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"Tooth worms", poverty tattoos and dental care conflicts in Northeast Brazil

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Abstract

While medical anthropologists have studied doctor–patient clinical conflicts during the last 25–30 years, dentist–patient communication clashes have received scant attention to date. Besides structural barriers and power inequities, such conceptual differences further dehumanize dental care and lower service quality. Potential for dentist–patient discordance is greater in developing regions—such as Northeast Brazil—where there exists a wider socio-economic gap between professionals and laypersons. A critical anthropological evaluation of oral health services quality is undertaken in two rural communities in Ceará, Brazil where the PAHO-inspired Local Oral Health Inversion of Attention Program was implemented in 1994. This 6-month qualitative field study utilized ethnographic interviews with key informants, participant-observation and projective techniques to probe professionals' and patients' explanatory models (EMs) of oral health. Despite the recent expansion of services into rural regions, the authors conclude that the quality of dental care remains problematic. Patients' culturally constructed EMs of teeth rotted (*estraga*) by "tooth worms" (*lagartas*) differ substantively from dentists' model of dental decay by *Streptococcus mutans*. "Exploding chins" (*queixo estourado*), "spoiled, rotting teeth" (*dente pôdi*) and "false plates" or teeth (*chapas*) tattoo and stigmatize the poor, reinforcing gross class inequities. Dentists' dominant discourse largely ignores lay logic, ridicules popular practices and de-legitimates, even castigates, popular healers despite their pivotal role in primary oral health care. Poor parents are not only barred from clinics but are blamed for children's rotten teeth. In sum, universal access to dental care is more a myth (even nightmare) than a reality. Dentists all too often "avert"—not "invert"—attention from poor Brazilian patients. In order to improve oral health in this setting, both "societal decay" and bacteria-laden plaque deposits must be removed. © 2002 Published by Elsevier Science Ltd.

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Cavities and conflicts in Northeast Brazil

> "Yank (*arrancar*) all of them out at once, doctor! It's better to suffer one big pain than to be bothered with that fine, shooting one every time you eat sweets!" ordered 24-year-old, illiterate Dona Rosa in rural Beberibe, Brazil. "You want to extract all of your teeth?" countered her stunned dentist. "Yeah, yank out every single one (*tudinho*) and put in that plate or false teeth (*chapa*) ... It's the prettiest thing in the world... all the teeth so white, straight, even and perfect.... Looks like a rich person's thing! Besides, they say yanking them out is the only way to kill the tooth worm (*lagarta*) ... just patching it up with that putty (*massa*) isn't good for anything!" "Woman, have you lost your mind or what?" fought back the exasperated dentist. "Listen up doctor, I might be poor, but I'm not ignorant!" furiously defended Dona Rosa.

Clinical showdowns such as this one between Dona Rosa and her dentist in poor rural Northeast Brazil are

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all too common. Patients and professionals hold differing—often conflicting—beliefs about a myriad of topics, from what causes tooth decay to the meaning of rotten teeth. Dona Rosa's world of tooth worms (*lagartas*), rotting teeth (*estragação*) and designer-label false teeth (*chapas*) is little known to wealthier, university-trained dentists, whose scientific explanations are experience-distant from the hard surfaces of life in rural poverty. Such grave cognitive conflicts, compounded by stifling structural barriers, block people's access to dental clinics and dehumanize oral health care.

For nearly half of Brazil's 140 million people who live in painful poverty (Valla & Stotz, 1993, p. 63), oral health is highly precarious. Economic recession, unemployment, class disparity, faulty public education, export-geared agriculture, hunger, protein-calorie malnutrition, exaggerated sugar consumption (51.1 kg/year person[1] compared to 18.6 worldwide) and absence of dental services contribute to the problem (Pinto, 1997). The high incidence of dental caries and periodontal disease—causing the needless loss of some 40 million teeth annually—has won Brazil the dubious distinction as the "World's Toothless Champion" (Narvai, 1997; Pinto, 1997). While Brazil hosts 11% of dentists worldwide, only 5% of its population receive public dental care (Narvai, 1997). Perversely lopsided, the bulk of highly trained specialists compete for the few private-paying patients in capital cities while the rural poor lack basic preventive care. While the 1994 implementation of the "Inversion of Attention—Local Oral Health Systems" Program in Ceará extended coverage to underserved rural areas (Loureiro, 1998),[1] the quality of dental practice remains problematic. The mere extension of a high-tech, disease-fixated and clinic-centered paradigm into rural areas failed to provoke a parallel "inversion" in the way (quality) dentistry is practised in this setting (Nuto, 1999). Although a number of factors explain this failure, this article will focus on one: the head-on confrontation of dentists' and patients' cultural constructions of reality. Professionals' biomedical disease focus often violates the attitudes, values, sentiments, rhythms and decencies of patients' daily lives. Such symbolic aggression often provokes patients' "non-compliance", revolt or even flat-out rejection of services. The imposition of positivistic disease models often deadens laypersons' incentive, spoil personal identities and break human spirits (Nations & Monte, 1996). To construct humanistic health interventions in hierarchically structured Northeast Brazil, people's participation (Freire, 1970; Valla & Stotz, 1993) and inclusion of their subjective interpretations, rationalities and valuations is fundamental (Mull & Mull, 1988; Nations & Rebhun, 1988; Nitcher, 1988). This study aims, then, to cut to the core of dentists' and patients' interior, meaning-laden worlds of lived experience, confronting popular and professional explanatory models (EMs) of dental care (Kleinman, Eisenberg, & Good, 1978) in order to identify conflicts and convergences. Improving dental care quality in Northeast Brazil demands such a probing ethnographic analysis.

[1] The Program is described in *Estação Saúde* documents (the Minas Gerais consulting firm responsible for program implementation and evaluation in Ceará).

Beberibe and Itapeim: tropical tourism to desolate destitute

This study was designed as a critical investigation (Singer, 1989) of the quality of dentist–patient relationships and oral health services in the context of rural Cearense culture. Beberibe County (pop. 38,000) was selected as our study site because local technical staff unanimously considered it "the best" Inversion of Attention pilot project in Ceará. Located 81 km from the state capital, Fortaleza, in Brazil's impoverished Northeast, Beberibe is a county of striking socio-economic contrasts. Of its 38,000 inhabitants, 29% are clustered into its hustling commercial center, bound by a lush tropical coastline. The remaining 71% are dispersed in vast outstretches of desert backlands or *sertão*. Two specific locations—Beberibe's town district and the Itapeim rural district—were identified for intensive study.

At first glance, Beberibe evokes a picture-postcard-fantasy of an exotic tropical paradise. Palm fronds rustle in soothing trade winds. White virgin sand beaches stretch for miles. Wind-sculptured, pastel-colored dunes tower in the distance. And bellowing, triangular-shaped cloth sails propel traditional wooden fishing rafts (*jangadas*) out to sea. Beberibe's indigenous Tupi-Guarani name means "a place where sugar cane grows with abundance". Today, however, tourist hotels have replaced sugar plantations. Pulsating *Axé* and *forró* rhythms and sensual, sun-bronzed, string-bikini-clad girls attract not only tourists to this picturesque seaside town, but increasingly drugs and prostitution.[2] For locals, life in Beberibe is far less romantic. The average monthly family income is US$30.00. Malnutrition afflicts 12% of children under the age of 2. The illiteracy rate of 11–17 year olds is 30.5% and 1636 school-age-

[2] Drugs (73%), infantile prostitution (56.7%) and early pregnancy (46%) were among the top risks for children and adolescents identified by a population survey in Beberibe. No institutionalized sex industry is identified in Beberibe. Informal prostitution, however, is growing with increased tourism from Fortaleza, where an international network of child prostitution has been recently uncovered by an official parliamentary investigation (CPI) (Câmara Municipal de Fortaleza, 1993; Diógenes, 1999).