Avanços e desafios na implantação da atenção básica em saúde bucal dos povos indígenas nos rios Tiquié e Uaupés – Distrito Sanitário especial indígena – Alto Rio Negro – Amazonas: análise de uma experiência

Avances y retos en la aplicación de la atención primaria en salud oral de los pueblos indígenas en ríos Tiquié y Uaupés - dsei - Alto Río Negro - Amazonas: análisis de una experiencia

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ABSTRACT

This study reconstitutes the implantation process of oral health services in Indian communities of the rivers Tiquié and Uaupés – Special Indian Sanitary District for the Alto Rio Negro – Amazons. In the political, administrative, anthropological and socioeconomic context, it aims at identifying its contribution to the organization of basic attention in oral health and its reflexes in the assistance provided. The reality in the realm of contracts 439/99 and 2349/00 is established as a recut, celebrated between Fundação Nacional de Saúde and the Associação Saúde Sem Limites in the period of 2000 – 2001 which object is the organization of health services in the Tiquié and Uaupés rivers area, in the implantation process context at the Rio Negro's Special Indian Sanitary District. It reveals the strategical dimension of establishing, in the field of organization and operation of the services, the guiding principles of Unique Health System. It points out, as fundamental in the oral health basic attention, the local planning, with emphasis in a greater visualization of life reality of the local population. Its daily practice reflects the restrictions regarding the political, technical and administrative sectors in order to define projects propose intervention mechanisms, allocate and manage the existing resources and the potential ones including human resources. It is necessary that the managers assume the challenges of power, work and knowledge relations between the population and the

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professionals and among different groups of these segments.

Uniterms: Unique Health System, organization and planning.

Indian Health; Public Health Policies; Local Strategies

RESUMO

Este estudo faz uma análise retrospectiva e reconstitui o processo de implantação dos serviços de saúde bucal em comunidades indígenas dos rios Tiquié e Uaupés – Distrito Sanitário Especial Indígena do Alto Rio Negro – Amazonas; no contexto político, administrativo, antropológico e socioeconômico, buscando identificar a sua contribuição para a organização da atenção básica em saúde bucal e seus reflexos na assistência prestada. Estabelece – se como recorte a realidade no âmbito dos convênios 439/99 e 2349/00, celebrado entre a Fundação Nacional de Saúde (FUNASA) e a Associação Saúde Sem Limites (SSL), no período de 2000-2001, cujo objeto é a organização dos serviços de saúde na região dos rios Tiquié e Uaupés, no contexto do processo de implantação do Distrito Sanitário Especial Indígena do Rio Negro. Revela a dimensão estratégica de concretizar, no campo da organização e operacionalização dos serviços os princípios orientadores do Sistema Único de Saúde (SUS). Aponta como fundamentais no processo de construção da atenção básica em saúde bucal os seguintes aspectos: o planejamento local, com ênfase na maior visualização da realidade de vida da população dessa região; a implementação do trabalho interdisciplinar; uma melhor organização dos serviços da rede de referência e contra-referência; e uma relação mais estruturada com as demais Instituições conveniadas neste Distrito, possibilitando uma ação integrada junto à população. Sua prática cotidiana reflete restrições no que se refere ao poder político, técnico e administrativo para definir projetos, propor mecanismos de intervenção, alocar e manejar os recursos existentes e os potenciais incluindo os recursos humanos. O tempo para consolidar um novo modo de organizar serviços e produzir ações de saúde bucal ainda é insuficiente, sendo levantados questionamentos para futuras implementações. Mudanças são processos lentos e é necessário que os gestores assumam o desafio de ser o "locus" das relações de poder, de trabalho, de saber entre a população e os profissionais e entre os diferentes grupos destes segmentos para que uma nova atenção à saúde bucal chegue a ser construída.UNITERMOS: Sistema Único de Saúde, organização e planejamento.

Saúde Indígena, políticas públicas de saúde. Estratégias locais.

RESUMEN

Este estudio es un análisis retrospectivo y reconstruye el proceso de implementación de los servicios de salud oral en las comunidades indígenas Tiquié y Uaupés - Distrito Sanitario Especial Indígena del Alto Río Negro - Amazonas, el contexto político, administrativo, antropológicos y socio- económica, tratando de identificar el su contribución a la organización de la atención dental básica y sus efectos en la prestación de atención. Es como cortar una realidad bajo los convenios 439/99 y 2349/00, entre la Fundación Nacional de Salud (Funasa) y la Asociación Health Unlimited (SSL)

en el período 2000-2001, cuyo objeto es la organización de los servicios de salud en la región de Tiquié Uaupés y ríos , en el contexto del proceso de implementación del Distrito Sanitario Especial Indígena del Río Negro . Revela la dimensión estratégica de lograr en el ámbito de los servicios de organización y funcionamiento de los principios rectores del Sistema Único de Salud (SUS) . Puntos fundamentales en la construcción de la atención dental básica el siguiente proceso: planificación local, con énfasis en una visión más amplia de la realidad de la vida en esta región y la puesta en práctica del trabajo interdisciplinario, una mejor organización de los servicios de referencia de la red y contra-referencia , y una relación más estructurada con las demás instituciones en este distrito encargados al exterior, permitiendo una acción integrada entre la población. Su práctica diaria refleja restricciones con respecto al poder político, técnico y administrativo para definir los proyectos, proponer mecanismos para la intervención, asignar y gestionar la actual y potencial , incluidos los recursos humanos. El tiempo para construir una nueva forma de organización de los servicios y producir acciones de salud oral sigue siendo insuficiente, y planteó preguntas para futuras implementaciones. Los cambios son procesos lentos y es necesario que los directivos toman el reto de ser el " locus " de las relaciones de poder, el trabajo, conocer entre la población y los profesionales y entre los diferentes grupos de estos segmentos para una nueva atención de la salud oral llegado a ser construido.

Palabras clave: Sistema de Salud, la organización y la planificación.

Salud de los indígenas, las políticas de salud pública. Las estrategias locales.

1- INTRODUCTION

In spite of the evolution of the practices of Health in Brazil - with the restructuring done by the Reforms Sanitary, the Constitution, the System of Only Health. And of the several progresses, they guaranteed that, in different degrees, an offer of services of health, the largest access of the population a services of these, we cannot consider that a population is healthier. Several of them are the determinant of the problems of health of the population - including the buccal health - and we should not only attribute to the biological aspects some fault of all the "males." Even with an universalization of the services of health, some minority groups are totally excluded of any insert possibility in programs of attention to health.[1]

Today, the big challenge is an implementation of a model of attention to be faithful to the principles of SUS – System of Only Health, because there is a need to observe a social complexity that involves the individual. For that there is a multiplicity of actions participative done not only for the health team, where you also find the dentist-surgeon, but also for the individual and his community. While subject of the action, they exercise their role in the act of rendering effective the process.[2]

This change has already begun in the 80s, with a search for redemocratization in the country. This decade is marked by the possibility of a larger participation of the local powers in the decisions about health. Certainly, an outstanding characteristic of the period is to think about reality, identifying and organizing

political forces capable to give sustentation to the proposals of public politics that include among their objectives an alteration of the situation of health and buccal health of each community. This was the great challenge put to those that have to take decisions in extent municipal/local.[3, 4, 5]

It can be affirmed with Narvai[6, 7] that this new politics contributed to health and "still contribute- a lot! To make better the buccal health of the Brazilians: decentralizing and, therefore, dividing powers and creating spaces for divergences and for the questioning or consolidation of decisions."

"In the odontology field in the perspective of System of Only Health.", Frazão[1, 8] affirm that "countless factors have been contributing to an incorporation of these modifications in odontology services in Brazil." And it emphasizes some of them as:

- "The high index of prevalence of dental caries and of the periodontal diseases, granting to these the statute of public health problems;

- the unbalance among the demand and offer of services of odontological attendance;

- the scientific-technological development in the ergonomics field, cariology and epidemiology, creating different systems, methods and work techniques;

- the technique horizontal and vertical division of odontological work (specialists and auxiliary people), incorporating different subject and reaching larger levels of quality and productivity;

- the propositions of rationalization and extension of the covering through the structuring of basic nets of health implemented in the field of the public politics of health.

- the multiplication of social movements, between them the right of health, being enlarged the participation of the local powers in the decisions about health."

Since 1996, discussions have been accomplished about the need to organize the services of health in the area of High Rio Negro. These discussions were provoked by the entrance of new social actors' in the local panorama of the institutions of health. At the end of this same year, an agreement was settle between the Federation Indigenous Organizations Rio Negro (FOIRN) and FUNASA with the main objective of accomplishing a mobilization of the community and to support the Agents of Indigenous Health (AIS) existents.[9,10]

The politic decision of the State Department of Health (MS), by FUNASA, to create a Special Sanitary Districts Indigenous (DSEIs), at the end of 1998, at the same moment of Rio Negro, it was discussed about the health of the indigenous people. This allowed that all the involved institutions put in practice some of the ideas defined long times ago.

Should join this process the accumulated experience from the Indigenous Organizations of Rio Negro that was result of a long historical process of fights against oppression from "white man" and for the demarcation of the lands. Recently, fighting for the right of health a key ingredient for the performance of the process of districting. During 2000, were implanted 34 DSEIs, all over Brazil.[11]

Each one of those DSEIs presents different development apprenticeships. These differences are current of the historical processes of contact of the indigenous groups, the established relationships with the involving society, with prominence for governmental bodies, and of the political organization of those groups, as for the right to fight for health.

Fratucci[12] puts us some questionings: does a warranty to access a program of health by itself would it be enough to promote health? How is understood the question about attention of health for the several instances: MS, General offices of State Health (CATHEDRALS), FUNASA, National Foundation of the Indian (FUNAI), Mayors, Secretaries, the Counsel of Health (CS), Local Programs of Health and Users? Will it be relevant a problem of buccal health in a place where children die from malnutrition, diarrhea and breathing problems before of their first year of life?

"Certainty the concern should not be centered in which pathologies will be more prevalent or 'important", but to establishing solid studies, that can contribute for the discussions about the health of the indigenous populations and that can collaborate in the structuring of the Indigenous Special Sanitary Districts - DSEI, that seek to guarantee the right for **universal** and **total** health of the indigenous people."[12]

From this information, any dentistry program that will be initiate should be preceded of a qualitative and quantitative analysis of the buccal diseases and other factors that can be influencing in the change of the incidence of those in the population. This evaluation should have as basis not only the odontological aspects of the question as well as it should consider the anthropological questions – cultural and-political that each region is submit. It should put up (up rise) characteristics of the population which will be worked, looking at them exempt of preconception, to get to defy the needs and priorities, its history past with the dentistry relation and which is the more appropriate way to reach the drawn goals.

2 – OBJECTIVES

This way, this work intends to contribute for an elaboration of programs of collective buccal health, that they have integrated characteristic, participative and transforming, as well as for a reformulation and improvement of actions related to the programs of collective buccal health in indigenous communities. They are, still, specific objectives of this work:

- supply subsidies to the reorganization of the services of basic attention in buccal health in the indigenous communities;

- to review the practices in buccal health for services of basic attention, the sense to assure a promotion of the buccal health and prevention of their offences;

- to provide subsidies for the training of necessary human resources for the development of the actions of buccal health.

3 – CHARACTERISTIC MAKES STUDY

At the methodological trajectory of this research we looked for some characteristics that resemble the studies of the "classic sociology." Some particularities are adjusted in the category of social research. Its main approach was the qualitative one.

Adorno[13] in "Sociology: an introduction rehearsal to in its field and a some of their slopes" refers to a methodology of studies of social facts, with use of techniques multivariate, such as the use of "qualitative method" X "quantitative method", that appear as a methodological innovations in the area of the health, however "Classic Sociology" were already found developed as constructions of its own sociological method.

Minayo[3] allows us to adopt a discussion of the object of social sciences as a historical object, that is, human societies exist in a certain time and space and "the social groups that compose them are changeable and everything, institutions, laws, world visions are temporary, passengers, are in constant dynamism and, potentially, everything will soon be transformed."

Also for the elaboration of this work seems to us interesting the considerations of Botazzo[14,15] as how it should be made a qualitative research. These considerations are based on the researcher Minayo[3] and in his idea of theoretical sustentation of a research. The researcher affirms that the observer should apprehend the reality and keep it "with an immediate perception of the lived", of one "experience captured as a flow." Defines the observation participant as "a presence of the observer in a normal social situation (...) about relations face to face with observed and, when participating in their lives, at their cultural scenery, picks facts."

Was concluded that any report of an experience should be based on the existence.

Thiollent[16], affirms that the researcher as part of the reality being studied, search to know it better to contribute in its transformation.

In this research what is put first for study, it is the area of the rivers Tiquié and Uaupés at the Special Indigenous Sanitary District at High Rio Negro, looking at the implantation process of services of buccal health in this area. In this context will be done the analyses proposed by the research, emphasizing the importance of recognizing that each area of this District is a singularity, because it is built inside of an own lócus of social relations, that are going to defy the roads for constitution of it.

4 – THE TRIANGLE TUKANO - DIAGNOSIS SITUACIONAL OF THE AREA

The region of the rivers Tiquié and Uaupés, with an area of 107.500 km^2, located 40Km (Uaupés) and 300Km (Tiquié) from the municipal district São Gabriel da Cachoeira. We defined as area of these rivers the area that includes communities located in their cot. From its mouth in the Black river until outlet in river Papuri, Uaupés is placed in Brazilian territory (342Km); between this point and the mouth of Querari, it serves as border between Brazil and Colombia (188Km); and from then on until their headboards it is located in Colombian territory. The river Tiquié with its mouth on the river Uaupés has an extension of 450km in Brazilian territory. This area is drained by rivers Igarapés, which is pointed out Iauiari, Cunuri, Drizzles, Chestnut tree, Cabari, Umari and Japu.

Officially this area becomes administratively demarcated, by the Ordinance of April14 of 1998, sanctioned by the president Fernando

Henrique Cardoso through the Law 6001 of 19/12/7343.

This area is traditionally inhabited for at least 2000 years by a diversified group of indigenous people. The number of existent communities in this area it is approximately 119, 55 communities are part of the river Uaupés and 64 are located at the river Tiquié. All the population, registered by the teams of SSL (2000/2001), it is approximately of 8000 inhabitants.

In this area there is predominance of the ethnic groups of the linguistic trunks of Tukano and Maku. The cultural diversity is represented by 22 and 19 existent languages in the area. Groups of Maku, present peculiarities in their way of living and in the epidemic aspects in relation to Tukano.

The communication in Portuguese with the Tukano linguistic trunk is possible and it has easy access, however with Maku is precarious and it has difficult understanding.

5 – EPIDEMIC SURVEY

Informally, what we can observe are risings in the index CPO (numbers of carious teeth, lost and filled) accomplished by dentists in some indigenous nations, what certainly doesn't offer us a positive fact of the general situation of this population. The indexes of incidence of decay give us just a quantitative reference and it has been varying a lot from group to group depending of the degree of contact of the indigenous population with a white circumjacent population.

- **Materials and Methods**

Were parts of the studies all ages above 05 years old, composing the sample everyone that spontaneously were disposed to participate. Also collaborated for the definition of the sample the professionals' available time during the visits.

- **Instrument of Data Collection**

It was used as data collection instrument a modification of the record used to work with natives accomplished in Acre by the Association of Health Without Limits in 1994.

The record counted with fields for the following basic data: data, river, community, filiations, race, age, sex and dental condition. The codes of the dental condition were based in the proposed by the OMS for epidemic studies in buccal health.

- **Used indexes**

The used index was the "CPOD" where C = decayed, P = lost, O = filled and the unit measure is D = tooth. This index expresses the number of permanent teeth attacked by the decay. For the individual it is expressed by the sum of the numbers of attacked teeth and, for a population, it is expressed by the average of the individuals' totality.

- **Results**

Only 9, 5% of the people that participated of the survey presented CPO-D equal zero. (figures 01, 02,03).

The decay can be considered the disease of larger prevalence in this area because it reaches 90% of the population. That is due to the high disinformation degree about cares for buccal

health and to the difficult access to the services of health. Most part of the community doesn't have access to toothpastes with fluorine and tooth brushes. There isn't basic sanitation in none of the communities, therefore not having treatment of water, it doesn't exist access to water with fluorine.

We verified, through the reports and existent surveys, that usually in the indigenous areas of little contact, or recent contact, the decay indexes are very low, almost zero. As larger or longer the contact, these indexes tend to arise. This modification in the incidence of the dental decay has been verified practically by all the professionals that work in indigenous areas. However, there is a lack of researches that confirm which the factors that really act in this modification are and how they interact. Some of those factors would be the change of the buccal flora; the largest consumption of industrial products, especially the sugar, and the change of habits and habits in the communities.

Today the alimentary change in the area, in spite of not being very big, already causes an unbalance that takes to the aggravation of the decay processes and the precocious loss of the teeth. We can also verify a substantial increase of decay lesions in the deciduous teething, taking some people to present problems of bad occlusion in the permanent teething. We observed a small amount of people that began to introduce the feeding bottle use, what can justify those problems.

When the bibliographies about buccal health in indigenous populations were revised were found several isolated studies or with differentiated methodologies. Some authors mention relative difficulties about the distance among the villages, the communication problems and the lack of motivation in behalf of the Indians in submit themselves to the exams; what hinders possible comparisons along the time.

Indigenous agent of health: an approach in buccal health

The proposal of the Special Indigenous Districts Sanitary contemplates the formation of indigenous agents of health as strategy for the improvement of the health situation in the communities. The process of formation of them were structured in the areas starting from the guidelines extolled by FUNASA/Department of Indigenous Health (DESAI) and, in the local level, it was coordinated by the School's Health Center D. Walter Ivan (CSE).

The experiences in the formation of auxiliary personnel show that this is an important road in the reduction of buccal diseases in the measure that the monitor of buccal health, besides executing preconception activities, exercises a paper of multiplier of information until then unknown by the community.

Odontological attendance

The service odontological clinical service began in April 2000 in the Pole-base of Taracuá.

During the period of activities the teams acted in indigenous area facing cultural differences and geographical barriers to reach the objective proposed by the institution of organizing strategies for the implantation of a Program of Buccal Health. For that they accomplished trips to the areas rendering healing and preventive odontological services

and collecting data about the situation of buccal health that incorporated the area diagnosis.

During some time the work was concentrated only in the service of the accumulated needs and in the attempt of reversion of concepts already ingrained as for the odontological subject (current of a practice mutilated accomplished previously).

- **Surgical Procedures**

The loss of some traditional ways of buccal higienize, allied to a modification in the alimentary consistence, takes a larger accumulation of bacterial plate, causing more decays and a worsening of the periodonto. As in this area, there is still a repressed demand to the healing and preventive procedures, what we found is a great number of teeth to be extracted, many to be filled and an expressive increase in the need of dental prostheses. Probably, if there is no modification in the system of attention to the health, in a few years the children's buccal health and indigenous young adults should be in very precarious condition, and the increase of the prosthetic need will have reached alarming levels.

Besides the lack of data regarding the buccal condition of the indigenous populations in this area, we observed that, historically, the odontological service have been maintaining a mutilated character, being few the experiences in the education area in health, prevention and formation of auxiliary personnel with specific characteristics for each area.

- **Atraumatic Restorative Treatment (ART)**

Countersigned by OMS, the social indications for use of the restorations atraumatics continue being the same ones done by Frencken, in other words, for situations where odontological clinics don't exist and the surgeon-dentists don't have possibility to restore carious teeth for the habitual means. Are included in this context the rural communities, indigenous, and social excluded. It also exist situations where patients come searching for service, due to pain and the impossibility of getting another type of service they request to the surgeon-dentist the extraction of the tooth. In these cases, many surgeons' dentists are faced with a situation where they know that the dental piece could be restored, but if it be left without treatment will develop and make the treatment unfeasible, because it will become much more complex and with the progress of the disease will also demand larger complexity and cost for treatment.

With the work in elapsing of those two years (2000/2001) it was possible to supply expectations and to change concepts, showing the importance of the prevention of the decay, of the accomplished dental restorations (Atraumatic Restorative Treatment - ART) and of the dental extractions that created a new problem: the prostheses for the repairing of the dental losses were many times impossible to be gotten. The educational work was only possible through the demonstration of the practical results that could be reached by the job of a "more preventive" dentistry and "conservative."

After some months it was possible to feel a change in the natives' posture because they began to discuss the possibilities of restorations of the teeth, as they started to realize that it

stayed intact for a long time, putting an end to the pain and reestablishing the masticatory function. The patients' coexistence with this new reality echoed quickly in the group of the population and, after the second year of activity, it was already difficult to convince some patient of the need of a dental extraction, when it was really inevitable.

6 – FINAL CONSIDERATIONS

The first year of implantation of DSEI-RN revealed to be possible to improve the services of health rendered to the population and it sends for the need of the Politics of Indigenous Health to fasten their space as a politics of State.

The continuity of the organization of the services of health and the participation executes of the indigenous population are fundamental so that, gradually, the serious picture of health presented, be modified.

Difficulties:

- To fill out clinical records and to understand the instruments of SIASI;
- To work with the cultural habits of the Indian;
- To evaluate and to measure the collective procedures;
- To direct patient for reference;
- Absence of courses for CD in technical and anthropological subjects;
- Inadequacy and high rotation of Human resources and of auxiliary personnel, generating discontinuity in the actions and loss of collected data;
- Inexistence of a politics for selection and recruiting of AIS and other professionals;
- Relations CD x number of people for service, generating professional overload;
- Inadequacy of the equipment, material, instrumental and infrastructure in the villages;
- Insufficient resources for the dentistry activities;
- Toothpaste waste and toothbrush as well as the bad quality of the acquired inputs;
- Absence of bio-security orientation and infection control in indigenous area;
- The user's impatience as for the execution of the stages of the program;
- Some bosses of DSEI and technical coordinators ignore the Politics of Buccal Health and they don't collaborate for execution of the actions, generating problems with the dentist – surgeon and his team;
- Migration and dispersion of the Indians;
- Participation executes of the Indians in the pieces of advice for planning of the actions;
- The lack of communication between DSEI/DESAI and tip professionals.

In the last years, the Dentistry, among the sciences of health, it has been assuming a prominence paper, due to its progress in the technician fields, biological and cultural. However, in spite of this progress, the

socioeconomic and cultural low conditions, of most of the Brazilian population, it has not been allowing their actions to extend in the dimensions that it would be wanted, aiming at an appropriate odontological attendance. The education in collective health should have as purpose the human being's promotion as a whole and of his atmosphere, before thinking in education in buccal health. The dentistry cannot be limited on the mouth, without before to analyze the man, the community in that he is inserted and how he links with it.

Many challenges persist, but we walk to build an attention of Buccal Health that it doesn't become exhausted in the managers' political will and in the governments' alternation, but has its own identity, defined by the users and the professionals that promote the health of the population.

7 – REFERENCES

1. Frazão P. Tecnologias em saúde bucal coletiva. In: Botazzo C, Freitas SFT. (org). **Ciências sociais e saúde bucal**: questões e perspectivas. Bauru: Edusc-Unesp; 1998.

2. Rede Cedros. Saúde Bucal em SILOS. O que fazer nos municípios? **Cadernos de Saúde Bucal**. Rio de Janeiro: Cedros; 1992.

3. Minayo MCS. **O desafio do conhecimento**. Pesquisa Qualitativa em saúde. São Paulo/Rio de Janeiro: Hucitec/ABRASCO; 1994.

4. Neves EG. Os índios antes de Cabral: arqueologia e história no Brasil. In: Silva AL, Grupioni LDB. (org). **A temática indígena na escola.** Brasília: MEC/MARI/UNESCO; 1995.

5. Roncalli AG. Modelos assistenciais em saúde bucal no Brasil: tendências e perspectivas. **Ação coletiva**. 1999;2:9-14.

6. Narvai PC. Saúde bucal: assistência ou atenção? São Paulo;1992. [mimeografado].

7. Narvai PC. **Odontologia e saúde bucal coletiva**. São Paulo: Hucitec; 1994.

8. Frazão P. Ambientes de trabalho odontológico na perspectiva do Sistema Único de Saúde. **Divulgação em saúde.** 1995;10:21-8.

9. Athias R. **Hupde – Maku el Tukano**: relations inégales entre deux sociétes du Uaupés Amazonien (Brésil). Nanterre; 1995. [Tese Doutorado – Universidade de Paris].

10. Athias R.; Machado M. A saúde indígena no processo de implantação dos Distritos Sanitários: temas críticos e propostas para um diálogo interdisciplinar. **Cad. Saúde Pública**. 2000;17(2):425-31.

11. Brasil. Ministério da Saúde, Secretaria Executiva. Programa saúde indígena: etnodesenvolvimento das sociedades indígenas. Brasília: Ministério da Saúde. 2001.

12. Fratucci MVB. **Alguns aspectos das condições de saúde bucal de uma população indígena Guarani – Mbyá no município de São Paulo.** São Paulo; 2000. [Dissertação Mestrado – Faculdade de Saúde Pública, Universidade de São Paulo].

13. Adorno RCF. Sociologia: um ensaio de

introdução ao seu campo e a algumas de suas vertentes. In: Botazzo C, Freitas SFT. (org). **Ciências sociais e saúde bucal**: questões e perspectivas. Bauru: Edusc-Unesp; 1998.

14. Botazzo C. **A saúde bucal nas práticas coletivas de saúde.** São Paulo, Instituto de Saúde; 1994 [Coleção Monografias, série tendências e perspectivas em saúde].

15. Botazzo C. Saúde bucal coletiva. Instituto de Saúde, Seção de Odontologia Sanitária, 1988. [mimeografado].

16. Thiollent M. **Metodologia da pesquisa-ação.** São Paulo:Cortez;1985.

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FIGURES

Age Group	Number of Examined People	CPOD	Standard Deviation
12	46	6,18	2,9
15 – 18	85	9,74	4,69
36 – 44	63	16,46	6,46

FIGURE 01 - Prevalence of Dental caries. CPOD - by Age group

Age Group	Number of Examined People	CPOD	Standard Deviation
05 a 06	46	8,83	3,97

FIGURE 02 - Prevalence of Dental caries – ceo - in the Children of 05 and 06 Years Old.

Age Group	Number of Examined People	C	O	E	Ei	H
12	46	195	8	51	30	921
15 – 18	85	374	18	278	158	1548
36 – 44	63	84	7	808	111	889

FIGURE 03 - Comparison among the Prevalence of Carious Teeth (C), Filled (O), Extracted (E), Suitable Extraction (Ei) and healthy (H) by Age group