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ARTICLE

HEALTHY OR DISEASED MOUTH? REPRESENTATIONS OF ORAL HEALTH IN VULNERABLE POPULATIONS.

¿Boca sana o boca enferma? Representaciones de la salud bucal en sectores vulnerables.

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ABSTRACT:

Background: The society and the State must provide dental care and help prevent oral health problems by implementing public policies with cultural relevance that allow society to address and improve the inequity in health care that systematically affects people's well-being. The present study seeks to understand the representations of dental health in people who attend primary care services in vulnerable urban and rural areas of the central zone of Chile. Specifically, the representations of the causes, morbidities, and symptoms attributed to the healthy and diseased mouth.

Material and Methods: A qualitative study based on the Grounded Theory was conducted, analyzing the social representations of oral health in a sample of 161 adult people receiving treatment at public primary care services and dental emergency units in rural and urban communes. Empirical saturation and triangulation by time, place, and subjects give reliability to the study.

Results: The data obtained show that dental health is mainly valued for its implications for self-esteem and social integration. A naturalization of dental health problems is evidenced as an adaptive strategy to traditional access barriers, which is counterproductive with preventive strategies.

Conclusion: The results of the study suggest the need to reinforce education in dental health implemented in a transversal manner, having aesthetic values and the population's expectations of sociability as the key to action.

KEYWORDS:

Oral health; health representation; public health; suburban population; vulnerable populations; social determinants of health.

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RESUMEN:

Antecedentes: Como sociedad y desde el Estado debemos cuidar y prevenir los problemas de salud oral invirtiendo en políticas públicas con pertinencia cultural que nos permitan subsanar la inequidad sanitaria que afecta de manera integral el bienestar de las personas. El estudio busca comprender las representaciones de la salud dental en personas que asisten a la atención primaria en sectores urbanos y rurales vulnerables de la zona central de Chile; en especial las representaciones de las causas, morbilidades y síntomas atribuidos a la boca sana y enferma.

Material y Métodos: Estudio cualitativo que analiza desde la Teoría Fundamentada las representaciones sociales de la salud bucodental en una muestra de 161 personas adultas consultantes de los servicios públicos de atención primaria y de urgencia odontológica en comunas rurales y urbanas. La saturación empírica y la triangulación por tiempo, lugar y sujetos otorgan confiabilidad al estudio.

Resultados: Los datos obtenidos dan cuenta que la salud dental es principalmente valorada por sus implicancias para la autoestima y la integración social. Se evidencia una naturalización de los problemas de salud dental, como estrategia adaptativa a las tradicionales barreras de acceso, lo que es contraproducente con las estrategias preventivas.

Conclusión: Los resultados del estudio nos alertan respecto de la necesidad de reforzar la educación en salud dental, teniendo como clave para la acción, de manera transversal, los valores estéticos y las expectativas de sociabilidad de la población.

PALABRAS CLAVE:

Salud Bucal; representación de la salud; salud pública; población suburbana; poblaciones vulnerables; determinantes sociales de la salud.

INTRODUCTION.

Despite calls from global health organizations to reduce the global burden of oral pathologies that affect the most vulnerable populations on the planet, they still persist.[1] Chile is not the exception. Advances in public policies for access to dental care have not been able to reverse the problems of supply and quality of care.[2] Although this situation is conditioned by the social determinants of dental health, it also involves cultural dimensions[3] that are manifested in the connotations, data, and images that organize and give meaning to the experience of the health-disease process and dental care.[4]

Reference is made, for example, to ways of explaining the nature and severity of caries, its causal agents, and the healing strategies or treatments that people consider relevant, which are shared and transmitted from generation to generation.

Likewise, it involves the association of a sign or symptom to an oral condition and its definition as a disease. From this perspective, social representations would be cultural products conditioned by the socioeconomic position of individuals and groups.[5] This new perspective moves all actors from an approach focused on understanding and curing the pathogenesis towards a preventive one with particular attention to the culture of the populations, called sociocultural epidemiology.[5] The integration of this cultural dimension poses a challenge for dental approaches, since its incorporation involves the possibility of enriching professional practices by rooting them in sociocultural realities.[6]

The main interest of this study is to know how people represent dental health, specifically, to understand the representations of oral health in people who attend primary care services in vulne-

rable sectors of the central zone of Chile, that is, the representations of the causes, morbidities, and symptoms attributed to the healthy and diseased mouth. The results of this qualitative study are limited to adults of both sexes who use dental public services in vulnerable urban and rural sectors located in different regions of Chile.

The review of the literature on the representations of dental health in vulnerable sectors, mainly urban, yielded an agreement on the lower assessment given to dental health with respect to general health.[7-11] Laziness is understood as an adaptive response to barriers to access to care associated with poor knowledge, care practices,[7,8,12] and preventive behaviors.[7,13] Knowledge of self-care would be restricted to tooth brushing,[7, 9,13-15] and the absence or presence of caries represented by the appearance of the teeth —pitted, with cavities, and dark in color.—[8,9,12,16] It is also reported that a diet free of sugary foods would protect people from caries.[7,9,12,14-17] Morbidities such as gingivitis are less well known; however, the understanding of dental pain is evident.[8,10,13] Bleeding and bad breath are not considered manifestations that motivate people to seek treatment.

People also recognize the use of traditional palliative practices to treat dental pain, and being pain the main motivation for seeking care, there follows the subsequent postponement of treatment.[12,15,16]

In this context, the representation of the mouth would be closely associated with the teeth as an aesthetic element of contact with society versus the emphasis of dental care providers on the dental arch.[9,17-20] This is reported, for example, in populations of young people in confinement,[15,16] vulnerable adults, mothers, and pregnant women.[11,19]

Likewise, healthy teeth are represented as white and uniform.[14,17,19] Dental trauma or fractured teeth would be less reported.[10] The studies also agree on the psychosocial importance –emotional, social, self-esteem, and labor insertion– that periodontal problems have for the population.[7,11,17,21,22]

It is observed that, although the reviewed bibliographical studies have examined the general theme of social representations of dental health, the specific objective of this study regarding the representation of the healthy and diseased mouth in vulnerable populations from a cultural approach could provide an innovative perspective.

MATERIALS AND METHODS.

This study follows a qualitative descriptive design based on the Grounded Theory[23] that studies the social representations of dental health from the perspective of people in the daily contexts of dental care without searching for associations but from a comprehensive perspective. It seeks to understand the knowledge, values, and definitions of dental health.

Sample: The methodological strategy consisted of applying individual semi-structured qualitative interviews to 161 people, without rejection or desertion (Table 1), recruited in the waiting rooms of health centers during August-December 2014-2018, in six communes of the VI and VII regions. The interviews were carried out mainly in the homes of the respondents and, exceptionally, in health center rooms safeguarding privacy and without publicity related to oral health care in health care centers.

The participants signed an informed consent to comply with the requirements set by the Scientific Ethics Committee of Universidad de Talca (folio 2015-099-GD, 2017043). (Table 1)

The communes included in the study present levels of poverty with incomes that are generally higher than the national average (8.6%) in the O'Higgins Region:

a) 14.79% in Paredones;
b) 10.2% in Rengo, in the Maule region:
c) 20.02% in San Javier
d) 9.85% in Sarmiento
e) 18.14% in the Curicó, Rauco communes; and
f) 7.98% in Talca.[24]

The communes correspond to vulnerable and emerging urban social sectors in the process of urbanization and recent growth, associated with agribusiness and the service sector.

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Precarious labor sources predominate, with minimum income and basic and medium educational levels. Rurality acts as a structural determinant and as a barrier to have access to dental care services, due to conditions of misinformation and limited resources. Consequently, the risk of oral diseases is higher. Interviews: Following the principle of theoretical sampling, the semi-structured interview script (Table 2) was adapted to fit the research problem in the data analysis process.

The scope of the sample is associated with different times and spaces (CESFAM), depending on the type of user recruited. The interviews, lasting 40 to 120 minutes, were carried out in the waiting rooms and rooms of the primary care centers or in the homes of the respondents. They were performed by dental and nursing interns, trained for this purpose and unrelated to the participants. Analysis: The analysis of the results complements the qualitative analysis (Figure 1 and Table 4) with thematic content analysis[25] (Table 3).

The recorded audios of the interviews were transcribed literally, and they were not reviewed by the participants. Ethical considerations: The participants were informed of the objective of the study and those responsible for its application. The digital audio files and the informed consents were properly protected, as well as the confidentiality of the empirical material. An identification number was assigned to each person, correlated with their age and sex. The computerized qualitative analysis (Nvivo10)[26] based on Grounded Theory, was carried out by the lead researcher. The empirical saturation of the data and triangulation by scenarios and subjects give reliability to the study.

RESULTS.

The population consisted of 67% women and 33% men between 21 and 63 years old, 61% from urban sectors and 39% from semi-rural or rural sectors, where they only receive free emergency dental care at local primary care centers (Table 1).

The results of the study show the representations of the healthy and diseased mouth and the knowledge, themes, and images that emerge when people share their experience of the health-disease process and dental care.

Representation of the healthy and diseased mouth

In this regard, it is observed that people represent a healthy mouth and a diseased mouth through their sensory experience, aesthetics, care practices, and the absence or presence of dental diseases and symptoms (Figure 1).

It is interesting to note that in the representation of the healthy and diseased mouth, psychosocial aspects predominate more than the functional difficulties caused by oral pathologies.

Gum problems: causes, symptoms, and dental treatments.

When people refer to dental health, they also associate it with a clean mouth, without diseases and with aesthetic patterns or a "cared for" mouth, which would be a synthesis of the previous attributes. The main diseases listed are caries and gum problems associated with a series of symptoms such as pain, inflammation/swelling, bleeding, and loss of teeth (Table 3).

They localize oral disease mainly in the teeth with caries, the molars, and the mouth. Secondarily, they localize oral disease in the gums and marginally refer to the tongue and palate. People also talk about dental health when referring to oral anatomy, symptoms, signs, known and/or experienced treatments and sensory-aesthetic dimensions (Figure 1 and Table 3).

Caries or *"pitting"* is represented by its shape – such as a cavity or "*little hole"*– and is associated with *"breaks"*, *"cracks,"* and dark colors such as "black spots" or "brown" or "dark" teeth; the larger and deeper caries as in *"it reaches the root"* or *"the nerve"*, the more serious cavities can *"kill the tooth"*. They are usually detected only when it would be too late to *"save the tooth"*. There is talk of *"white cavities" "that are not known to be there"*.

For some people, cavities are caused by *"a*

bug that eats things" or *that "eats through," "rots"* or *"infects teeth"* or because of decaying food debris. Others refer to wounds that eat away at the tooth and reach the root. In all cases, they are invisible external agents and *"devourers"* that are difficult to identify. A feeling of lack of control and a certain fatality is inferred with respect to caries represented as a slow invisible internal process whose symptoms appear when the damage is irreversible (Table 4).

Some eating/consumption habits –sugars, lack of calcium due to pregnancy, alcoholism, and drugs– and smoking are associated with tartar, caries, and bad breath (Table 3). Barriers to access to care are minimally pointed out as a cause of the quality in dental health; however, some advances in dental education are perceived. A minority lists biological inheritance or specific health conditions as causes of dental health quality (Table 3).

Gingivitis is the second most frequently reported disease (Table 3). It is recognized by the swelling, the *"loose gum"*, *"shaped in V"*, *"low"*, *"separate from the teeth"* or irregular in shape, which affects the *"support/base of the tooth"*. It is observed that the notion of periodontal disease and gingivitis is handled by a restricted spectrum of people associated with those with a higher educational level. Although, like other oral problems, gum damage is associated with poor hygiene or infections, it is also attributed in decreasing order to: the mechanical action itself during brushing or *"rough brushing"*; to exogenous elements with hard textures, such as a *"very hard brush"*, to eating or consuming hard foods such as apples, and exceptionally to the accumulation of tartar; to cavities, to high temperatures *"to drink very hot tea"* or to *"some unknown disease"*. Few people refer to the risk of tooth loss and bad breath as consequences of gingivitis, and generally they are those who have already had the condition.

Regarding the symptoms associated with dental health, dental pain is represented as that acute and intense tenderness that radiates to other parts of the face, whose origin is attributed to decayed teeth or mouth infections (Table 4).

In general, people indicate that they *"endure"* dental pain until the tooth is extracted in the public health system, since obturation is not covered by health insurance and private care is too expensive. Gum pain is expressed as *"sensitivity"* or *"irritation"* and it is defined as a temporary and/or reversible non-specific discomfort, which is not, therefore, a reason for dental consultation.

Another important symptom is inflammation or swealing —*"bean"*, *"pimple"*, *"abscess"*— and although it is associated with caries, it is mostly recognized as a symptom of periodontal infection. Answers reveal that people tend to wait for the "gum to mature", treating it with home remedies to disinfect it and stop the bleeding. Inflammation is described in many ways, including: *"raised gums"*, *"little beans"*, *"blood blister"*, *"little balls"*, *"pimples"*, *"blisters"*, *"abscesses"*, *"popped gums"* and *"swellings of/in the face"*, associating this last symptom with the need for emergency dental care.

The symptom *"bad breath"* is associated with hygiene problems —rotting food remains, bacteria, tooth decay and smoking– and self— esteem, affecting sociability and social integration. Two aggravating factors are added to the above:

1) People try to reduce it by consuming flavored products high in sugar (*"mints"* and *"chewing gum"*),

2) People try to solve it by just brushing their teeth, consequently they do not seek professional dental care. Bad breath has a stronger social connotation than being toothless since it also affects the quality of life of others, which reinforces its taboo nature and the search for solutions.

Bleeding and tartar would be naturalized symptoms. Bleeding is recognized by the red or pink color of the gums and is described as a mild, sporadic, intermittent, and practically painless *"tenderness"*. In general, bleeding, infection, and *"tenderness"* of the gums are not associated with disease or dental care. Tartar is described as the yellow color of the teeth. It is exceptionally associated with loose teeth, gum disease, dental loss, or obstruction of the salivary glands. Its origin is attributed to lack of care or food remains that solidify in the teeth, also

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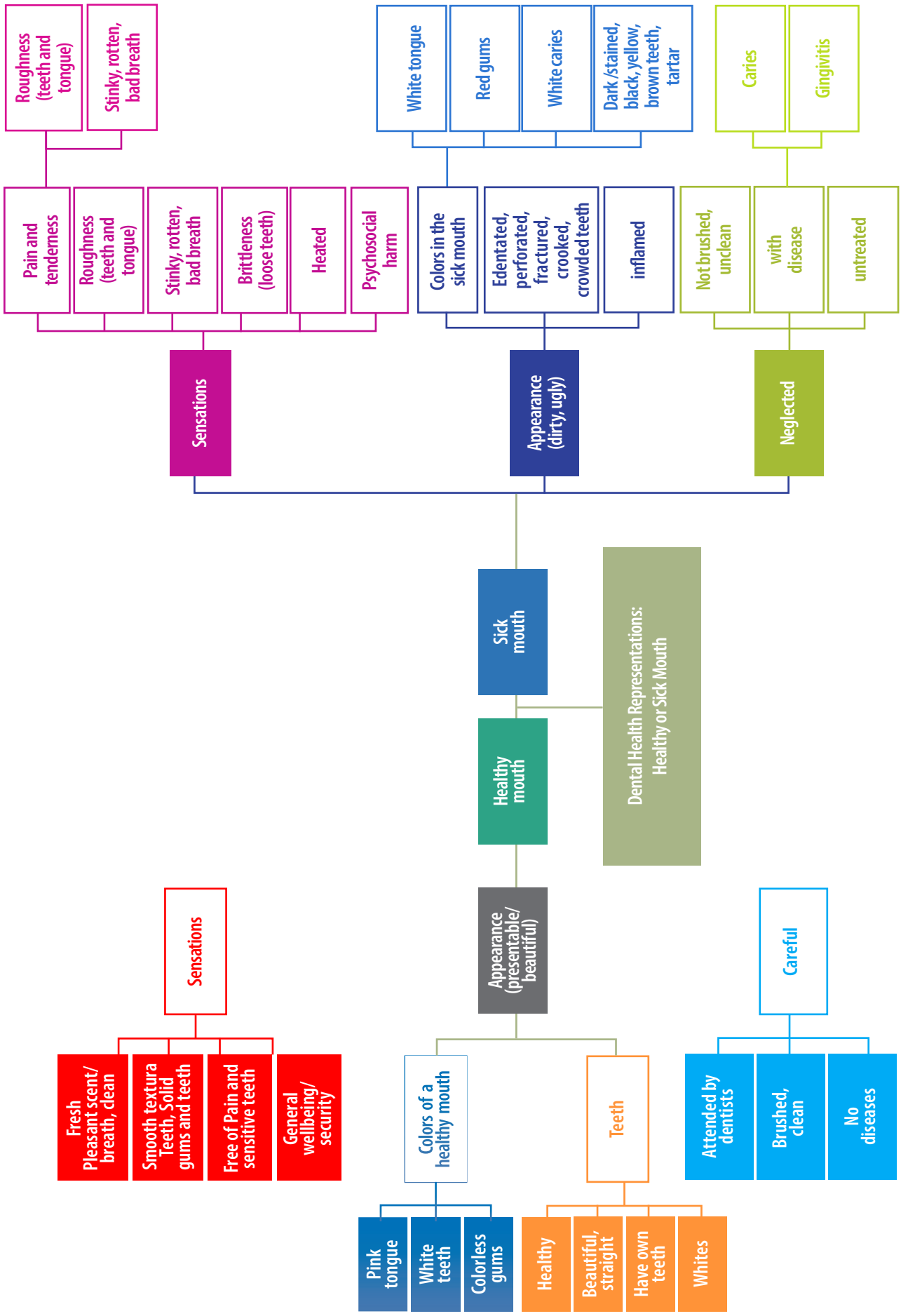

Figure 1. Conceptual map of the representations of the healthy mouth and the diseased mouth based on the categories and subcategories of the qualitative analysis of the interviews.

Table 1. Biogeographical description of the participating people.

	Attribute	Frequency n=161	Percentage (%)	Rural, Urban, Suburban
Communes (Counties)	Paredones (VI)	24	15	Rural and urban
	Rengo (VI)	20	12	Rural and urban
	Talca (VII)	69	43	Urban
	San Javier (VII)	24	15	Rural and urban
	Rauco (VII)	12	7	Rural and urban
	Sarmiento (VII)	12	7	Rural and urban
Regions	VII O´Higgins	44	32	
	VII Maule	117	73	
Age	≤ 25	21	13	
	25-34	26	16	
	35-44	30	19	
	45-54	40	25	
	55-67	44	27	
Gender	Female	108	67	
	Male	53	--	
Residence	Urban	99	61	
	Rural	62	39	

Table 2. Dimensions and sub-dimensions collected from the semi-structured interview protocol.

Dimension	Sub-dimensions
Knowledge of oral health	Knowledge of oral health. Healthy mouth and sick mouth.
Oral diseases	Diseases associated with oral health (gums, halitosis (bad breath), gingivitis (bleeding gums), periodontitis (tartar, loose tooth), abscess (pimple on the gum, little ball). Report of experiences, definition, causes and consequences.
Experiences associated to oral health	Representation of dental health (as described, values and meanings attributed). Report of experiences in dental health (pain/symptoms and associated practices) and in dental care (motivation, report of the health-disease process and care).
Health condition and quality of life	Self-care habits in health and dental health. Protective factors (hygiene, support network) and risk factors (smoking, alcohol, among others).

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Table 3. Representation of dental health according to categories and subcategories by frequency and percentage in the interviews.[1]

CATEGORY / N= 161 Interviews	Frequency (%)	Subcategories	Frequency (%)
Diseases mentioned	161-100	Caries	152-94
		Gingivitis	84-52
Treatments mentioned	159-100	Filling	105-66
		Tooth removal	81-51
		Prosthesis, Denture, Insert, Bridge, Implant, Crown	71-45
		Root canal	40-25
		Surgery, Endodontics, Obturation	25-16
		Braces	21-13
Orofacial organs mentioned	153-100	Teeth	153-100
		Molars	111-73
		Mouth	81-53
		Tongue	37-24
		Gums	19-12
		Palate	09-6
Representation of the healthy mouth	152-94	Clean mouth	142-88
		Brushed	92-57
		Mouthwash	42-26
		Floss	41-25
		Disease-free mouth	129-80
		Mouth cared for	95-59
		“Presentable” mouth	95-59
		Social Self-Esteem	93-58
		Having teeth	75-47
		Image and Personal Presentation	64-40
		Fresh breath	36-22
Causes attributed to poor dental health	142-88	Behavioral Causes of a Sick Mouth	120-75
		Bad hygiene	105-65
		General Consumption	72-45
		Sugar Consumption	54-34
		Cigarette Consumption	33-21
		Biomedical Causes of Sick Mouth	84-52
		Natural wear, inheritance	84-52
		Health condition	59-37
		Bacteria	13-9
Sick mouth symptoms	129-80	Appearance of the denture	109-68
		Pain	105-65
		Inflammation (pimple, lump)	87-54
		Smell	69-43
		Sensation	64-40
		Tartar	49-30
		Color	42-25

Table 4. Representations of dental health from a sample of citations representative of the interview categories.

Row	Categories	Actual quotes from the interview representative of each category
1	Caries-free mouth	As for a healthy mouth, it is free of caries or disease, without all the problems it may have, gums, caries (Interview 74, female).
2	Representation of caries	Caries appears suddenly, you may think that it appears when you see the little black dot and no, suddenly it's there...cavities are big, you don't even realize that cavities are inside, not outside and Thank God, mine didn't reach the bone, they were all like that, on the surface, they were big indeed (Interview 42, female).
3	Origin of caries	They are bacteria that eat your teeth because you eat lot of sweets or because of weakness, maybe you have low defenses, I think that could be the reason, because there are people who brush every day and still have cavities, so it is not really due to poor oral hygiene but because of their week immune system (Interview 80, female). You notice it when the black spot is already eating your tooth. It is caused by poor hygiene, due to food debris that began to decompose, and time passed and passed, and it remained there, it's kept inside until your tooth rots. (Interview 10, female).
4	Healthy mouth (Symptoms)	I think a healthy mouth is when you have clean teeth, no tartar, no bad breath, when you look okay. It's bad when you have cavities, bad breath, a white tongue, if your teeth hurt and all that (Interview 129, female). A diseased mouth has swellings, it is ugly, there are swollen areas of the gums, stained teeth, or teeth with different colors (Interview 9, female).
5	Healthy mouth (Hygiene)	I think having a healthy mouth is having perfect teeth, knowing how to clean your teeth, brush your tongue; a sick mouth causes bad breath, a bad smell comes out of your teeth, so the essential thing is to have very good hygiene and seek treatment if you have caries (Interview 130, female).
6	Healthy mouth (Reveals aesthetic and social aspects)	A healthy mouth consists of white, beautiful teeth, good breath, having a nice "Pepsodent" smile (Interview 93, female). If you have good oral hygiene, many people will congratulate you and that will open doors for many things, because our smile will be the gateway to work, communication, contact, and many other things (Interview 74, female).
7	Motivations for dental care and treatment	[Representation of the causes of the sick mouth and motivation to take care of dental health]. …not having germs in the mouth that cause bad breath in that sense and avoiding the accumulation of tartar, which is what normally causes a tooth to get loose, I suppose (Interview 68, male). The dentist told me I should have my teeth cleaned, and I saw that they removed the tartar with a small hook, so you think about the pain and also that it is not necessary, because you ask yourself: - "What can the tartar cause me?" - It looks ugly, and obviously it produces such and such things, but you think: - "perhaps it won't cause something more serious"- then you think: - "I won't do it because it won't cause major problems"-, so I didn't see it necessary. I know that check-ups are recommended, but the person who goes to check-ups is the one with the highest income (Interview 14, male).

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Row	Categories	Actual quotes from the interview representative of each categor
8	Access barriers	Yes, I've had a toothache, because I've had caries, and I've had some teeth removed because I don't have money and because dental treatment is expensive, dental fillings cost $30,000 or $40,000 pesos* in cash or more, and that money : -From where do I get it?- You know, you have to pay for electricity, water, gas (Interview 04, male). *Around 35-45 USD; approximately 10-15% of the minimum wage in Chile in 2018 .
9	Pain	Toothache is horrible, headache is bearable, but toothache is like a bomb; the head hurts, the ears hurt, everything hurts; because I think that the nerves go to your brain, that's why everything hurts (Interview 63, male). Toothache is the most extreme pain, stabbing, it is a very intense pain, I can't compare toothache with any other pain. I think I would have pulled out all my teeth and eaten baby food from then on (Interview 22, male).

to infections, and consumption of tea or coffee. In addition to brushing and professional dental cleaning, home practices such as *"tooth scraping"* are identified as ways to prevent it. Exceptionally, it is reported that the cleaning of tartar has been a reason for dental consultation. It should be noted that people rarely refer to dental treatments other than extractions, restorations, and prostheses, highlighting the precarious offer of public dental care and their preference for the private system, despite access barriers.

Secondarily, they refer to expensive treatments such as root canals, surgeries, endodontic therapy, obturations, and braces.

Clean mouth

Dental health is intrinsically linked to oral hygiene, defining it as the main cause of its quality (Table 3). The cultural value implicit in the representation of a healthy mouth is that of a "clean person" versus a "dirty person" and/or "lazy person", who does not take care of their teeth. Dental health would be an individual responsibility, with a self-critical vision prevailing in this regard due to devaluation, generalized ignorance, and lack of brushing routines. In the sample as a whole, the use of mouthwash and dental floss is scarce. There is evidence of lack of knowledge regarding the type of brush to be used, the replacement criteria, the moment, and the frequency. Older adults say they did not receive prior education in dental health until after significant loss of their teeth; they previously ignored and devalued the symptoms. Some prefer removal and use of dentures instead of dental care.

The aesthetic and social value in the representation of dental health

As has already been shown, the aesthetic and psychosocial aspects are relevant in the representations of dental health. The aesthetic dimension is part of the representation of a healthy mouth, also understood as a mouth with complete, white, uniform teeth, with smooth and clean teeth, uniform white gums, and good breath. A healthy mouth refers to a beautiful smile and is synonymous with comprehensive social and psychological well-being (Figure 1 and Table 3). On the contrary, a diseased mouth has caries, is toothless, smelly, and the person has a swollen face and is in pain. The diseased tooth is represented as being stained -brown and yellow- and elongated, cracked, perforated or sharp.

People refer to the effects on the oral health-related quality of life, highlighting the embarrassment caused by the absence of a smile; reluctance; absenteeism from work and school due to pain; difficulties in expressing oneself; irritability; low self-esteem; the reduction of job opportunities; social isolation, discrimination – it implies looking ugly, looking old and poor –, humiliation and depression.

In contrast, a healthy mouth would be an advantage in the job since it would favor "social confidence", "looking younger," and "the feeling of belonging". The social aesthetic dimension of dental health is presented as an intermediate social determinant of health.

DISCUSSION.

Regarding the question about people's representations of dental health, the results of the study allow us to recognize that the medical field (diseases, treatments, symptoms) constantly overlaps with the psychosocial field (aesthetics, social consequences, and role in the quality of dental health).

The healthy mouth and the diseased mouth are defined based on the sensations of discomfort or well-being that are experienced and that vary from sensitivity to pain that ends up in the extraction of the tooth. Although diseases, symptoms, and dental treatments are an important part of the representations of dental health, so is the psychosocial discomfort related not only to the impossibility of continuing with daily routines but also to feelings of exclusion and low self-esteem. Here the representation of the diseased organ is merged once again with the ugly and, therefore, socially undesirable condition.

The reported symptoms of the disease have already been extensively studied,[8,9,12,13,17,22] but not their aesthetic and social dimensions. In this regard, it is worth highlighting studies conducted on young people —in a situation of confinement and mothers and fathers responsible for minors, among others,—[12,16,17,22] which provide clues about the emerging interest of the new generations towards these aspects. This study contributes to describing with greater precision the dimensions and relationships between the biomedical, sensory, and aesthetic attributes involved.

The caring attitude of people towards dental health is another dimension through which the healthy and diseased mouth is defined and where the biomedical spheres once again intertwine with the social ones. A healthy mouth is a cared for mouth and the lack of care or hygiene is engraved in the body in the form of diseases and social stigma, as in the case of a *"toothless"* and *"stinky"* mouth. In this regard, people assume that oral care is an individual responsibility but that it does not represent a priority for them.

Dental health would be, in this sense, less important than general health, since it is represented as an acute non-disabling condition, whose consequences would be limited to the extraction of the tooth and whose symptoms have become natural. Regarding dental disease, it revolves around caries, specifically the pain that is experienced, the suffering that it entails, the strategies to alleviate it and tooth extraction as a solution.

We tend to agree on this point with previous studies that attribute disinterest in dental health,[8,10,11,19] as well as the naturalization of symptoms and the postponement of care, to lack of knowledge and access barriers.[7,8,13]

We understand in this context that people tend to solve the challenges of dental care that public health policies face with their own cognitive resources, attitudes, and cultural practices.[10]

Within the limitations of the study, we report that no relationships were established between representations of dental health and social determinants, which could have helped to understand the importance of context in this area in greater depth. Despite this, the study achieves a broad approach, with a significant sample, to the representations of dental health in vulnerable sectors.

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CONCLUSION.

The results of the study indicate, for the time being, the need to strengthen dental health education, with aesthetic values and social expectations as the key to action, apparently independently of the precarious socioeconomic conditions of the target population.

As a society and from the implementation of public policies, it is essential to care for and prevent oral health problems by implementing public policies with cultural relevance that allow society to address and improve the inequity in health care that systematically affects people's well-being.

Oral health problems affect millions of people around the world, and they will not be solved in the medium term. We need to continue researching the representations of dental health in epidemiological subpopulations to identify specific content such as values, norms, and habits, which guide prevention programs, since we know that these vary according to each context.

Conflict of interests:

The author declares that she has no conflict of interest.

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Davis-Toledo G: Conceptualization, design, research, methodology, analysis, supervision, validation, writing, review, and editing.

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REFERENCES.

1. Word Health Organization. World Health Assembly Resolution paves the way for better oral health care. World Health Assembly Resolution paves the way for better oral health care. 2021. https://www.who.int/news/item/27-05-2021-world-hea.
2. Gallego F, Larroulet C, Palomer L, Repetto A, Verdugo D. Socioeconomic inequalities in self-perceived oral health among adults in Chile. Int J Equity Health. 2017; 16(1):23.
3. Northridge ME, Kumar A, Kaur R. Disparities in Access to Oral Health Care. Annu Rev Public Health. 2020; 41:513-535. doi: 10.1146/annurev-publhealth-040119-094318. PMID: 31900100; PMCID: PMC7125002.
4. Jodelet D. La representación social: fenómenos, conceptos y teoría. In S. Moscovici (Ed.), Psicología Social II: Pensamiento y vida social. Barcelona, Páidos. 1986.
5. Menendez EL. Epidemiología sociocultural: propuestas y posibilidades. Región Y Sociedad. 2016; 20(2). doi.org/10.22198/rys.2008.2.a526
6. Cartes Velásquez R. Some ideas for qualitative research in oral and craniofacial sciences. J Oral Res; 6(5):108-9. doi.org/10.17126/joralres.2017.041
7. Silvina DM. Conocimientos de salud bucodental en relación con el nivel socioeconómico en adultos de la ciudad de Corrientes, Argentina. Rev Fac Nac Salud Pública. 2015; 33(3): 361-369. doi.org/10.17533/udea.rfnsp.v33n3a05.
8. Zelocuatecatl Aguilar A, Ávila Rosas H, Caballero Peña IN. Actitudes y prácticas ante la búsqueda de atención odontológica en personas de la ciudad de México. Estudio cualitativo. Univ Odontol. 2019. doi.org/10.11144/Javeriana.uo38-80.apba
9. Canseco Prado G, Jarillo Soto EC. Acceso y práctica odontológica en ámbito de atención privada. Representaciones sociales y salud bucal. Rev Odont Mex. 2018; 22(3): 128-136.
10. Davis-Toledo G, Nuñez L, Espinosa A, López L. What do people do before going to the dentist? Qualitative study of cultural practices of pain relief in primary care. J Oral Res. 2018;7(8):299–307. doi: 10.17126/joralres.2018.074
11. Ariceta A, Bueno L, Andrade E, Arias A. Efectos psicosociales de la enfermedad periodontal en la calidad de vida de pacientes de la Facultad de Odontología (UdelaR) Un estudio cuali cuantitativo. Odontoestomatología. 2021; 23(37): e201. doi.org/10.22592/ode2021n37a1.
12. Ospina Lozano EJ, Lizcano Pinzon YD. Ethnography on dental pain in Pijao population in Ortega, Tolima. 2018;33(1):45–55.
13. Sánchez-Peña MK, Sánchez-Delgado, KJ, Agudelo-Ramírez A. Estrategias lúdicas para aumentar el conocimiento de un grupo de adolescentes escolarizados sobre la gingivitis. Duazary. 2015; 12(2):100–11. doi.org/10.21676/2389783X.1466
14. Aristizábal Escobar A, Bedoya Gallego JM, Orrego Jiménez JF, Ortiz Polanco S, Gómez R. Creencias, Hábitos y Estado de salud oral en estudiantes de una institución educativa en la ciudad de Pereira en el 2014. Revista CES Salud Pública. 2015; 6(2):131-137.
15. Barnetche MM, Cornejo LS. El componente bucal en las representaciones del proceso salud-enfermedad-atención construidas por jóvenes en situación de encierrode la ciudad de Córdoba, Argentina. Odontoestomatología. 2019;21(33):14–27. doi:10.22592/ode2019n33a3.
16. Barnetche MM, Cornejo LS. Experiencia de caries y calidad de vida de jóvenes en situación de encierro. Rev Sal Públ. 2016;18(5): 816-826.
17. Olave-Müller P, Fajreldin V, Coronado-Vigueras L, López-Contreras N, Valenzuela María Teresa. Necesidades, Creencias y Prácticas en Salud Oral de Padres y Cuidadores de Preescolares: Un Enfoque Cualitativo. Int J Odontostomat. 2021;15(4): 888-897.
18. Rotemberg E, Salveraglio I, Piovesán S, Almaráz MT, Ferreira B, Smaisik K, Mazzuco MC. Percepción del estado de salud bucal de adolescentes y adultos jóvenes en tratamiento por drogodependencia. Odontoestomatología. 2020; 22(36): 44-54. doi.org/10.22592/ode2020n36a6.
19. Rengifo Reina HA, Muñoz Ordóñez LM. Creencias, conocimientos y prácticas de madres respecto a la salud bucal en Popayán, Colombia. Universitas Odontologica. 2019; 38(80):1-28. doi:10.11144/Javeriana.uo38-80.ccpm.
20. Padilla Loredo S, Cerón Argüelles J, Valles M, Navarro J, Esteban M, Iñiguez L, et al. Técnicas cualitativas de Investigación social. Reflexión metodológica y práctica profesional. Reflexión Metod y Práctica Prof. 2003;53(5):1–9.
21. Contreras-Ramírez R, Davis-Toledo G, Nuñez-Franz L. Patient satisfaction and quality of emergency dental care in Chilean public health services. J Oral Res. 2018;7(6):176–83. doi.org/10.17126/joralres.2018.057
22. Humeres-Flores P, Guzmán-Orellana D, Madrid-Canales C, Fredes-Ziliani A, Mustakis-Truffello A. Cuidado de la salud oral en la primera infancia: La perspectiva de sus madres-un estudio cualitativo. Int J Interdiscip Dent. 2020; 13(2): 62-66.
23. Strauss Al, Corbin J. Bases de la investigación cualitativa: Técnicas y procedimientos para desarrollar la teoría fundamentada. Contus. Antioquia U de, editor. Antioquia: Sage Publications; 2002. 354.
24. Gobierno de Chile. Reportes estadísticos comunales 2015. Indicadores comunales de fuentes oficiales. 2015.
25. Herrera CD. Qualitative research and thematic content analysis. Intellectual orientation of Universum journal. Rev Gen Inf y Doc. 2018;28(1):119–42.
26. International Qsr. Desarrollador: Qsr International. 2022.