

KNOWLEDGE OF PREGNANT WOMEN ABOUT ORAL HEALTH AND ASSOCIATED FACTORS

CONHECIMENTO DE GESTANTES SOBRE SAÚDE BUCAL E FATORES ASSOCIADOS

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ABSTRACT

The knowledge of pregnant women about the importance of caring for their oral and baby hygiene contributes to the reduction of oral diseases and the attainment of healthy habits since pregnancy. This study aimed to assess the knowledge about oral health of pregnant women, as well as the factors associated with this knowledge. This is a cross-sectional study with a quantitative approach, conducted with 196 pregnant women. Two questionnaires were filled out, with the first addressing sociodemographic and economic aspects and the second related to prenatal care and knowledge about the baby's oral health. Knowledge scores were compared using the Mann-Whitney test and Kruskal-Wallis. The significance level adopted in the study was 5% ($\alpha = 0,05$). Pregnant women from 31 to 44 years old, with higher education, with family income higher than 3 minimum wages and who thought it necessary to go to the dentist during pregnancy presented higher knowledge score, compared to their peers. Knowledge about the oral health of pregnant women and their babies is still very limited to some social groups.

Keywords: Dental care. Knowledge. Oral health. Pregnant women. Prenatal care.

RESUMO

O conhecimento das gestantes sobre a importância do cuidado com sua higiene bucal e do bebê contribui para redução de doenças bucais e obtenção de hábitos saudáveis desde a gravidez. Este estudo teve como objetivo avaliar o conhecimento sobre saúde bucal de gestantes, bem como os fatores associados a esse conhecimento. Trata-se de um estudo transversal, com abordagem quantitativa, realizado com 196 gestantes. Dois questionários foram preenchidos, com o primeiro abordando aspectos sociodemográficos e econômicos e o segundo relacionado ao pré-natal e conhecimento sobre a saúde bucal do bebê. Os escores de conhecimento foram comparados por meio dos testes Mann-Whitney e Kruskal-Wallis. O nível de significância adotado no estudo foi de 5% ($\alpha = 0,05$). As gestantes do grupo etário de 31 a 44 anos, com ensino superior, com renda familiar maior que 3 salários mínimos e que achavam necessário ir ao dentista durante a gravidez apresentaram maior escore de conhecimento, quando comparadas aos seus pares. O conhecimento sobre a saúde bucal das gestantes e do bebê ainda é muito limitado a alguns grupos sociais.

Palavras-chave: Assistência odontológica. Conhecimento. Cuidado pré-natal. Gestantes. Saúde bucal.

INTRODUCTION

Maintaining satisfactory oral health during pregnancy has been a constant challenge for health organizations (GEORGE *et al.*, 2013). Since, during this period, women have a high incidence of oral health disorders, such as gum inflammation and periodontal disease. Furthermore, these disorders are associated with unfavorable conditions presented by the child at birth, such as prematurity and low birth weight (RAKCHANOK *et al.* 2010; GUPTA *et al.*, 2015; COSTA; SILVA, 2020).

Also in this context, due to so many myths surrounding dental care during this period, women show some resistance to treatment because they believe that it can harm the baby's formation (MARTINS *et al.*, 2014; OLIVEIRA *et al.*, 2014; PATTANSHETTI *et al.*, 2020). Added to this, there is insecurity on the part of many professionals, who avoid caring for this group (OLIVEIRA *et al.*, 2014). These factors, together, make it difficult to access oral health services during the gestational period (MARTINS *et al.*, 2014). Practices related to general and oral health are, to a large extent, influenced by the environment in which the pregnant woman lives, so that sociodemographic particularities must be taken into account (VIJAYALAKSHMI; SUSHEELA; MYTHILI, 2015).

Nevertheless, it is known that pregnancy and puerperium are phases in which women are more sensitive to the adoption of knowledge and, therefore, new habits. Accordingly, this moment of life can be considered favorable to Health Promotion actions, including oral health, and should therefore count on the special attention of the professionals involved (GAMBHIR *et al.*, 2015).

In this context, the dental surgeon stands out for the role it assumes in the maintenance of oral care, and this professional should be the great encourager and diffuser of information aimed at enabling future mothers to be agents of health promotion in the family environment (MARTINS *et al.*, 2013). From this perspective, due to the initial and lasting contact with the physician (obstetrician and pediatrician) and the nurse, the dentist should work together with these professionals so that the woman receives comprehensive and sufficient pre and postnatal care to maintain the well-being of both her and the baby (HARTNETT *et al.*, 2016; RODRIGUES *et al.*, 2018).

Accordingly, the aim of this study was to assess the knowledge of pregnant women on oral health, as well as the factors associated with this knowledge.

MATERIAL AND METHODS

Study design and population

A cross-sectional study, with a quantitative approach, was conducted from December 2015 to March 2016. The study population was a convenience sample composed of 196 pregnant women, 101 of whom were users of two obstetric offices in the private network and 95 of a primary health care unit (UBS, as per its Portuguese acronym), located in the city of Jequié, State of Bahia, with an estimated population of 162,209 thousand inhabitants (BRASIL, 2015).

During the period of data collection for this research, there were five private obstetric offices and four UBS in the city. The offices were selected due to their central location and the UBS for being the largest of them.

All pregnant women, in any gestational period, who underwent prenatal care in two private offices and in a primary health care unit in the aforementioned city, were considered eligible participants for this study. Upon prior authorization from the obstetricians in charge (in this case, from the private sector) and from the unit's coordinator and nurse (regarding the public sector), the pregnant women were approached in the reception room of the offices and UBS while waiting to be served or after the service. It is worth highlighting that there was no exclusion criterion for the sample.

Study variables

Two questionnaires were filled out, prepared by the study researchers, containing only objective questions.

The first questionnaire portrayed sociodemographic and economic aspects, represented by age, marital status, schooling, place of residence, number of children, monthly family income and the participant's insertion in the labor market. The second addressed aspects of prenatal care, knowledge on self-care with oral health and in relation to baby's health, guidance on oral hygiene during prenatal care and knowledge regarding the main harmful habits, breastfeeding and dental caries. The instrument had 16 questions, 8 of which were designed to assess knowledge on oral health itself.

The application of the questionnaires was performed by two study researchers, trained not to interfere with the participant's responses, since they were self-explanatory.

Statistical analysis

The EpiData 3.1 program was employed for data tabulation and descriptive statistics procedures were used to express the results as absolute and relative frequencies, means or medians and standard deviations (SD) or interquartile ranges (IQR).

The knowledge scores (sum of right responses in the ten questions about the oral health of the mother and her baby) were compared using the Mann-Whitney test (for variables with two independent groups) and Kruskal-Wallis (for variables with three independent groups). In cases where the Kruskal-Wallis test indicated a statistical difference, comparisons between pairs were performed using the Mann-Whitney test. The significance level adopted in the study was 5% ($\alpha=0.05$) and all analyses were performed using IBM SPSS Statistics for Windows (IBM SPSS, 21.0, 2012, Armonk, NY: IBM Corp.).

Ethical aspects

This research was approved by the Research Ethics Committee of the State University of Southwest Bahia (CAAE: 43963615.0.0000.0055), under opinion n° 1.043.296, in accordance with Resolution n° 466/2012 of the National Health Council.

RESULTS AND DISCUSSION

The age of the 196 pregnant women participating in the study ranged from 15 to 44 years, with a mean of 27.4 years (SD=6.7 years). The results regarding the descriptive characteristics of pregnant women are shown in Table 1.

Table 2 shows the distribution of pregnant women, according to the knowledge on the oral health of the mother and her baby. Among the ten questions asked, there was a large variation in the percentage of right responses, which ranged from 10.2% to 71.9%.

The knowledge score (sum of right responses in the ten questions) of the pregnant women ranged from 0 to 10, with the median being 6.0 points (IQR= 2.0). Table 3 shows the comparisons of the knowledge score according to the characteristics of the pregnant women participating in the study. The analyses indicated that the knowledge score ranged significantly according to age group, schooling, family income and the fact of thinking it is necessary to go to the dentist during pregnancy. Pregnant women aged 31 to 44 years, with higher education, with a family income greater than 3 minimum wages and who thought it was necessary to go to the dentist during pregnancy had a higher knowledge score when compared to their peers. There were no statistical differences according to marital status, place of residence, work, number of children, gestational trimester, service, guidance on oral hygiene during prenatal care, having received guidance to look for a dentist during pregnancy and on who provided guidance on the care of the baby's mouth.

Table 1 - Sociodemographic and economic characteristics and prenatal care of pregnant women

Characteristics	% Response	n	%
Age group	98.5		
15-24 years		70	36,3
25-30 years		63	32,6
31-44 years		60	31,1
Marital status	100.0		
Single/without partner		21	10.7
Married/with partner		175	89.3
Place of residence	100.0		
Rural area		24	12.2
Urban area		172	87.8
Schooling	100.0		
Elementary school		28	14.3
High school		111	56.6
Higher education		57	29.1
Family income	100.0		
≤ 1 minimum wage		97	49.5
> 1-3 minimum wage		60	30.6
> 3 minimum wage		39	19.9
Work activity	100.0		
No		132	67.3
Yes		64	32.7
Number of children	99,5		
One		103	52.8
Two		67	34.4
Three or more		25	12.8
Gestational trimester	95,9		
1° trimester		59	31.4
2° trimester		58	30.9
3° trimester		71	37.8
Service	100.0		
Public service		95	48,5
Private service		101	51,5
Do you think it's necessary to go to the dentist during pregnancy?	100.0		
Yes		168	85.7
No/don't know		28	14.3
Guidance on oral hygiene during prenatal care	100.0		
Yes		70	35.7
No/don't know		126	64.3
Received guidance to look for a dentist during pregnancy	100.0		
No		103	52.6
Yes		93	47.4
Who provided guidance on the care of the baby's mouth?	100.0		
Dentist		32	16.3
Other professionals		67	34.2
Never received guidance		97	49.5

Source: the authors.

Table 2 - Distribution of pregnant women according to knowledge on the oral health of the mother and her baby

Question	Right	Wrong/don't know
Do you think your baby can "steal" calcium from your teeth?		
<input type="radio"/> Yes		
<input type="radio"/> No	99 (50.5%)	97 (49.5%)
<input type="radio"/> Don't know		
Do you think breastfeeding is important for the development of the mouth and the baby?		
<input type="radio"/> Yes		
<input type="radio"/> No	20 (10.2%)	176 (89.8%)
<input type="radio"/> Don't know		
In your opinion, when should you start cleaning your baby's mouth?		
<input type="radio"/> Before the teeth come out		
<input type="radio"/> Soon after the first teeth come out		
<input type="radio"/> When all the "baby teeth" have come out	73 (37.2%)	123 (62.8%)
<input type="radio"/> Don't know		
How should this care be?		
<input type="radio"/> Gauze or diaper soaked with water		
<input type="radio"/> Brush	29 (14.8%)	167 (85.2%)
<input type="radio"/> Brush and toothpaste		
In your opinion, when should your child's 1 st visit to the dentist take place?		
<input type="radio"/> Soon after birth		
<input type="radio"/> When the first teeth come out		
<input type="radio"/> Around the age of 2 years	61 (31.1%)	135 (68.9%)
<input type="radio"/> Around the age of 3 years		
Do you believe that prolonged use of the pacifier causes teething problems?		
<input type="radio"/> Yes		
<input type="radio"/> No	21 (10.7%)	175 (89.3%)
<input type="radio"/> Don't know		
Do you think that dental caries can be transmitted from mother to child?		
<input type="radio"/> Yes		
<input type="radio"/> No	128 (65.6%)	67 (34.4%)

Source: the authors.

Pregnancy is a transitory physiological state that produces several hormonal changes in the woman's body, and is capable of provoking a series of adverse effects in the body, in a general way and also in the oral cavity. This can be minimized or avoided based on a better knowledge and understanding of these factors, both among health professionals and among pregnant women (MARLA *et al.*, 2018).

It is known that sociodemographic and economic factors can influence the quality of life related to oral health, besides also being associated with the acquisition of knowledge by pregnant women, interfering in the health-disease process and in the maintenance of women's health (PACHECO *et al.*, 2020). Accordingly, based on the identification of the knowledge of pregnant women on oral health, this study seeks to reinforce the importance of identifying the factors associated with this knowledge, in order to foster the need for dental follow-up during prenatal care, as well as the need to subsidize information and provide autonomy to mothers with respect to the care of their oral health and that of their babies.

In this research, the older pregnant women showed greater knowledge on their oral health and that of their babies. This result may be associated with the fact that maturity generates greater responsibility for oneself and for other (BASTIANE *et al.*, 2010). Worldwide data point to an increase in the age of pregnant women, as motherhood has been postponed (WHO, 2017), since women are seeking to elevate their position in the labor market with greater qualification and recognition (ALDRIGHI *et al.*, 2016).

Table 3 - Knowledge score on the oral health of the mother and her baby according to the characteristics of the pregnant women participating in the study

Characteristics	Median ± IQR	*p-value
Age group ^a		
15-24 years	6.0 ± 3.0	0.042
25-30 years	6.0 ± 2.0	
31-44 years	6.5 ± 3.0*	
Marital status ^b		
Single/without partner	6.0 ± 3.0	0.919
Married/with partner	6.0 ± 2.0	
Place of residence ^b		
Rural area	7.0 ± 4.0	0.115
Urban area	6.0 ± 2.0	
Schooling ^a		
Elementary school	6.0 ± 2.0	0.001
High school	6.0 ± 3.0	
Higher education	7.0 ± 2.0	
Family income ^a		
≤ 1 minimum wage	6.0 ± 3.0	0.001
> 1-3 minimum wages	6.0 ± 2.0	
> 3 minimum wages	7.0 ± 3.0	
Work activity ^b		
No	6.0 ± 2.0	0.918
Yes	6.0 ± 2.0	
Number of children ^a		
One	6.0 ± 2.0	0.301
Two	6.0 ± 3.0	
Three or more	6.0 ± 2.0	
Gestational trimester ^a		
1° trimester	6.0 ± 2.0	0.737
2° trimester	6.0 ± 3.0	
3° trimester	6.0 ± 2.0	
Service ^b		
Public service	6.0 ± 2.0	0.219
Private service	6.0 ± 2.0	
Do you think it's necessary to go to the dentist during pregnancy? ^b		
Yes	6.0 ± 2.0	< 0.001
No/Don't know	5.0 ± 2.0	
Guidance on oral hygiene during prenatal care ^b		
Yes	6.0 ± 2.0	0.985
No/Don't know	6.0 ± 2.0	
Received guidance to look for a dentist during pregnancy ^b		
No	6.0 ± 2.0	0.261
Yes	6.0 ± 2.0	
Who provided guidance on the care of the baby's mouth? ^a		
Dentist	6.0 ± 3.0	0.334
Other professionals	6.0 ± 2.0	
Never received guidance	6.0 ± 2.0	

Notes: IQR, interquartile range. “^a” Kruskal-Wallis Test; “^b” Mann-Whitney Test; “*” Significant result.

Source: the authors.

According to Barbieri *et al.* (2018), the experiences arising from a previous pregnancy may contribute to the acquisition of greater knowledge, and may help to direct oral health actions in prenatal care, thus avoiding mistakes already made previously and adding knowledge that will bring benefits for both the baby's oral and general health, a condition not corroborated in the present study.

It was observed that pregnant women with higher education and higher family income had a higher level of knowledge. The pertinent literature points out that the higher the level of schooling and the better knowledge, the more capable they will be to carry out, in their daily lives, the learning and information acquired (PATTANSHETTI *et al.*, 2020). Similarly, a higher income and higher level of schooling can favor oral health care, as they enable greater access to dental services and, consequently, the acquisition of information (BARBIERI *et al.*, 2018). Meanwhile, families with lower incomes can also be associated with a lower level of schooling, a decrease in the valuation of health and the lack of access to oral health services (NOURIJELYANI *et al.* 2014; SILVA *et al.*, 2020).

According to Barbieri *et al.* (2018), the lack of information on the part of pregnant women on the importance of taking care of their oral health is one of the main reasons for them not to seek dental care. In addition, barriers that hinder access to specialized services, whether public or private, such as the waiting time for care and, sometimes, the distance to the health service, contribute to the fact that pregnant women stay away from prenatal dental care. Recently, a systematic review indicated that socioeconomic, demographic, behavioral, psychological factors, as well as the pregnant woman's perception of the need for dental treatment at this stage, interfere with the demand of this audience for the dental service (ROCHA *et al.*, 2018).

By the same token, doubts and beliefs regarding dental care during the gestational period permeate the pregnant woman's imagination. This lack of knowledge has produced a gap between pregnant women and prenatal dental care, which, on the other hand, can be reflected in precarious oral conditions in this group and in children in early childhood (CABRAL; SANTOS; MOREIRA, 2013; MARTINELLI *et al.*, 2020).

The knowledge on the oral health of the mother and the baby was greater among pregnant women who said it was necessary to go to the dentist during pregnancy. This prior knowledge of pregnant women on the importance of dental follow-up suggests that they have already received guidance from a health professional or through other means of information, since the present study showed that there was no influence on whether or not they had received guidance on their oral health and that of their future babies. These results reflect that there are factors that can influence this knowledge, such as the ability to convince and the art of teaching on the part of health professionals involved in clinical and prenatal dental care, as well as the interest and level of schooling of the pregnant woman (VAMOS *et al.*, 2015).

Early childhood has deserved special attention, as it comprises a period of paramount importance for the baby's development and that has repercussions for the rest of life. In this context, exclusive natural breastfeeding up to six months of life should be highlighted, without the offer of water, teas or other liquid. After six months of life, the timely and gradual introduction of food, in accordance with the recommendations of the World Health Organization (WHO), should be introduced with maintenance of breast milk until, at least, two years of age. This behavior promotes benefits for the baby's health, such as reduced obesity and increased Intelligence Quotient (IQ) (VICTORA *et al.*, 2016).

Breastfeeding during this period has repercussions on the development of orofacial muscles and the stomatognathic system, respiratory function, chewing and dental positioning. Breast milk varies in flavor according to the mother's diet, thus influencing the baby's food preferences. A maternal diet rich in sucrose will develop in the child's taste buds a predilection for the sweet taste, which can impact oral health due to caries (PANTANO, 2018). Breastfeeding in the first hours of a child's life protects against pacifier use in the first year of life, minimizing the implementation of harmful habits (BRAGA *et al.*, 2020).

It is worth highlighting that surveys show that the care of the baby's oral health begins in the gestational period and extends to the first 28 days of the infant's life and that, for this to be effective, it is directly related to scientific knowledge and the professional's ability to transmit it to caregivers (RIGGS *et al.*, 2019). Although the present study has shown that pregnant women who said they went to the dentist during pregnancy had greater knowledge on their and the baby's oral health, it makes us reflect on the difference between receiving dental care and/or treatment and undergoing prenatal dental care, since the latter should include actions to care for the oral health of pregnant women and their babies. Riggs *et al.* (2019) mention that, in this context of prenatal dental care and care for the pregnant woman and the baby, and not only during pregnancy, but also during the child's first month of life, it is understood that the baby's first visit to the dentist is soon after birth, with a view to reinforcing the guidance provided during prenatal care, identifying any abnormality in the oral cavity and establishing the beginning of a bond between family and dentist. Although this scenario is still not frequent in the clinical routine of baby care, it is necessary to continue investing in the guidance and prenatal dental care of pregnant women, in order to achieve this goal. When this first consultation does not take place during this period, it should not go beyond the child's first year of life (AAPD, 2018).

Dental caries remains the most prevalent chronic disease in early childhood. It is multifactorial, dependent on sucrose and the presence of biofilm, which results in demineralization of the tooth's hard tissues. Primary prevention measures for caries include raising awareness among health professionals and the family nucleus, limiting sucrose consumption and providing daily exposure to fluoride (PITTS, 2019). The hygiene of the oral cavity must be introduced when the first deciduous tooth appears and with the use of a toothbrush and fluoride toothpaste at a concentration of at least 1000 ppm (RIGO, 2016).

It is known that the knowledge and behavior of health professionals play a fundamental role regarding the promotion of oral health in pregnant women, a fact that indicates greater interdisciplinarity (MARAGNO *et al.*, 2019). Nevertheless, it should be emphasized that prenatal dental care is necessary, as the dentist will accompany the woman during the gestational period, observing her oral health status, in order to take care of the problems that already exist and avoid the appearance of other problems, acting strongly in the policies of health promotion and prevention, as well as in the establishment of healthy habits (SOUSA *et al.*, 2016).

Limitations of this study are recognized, given the cross-sectional design and the convenience sample, which does not allow inferences about the causality of the observed associations.

CONCLUSION

At the end of the study, a lack of knowledge on oral health on the part of pregnant women and the need and importance of performing prenatal dental care was noticed. It was also found that access to information on the oral health of pregnant women and babies is still very limited to some social groups.

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