

POPULAR KNOWLEDGE IN ORAL HEALTH: CONTRIBUTIONS TO HEALTH EDUCATION IN CONCEIÇÃO DE MACABU-RJ

*Saberes populares em saúde bucal: contribuições para a educação em
saúde em Conceição de Macabu-RJ*

*Saberes populares en salud bucal: contribuciones a la educación para
la salud en Conceição de Macabu-RJ*

Carlos Dannyel Fernandes Cardoso¹
Alessandra Aniceto Ferreira de Figueirêdo²
Nilcimar dos Santos Souza³

ABSTRACT

Popular knowledge about oral health constitutes a repertoire of care related to memory, family and community networks, and access to services. The objective was to analyze how this knowledge is produced, shared, and mobilized in the studied communities and to discuss its contributions to dialogical educational practices in the Family Health Strategy (FHS). This is a qualitative research study conducted with adult residents of three peripheral and rural communities in Conceição de Macabu-RJ, through conversation circles. The narratives were examined using Reflective Thematic Analysis. The analysis produced four themes: memory of scarcity and extraction dentistry; home pharmacy and natural resources against pain; informal education and intergenerational transmission; and the demand for dialogue and humanization of care. The findings suggest that critically recognizing these repertoires can offer support for more contextualized health education actions, without replacing technical-scientific guidance or validating potentially unsafe practices.

Keywords: Oral Health. Popular Culture. Health Education.

¹Master's in Science and Health Education. Universidade Federal do Rio de Janeiro. Macaé, Rio de Janeiro.

²PhD in Public Health. Universidade Federal do Rio de Janeiro. Macaé, Rio de Janeiro.

³Doctor of Science. Federal. Universidade Federal do Rio de Janeiro. Macaé, Rio de Janeiro.

Contact:

*Nilcimar dos Santos Souza. E-mail: nilcimars@yahoo.com.br

RESUMO

Os saberes populares sobre saúde bucal constituem repertórios de cuidado relacionados à memória, às redes familiares e comunitárias e às condições de acesso aos serviços. O objetivo foi analisar como esses saberes são produzidos, compartilhados e mobilizados nas comunidades estudadas e discutir suas contribuições para práticas educativas dialógicas na Estratégia Saúde da Família (ESF). Trata-se de pesquisa qualitativa realizada com moradores adultos de três comunidades periféricas e rurais de Conceição de Macabu-RJ, por meio de rodas de conversa. As narrativas foram examinadas pela Análise Temática Reflexiva. A análise produziu quatro temas: memória da escassez e Odontologia da extração; farmácia doméstica e recursos naturais contra a dor; educação informal e transmissão intergeracional; e demanda por diálogo e humanização do atendimento. Os achados sugerem que reconhecer criticamente esses repertórios pode oferecer subsídios para ações de educação em saúde mais contextualizadas, sem substituir a orientação técnico-científica nem validar práticas potencialmente inseguras.

Palavras-chave: Saúde Bucal. Cultura Popular. Educação em Saúde.

RESUMEN

Los saberes populares sobre salud bucal constituyen repertorios de cuidado relacionados con la memoria, las redes familiares y comunitarias y las condiciones de acceso a los servicios. El objetivo fue analizar cómo estos saberes se producen, comparten y movilizan en las comunidades estudiadas y discutir sus contribuciones a prácticas dialógicas de educación para la salud en la Estrategia de Salud de la Familia (ESF). Se realizó una investigación cualitativa con residentes adultos de tres comunidades periféricas y rurales de Conceição de Macabu, Rio de Janeiro, Brasil, mediante ruedas de conversación. Las narrativas fueron examinadas mediante Análisis Temático Reflexivo. Se produjeron cuatro temas: memoria de la escasez y Odontología de la extracción; farmacia doméstica y recursos naturales contra el dolor; educación informal y transmisión intergeneracional; y demanda de diálogo y atención humanizada. Los hallazgos sugieren que el reconocimiento crítico de estos repertorios puede aportar elementos para prácticas educativas más contextualizadas, sin sustituir la orientación técnico-científica ni validar prácticas potencialmente inseguras.

Palabras clave: Salud Bucal. Cultura Popular. Educación en Salud.

INTRODUCTION

Oral health, when observed from the perspective of popular communities, is not limited to the technical space of the dental office. It appears in childhood memories, in stories of pain, in the names given to decayed teeth, in recipes kept by mothers and grandmothers, in improvised alternatives before accessing public services, and in the way the population interprets its own body. Analyzing this knowledge, therefore, requires recognizing that care practices are produced within historical, material, and relational contexts.

The historical development of oral health in Brazil has been marked by inequalities in access, a predominance of curative practices, and a late expansion of public policies capable of broadening dental care. This trajectory helps to understand why memories of pain, extractions, and care conditioned by the ability to pay remain present in community narratives¹⁻².

In this scenario, community education approaches the tradition of popular education by valuing participation, local culture, and the shared production of meaning³. In Freire's view, the educational encounter presupposes subjects who arrive at the relationship bringing language, experience, beliefs, and memory⁴. In oral health, this perspective shifts the community from the role of passive recipient of recommendations and recognizes the previously constructed repertoires for coping with pain and organizing care.

This recognition does not imply transforming popular practices into clinical prescriptions or treating them as equivalent to scientific knowledge. The challenge is to understand them as part of the care experience,

identifying their cultural meanings, the risks involved, and the opportunities for dialogue between users and professionals.

In the field of health education, approaches focused solely on the transmission of information prove insufficient in the face of realities where care is learned through orality, observation, and relationships of trust⁵. Recent policies and studies reinforce the importance of interactive educational strategies, autonomy, and popular participation in Primary Health Care (PHC), as well as Popular Health Education in the practice of dental surgeons⁶⁻⁷.

The National Oral Health Policy, linked to the Unified Health System (SUS), expanded the inclusion of Dentistry in Primary Health Care and consolidated the presence of oral health teams in the Family Health Strategy (FHS)⁸. However, the existence of policies and services does not, in itself, guarantee educational practices that are sensitive to the ways in which each territory names problems, circulates knowledge, and seeks answers to suffering.

Studies on health education in primary health care indicate that autonomy and participation require more than prescriptive guidelines: they depend on connection, listening, and understanding of life conditions⁶. In oral health, recent research on educational practices of dentists also reveals tensions between traditional models and principles of Popular Health Education⁷.

At the same time, the organization of dental care in the FHS involves challenges in work processes, team integration, and territorial action, aspects that interfere with the possibility of developing continuous collective and educational actions⁹. Thus, understanding popular knowledge can help bring professional language closer to the experiences actually lived by users.

In this research, popular knowledge is treated as a socially produced repertoire, transmitted within family and community networks and mobilized in response to concrete needs. The analysis seeks to understand both its function in daily life and the points of tension between cultural appreciation, health protection, and timely access to services.

The question that guided the study was: how are popular knowledge about oral health produced, shared, and mobilized in the communities studied, and what contributions do they offer to health education practices in the Family Health Strategy (FHS)?

As a consequence of this question, the objective of the research was to analyze how popular knowledge about oral health is produced, shared, and mobilized in the communities studied, and to discuss its contributions to dialogical educational practices in the Family Health Strategy (FHS).

METHOD

This qualitative study was conducted in three peripheral communities of Conceição de Macabu, a municipality located in the North Fluminense region of the state of Rio de Janeiro: Rhodia, Calçadinha, and São Henry. Participants included adult residents of these territories and, in the discussion groups, professionals linked to the respective Family Health Strategy (FHS) teams. Each group consisted of eight participants: six community residents, one dentist, and one community health agent (CHA). Among the participating residents, there was a predominance of brown-skinned women, literate, with incomplete primary education, and aged between 60 and 80 years, in addition to one participant under 30 years old and another aged 90 years. The accounts revealed long life trajectories in the communities and memories related to old forms of dental care, hygiene practices, and popular alternatives used for pain relief.

The data was collected through three discussion circles. The discussion circle was chosen because it favors the horizontal circulation of words. Figueiredo and Queiroz¹⁰ understand this device as a methodology that enables dialogue, sharing, and the collective production of meaning. Instead of subjecting participants

to closed questions, the circle allows one memory to lead to another, a disagreement to reveal a nuance in the form of laughter, astonishment, or hesitation, for example. This dynamic is relevant when dealing with popular knowledge, as such knowledge rarely appears organized. It emerges in stories, gestures, examples, and corrections made among the participants themselves.

A group session was held in each of the communities surveyed, in the following order: Rhodia, Calçadinha, and São Henry. The meetings took place between March and April 2025, in the afternoon, lasting approximately one hour each, ending around 3 pm. The activities were developed in rooms of the Family Health Strategy units in the respective communities.

The composition of the groups was guided by previously defined eligibility criteria, and the recruitment of residents was carried out with the mediation of community health agents, who, due to their knowledge of the territories and their residents, made the invitations orally. Residents aged 18 or older and residing in the community for at least five years were considered eligible. Those under 18 years of age and those who had resided in the territory for less than five years were excluded. The principal researcher conducted and moderated the three discussion groups, using a semi-structured script and encouraging spontaneous participation, without imposing opinions or positions on the participants.

The saturation criterion was not adopted to determine the end of data collection. Each round was completed after the questions foreseen in the script had been addressed and answered, and the topics previously established in the data collection plan had been covered, including the questions considered necessary to answer the study's objectives.

A semi-structured script was used, containing questions about everyday oral care practices, the use of herbs and plants for pain, inflammation, or swelling, the exchange of knowledge among family and neighbors, interaction with healthcare professionals, and the experience of collectively discussing the topic. The script also allowed for the exploration of other content related to the research objectives as it arose during the interaction between participants.

The conversations were audio-recorded using the researcher's cell phone. Subsequently, the audio recordings were listened to in their entirety and converted into typed transcripts. The transcripts were reviewed and checked by the researcher and, later, verified with the participation of the supervisors, seeking to ensure correspondence between the recorded material and the text used in the analysis.

The audio files and transcripts remained stored on the researcher's personal device and in a cloud storage service linked to their personal email account, access to which depended on the individual account credentials, restricting access to the research material.

The analysis was guided by Reflective Thematic Analysis (RTA), as per Braun and Clarke¹¹⁻¹³. In this approach, themes are understood as analytical constructs produced in the interaction between the data, the research question, the theoretical assumptions, and the researcher's interpretative position, and not as categories that simply emerge from the data independently of interpretation. Braun and Clarke¹² define thematic analysis as "a method for identifying, analyzing, and reporting patterns within data." The authors emphasize that reflection is not an accessory detail, but a constitutive dimension of the analytical process.

The analytical process occurred recursively. Initially, familiarization with the transcripts was achieved through successive readings and recording of analytical impressions. Subsequently, codes were produced associated with expressions, images, experiences, and situations considered significant to the research question, including references to untreated pain, to "teeth as pots," to care learned from grandparents and other family members, to "backyard remedies," to fear of extraction, to faith related to healing, and to the desire for greater dialogue with the dentist.

These codes were subsequently grouped into provisional patterns of meaning, confronted with the set of transcripts and successively revised, refined, delimited and named. In the final stage, the four constructed themes were articulated to the research question and the discussion on health education, selecting excerpts from the speeches capable of supporting and making visible the interpretation developed¹¹⁻¹³.

Reflexivity was considered a constitutive part of the data production and analysis process. The principal investigator is a resident of the municipality of Conceição de Macabu and works professionally as a dental surgeon in the Brazilian Unified Health System (UHS), circumstances that provided familiarity with the territory, the healthcare context, and locally used expressions. At the same time, this proximity could generate asymmetries, expectations, or constraints arising from the relationship between the healthcare professional, the researcher, and the participants, as well as influence the interpretation of the material produced.

To mitigate these effects, it was explicitly stated orally from the recruitment stage that participation was voluntary and that no one was obligated to participate. Before the start of each session, the Informed Consent Form was read aloud, and the voluntary nature of the research and the right to withdraw at any time without penalty were reinforced.

During the meetings, participants were instructed to speak only about topics with which they felt comfortable, were free to participate in discussions and interrupt or complement the speeches, and the chairs were arranged in a circle, seeking to favor a dialogical relationship and reduce hierarchical markers among the participants. The researcher's position as a professional and resident of the municipality was critically considered during the interpretation of the data, in accordance with the reflective perspective of RTA¹³.

From an ethical standpoint, participants were identified by letters in the transcripts and in the presentation of results, without disclosing names or other personal information that would allow their identification. Elements of oral expression present in the accounts were preserved when necessary for understanding the meaning.

All participants received explanations about the research and signed the Informed Consent Form (ICF) after reading and discussing it. The document informed them about the voluntary nature of participation, the right to withdraw consent at any stage of the study, the absence of prejudice in case of withdrawal, the preservation of their identity, and the possibility of analyzing and publishing the results without personal identification. The sessions were audio-recorded after the consent process.

The study was approved by the Research Ethics Committee of the Institute of Collective Health Studies of the Universidade Federal do Rio de Janeiro (IESC/UFRJ), under CAAE No. 76177023.3.0000.5286 and Opinion No. 7.007.125.

RESULTS

Three discussion groups were held, one in each community investigated (Rhodia, Calçadinha, and São Henry), with eight participants per meeting, as per the composition foreseen in the research design: six community residents, one dental surgeon, and one community health worker. Among the residents, the majority were brown-skinned women, literate, with incomplete primary education, and aged between 60 and 80 years; one person under 30 years old and one participant aged 90 also participated. The Reflective Thematic Analysis organized the narratives into four themes, presented in Table 1 and developed below. Each theme addresses a dimension of the research question: historical conditions of knowledge production, community circulation, forms of mobilization in the face of pain, and perceived implications for educational dialogue.

Table 1 - Final thematic tree of the Reflective Thematic Analysis

Theme	Analytical core	Empirical examples
Memory of scarcity and Dentistry of extraction	Memories of restricted access, extraction, fear, and improvised care.	Ashes for cleaning teeth; service associated with payment; expression "teeth like a pot".
Home pharmacy and Natural Pain Relief	Mobilizing plants, food, household products, and medicines in response to pain.	Cloves, mint, roots, warm water with salt, castor oil, and processed foods.
Informal education and intergenerational transmission	Learning through oral tradition and by relying on family, neighbors, and local leaders.	Mothers, grandmothers, great-grandmothers, prayer leaders, neighbors; faith and support during caregiving.
Dialogue demand and humanization of service.	A desire to listen, less judgment, and recognition of the language and experiences of the territory.	Fear of judgment; accounts of how the service communicates; valuing the circle as a space for speaking.

Memory of scarcity and Dentistry of extraction

The first theme brings together narratives in which the past of dentistry is associated with the absence of professionals, difficulty of access, and procedures focused on extraction. Older participants recalled situations in which institutional care was perceived as distant and in which practitioners, including barbers, were remembered as responsible for rudimentary procedures.

In these narratives, paying for a consultation, enduring pain, or losing a tooth appear as recurring possibilities. The following account shows how healthcare was perceived as a privilege and how childhood is marked by improvised preventative practices, for example, cleaning children's teeth:

That's true. It wasn't the same for everyone today. At least not on paper, right? It wasn't for everyone. It was only for those who could afford it. It was something very inaccessible. So we were so scared by that, that Mom told us to take that ash stuff from the stove and clean our teeth so that what happened to her wouldn't happen to us. So my siblings and I were so scared that every morning and afternoon, we would take the ash, fill our mouths, rub it with a cloth, and our teeth would get clean (Participant D, discussion circle).

The excerpt links fear, family discipline, and improvised resources. Ash, water, and cloth appear as available resources in a context where a toothbrush, toothpaste, and preventive checkups were not mentioned as regular parts of daily life. Domestic care is therefore narrated as a response to the experience of pain and the scarcity of alternatives.

The wheels also revealed a unique language for naming the illness. The expression 'tooth like a pot' was used to describe a 'hollow' tooth that retains food. This image shows how participants construct bodily explanations through analogies with everyday objects and situations.

When comparing the past and present, participants acknowledged greater availability of care through the Brazilian Public Health System, but maintained references to fear of extraction and the perception of few educational actions directed at adults. Thus, the theme connects memories of restricted access, domestic methods of prevention, and current expectations regarding the service.

Home pharmacy and natural remedies for pain.

The second theme brings together home remedies used to relieve pain, inflammation, and oral discomfort. Mention included cloves, mint, ginger, kalanchoe, parsley, garlic, plantain, thatch, roots, warm water with salt,

ash, and castor oil, in addition to medications, topical anesthetics, and mouthwashes. The accounts indicate a heterogeneous repertoire, built through experience, trust in the instructor, and the urgency to alleviate symptoms.

The circulation of this knowledge appears in neighborhood relations. One participant reported that she was caring for a resident with an inflamed tooth using a recipe taught by another neighbor, but decided not to add mint because she was unsure which variety should be used.

We still use a lot of folk knowledge. I'm taking care of a neighbor with an inflamed tooth, and another neighbor taught me how to make tea with about ten cloves, let it cool slightly, and then bathe with it. You can also add mint if you want. But I didn't add any because I don't know if it's a spice or the kind used to make kibbeh. So I didn't add any (Participant C, group discussion).

The excerpt highlights transmission and prudence within the popular repertoire itself: the participant not only reproduces the guidance but also establishes a limit when she does not recognize the ingredient. Another account described the use of a root offered by a neighbor and the perception of rapid pain relief:

I have a neighbor who, whenever someone in the neighborhood had a toothache, would bring a root that I don't know the name of. He'd tell them to chew the root, and then the toothache would go away. He always brought these things. The root would numb the pain. Ten minutes and the person would already feel relieved (Participant B, group discussion).

The expression 'it numbed the pain' records a perceived effect, without constituting pharmacological proof. The account also shows that coping with the pain involved mobilizing people from the neighborhood and resources available outside of formal services.

Some narratives involved potentially harmful practices, such as the use of castor milk associated with tooth breakage in accounts of self-extraction. In the empirical material, these practices appear as memories of solutions adopted in the face of pain and difficulty of access, and not as clinical recommendations.

The reports also showed that natural resources and manufactured products do not form separate universes. The same person can combine tea, roots, pharmacy medication, topical anesthetic, or mouthwash, selecting alternatives according to availability, previous experiences, and confidence in the guidance received.

Informal education and intergenerational transmission

The third theme highlights that mothers, grandmothers, great-grandmothers, neighbors, and healers occupy a central place in learning about care. The narratives situate this transmission in the kitchen, in the backyard, next to the stove, in the care of children in pain, and in conversations among residents. Knowledge is taught and corrected in close relationships, without depending exclusively on formal health education spaces.

Participants summarized this transmission by stating that knowledge comes from grandparents and uncles and is passed down from generation to generation. Popular knowledge demonstrates value when associated with trust in loved ones and the memory of relief in concrete situations, as highlighted in the following statement, in which the dimension of faith also appeared explicitly:

We have faith. The key here is faith. The confidence that it will heal. If you don't have faith, it won't work. Anything, if you don't have faith, it's no use. When the pain starts to subside, we sleep. Someone stays watching, because it could burn and get cold (Participant C and Participant D, discussion circle).

In the excerpt, faith is associated with the expectation of improvement and with accompanying those who are suffering. At the same time, the mention of the need to 'keep watching' indicates that the participants themselves recognize the possibility of undesirable effects from certain practices.

Intergenerational transmission has been shown to be predominantly oral and linked to specific episodes of pain, inflammation, and care. Recipes, plant names, preparation methods, and observed signs circulate as practical memory and are reworked by residents over time.

Women appeared with particular frequency in these narratives: mothers, grandmothers, and healers were remembered as being responsible for remedies, childcare, support for neighbors, and mediation between suffering and the search for solutions. This pattern was particularly visible among the older participants.

Demand for dialogue and humanization of service.

The fourth theme brings together accounts of the need for listening when interacting with services. Participants did not reject technical knowledge; on the contrary, they expressed interest in guidance, but linked the possibility of talking about home practices to how they perceive acceptance or judgment on the part of the professional.

In the therapy sessions, the most humane aspect of care was related to the possibility of sharing one's own story, explaining what had already been used to alleviate pain, and asking questions without embarrassment. The concern was not limited to the amount of information offered, but also to the type of relationship established during the care.

The very dynamics of the circle fostered the circulation of words: by presenting the meeting as a space where the residents were the main connoisseurs of their popular knowledge, the facilitator encouraged accounts, additions, and disagreements among participants. This movement broadened the quantity and diversity of experiences narrated.

Fear also permeated this theme. Memories of tooth extraction, pain, and difficulty paying for treatment were associated with the image of the dental surgeon, producing ambivalence between the need to seek the service and the fear of judgment or painful procedures.

Accounts such as the use of ash for hygiene and plants for pain relief encapsulate material and relational dimensions: absence or distance from services, improvisation, family learning, and the search for protection with available resources. These elements help explain why knowledge continues to be mobilized even when there is a greater availability of formal care.

Participants also mentioned community members who serve as points of reference for obtaining information and assistance. Although the role of the Community Health Agent (CHA) was not investigated as a specific topic, discussions about neighborhood, leadership, and the flow of information point to territorial networks that can mediate the relationship with the health unit.

Taken together, the four themes show that popular knowledge is produced from experiences of access and suffering, shared through relationships of trust, and mobilized to respond to immediate needs. The demand for dialogue connects these repertoires to health education practices in the Family Health Strategy (FHS).

DISCUSSION

The articulation of the four themes indicates that popular knowledge in oral health plays simultaneous roles: it offers practical solutions to pain, preserves memories and community ties, and makes visible gaps in access and communication with services. This interpretation brings the findings closer to studies that advocate

participatory educational approaches in primary health care and highlight the importance of autonomy and popular participation, in contrast to models focused solely on the transmission of information⁵⁻⁷.

The memory of scarcity and extraction must be read within the context of Brazil's trajectory of inequalities in dental care¹⁻². In the accounts, the ash used for hygiene and the perceived accessibility of care only to those who could pay do not appear as isolated curiosities, but as marks of social experiences that continue to influence expectations and fears. At the same time, studies on the work process in the Family Health Strategy show that the institutional expansion of oral health coexists with challenges of integration, territorialization, and continuity of actions⁹.

When an elderly woman reports using ash to clean her teeth, this information should not be received merely as a curiosity. It reveals a lack of toothbrushes, domestic improvisation, maternal discipline, fear of pain, and attempts to maintain hygiene with available resources. The participants recognize differences between the past and present, although they remain critical of the insufficiency of educational actions for adults. Formal rights do not eliminate accumulated fears, images, and habits. Therefore, the Family Health Strategy plays a fundamental role in transforming the memory of tooth extraction into a starting point for discussing dental preservation, prevention, conservative treatment, and the bond with the team. It should be read as a social archive of the territory.

The demand for dialogue is also linked to fear. In communities where dentistry has been associated with extraction, difficult payment, or pain, the figure of the dentist can carry contradictions. The user needs care, but fears judgment, painful procedures, or tooth loss. Community education can reduce this distance by showing that the professional recognizes the local history. When the team asks about popular practices, not to ridicule them, but to understand them, it produces a type of bond that favors prevention and adherence to treatment.

The theme of home pharmacy shows that plants and other household resources are incorporated into care through family and community experiences. Recent qualitative research on medicinal plants, oral health, and the Brazilian Unified Health System identified knowledge and practices among oral health teams and community agents, highlighting the need for professional qualification to guide their safe use¹⁴. In other studies, family knowledge about children's oral health has been shown to be strongly influenced by individual and family experiences¹⁵. The data from Conceição de Macabu add to this literature the importance of neighborhood networks and the popular prudence observed when participants recognize the limits of their own knowledge.

These contributions help to understand that popular practices do not appear outside the health system. They enter the consultation room with the patient, even though they often remain unspoken due to shame or fear of censure. One participant recounted the care provided to a neighbor with an inflamed tooth and showed how knowledge circulates among residents.

Intergenerational transmission and local vocabulary reinforce the relevance of educational practices that start from the subjects' repertoire without confusing cultural recognition with clinical validation. Popular education, according to Freire and Gadotti, understands dialogue as a relationship between subjects and values the collective production of meanings³⁻⁴. Research on Popular Education in oral health has also found tensions between traditional educational practices and participatory principles in primary health care⁷. Thus, expressions such as 'tooth as a pot' or 'numbing the pain' can function as starting points for conversations about biological processes, risks, and the need for care, without erasing community language.

There is also a specific language for naming the process of becoming ill. The expression "tooth as a pot," mentioned in conversations to describe a decayed tooth that accumulates food, is highly relevant. The term is not equivalent to a technical diagnosis, but it offers a bridge to explain caries, cavities, residue retention, pain, and inflammation. Studies on health communication in intercultural contexts also reinforce the need to recognize linguistic and cultural repertoires in the encounter between professionals and users. In the territory, critical awareness does not arise from the negation of local culture, but from its shared problematization⁵. The community does not passively await the arrival of technical knowledge. It learns, teaches, compares, and corrects. The health educator who wishes to build rapport needs to enter this conversation as an interlocutor¹⁷⁻¹⁸.

The demand for listening observed in the circles converges with community experiences in oral health where users and workers valued participatory educational and care relationships and the approach to spaces in the territory¹⁶.

The study was conducted in a single municipality, and the narratives presented reflect the specific composition of the groups, with a significant presence of elderly women, which limits the transfer of findings to other groups and territories. Furthermore, the researcher is a dentist in the municipality and works in the region, a position that favors understanding the context but may influence the freedom of expression and the interpretive construction itself. In RTA, this influence is not eliminated; it needs to be made explicit and examined reflectively¹³. Future studies could include greater age and gender diversity, other territories, and designs that compare perspectives of users, community health agents, and oral health teams. The community dimension discussed by Gadotti contributes to situating these possibilities as relationships of knowledge production, and not as a simple transfer of techniques³.

CONCLUSIONS

The findings show that popular knowledge about oral health in the communities studied is produced through experiences of restricted access, pain, and home care; shared mainly through family and neighborhood relationships; and mobilized through plants, homemade products, medicines, and support networks. The narratives also expressed a demand for listening and for less judgmental forms of communication with the service.

These results suggest the potential for such repertoires to be used as a basis for dialogical educational practices in primary health care, and do not, in themselves, demonstrate that their valorization produces clinical improvement, adherence, or autonomy. Discussion circles, careful use of local vocabulary, and questions about domestic practices can facilitate the identification of doubts, risks, and barriers to access when integrated with technical-scientific care.

Regarding medicinal plants, the central educational implication is to recognize that their use is part of community experience and to create space for users to report what they use, how they prepare them, and in what situations. This dialogue should be accompanied by guidance on the limits of symptomatic relief, the possibility of adverse effects, and signs that require attention, without transforming popular accounts into prescriptions or validating potentially unsafe procedures.

Training and work in oral health can benefit from territorial and participatory experiences that articulate listening, health education, and access to care. Dentists who know the local vocabulary, identify community mediators, and understand the history of access to care are better able to situate their guidance within the reality of users. This approach, however, must preserve safety criteria and the right to evidence-based information.

Health is a fundamental right, and its guarantee depends on concrete policies and conditions of access, according to Law No. 8.080/1990. In this sense, reports of pain without care and improvised solutions can also be interpreted as indicators of territorial needs that go beyond the educational dimension and require the organization of care flows.

The conclusions should be read in light of the study's limitations: it was conducted in a single municipality, had a specific composition among the participants, and the researcher was a practicing dentist in the region. These aspects restrict generalizations and may have influenced the production and interpretation of the statements.

Future research could explore the same themes in other territories, include more diverse groups, and specifically examine how professionals and users negotiate popular knowledge during care and collective actions. It is also relevant to investigate the effects of dialogical educational strategies on communication, safety of care, and access to services.

It is concluded that popular knowledge constitutes a relevant dimension of community experience in oral health and can inform the planning of more contextualized educational practices in the Family Health Strategy, provided that they are approached critically and articulated with scientific knowledge, safety, and the right to care.

REFERENCES

1. Narvai PC, Frazão P. Saúde bucal no Brasil: muito além do céu da boca [Internet]. Rio de Janeiro: Editora Fiocruz; 2008 [cited 2026 Aug 13]. Available at: <https://books.scielo.org/id/ty266>
2. Soares CLM, Paim JS, Chaves SCL, Rossi TRA, Barros SG, Cruz DN. O movimento da Saúde Bucal Coletiva no Brasil. *Cien Saude Colet* [Internet]. 2017 [cited 2026 Aug 13];22(6):1805-16. doi: <https://doi.org/10.1590/1413-81232017226.22972016>
3. Gadotti M. Educação popular, educação social, educação comunitária: conceitos e práticas diversas, cimentadas por uma causa comum. *Revista Dialogos: pesquisa em extensão universitária* [Internet]. 2012 [cited 2026 Aug 13];18(1):10-32. Available at: <https://portalrevistas.ucb.br/index.php/rdl/article/view/3909>
4. Freire P. *Pedagogia do oprimido*. 17th ed. Rio de Janeiro: Paz e Terra; 1987.
5. Falkenberg MB, Mendes T, Moraes EP, Souza EM. Educação em saúde e educação na saúde: conceitos e implicações para a saúde coletiva. *Cien Saude Colet* [Internet]. 2014 [cited 2026 Aug 13];19(3):847-52. doi: <https://doi.org/10.1590/1413-81232014193.01572013>
6. Fittipaldi ALM, O'Dwyer G, Henriques P. Educação em saúde na atenção primária: as abordagens e estratégias contempladas nas políticas públicas de saúde. *Interface (Botucatu)* [Internet]. 2021 [cited 2026 Aug 13];25:e200806. doi: <https://doi.org/10.1590/interface.200806>
7. Amarante LF, Forte FDS, Nuto SAS. Educação Popular na saúde bucal: análise de práticas educativas na Atenção Primária. *Physis* [Internet]. 2024 [cited 2026 Aug 13];34:e34086. doi: <https://doi.org/10.1590/S0103-7331202434086pt>
8. Brazil. Ministry of Health. *Diretrizes da Política Nacional de Saúde Bucal* [Internet]. Brasília, DF: Ministry of Health; 2004 [cited 2026 Aug 13]. Available at: <https://www.gov.br/saude/pt-br/composicao/saps/brasil-sorridente/saude-bucal>
9. Oliveira MTP, Farias MR, Vasconcelos MIO, Brandão IR. Os desafios e as potencialidades da saúde bucal na Estratégia Saúde da Família: uma análise dos processos de trabalho. *Physis* [Internet]. 2022 [cited 2026 Aug 13];32(1):e320106. doi: <https://doi.org/10.1590/S0103-73312022320106>
10. Figueirêdo AAF, Queiroz TN. A utilização de rodas de conversa como metodologia que possibilita o diálogo. In: *Seminário Internacional Fazendo Gênero 10: Desafios Atuais dos Feminismos*; 2012; Florianópolis, SC. *Anais Eletrônicos* [Internet]. Florianópolis: Universidade Federal de Santa Catarina; 2012 [cited 2026 Aug 13]. p. 1-10. Available at: https://www.fg2013.wwc2017.eventos.dype.com.br/resources/anais/20/1384186533_ARQUIVO_AlessandraAniceto.pdf
11. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* [Internet]. 2006 [cited 2026 Aug 13];3(2):77-101. doi: <https://doi.org/10.1191/1478088706qp063oa>
12. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health* [Internet]. 2019 [cited 2026 Aug 13];11(4):589-97. doi: <https://doi.org/10.1080/2159676X.2019.1628806>

13. Braun V, Clarke V. A critical review of the reporting of reflexive thematic analysis in Health Promotion International. Health Promot Int [Internet]. 2024 [cited 2026 Aug 13];39(3):daae049. doi: <https://doi.org/10.1093/heapro/daae049>
14. Teixeira GB, Conceição AO. Plantas medicinais, saúde bucal e SUS: uma difícil integração das políticas públicas no interior da Bahia? Physis [Internet]. 2023 [cited 2026 Aug 13];33:e33085. doi: <https://doi.org/10.1590/S0103-7331202333085>
15. Oliveira CL, Lenz MLM, Garcia R, Faustino-Silva DD. Percepções e saberes da equipe de saúde e de familiares de crianças menores de dois anos sobre a atenção em saúde bucal infantil na Atenção Primária à Saúde. Tempus Actas Saude Colet [Internet]. 2020 [cited 2026 Aug 13];13(3):61-77. doi: <https://doi.org/10.18569/tempus.v13i3.2613>
16. Kinasz R, Sanches MA, Garbelini MCDL, Sanches LC. Imigração de haitianos: enfoque na comunicação em saúde. Espac Saude [Internet]. 2023 [cited 2026 Aug 13];24:e893. doi: <https://doi.org/10.22421/1517-7130/es.2023v24.e893>
17. Carvalho DMCF, Mafra TF, Melo DCS, Monteiro IS, Melo MMDC. O olhar de usuários, residentes e trabalhadores sobre uma intervenção em saúde bucal de abordagem comunitária na ESF do campo. Rev ABENO [Internet]. 2022 [cited 2026 Aug 13];22(2):1701. doi: <https://doi.org/10.30979/revabeno.v22i2.1701>
18. Fonseca AF, Morosini MV. O caráter estratégico do Agente Comunitário de Saúde na APS integral. APS Rev [Internet]. 2021 [cited 2026 Aug 13];3(3):210-23. doi: <https://doi.org/10.14295/aps.v3i3.218>

