person's got to take care of themselves, isn't that right? To be healthy, right? You generally have to examined when necessary [...]".* **Interviewee 03:** *"Take care, right? Look after your body, look after your health, go to the doctor now and then, take the right medicine. I always worry about my health."* **Interviewee 04:** *"What does it mean to be healthy? I think it's always following the things you have to follow, the rules... the hygiene thing. I think that's it."* *Interviewee 06: "Being healthy is not only looking after your oral hygiene, your own hygiene, but also adapting some situations in your life to reduce things that lead to some kind of illness, like diet, exercise".* **Interviewee 08:** *"[..] You have to take medicine, you have to be examined, you have to do all that".* **Interviewee 09:** *"Take good care, of your health. [...] You have to do it, see a doctor, see a dentist to have better health".* **Interviewee 10:** *"Health? It's being... You have to take good care of yourself, look after your health, take good care..., wash your hands, wash them properly. Brushing... even if you've got no teeth, you brush your mouth just the same [...]".* **Interviewer:** Do you think the condition of your mouth and teeth can affect your health? Comment on your answer. **Interviewee 01:** *"I think it can, it brings a lot of things, your mouth brings a lot of health problems, you have to take care. [...] It can even cause that cancer thing, which these days you can have, the mouth thing and you can get cancer, you can have other problems too".* **Interviewee 02:** *"I think it's important, because what commands... what really commands in part... other parts, right? It's the mouth, right? You've always got to have ideal oral hygiene, always brush your teeth after eating. If you eat, you brush so as to keep your teeth, because generally if you don't have good oral hygiene you can generally catch a serious disease in your mouth. Isn't that right? And these diseases, there are certain types of diseases that are difficult to combat, especially cancer, right? Generally, you see in the statistics a lot of people having problems because of not having oral hygiene, you know? Causing mouth cancer. And when it actually causes cancer, it's difficult to fight."* **Interviewee 03:** *"Yes, it does have an effect. I mean you're eating something, then whatever bacteria there are... they come and go down. [...] Because there are bacteria that go down. Some go to the lungs, others go to the heart vein. Dentists always warn you, don't they?"* **Interviewee 04:** *"It can (have an effect). Even more like, the same glass you use. Even talking, I think it has an effect. [...] I have an idea, because like, when my grandchildren are here, my husband even then has this thing of taking food and eating, taking it from his mouth and putting it in the child's mouth. Or blowing on it to cool it down, because I don't do that.".*

it continues

ing as risk factors for developing oral cancer (Chart 3). The mention of oral cancer and the perception that this disease can have more severe repercussions on a person's overall health was an interesting point that emerged in the interviews. However, educational actions are needed to raise awareness of the main risk factors relating to oral cancer, because only one interviewee mentioned any these factors.

Chart 3. Thematic category "relating oral health and overall health", according to empirical data from the interviews.

Theme	**Therapeutic itineraries of quilombola adults for oral health in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Relationship between oral health and overall health	**Interviewee 05:** *"It does have an effect. I'm not a doctor, I don't have that much education, but I'm sure it has an effect. [...] It can. And if you don't take care, there's even danger of getting cancer in your mouth or tooth. [...]* **Interviewee 06:** *"I don't know how to explain it like, in general, but if you don't take good care of hygiene in your mouth, you can get bad breath and, when you get somewhere where you talk to someone closer, you can end up, right, spreading bad breath and that is upsetting, because it has happened to me and it happened like another person arriving at the same time as you're talking and there's that situation. So, that's what I think."* **Interviewee 07:** *"It can cause a lot of problems of disease in the body, headaches. Body pains. Migraine pain. And your mouth is most important. It brings you better health."* **Interviewee 08:** *It does have an effect. [...] It can have an effect, because when I had some bad teeth in my mouth, I had headache. I felt so many things. After I pulled them... had them all out, it got better. I don't feel any of that anymore."* **Interviewee 09:** *"Yes, it can. [...] There's no problem, many tooth problems harm your health."* **Interviewee 10:** *"Yes. I think it can. Sure. [...] It can if your mouth is bad, you can get mouth cancer. There's mouth cancer. There's all sorts. And the person looks after their mouth, their health, you don't get those things. [...] Not smoking, not drinking. Not doing any of that in your life to have a healthy mouth."*

Source: Authors.

Access to oral health services

Travassos and Martins[34] argue that health service use is mediated by accessibility, that is, by characteristics of supply that relate to service use and user behaviour, which is influenced, in turn, by social, cultural, psychological and economic factors.

Four interviewees reported histories of oral health care provided exclusively in public services, four in private services and two, in both public and private services (Chart 4).

The data on health service use show a balance between public and private oral health-related services. Silva *et al.*[17] found that 41.3% of *quilombola* study participants reported having received dental care from public services. Souza and Flório[16] found that 57.9% of *quilombolas* referred mainly to public health services for oral health care. Silva *et al.*[27] revealed that 22.7% of *quilombola* adolescents had never had a dental appointment in their lives, in contrast to 10.3% of non-*quilombola* adolescents. That same study showed that 69% of *quilombola* adolescents reported using public services for their last dental appointment[27].

When interviewees from the rural community were asked about the ease or difficulty in obtaining health care, seven interviewees reported ease in using health services, without, however, mentioning oral health specifically (Chart 4). In this respect, interviewees cited geographic, organisational and economic health service access barriers resulting from bureaucracy in care services, financial travel expenses and, when using a private service, high-cost treatment incompatible with family income. Interviewees who reported health service accessibility attributed this facility to factors such as more opportunities for being examined, the existence of community health workers to schedule appointments, provision of a dentist at the health post and good reception and care by health personnel.

Three interviewees reported difficulties in using health services (Chart 4), while interviewee 10 mentioned needing to being examined privately to expedite matters (Chart 4). A contrast was noted between the perceived ease of access reported by most of the adults interviewed and self-reported oral health, which was notable, for the most part, for histories of multiple tooth loss combined with the need to have dentures made

or replaced (Chart 2). The most typical sociodemographic profile of these adults included low levels of education and income. Lack of education can influence occupation type and income, which are two fundamental predictors for evaluating health differences from an ethnic-racial perspective and for thinking about persisting health inequities[18,35].

None of the interviewees reported receiving care at the Dental Specialities Centre (*Centro de Especialidades Odontológicas*, CEO) in the municipality of Vitória da Conquista, 19 km from

Chart 4. Category "access to oral health services", according to empirical data from the interviews.

Theme	**Therapeutic itineraries of quilombola adults for oral health in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Accessibility to oral health services	**Interviewer:** For people living in a rural quilombola community, is it easier or more difficult to get healthcare services? Comment on your answer. **Interviewee 01:** *"To me, I don't think it's very easy, no, because sometimes, when we need to, there's so much democracy (bureaucracy) there for us to get over. [...] I think it's more difficult, it's a little difficult, because until we manage it, it's difficult, at least through the post, or even privately, it's difficult, because the business of teeth, when you set out to be able to get treatment, it's very expensive. I mean, you know that a wage is for upkeep at home. So, no way is there any left over to be able to take care of your mouth."* **Interviewee 02:** *"In my opinion, it makes it easier, because generally when you live in urban areas, the service in urban areas, I don't think is the same as in rural areas. Understand? Because here... here whenever you need to here, you go to a clinic, you are seen. Understand? And there in urban areas, especially now, after this pandemic, for you to get to be examined, the bureaucracy's tough".* **Interviewee 03:** *"I think it's more difficult. [...] Because... about the health posts, because here there's only the posts over the other side of [...]. Everyone here goes there. Here (in the locality) there is none. There (at the main office) it's difficult."* **Interviewee 04:** *"It's easier for those who live here in the quilombolas, because there's a health worker. If you need to, you can go to them."* **Interviewee 05:** *"I think it's easier. I'm almost certain".* **Interviewee 06:** *"I say this because I'm not familiar with the urban area, I believe that the difficulty here in the quilombo is just because of the financial aspect, because the doctors are not always in the area, but I believe it's easier."* **Interviewee 07:** *"Easier. [...] Because there are health workers who help us. There's the... They come and warn us. Then it gets more difficult. Easier".* **Interviewee 08:** *"It's easier. [...] Every time we go to the [...] to be examined, we are well received there. Thank God. In the town too, at the posts too that I've been to, everything is well received."* **Interviewee 09:** *"Certainly (easier)".* **Interviewee 10:** *"I think it's difficult. [...] There are times when you pay to be seen, because the SUS takes years to see you."* **Interviewer:** Before the COVID-19 pandemic, did you ever have treatment for your teeth or mouth from a dentist at the health centre or at the Dental Specialities Centre (Centro de Especialidades Odontológicas, CEO) or from a dentist in a private practice or from an association or union? If so, talk about your experience. **Interviewee 1:** *"It was (at a health post). [...] Yes, I've done it privately [...]".* **Interviewee 2:** *"I've heard of (the CEO), but I've never been. [...] The treatment by the (private) dentist there was very good, it was excellent. [...] That was before the pandemic".* **Interviewee 3:** *"It was (dental care) before (the pandemic). Long before (the pandemic). [...]It was private. I paid".*

it continues

Chart 4. Category "access to oral health services", according to empirical data from the interviews.

Theme	**Therapeutic itineraries of quilombola adults for oral health in a rural district of Vitória da Conquista, Bahia**
Thematic category	**Record Units**
Accessibility to oral health services	**Interviewee 4:** *"Only here (in the rural location) [...] and only at the time when I had a tooth out near Anagé [...] when the dentist used to come here and I just had the tooth out, that's all. [...] He was a dentist (treatment when he was young) who came from Conquista. Then he used to come to rural areas and we would "took it out", but that was paid. We paid."* **Interviewee 5:** *"Well before (the pandemic). [...] It was at the dentist at the post. [...] At the health post. It was actually my son who got me an appointment there in Barra do Choça. [...] In Conquista, I never had a tooth pulled. I had teeth out right here, on the farm."* **Interviewee 6:** *"Yes. [...] It was at the dentist of the [health] team here, which is part of the locality. I was treated for cavities even though I was cleaning."* **Interviewee 7:** *"It was always here at the health post".* **Interviewee 8:** *"[...] A little [health] post there. [...] It was right here. [...]. I don't think I've ever had a tooth out and had to pay for it, no. It was all covered by the municipal government."* **Interviewee 9:** *"I went to a dentist. [...] Private".* **Interviewee 10:** *"[...] It was at a private dentist, paid for. It was paid. I paid".* **Interviewer:** During the COVID-19 pandemic, did you ever have treatment for your teeth or mouth from a dentist at the health centre or at the Dental Specialties Centre (Centro de Especialidades Odontológicas, CEO) or from a dentist in a private practice or from an association or union? If so, talk about your experience. **Interviewee 1:** *"Since then, I haven't needed to. I have some problems in my mouth, as I'm telling you, which I still have, I have these cavities in these front teeth, but you leave it, you're not feeling pain or anything and so you leave it. I wasn't.. [...] Among other things, because of the pandemic, there are things that we are leaving to be desired, we are not going, because of the pandemic as well, because right away we are scared of going out".* **Interviewee 2:** *"I went to the dentist, I even told you, that I did the... the tooth business,.... the restoration. [...] During the pandemic. [...] It was at the union."* **Interviewee 3:** *"No".* **Interviewee 4:** *"No".* **Interviewee 5:** *"I did need to, but I didn't, no, now during the pandemic".* **Interviewee 6:** *"No".* **Interviewee 7:** *"I never got to go."* **Interviewee 8:** *"I didn't do it, because, for now, there's no problem."* **Interviewee 9:** *"I didn't need to".*

Source: Authors.

this rural district. A case study involving the only two Dental Speciality Centres in the Vitória da Conquista health region observed a lack of specialised oral health services, in addition to organisational difficulties, revealing service management weaknesses and bureaucratic and ritualistic practices incompatible with the coordination and continuity of oral health care[36].

It was demonstrated that, during the COVID-19 pandemic, only one interviewee used a private dental service, although most interviewees reported some condition amenable to clinical treatment or monitoring (Chart 4). Interviewees 1 and 3 (Chart 4) mentioned being afraid to see a dentist during the pandemic period: *It's difficult for me to go to the dentist, you know? It's really difficult to go to the dentist. Even more so now, with this pandemic, you're scared, right? But I really need to* (Interviewee 3).

Self-perceived oral health

Self-perceived oral health is considered a good indicator of individual health condition, because it comprises physical, cognitive and emotional aspects and derives from information,

experiences and knowledge acquired in a given historical, cultural and social setting that inform the individual's subjective ability to perceive and assess their own oral health[37,38].

Respondents 4, 5 and 7 reported dissatisfaction at their oral health condition, particularly needing to have teeth extracted and to use dentures in order to be able to chew properly, but that they had not undergone these procedures yet, because of financial conditions (Chart 5).

Interviewees also said they felt "weak" due to difficulties chewing and would be happy if they could eat properly and try foods that were hard to chew. These accounts show that oral health is related to aspects of overall health[8-10]. Conditions favouring social vulnerability influence nutritional and health status, especially as regards food and nutrition security and oral health[39].

Other interviewees mentioned dental prosthetics. Interviewee 2 was satisfied with the state

Chart 5. Category "self-perceived oral health", according to empirical data from the interviews.

Theme	**Therapeutic itineraries in oral health for quilombola adults in a rural district of Vitória da Conquista, Bahia.**
Thematic category	**Record Units**
Self-perceived oral health	**Interviewer:** Talk about how you feel about the condition of the teeth in your mouth or your dentures or the lack of teeth in your mouth. **Interviewee 01:** *"What I'd like to do is have these front teeth of mine done. I really want to, but it's difficult, particularly as we said, after the pandemic it got more difficult. I want to, even at my age, but I want to fix them, I want to take care of those front teeth. [...] I feel. Now, what I want is to take care of these here. No, I don't feel satisfied."* **Interviewee 02:** *"I'm sort of unsatisfied with it (prosthesis), because, just like I tell my wife, I've been using these dentures for a long time. I'm unsatisfied, because now it (prosthesis) is bothering the tooth. [...]I feel satisfied with how my teeth look. Except, like I'm telling you, the restoration is bothering me. Just that."* **Interviewee 03:** *"I am (satisfied with my prosthesis). [...] I just need to get rid of the one that is getting in the way here. That's because there's the stump of the tooth here in the gum, so it (prosthesis) doesn't fit, you know? Then when I chew, it starts to hurt. [...] I'm satisfied (with my teeth)".* **Interviewee 04:** *"No, I'm not satisfied. [...] I think they needed pulling, because I don't think there's any other way now. I needed to have them out and put in a plate, but... I can't afford it."* **Interviewee 05:** *"No, I'm not satisfied. [...] I need to have my teeth out and put in a plate. Then I'd be the happiest man in the world. [...] I feel, because there are days when I go to eat, I don't eat properly and I always end up getting weak, weakening. [...] It leaves me uncomfortable. There's no way you can be satisfied."* **Interviewee 06:** *"I feel good. I think it's time to have a go at them again, because some of the treatments I had, where she put in some 'caps', some things, and I think it's time to give that a reinforcing, but I feel good. No complaints".* **Interviewee 07:** *"Sometimes it's uncomfortable, right? There's something there that you're dying to eat, but can't. So it gets harder to try things like that, right? Then there are times when you think... you start to have difficulty. But you find a way. [...] I'd like... if I could... I'd like to have a bridge. Just a top one. Not the bottom one. The bottom ones are OK. I had more of the top ones out. But I can't afford to have it done. It's a lot for us to pay and my husband's stuck at home without work. I don't work, my children don't work yet. (the children) still depend on us for everything."* **Interviewee 08:** *"I'm all right, son. I'm used to it. I've got used to my teeth. [...] I'm (satisfied), thank God."* **Interviewee 09:** *"Satisfied".* **Interviewee 10:** *"Yes, I am. I've got a [trouble] free mouth, because before I had a bad mouth, bad teeth, I couldn't do anything. One day I'm going to put a plate in my mouth, but I don't even want to put a plate in anymore, because I'm old now".*

Source: Authors.

of his natural teeth, but dissatisfied with the condition of his partial denture, while interviewee 10 reported satisfaction at having extracted those teeth that were in poor condition, while recognising that his oral health could be improved by using a dental prosthesis (Chart 5). Interviewee 3 reported being satisfied with her oral health, even though mentioning that her prosthesis was impossible to use because it fit badly and she had a tooth in a very unhealthy condition (Chart 5).

Seven interviewees mentioned using or needing to use dentures and how to deal with partial or total tooth loss (edentulism). Miranda *et al.*[13] identified a 52% rate of edentulism and 88% need for dental prostheses among elderly people in a QRC. Bidinotto *et al.*[40] found an association between dissatisfaction with oral appearance and chewing ability and worse self-perceived oral health. Lira Júnior *et al.*[41] found that the majority of elderly people with negative self-perceived oral health was associated with the need to use dental prostheses.

Some interviewees reported satisfaction as to their own oral health without displaying clinical needs that might cause any discomfort (interviewees 6 and 9) (Chart 5). When asked about her perception of her oral health, interviewee 1 reported dissatisfaction with her front teeth and difficulty in getting treatment, aggravated by the pandemic context (Chart 5).

The perception of edentulism and use of dental prostheses proved to be common to most of the reports. Tooth extraction was sometimes described with a feeling of regret, sometimes as a strategy, combined with the use of prostheses, to achieve oral health. Souza *et al.*[15] found that all elderly *quilombola* women interviewed were partially or completely toothless and that most related tooth loss to natural aging.

Final remarks

Some reports contextualised the relationship between individuals' oral health and overall health. In addition to tooth decay, oral cancer figured prominently among the oral diseases mentioned. Some interviewees associated health with professional care, self-care (hygiene measures) and being examined as fundamental to achieving or preserving good overall or oral health. This study also revealed popular therapeutic strategies. The results indicated an absence and/or deficiency in oral hygiene at some stage of life, especially in childhood and adolescence. The reports indicated that health services were used, for the most part, in the period before the COVID-19 pandemic and that the procedures most performed were tooth extractions. Respondents from the rural community differed in their perceptions of ease of access to health services.

It is clear from the therapeutic itineraries of the adults studied that an enormous challenge needs to be met to promote oral health at all stages of life, jointly with social inclusion actions to assure basic sanitation, education, plus employment and income promotion policies and others, in order to overcome social inequities, especially those experienced by rural communities of *quilombo* remnants and also present in this rural community which was studied.

It is necessary to pursue social inclusion strategies as a way of guaranteeing special protection to traditional Afro-descendant populations and, in that way, promote reparation for the historical oppression black Brazilians have been subjected to, given that the denial of these people's rights and cultural and historical identity has resulted from historical discrimination and structural inequality[6,42,43].

This study, based on narratives of experiences of oral health care, examined the interviewees' experiences in depth. Health situations considered significant from a technical standpoint may not be remembered or valued from the health user's perspective. This may be considered a limitation of this type of study. However, the lack of standardisation allowed interviewees to choose the course of their narrative, from which the researcher could then recognise the intentionality of the discourse. Silencing can conceal structural violence and historical inequalities. Informed listening, in addition to sensitising family health teams and health managers, gives researchers opportunities to evaluate the results of their day-to-day work, understand the connections between different levels of complexity of Brazil's Unified Health System and obstacles to health service access and, lastly, obtain an understanding of cosmopolitics, which integrates the health service and the territory. The barriers to accessing health can be understood only by recognising the Other at the different levels of his or her existence.

Collaborations

RA Souto and R Souzas participated in the study conception and design, in writing and reviewing the intellectual content and in final drafting of the manuscript. JS Nery, EKP Silva and LL Pereira participated in writing and reviewing the intellectual content and final drafting of the manuscript.

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