ORIGINAL RESEARCH

Health Education as a strategy for the Promotion of Oral Health in Pregnant Women in the Salesian Neighborhood in the Municipality of Juazeiro Do Norte–Ceará, Brazil

Jeanne Maria Melo de Matos[1], Rayanne Maria Melo de Matos[2], Jefferson David Melo de Matos[3], Antonio Jackson Andrade Gonzaga de Oliveira[4], John Eversong Lucena de Vasconcelos[5]; Isabela Barbosa de Matos[6]

1,2-Graduated of Dentistry, Centro Universitário UNILEÃO, Juazeiro do Norte – CE, Brazil. 3-School of Dentistry, Centro Universitário UNILEÃO, Juazeiro do Norte – CE, Brazil. 4-Graduate in Letters - English Language, Universidade Regional do Cariri - URCA, Crato–CE, Brazil. 5-Professor of Oral Implantology, Department of Dentistry, Centro Caririense de Pós-Graduação CECAP, Juazeiro do Norte – CE, Brazil. 6-Professor of Oral Endodontics, Department of Dentistry, Centro Universitário UNILEÃO, Juazeiro do Norte – CE, Brazil.

Correspondence to:
Dr. John Eversong Lucena de Vasconcelos, Professor of Oral Implantology, Department of Dentistry, Centro Caririense de Pós-Graduação CECAP, Juazeiro do Norte – CE, Brazil.
Contact Us: www.ijohmr.com

ABSTRACT

Purpose: The present study focuses on the to analyze health education as a strategy to promote oral health in pregnant women in the municipality of Juazeiro do Norte, State of Ceará, in the Salesian neighborhood. **Materials and Methods:** The respective research was carried out using UBS of the mentioned municipality in the district of the Salesiano, where invited fifty pregnant women chosen at random; To which they were submitted to a structured interview, through a simple random sampling, and a questionnaire with twenty-nine questions was applied. The study was exploratory-descriptive, with a quantitative approach. The data collection was carried out during the period of May, 2015, after issuance of the Authorization Term in the mentioned unit. The resource used to reach the required information was a form with closed (multiple choice) and open (free) questions. **Results:** At the end of the research, the results were similar to those described in the literature. It was observed that there were many doubts regarding oral problems, many pregnant women still present the distorted idea that during dental treatment dental treatment should not be performed. **Conclusion:** However, intervening prematurely in the lives of these women, will be contributing to their cultural growth and consequent changes in habits that will influence their entire family, thus reducing negative oral health indices of the local community.

KEYWORDS: Pregnant Women, Health Education, Dental Caries

INTRODUCTION

Pregnancy is a process that involves changes and complex physiological and psychological changes that lead to modifications to the female organism and significantly affect the health of women.[1]

The relevance of comprehensive health care for women has been taking account of the country's public policies and the Unified Health System proposes educational, preventive, diagnostic, treatment and recovery actions at all levels of care, including prenatal care, childbirth And puerperium, gynecology, family planning, climacteric, among other needs according to the profile of each population; Second handbook of the public health school of Ceará.[2]

The report of the First National Oral Health Conference, held in 1986, emphasizes oral health as an integrating part cannot be separated from generalized health of the individual, being directly related to the conditions of food, housing,work, income, environment, transportation, leisure, Freedom, access to and possession of land, access to health services and information.[3]

In practice, we can observe that, despite current oral health policies, there is still no comprehensive prenatal dental care as health promotion suggests. Beliefs and myths that the dental treatment performed during pregnancy impair the development of the child still accompany pregnant women and contribute to hinder oral health care in this period. On the other hand, one has to consider that there are still difficulties in the access the population to the professional, both in the private and public sphere.[4]

In order to face the difficulties of implementing women's health policies, in 2001 the Ministry of Health developed the Operational Health Care Standard (NOAS), with the aim of "increasing the responsibilities of municipalities in Primary Care, defining the process To create mechanisms

How to cite this article:
Matos JMM, Melo de Matos RM, Melo de Matos JD, Gonzaga de Oliveira AJA, Lucena de Vasconcelos JE, Barbosa de Matos I. Health Education as a strategy for the Promotion of Oral Health in Pregnant Women in the Salesian Neighborhood in the Municipality of Juazeiro Do Norte–Ceará. Int J Oral Health Med Res 2017;4(3):8-14.

for strengthening SUS management and to update eligibility criteria for states and municipalities."This document provides the municipalities with the guarantees of minimum basic prenatal and puerperal actions, family planning and prevention Of cancer of the uterine cervix and breast.[5]

With regard to oral health actions, NOAS foresees as the responsibility of municipalities the prevention of dental problems and the priority registration, in the population from zero to fourteen years old and pregnant women. Among the activities, such as "epidemiological survey, supervised brushing and plaque disclosure, fluoride mouthwashes and oral health education".[6]

Pregnancy is a period involving complex physiological and psychological changes; Thus, it becomes a favorable stage for the promotion of health, for the possibility of establishment, incorporation, and changes of habits, because this period refers to a series of doubts that can stimulate the pregnant woman to seek information and, with this, acquire new and Best health practices. In this way, it is possible to obtain improvements in the self-care of the pregnant woman in relation to oral health and consequent decrease of the appearance of dental caries and periodontal disease during pregnancy.[7]

The present study focuses on the to analyze the level of knowledge about oral health on the part of the pregnant women who attend the service stations of the city of Juazeiro do Norte, in addition to their satisfaction regarding the care of the professionals.

MATERIALS AND METHODS

The present study was of an exploratory-descriptive nature, with a quantitative approach, with the purpose of evaluating the perception of the pregnant women of the UBS 15, 25, 37, 38,59 in the district of the Salesiano do Juazeiro do Norte-Ce, on dental care in pregnancy. The population of this study was made up of pregnant women living in the Salesiano district who, during the study period, had a prenatal dental consultation at the UBS in the abovementioned neighborhood. In a sample composed of a group of 50 pregnant women, randomly selected, corresponding to the population. The inclusion criterion was being pregnant and performing the prenatal care at the UBS.

Data collection was performed during the period of May and June 2015, after acquiring the Authorization Term in the mentioned unit. The resource used to reach the required information was a form (Annex) with closed (multiple choice) and open (free) questions. To facilitate the analysis of the data, the form was divided into the following topics: I - Socio-economic and cultural aspects; II - Self-care measures in oral health; III - Aspects that interfere in access to dental treatment during pregnancy.

Quantitative data were analyzed and edited through tables and graphs. The qualitative analysis of the data was based on MINAYO (1999) and carefully detailed, to give greater visibility of the process. The answers were organized in a table, with a horizontal and vertical reading of the answers, allowing the identification of common points, trying to group the similar ones and pointing out the divergences, allowing the categorization of the data, so that they respond to the objectives of the study.

According to Resolution No. 196/96, which governs research on human beings, according to guidelines of the National Health Council. The ethical aspects were respected, and the study was authorized by the participants who signed a Term of Consent, in which they declared that they would accept to participate Of the study, after the exposure of the objectives, and knowledge that would guarantee anonymity and the right to removing from the survey what was not summative, at any time, therefore as the right to know the result of the same.

RESULTS

Fifty-five pregnant women, according to the results of the research, found a young profile among the pregnant women interviewed, who presented among 15 and 55 years of age, 46% with an average of 25-35 years.

It was also observed the presence of pregnant women over 35 years of age (20%) and a significant percentage of adolescent pregnant women (26%). In this aspect age is a factor that can interfere with the care with your oral health and also with the oral health of your children. Based on observations taken from our daily practice, we can say that, as a rule, the younger the pregnant woman, the less care she is given to her health (Table 1).

Age group	Freq. absolute	Freq. relative (%)
15-25	13	26%
25-35	23	46%
35-45	10	20%
45-55	4	8%

Table 1 - Age range of pregnant women interviewed at UBS

According to the marital status, it was observed that 19 pregnant women were single (38%), 25 married (50%), 6 declared others (12%). Marital status and marital status present significant elements in the development of pregnancy, both through economic support and emotional support (Figure 1).

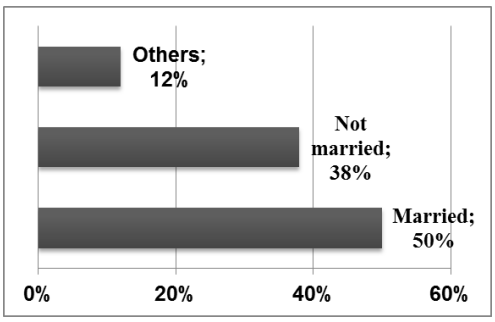

Figure 1 - Graph of the marital status of the UBS pregnant women.

Regarding the occupation of the pregnant women, the results showed that 14 (56%) of these women work

outside the home, while 11 (44%) pregnant women performed some kind of work outside the home (Figure 2).

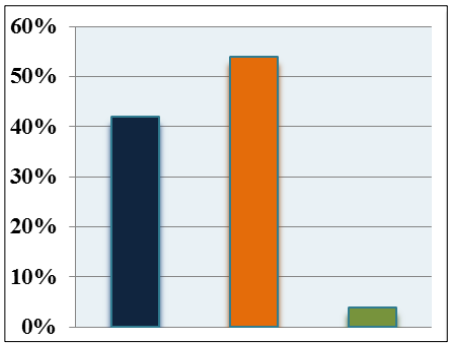

Figure 2-Graph on the occupation of the pregnant women of the UBS.

Regarding the educational level, it was evidenced that of the total of interviewed women only (14%) had finished elementary school; (16%) of them did not finish elementary school; (4%) pregnant women who cannot read and write. It was also observed that in the present study sample (34%) of the pregnant women had complete secondary education, (24%) had incomplete secondary education and only (8%) had higher education (Table 2).

Education	Freq. Absolute	Freq. Relative (%)
Cant you read	2	4%
E.F. Incomplete	8	16%
E.F. Complete	7	14%
E.M. Incomplete	12	24%
E.M. Complete	17	34%
Higher level	4	8%

Table 2 - Degree of schooling of pregnant women interviewed at UBS.

Regarding the amount of toothpaste used, 32% responded to brushing with paste in the size of pea grain, 28% answered that it would be correct to cover all the bristles of the brush, 10% said that the amount for ideal brushing was sufficient for production Of foam, while 30% reported that they did not know how to respond (Figure 3).

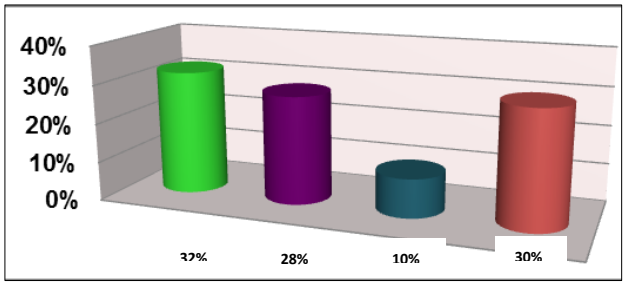

Figure 3 - Graph on the amount of toothpaste used by the UBS pregnant women.

Regarding dental brushing performed by the pregnant women, 12% reported that the ideal force was applied, (10%) responded that the amount of toothpaste was the most important, (58%) stated that the technique used was the (10%) showed no knowledge at all (Table 3).

What is most important in dental brushing?	Freq. Absolute	Freq. Relative (%)
Applied force	6	12%
Amount of toothpaste	5	10%
Technique used	29	58%
Not know	10	10%

Table 3 - The importance of dental brushing of the pregnant women interviewed at the UBS.

In daily flossing, 12% of pregnant women responded that they used after brushing, 20% answered that the ideal should be once a day, 28% said they used when there were foods among their teeth, 40% said they did not use (Table 4).

Use of Dental Floss	Freq. Absolute	Freq. Relative (%)
Once a day	10	20%
When there is food between the teeth	14	28%
Do not use	20	40%
After brushing	6	12%

Table 4 - The use of dental floss by pregnant women interviewed at UBS.

The results obtained on the usefulness of fluoride show that 38% answered that they were used to prevent and prevent cavities, while 24% claimed teeth strengthening together with protection, whereas 22% of pregnant women stated that their usefulness would be in combating 20% said they would clean their teeth, 18% responded to bad breath, 10% said they would mouthwash, 14% said to treat their teeth, 22% to lighten and 24% did not know answer (Figure 4).

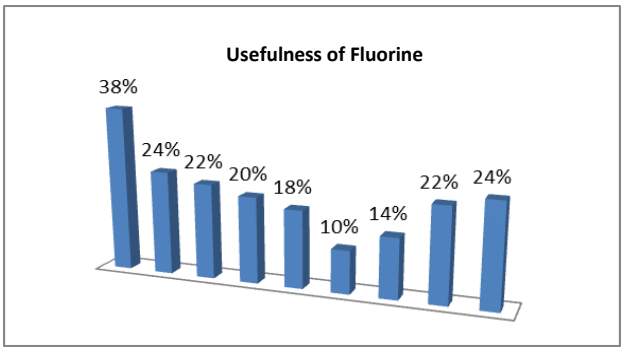

Figure 4 – Graph on the use of fluoride by UBS pregnant women.

Regarding bleeding during pregnancy, 56% of the pregnant women stated that they did not have it, but 44% had gingival bleeding rather than during gestation. However, it was observed during the interview that many of them had no symptoms such as gingival pain or bleeding (Figure 5).

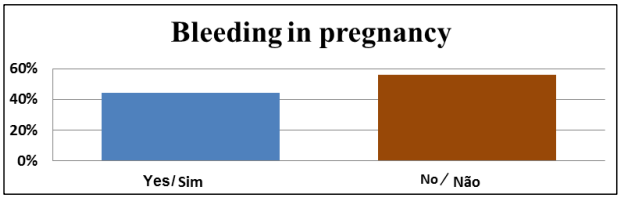

Figure 5– Chart regarding gingival bleeding of pregnant women at the UBS.

According to the fear of dental treatment in gestation, it was reported that 73% showed positive, with great anxiety, but only 27% were able to face a dental procedure. Among the main justifications cited, 7% reported that they would harm the baby, 5% did not accept treatment for fear without knowing the specific cause, 4% claimed to be impaired due to anesthesia, 1% reported for insecurity, lack of care and Absence of good professionals (Figure 6).

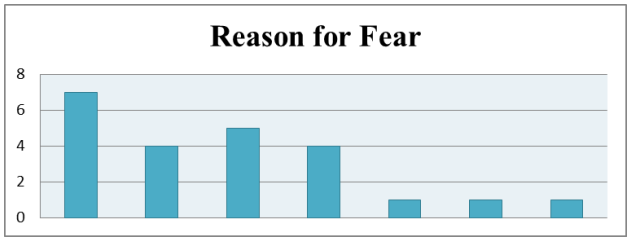

Figure 6 – Graph on the justification for the fear of the pregnant women of the UBS.

These results demonstrate that the pregnant women did not recognize the importance and the need of dental care, but only 18% sought the dentist during gestation, a different result found by Ramos et al. (2006) 31 in which only 32% of the pregnant women sought a professional in the gestational period (Figure 7).

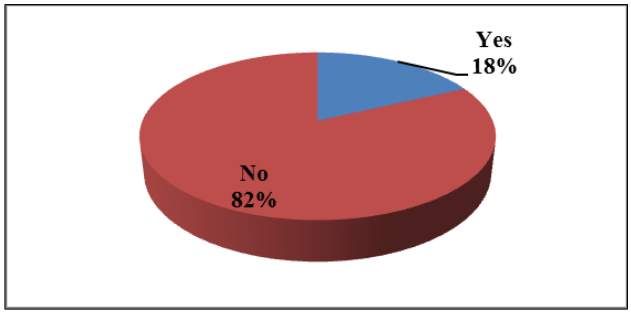

Figure 7 – Graph on the demand for guidance of dental treatment by the pregnant women of the UBS.

The gestational period is considered a high risk for the occurrence of caries, not due to the increase of the oral microbiota or even its pathogenicity, but due to the increase in plaque due to the carelessness of the pregnant woman with her oral hygiene. Because of this the results of Figure 6 showed that 32% responded that "it is not a transmissible disease"; 62% "they do not know", and only 6% answered that "it is disease and it is transmitted from one person to another" (Figure 8).

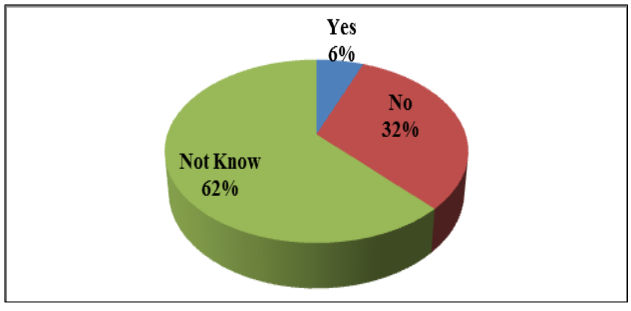

Figure 8 – Graph on the knowledge of the pregnant women of the UBS on the caries transmission.

The results presented on the knowledge on the part of the pregnant woman in relation to the alimentary diet in influencing the health of the teeth were the following: 58% answered that yes, 16% said no and 26% did not know about it (Figure 9).

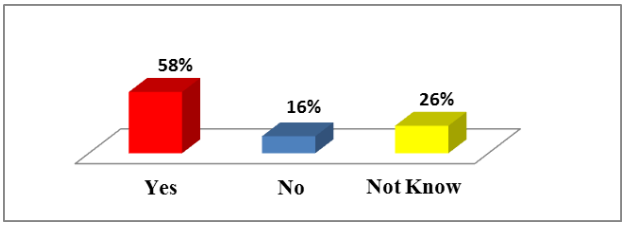

Figure 9 – Graph on the knowledge of the pregnant women of the UBS on the alimentary diet in the influence on the health of the teeth.

Few were pregnant women who received guidance on oral health during prenatal care (34%). Of these, a significant percentage did not receive the guidelines through the oral health team (66%). This low percentage of pregnant women who received guidance on oral health demonstrates the need for a greater integration of the team within the Family Health Strategy, considering that this is a priority group and because of the role that these women will play in the promotion of oral health in the family nucleus . Thus, it is extremely important that UBS motivate pregnant women to control plaque through oral health promotion actions that include educational actions in oral health, supervised brushing and topical application of fluoride (Figure 10).

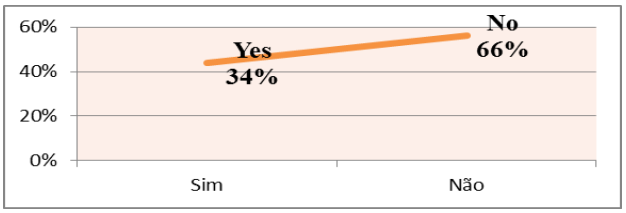

Figure 10 – Guideline chart on oral health during prenatal care.

DISCUSSION

The definition of health is not limited to the absence of disease, but it must be understood as a set of factors that promote a better quality of life, so educational actions are important when they act in the transmission of knowledge and information, qualifying the population To the new concepts and attitudes about oral health, aimed at the promotion, prevention of oral pathologies, health professionals act as multipliers of oral health.[8]

Observing the total sample, 52.1% were primigravida, a similar result was found by Codatoet al. (2008), in which 48.1% of the pregnant women were in the first gestation. It was also observed that the majority of the women were primigravidae. This is an important characteristic of the sample since it is known that, mainly, the primigravidae mothers are hungry for all kinds of information related to the care related to their health and, mainly, With that of the baby.[9]

Regarding the number of pregnancies, most of the interviewees were 56% in the first gestation and 2.5% in

the fifth or more gestation, there was no statistically significant difference between the variables tested (p = 0.327). According to marital status, 25 were married (50%); Marital status and marital status present significant elements in the development of pregnancy, both through economic support and emotional support. Similar results were found regarding marital status, the majority (67.5%) were married, 25% reported being single and 7.5% were widows.[10]

Marital status and marital status present significant elements in the development of pregnancy, both through economic support and emotional support; In a single pregnancy, gestation difficulties can be identified from the prenatal follow-up, and intercurrences may occur, which may aggravate the maternal-fetal diagnosis, in the evolution of gestation.[11] In relation to the level of education, it was evidenced that of the total Pregnant women interviewed only (14%) had completed primary school; (16%) of them did not finish elementary school; (4%) pregnant women who cannot read and write; (34%) of the pregnant women had complete secondary education, (24%) had incomplete secondary education and only (8%) had higher education.[12]

Comparison with the work of Pharia (1996) (40%) presented complete fundamental, (30%) fundamental incomplete, complete high school with (10%) and incomplete secondary education (20%). He observed that the majority had completed high school. Thus, the maternal educational level is an important variable to be considered, since studies show that mothers who have a higher educational level positively influence the oral health of their children.[13]

According to Ferreira (1989), infection is an important risk factor for preterm labor and low birth weight infants, with periodontal disease being the most common cause of gonadal bleeding in 44% of the interviewees. A risk factor of extreme value, since the presence of inflammatory cells during periodontal inflammation raises the concentration of prostaglandins and proteolytic enzymes that are fundamental for the onset of preterm labor.[14]

Regarding the oral alterations, approximate results found, they also reported that the occurrence of gingival bleeding in 20.3% and 32.5%, respectively. This is probably due to the more frequent feeding and the discomfort at the time of the brushing in the first months of gestation, besides the hormonal changes of the period.[15]

Regarding dental brushing performed by the pregnant women, 12% reported that the ideal is the applied force, (10%) answered that the amount of toothpaste was the most important, (58%) stated that the technique used was primordial, but (10%) it showed no knowledge. The pregnant women were aware of the greater need to care for the teeth during the gestational period, but they showed little or no knowledge of how to perform the teeth. This is a relevant aspect since several studies have shown that mothers are mainly responsible for the healthy maintenance of their children.[16]

In brushing, there are a number of brushing techniques, but the most indicated are Bass, in which the brush is applied at a 45° angle to the long axis of the tooth, pressed against the marginal gingiva by penetrating the gingival sulcus and Rotational and vibratory movement. In daily flossing, 40% said them.[17] Dental floss occupies an important place in the prevention and periodontal therapy, contending with the brushes the primacy of being the most efficient resource of interdental hygiene, however when the technique is mastered correctly not forgetting to carry through this the cleaning of the subgingival region.[18]

The usefulness of fluoride shows that 38% responded that it serves to prevent cavities; fluorides are widely used in the prevention of dental caries; Fluoride of the toothpaste is considered the main reason for the decay of caries observed in all countries.[19] Considering the fear of dental treatment in pregnancy, 73% reported positive, but with great anxiety, but only 27% were able to face a dental procedure. Among the main justifications cited, 7% reported that they would harm the baby, 5% only fear alone, without knowing the specific cause 4% complained of anesthesia, 1% reported for insecurity, lack of care and lack of good professionals.[20]

There is still much fear of anesthesia, of harming the baby and bleeding (37% of SUS responses and 19% of private clinic answers). It was observed that the pregnant women interviewed reported having a fear of going to the dentist during gestation, and the fear of harming the baby was what prevailed[21]. However, the study by Minayo (1999) showed that the majority of respondents stated that they did not present fear of performing dental treatment during pregnancy and, among those who answered affirmatively, the fear of harming the baby was the main answer.[22]

When asked to receive more information, the results show that there is an interest of 97.5% (48.75) of the pregnant women, confirming the data found in the literature, which reports that gestation is a period where the woman is hungry for more information. Results Similar results show that there is interest in 97.5% (195) of the pregnant women, confirming the data found in the literature, which reports that gestation is a period where the woman is eager for more information.[23]

Concerning to consider their teeth weaker during the gestation, it was observed that 30% of the pregnant women do not consider that the gestation weakens the teeth, is that of these 70% believed. In the study by Peres et al. (2001), the percentage of pregnant women who believed that calcium withdrawal to the baby was the cause of tooth decay was higher (37.9%), they also found different results, with 52.4% of the Interviewees not believing that gestation is responsible for oral changes, and 38.3% believe that it is due to the removal of calcium for the baby.[24]

The results of figure 6 showed that 32% responded that "it is not a transmissible disease"; 62% "they do not know," and only 6% answered that "it is disease and is transmitted from one person to another." There is an increase in carious lesions during pregnancy; the majority of authors disregarded that hormonal changes and salivary hyperacidity are sufficient to cause dental caries; Its highest incidence during pregnancy is motivated by neglect of treatment.[25]

Some pregnant women were aware of dietary influences on their health, 58% said yes, 16% said no, and 26% did not know about it. Analyzed the studies stated that when asked about the importance of adequate food during pregnancy, the majority (29) answered that it was very important to have adequate food (72.5%), and the other 11 (27.5%) reported being Little or no importance at all.[26-30]

Few were those who received guidance on oral health during prenatal care (34%); Of these, a significant percentage did not receive the guidelines (66%).[31] The importance of this information should be emphasized and should be addressed to mothers not only by the dental surgeon but also by the gynecologist, pediatrician, obstetrician and all health professionals involved in an interdisciplinary way, in order to increase their knowledge About the gestation, the general and oral changes that occur in them and in the baby, there is a need to know the level of perception of the pregnant women regarding oral health to be successful in a prevention program.[32]

There is a clear need for the development and implementation of preventive programs, with information for future mothers about cariogenic bacteria, hygiene techniques, their role in caries transmission, and the improvement of their oral health condition, suggesting that this program should be developed during prenatal care.[33] The benefits of good health practices will certainly extend to the future baby, through the adoption of adequate eating habits and preventive measures, minimizing the possibility of the emergence of several pathologies in the child, among them dental caries.[34]

In this sense, the health professional, depending on the degree of information and the capacity to transmit it, may or may not stimulate self-care of the mother-child binomial.[35] It is expected that this professional will act as an important agent in health education and, thus, contribute to the demystification of fears and myths related to dental care during prenatal care and also to oral-dental alterations attributed to being pregnant.[36-38] However, oral health and dental care of pregnant women are targets of different positions and behaviors, only of the pregnant women themselves, but also of the professionals involved in the care of this part of the population.[39,40]

CONCLUSION

From the respective study, it is concluded that dental care is not a priority for the group, even when real problems such as gum pain and bleeding are present. Few were those who received guidance on oral health during prenatal care. Of these, a significant percentage received guidelines through the oral health team dentist, and physician. This low percentage of pregnant women who received guidance on oral health demonstrates the need for a greater integration of the team within the Family Health Strategy, considering that this is a priority group and because of the role that these women will play in the promotion of oral health in the family nucleus.

The pregnant women understand that the onset of dental caries can be caused by excessive consumption of sweet food, poor hygiene habits, lack of fluoride use, lack of access to dental services, neglect of dental flossing and lack of care with oral health. Thus, it is necessary to encourage the demand for professional dental care to succeed in pregnancy, and at least once in the trimester during pregnancy, in order to prevent future complications, as well as to reinforce the need for multi-professional care for pregnant women, so as to act in the global health of the same.

REFERENCES

1. Applebaum, M.H. Radioactive phosphate permeability in dentin following the use medicaments. J. dent. Res. 27(5):635-9, May, 1931.
2. Appelbaum M. Plans of occlusion.DentClin North Am. 1931; 28(2): 273-85.
3. Batistella FID, Imparato JCP, Raggio DP, Carvalho AS. Conhecimento das gestantes sobre saúde bucal; na rede pública e em consultórios particulares. RevGauchaOdontol, 2006;54:67-73.
4. Bodecker, C.F. & Applebaum, E.The variable permeability of the dentin and its relation to operative dentistry.Dent. Cosmos. v.75, n.1, p.21-31, 1931.
5. Berlinguer, G. A Promoção da Saúde. In: Questões de Vida: ética, ciência, saúde. São Paulo: Hucitec, 1993. p. 149-158.
6. Bernd B, Souza CB, Lopes CB, Pires Filho FM, Lisbôa IC, Curra LCD, Souza LNS, Pignone AO. Percepção popular sobre saúde bucal: o caso das gestantes do Valão. Saúde Debate 1992; 34:33-39.
7. Brasil. Ministério da Saúde. Coordenação de Saúde Bucal. 8ª Conferência Nacional de Saúde. Iª Conferência Nacional de Saúde Bucal. *Relatório Final.* Brasília: Ministério da Saúde; 1986.
8. Brasil. Ministério da Saúde. Secretaria de Gestão e Investimento em Saúde. Departamento de Gerenciamento de Investimentos. Projeto Cartão Nacional de Saúde. Diretrizes para o cadastramento Nacional de Usuários do SUS: planejamento municipal. Brasília: Ministério da Saúde; 2001.
9. Braga JMF. In: Zugaib M, Sankovski M. O pré-natal. Atheneu. São Paulo, 1991. p. 23.
10. Codato LAB; NakamaL.; JúniorLC; HigasiMS. Atenção odontológica à gestante: papel dos profissionais de saúde. Ciência & Saúde Coletiva, 2008.
11. Chagas, M.I.O. Gestação e trabalho: alegria e sofrimento, um enfoque cultural. Fortaleza: UVA, 2001. 128p.
12. Day Ra. Como escribir y publicar trabajos científicos. Washington: OPS/OMS; 1933.
13. Faria, C. F. Programas odontológicos durante a gravidez e o impacto na saúde bucal do bebê. Araraquara, 1996. 55 p.

14. Ferreira ABH. Mini dicionário Aurélio. 2ª ed. Rio de Janeiro: Nova Fronteira; 1989.
15. Granville-Garcia AF, Silva JM, Guinho SF,Menezes V. Conhecimento de professores doensino fundamental sobre saúde bucal. RGO. 2007Jan/Mar;55(1):29-34.
16. Garbin CAS, Lelis RT, Garbin AJI, Moimaz SAS. A percepção de gestantes em relação à assistência odontológica. ROPE RevIntOdonto-PsicolOdontol Pacientes Espec 2005; 1(3/4):82-87.
17. Gebran, M.P.; Gebert, A.P.O. Controle químico e mecânico de placa bacteriana. Ciências e Cultura, 26(3): 45-58, 2002.
18. Guimarães AO, Costa ICC, Oliveira ALS. As origens, objetivos e razões de ser da odontologia para bebês. JBP J BrasOdontopediatrOdontol Bebê 2003; 6(29):83-86.
19. Konish F. Odontologia intra-uterina. Rev. APCD 1995; 49(2):135-136.
20. Konishi F, Lima PA. Odontologia intrauterina: a construção da saúde bucal antes do nascimento. RevBrasOdontol 2002; 59(5):294-295.
21. Matilda ML Åstrøm AN Changes in dental health and dental health habits from 3 to 5 years of age. J Public Health Dent. 1998;58:270-4.
22. Minayo, M. C. S. O desafio do conhecimento: pesquisa qualitativa em saúde. 6ª Edição. São Paulo – Rio de Janeiro: HUCITEC – ABRASCO, 1999.
23. Miranda KCL, Barroso MGT. A contribuição de Paulo Freire à prática e educação crítica em Enfermagem. Rev Latino-am Enfermagem 2004; 12(4):631-635.
24. Peres SHCS, Cardoso MTV, Garcez RMVB, Peres AS, Bastos JRM. Tratamento alternativo de controle da cárie dentária no período materno-infantil. Rev. APCD 2001; 55(5):346-351.
25. Pessoa, V.M. et al. Atenção integral á saúde da mulher no ciclo gravídico puerperal; Escola de Saúde Pública do Ceará. Fortaleza; 2009. 7p.
26. Politano GT, Silva SREP, Imparato JCP, Pellegrinette MB. Avaliação da informação das mães sobre cuidados bucais com o bebê. Rev. Ibero Americana de Odontopediatria e Odontologia do Bebê 2004; 7(36):138-148.
27. Ramalho, A. C. Transplantes homógenos de incisivos de ratos (rattusnorvegicus) em alvéolos dentais homólogos - Contribuição para o estudo. Tese de doutoramento. Faculdade de Odontologia de Araraquara, 1968.
28. Ramalho, A. C. et al., Estudos das alterações teciduais dos transplantes homógenos de dentes de crescimento contínuo. Rev. Fac. Farm. Odont. Araraquara, v. 3, p. 191-214, 1968.
29. Ramos TM et al. Condições bucais e hábitos de higiene oral de gestantes de baixo nível sócio-econômico no município de Aracaju / SE. Pesq Bras Odontoped Clin Integr, 2006;6:229-235.
30. Rocha MCBS. Avaliação do conhecimento e das práticas de saúde bucal: gestantes do distrito sanitário docente assistencial Barra/Rio Vermelho - município de Salvador, BA [tese]. Bauru: Faculdade de Odontologia, Universidade de São Paulo; 1993.
31. Rodrigues EMGO. Promoção da saúde bucal na gestação: revisão da literatura. Juiz de Fora: Faculdade de Odontologia da Universidade Federal de Juiz de Fora; 2002.
32. Santos-Pinto, L. et al. O que as gestantes conhecem sobre saúde bucal? J. Bras. Odontopediatria e Odontologia do Bebê, v. 4, n. 20, Curitiba, set-out/2001, p. 429-434.
33. Silva, S. Atendimento à gestante: 9 meses de espera? Rev. APCD, v. 56, n. 2, mar-abr/1997,p.89-99.
34. Silva, L. Postura de um grupo de gestantes da cidade de Curitiba-PR em relação à saúde bucal de seus futuros bebês. J.Bras. Odontopediatria e Odontologia do bebê, v. 2, n. 8. 1999, p. 262-266.
35. Scavuzzi AIF, Rocha MCBS, Vianna MIP. Percepção sobre atenção odontológica na gravidez. J BrasOdontopediatrOdontol Bebê, 2000; 1:43-50.
36. Scavuzzi, A.; Rocha, M. Atenção Odontológica na gravidez: uma revisão. Rev. da Faculdade de Odontologia da UFBA, v. 18, jan-jun/2000, p. 46-52.
37. Silveira EG, Silva RHH, Almeida ICS. Avaliação de uma metodologia para um programa educativo-preventivo em saúde bucal para escolares. Rev Paul Odontol 1998; 20:22-27.
38. Trevisan AR, Benfatti SV, Bausells J. Avaliação do conhecimento das práticas de saúde bucal em gestantes do município de Adamantina-SP. RBP- Rev Ibero-AmOdontopediatrOdontol Bebê. 2002;7(35):66-77.
39. Veras MSC, Sekulic E, Sabóia VPA, Almeida M I. Educação em saúde e a promoção de saúde bucal: marcos conceituais, teóricos e práticos na odontologia. RevOdontol UNICID 2003; 15(1):55-61.
40. Vokurka VL, Eduardo MAP, Carcacés LB, Valdez GO, Walter LRF. Odontologia intrauterina: o começo de tudo.Rev ABO Nac 1997; 5(2):70-77.

Source of Support: Nil
Conflict of Interest: Nil