

Self-Care Applied to Oral Health in the Perception of People with Type 2 Diabetes Mellitus

Autocuidado Aplicado à Saúde Oral na Percepção de Pessoas Com Diabetes Mellitus Tipo 2

Autocuidado Aplicado a la Salud Bucal en la Percepción de Personas con Diabetes Mellitus Tipo 2

RESUMO

Objetivo: Identificar as percepções de pessoas com diabetes mellitus tipo 2 (DM2), cadastradas no programa HIPERDIA de uma Estratégia Saúde da Família, sobre o autocuidado oral. **Método:** Estudo descritivo, qualitativo, com análise de conteúdo de Minayo, realizado por meio de grupo focal, utilizando instrumento de caracterização sociodemográfica e de cuidados em saúde oral e roteiro com questões norteadoras. **Resultados:** Participaram 11 indivíduos com DM2, distribuídos em dois grupos, com predomínio de mulheres (63,6%) e de idosos entre 61 e 70 anos (72,7%). Emergiram duas categorias e três subcategorias. **Discussão:** O autocuidado oral foi compreendido principalmente como escovação diária, em geral três vezes ao dia, uso esporádico de fio dental e enxaguante bucal e escolha de escova de cerdas macias devido ao sangramento gengival. **Conclusão:** O estudo permitiu apreender percepções, significados, crenças, facilidades, desafios e potencialidades relacionadas ao autocuidado oral sob a ótica de pessoas com DM2.

DESCRIPTORIOS: Autocuidado. Diabetes Mellitus tipo 2. Saúde Bucal. Atenção primária à Saúde. Pesquisa qualitativa.

ABSTRACT

Objective: To identify the perceptions of people with type 2 diabetes mellitus (T2DM), registered in the HIPERDIA program of a Family Health Strategy, regarding oral self-care. **Method:** Descriptive, qualitative study, using Minayo's content analysis, conducted through a focus group. A structured instrument was used to characterize sociodemographic profile and oral health care, along with a script of guiding questions for the focus group. **Results:** Eleven individuals with T2DM participated, distributed into two groups, with a predominance of women (63.6%) and older adults aged 61 to 70 years (72.7%). Two categories and three subcategories emerged. **Discussion:** Oral self-care was mainly understood as daily toothbrushing, generally three times a day, occasional use of dental floss and mouthwash, and preference for soft-bristled toothbrushes due to gingival bleeding. **Conclusion:** The study enabled the understanding of perceptions, meanings, beliefs, facilitators, challenges, and potentialities related to oral self-care from the perspective of people with T2DM.

DESCRIPTORS: Self-care. Type 2 diabetes mellitus. Oral health. Primary health care. Qualitative research.

RESUMEN

Objetivo: Identificar las percepciones de personas con diabetes mellitus tipo 2 (DM2), registradas en el programa HIPERDIA de una Estrategia de Salud de la Familia, sobre el autocuidado oral. **Método:** Estudio descriptivo, cualitativo, con análisis de contenido de Minayo, realizado mediante grupo focal. Se utilizó un instrumento para la caracterización del perfil sociodemográfico y de los cuidados en salud bucal, además de un guion con preguntas orientadoras para el grupo focal. **Resultados:** Participaron 11 individuos con DM2, distribuidos en dos grupos, con predominio de mujeres (63,6%) y de personas mayores entre 61 y 70 años (72,7%). Emergieron dos categorías y tres subcategorías. **Discusión:** El autocuidado oral fue comprendido principalmente como el cepillado diario, en general tres veces al día, uso esporádico de hilo dental y enjuague bucal, y elección de cepillo dental de cerdas suaves debido al sangrado gengival. **Conclusión:** El estudio permitió comprender percepciones, significados, creencias, facilidades, desafíos y potencialidades relacionadas con el autocuidado oral desde la perspectiva de personas con DM2.

DESCRIPTORIOS: Autocuidado. Diabetes mellitus tipo 2. Salud bucal. Atención primaria de la salud. Investigación cualitativa.

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INTRODUCTION

Diabetes mellitus (DM) is one of the most common metabolic disorders, characterized by the lack of production or reduction in the secretion of insulin, a hormone produced by the pancreas. Its complications are a major cause of premature mortality in several countries, having caused more than four million deaths in people aged 20 to 79 in 2019¹. DM is classified as type 1 (DM1), resulting from the destruction of insulin-producing beta cells, and type 2 (DM2), characterized by persistent hyperglycemia often associated with insulin resistance in peripheral tissues, accounting for about 90% of cases^{1, 2}.

The increase in the prevalence of DM is related to rapid urbanization, epidemiological transition, nutritional changes, physical inactivity, excess weight, population aging, and longer survival of people with DM2¹. When left untreated, DM causes physiological changes that compromise the inflammatory and immune response, favoring infections, cardiovascular complications, retinopathy, nephropathy, neuropathy, and oral diseases^{1, 3, 4}. With proper treatment and lifestyle changes, it is possible to prevent or delay such outcomes^{5, 7}.

Estimates from the International Diabetes Federation indicate that in 2019, approximately 463 million adults were living with DM, with a

projection of 700 million by 2045, 79% of whom are in developing countries^{1, 6}. In Brazil, an estimated 15.7 million people will have DM in 2021⁶. This high prevalence reinforces the need for person-centered strategies aimed at strengthening self-care³. DM poses a significant challenge for individuals, families, society, and health systems due to its impact on quality of life, disabilities, loss of productivity, and chronic complications². Due to its prolonged and generally irreversible clinical course, it requires permanent and comprehensive care in the Unified Health System (SUS)^{7, 8}.

People with DM2 are at greater risk of oral health problems and early-onset periodontal diseases due to increased salivary glucose, hyposalivation, ischemic changes in pulp tissue, and increased production of inflammatory mediators, associated with poor oral hygiene habits and prolonged lack of glycemic control^{8, 9}. In addition to chronic complications such as renal failure, amputations, blindness, and cardiovascular disease, they may develop oral disorders and an increased risk of oral cancer^{10, 11}, as well as changes in the salivary glands that contribute to halitosis, fissured tongue, caries, peri-implantitis, delayed healing, and difficulties in maintaining prostheses^{3, 4, 9}.

Historically, oral health practices have been concentrated in private clinics, focusing on surgical proce-

dures and the use of dental equipment^{11, 12}. Although the International Conference on Primary Health Care (1978) already included oral health among its priority actions, for a long time public policies were limited and centered on mutilating procedures such as tooth extractions^{12, 13}.

Given this context, it is essential to understand the oral health habits and practices, values, and perceptions of people with DM2 in relation to the disease, treatment, and self-care applied to oral health. Thus, we asked: what is the perception of people with DM2 in relation to oral self-care? What does oral self-care mean to these people? What beliefs exist about oral complications resulting from non-treatment? What difficulties and potentialities are perceived in oral self-care? Based on these questions, this study was proposed from the perspective of people with DM2, aiming to support the planning of educational actions in primary care for the promotion of oral health, prevention of complications, and strengthening of self-care.

METHOD

This is a descriptive study with a qualitative approach. The descriptive study was chosen to describe the characteristics of a population or phenomena(15) (Gil, 2002). The present study was developed in an ESF located in a matrix health unit in the urban

area of a municipality in the Triângulo Mineiro region.

The inclusion criteria were: people with DM2 in the area covered by the aforementioned ESF; age 18 years or older; registration in the HIPERDIA Program; and being monitored by a Community Health Agent (ACS).

Data collection began with the researcher obtaining access to the HIPERDIA records, verifying information about potential participants with DM2. After telephone invitations, face-to-face meetings were held at a health unit using the focus group technique. An instrument was used to characterize the sociodemographic profile and oral health care, and a script with guiding questions for the focus group was used.

Both instruments were submitted for appearance and content validation by three experts in the subject and/or research methodology, upon signing the Free and Informed Consent Form (FICF) for validators.

The researcher, as moderator, applied validated instruments, promoting comfortable and rich interactions. The collection involved two groups, recorded on audio, and the field diary complemented the nuances not captured in the transcripts, highlighting the importance of an adequate number of participants to facilitate the collection process.

The researcher conducted two focus groups in March 2023, recording and transcribing discussions on oral self-care in people with DM2. Names were replaced with fictitious ones to preserve identity (Aparecida, Bruno, Claudia, Diolina, Esmeralda, Fátima, George, Helena, Ilma, Jurandir, and Kleber). The content analysis, following¹³, involved pre-analysis, exploration of the material, and treatment of the results, highlighting the importance of the theoretical framework on oral health self-care for people with DM2. The first focus group took place on March 9, 2023, at 8:00

a.m., lasted 70 minutes, and had six participants. The second focus group took place on March 23, 2023, began at 8 a.m., lasted 50 minutes, and had five participants.

This study was approved by the Research Ethics Committee (CEP) of a university in the Triângulo Mineiro region, under registration number CAAE 66720823.3.0000.5154. All participants signed the Free and Informed Consent Form.

RESULTS

According to the inclusion criteria, there were 66 people with DM2. However, 16 were institutionalized, three had communication problems (deafness), and two were bedridden. In an attempt to contact the remaining 45 people with DM2, five were not found after three attempts to schedule an appointment.

Of the 40 people with DM2 contacted, 19 were not interested in participating. The study would therefore include 21 people with DM2 as participants. However, 10 missed the previously scheduled meeting. Thus, there were 11 participants with DM2, six in the first group and five in the second. The focus group was scheduled immediately after the HIPERDIA group activities, and it is believed that the absence of some of the people with DM2 from both groups was due to the fact that those who were absent did not need to change their medical prescriptions at that time. This is because the renewal of medical prescriptions for people with DM2 in this ESF occurs after participation in the HIPERDIA group.

There was a predominance of participants in the 61-70 age group (72.7%) and female participants (63.6%). Regarding the profile of oral health care, participants with DM2 were characterized according to daily tooth brushing, flossing, number of times flossing, use of toothpicks,

mouthwash, number of times using mouthwash, use of dental prostheses, and type of dental prostheses.

There was a predominance of brushing teeth three times a day (63.6%) and flossing (54.5%), with two participants (33.3%) indicating that they floss twice a day and another two (33.3%) who did not indicate the frequency. Most do not use toothpicks (90.9%) and do not rinse their mouths with mouthwash (72.7%). Among those who use mouthwash, only one (33.3%) does so once a day. Six participants with DM2 use dentures (54.5%). Three of them (50%) use upper full dentures (UFD) and lower full dentures (LFD); two (33.3%) use only UFD; and one (16.7%) has a removable partial denture (RPD).

The perceptions, meanings, beliefs, difficulties, and potentialities in oral self-care for people with DM2 participating in this study were analyzed below.

THEMATIC CATEGORIES

Two categories and three subcategories emerged regarding the perceptions of people with DM2 registered in the HIPERDIA program of an ESF in relation to oral self-care, as shown in Table 1.

Table 1- Categories and subcategories that emerged from the interviews through Thematic Content Analysis. Uberaba-MG, 2023.

CATEGORIES	SUBCATEGORIES
Self-care applied to the oral health of people with DM2 in actions with and without the support of a health professional	Oral self-care such as brushing, flossing, mouthwash, and toothbrush choice by people with DM2
	Oral self-care in dental care for people with DM2
	Oral self-care as a search for health information by people with DM2

Experiences of people with DM2: a broader view of oral self-care

Source: Research data, 2025.

Regarding the first category, **“Self-care applied to the oral health of people with DM2 in actions with and without the support of a health professional,”** self-care is understood as the actions that people with DM2 reported applying to oral health, with or without the support of a dentist.

“Oh, I use it early in the morning, brush my teeth after lunch. In the afternoon, sometimes I don’t, because I go out, right? After lunch I already brushed, at dinner and at night. I use dental floss, I’ve never used toothpicks, I don’t like them.” (Fatima, 2023).

“(…) it bled a lot, you know? (…). I tried to treat it and stuff, but they told me to do it that way. Then after I went to the dentist, she said: You’ll have to have it pulled. Then pull everything out and put in dentures.” (Jurandir, 2023).

The first subcategory, **“Oral self-care such as brushing, flossing, mouthwash, and toothbrush choice by people with DM2,”** discusses what constitutes the meaning of oral self-care for people with DM2 without the support of a dentist.

During the focus group, statements emerged in which oral self-care is per-

ceived by people with DM2 as daily brushing, predominantly three times a day, regardless of whether or not they use dentures; sporadic use of dental floss and mouthwash; and the choice of a toothbrush with soft bristles due to bleeding gums. The use of toothpicks was denied by some participants who made a point of mentioning it.

“(…) I floss and… brush and… first I floss, then I brush, then I use mouthwash. Yes, but I always use it after lunch and after dinner. And if I eat something outside of those times that leaves some debris, I use it to remove it because it bothers me, right?” (Ilma, 2023).

The second subcategory, **“Oral self-care in dental care for people with DM2,”** demonstrates the meaning of oral self-care for people with DM2 with the support of a dentist, through factors related to the frequency of seeking dental care, facilities, procedures performed, and suggestions for improving the service.

Regarding the demand for dental care, statements emerged related to previous experience and fear and anxiety about procedures, difficulty in scheduling appointments, and the pandemic, as justifications for the frequency of self-care with the support of a dentist:

“I’m 80 years old, so I’ve been to

so many dentists, right? And there’s a certain fear. Unfortunately, the dentist’s job is to have us sit in a dental office and then the professional starts pouring the tools out there on the side. What are they going to do to you? It’s pliers, it’s a knife, it’s a needle (laughter in the background). And another observation, when they’re going to administer anesthesia, they come up to the patient’s face and do this [demonstrates with his hands] until the first drop comes out: Open your mouth. It’s a joke, man!” (Bruno, 2023).

Some participants mentioned facilities for seeking oral self-care with the dentist, such as health insurance and the dentist’s way of providing care with an expanded view:

“Of everyone here, I am 80 years old (…). Right? I have health insurance from the barracks that gives me this possibility (…).” (Bruno, 2023).

“Yeah. That’s right, in my day, uh, many years ago when I had treatment, it was cool, you’d get to the dentist and she’d look, it wasn’t just a no. Now you get there, look here (…). No (stutters) so, she didn’t, she would come and do four, five fillings and look, clean, no, everything’s fine. Today it has changed a lot (…).” (Diolina, 2023).

Comments emerged about various procedures, such as counseling, extraction, implants, root canal treatment, and cleaning:

“(…) I also had an implant, I’m diabetic. I had an implant. And they demanded to see if my diabetes was under control (…). This dentist I go to a lot. I’m having treatment there, the prosthesis with her. Whenever I wanted to extract my teeth, because it was

cheaper (...). When I was going to have root canal treatment. Then she took it, she always wanted to know exactly (emphasizes) how my diabetes was, because otherwise she couldn't do it. So that means something had to do with it, right? (...)." (Esmeralda, 2023).

To practice oral self-care with the support of a dentist, the following suggestions were made:

"I also think that today, the receptionists should be attentive when answering the phone and we should be able to make appointments by phone. Because almost all of us who have diabetes are in a lot of pain and have serious problems, you know?" (George, 2023).

"Yes. I think the following, in my view. If it were the same, just like this group here, a... you come, right away, just like [name of a dentist] does, the other [name of another dentist] there does, she refers you to another one right away." (Kleber, 2023).

In the third subcategory, **"Oral self-care as a search for health information by people with DM2,"** the meaning of oral self-care is defined as the search for health information by people with DM2, in addition to the source and information received about DM2 and oral health.

Participants reported seeking information about DM2 and self-care on television, the internet, and from health professionals such as dentists, doctors, and nurses from the ESF.

"(...) but I also check YouTube, right? So we look for more information there, but it's more about that, not about dental advice. Dentists give that, right?" (Aparecida, 2023).

"In my case, the dentist himself (...). It's information that I read a lot about, but tell me that diabetes can cause oral problems, no. I didn't know that either." (Claudia, 2023).

The participants reported seeking information about health, DM2, and self-care, but they did not have access to information about oral self-care for people with DM2. In other words, they did not have knowledge about the specificities of oral health for people with DM2.

"I'll tell you, it's a surprise! No one ever said anything to me about diabetes and the mouth. No one. I've never seen anything on the radio, television, or in the newspaper. No dentist ever told me. Not even the doctor, who is an endocrinologist (laughs), who treats diabetes, ever told me." (Bruno, 2023).

The second category, **"Experiences of people with DM2: a broader look at oral self-care,"** covered the experiences, beliefs, and perceptions of participants in discovering their DM2 diagnosis, seeking health professionals, and changing their self-care habits.

The participants' discovery of their DM2 diagnosis occurred based on signs and symptoms that required immediate intervention and was, for many, desperate:

"I got up early for work and started having cramps, sweating, drinking water, and going to the bathroom all the time. And then I started feeling really, really bad. So I said, 'Guys, I'm dying'" (Diolina, 2023).

"Yeah. You get dizzy, and you think it's a maze, but it's not." (Kleber, 2023).

Faced with a diagnosis of DM2,

they sought out different health professionals who provided guidance:

"From what we understand, I went to the endocrinologist, and he just said to me: 'You are prediabetic. Why, doctor? Because you're over 100, you're at 110, you're going to have to take medication. But he didn't tell me anything else, right? (...). But he didn't tell us who is (stutters) prediabetic, he doesn't say anything, just use this, that's it, and that's the end of it (laughs)." (Aparecida, 2023).

(...). When I was diagnosed with diabetes, I remember coming here to the clinic (...). I thought I was going to die, right? I was sentenced to death. I had diabetes! The first endocrinologist I went to (...) said: No, I'll prescribe you Glifage to take at lunch and dinner. And he already had a piece of paper ready (...) about three pages, saying what I could eat (...). Five spoonfuls of rice, five spoonfuls of rice, such and such (...). And when you finish the Glifage, come back here and I'll give you another prescription and that's it (...). He didn't say I was going to go blind, or that they were going to amputate my leg, that my hair was going to fall out (laughter in the background), that I was going to get prostate cancer (...). No, he didn't say anything. No, I came here [to the health center] (...). The nurse said: No, you're not going to die, diabetes is (...). (Bruno, 2023).

Participants diagnosed with DM2, after receiving health guidance, made changes in self-care through medical follow-up, medication use, smoking cessation, and even nail care.

"One medicine I use is Glifage (...). So I only use one." (Aparecida, 2023).

"I take two, two tablets (...). Two, uh, Glifage." (Bruno, 2023).

Taking a broader view of people with DM2, it is clear that their experiences and beliefs as a whole are decisive factors in self-care applied to oral health.

Thus, based on the statements cited, it is possible to understand some of the difficulties mentioned by the participants due to DM2 in performing self-care applied to oral health, such as pain, neuropathy, and transportation difficulties:

"That's right. I have a problem with walking. I've even had to be taken out of the bus by ambulance. Because there are days when I can't get on the bus because of problems with my legs and hands. Because I don't have the strength in my hands to hold on. They stop in the middle of the street and you have to grab those bars and pull yourself into the bus (...). Because of the neuropathy, some days I have it, some days I don't, some days I have less strength. Like today, I have less strength. Then, oh, my hand won't do it (...). So, I got on the bus, forcing myself, my leg locked up and, pain, pain, I fell, I fell sitting inside the bus." (Ilma, 2023).

DISCUSSION

We analyzed the perceptions, meanings, beliefs, difficulties, and potentialities in oral self-care of people with DM2 from their own perspective, as well as their sociodemographic profile and oral health care. We chose to discuss the most frequent data, without disregarding the relevance of the others. There was a predominance of people aged 61 to 70 (72.7%), female (63.6%), with elementary school education (72.7%), unemployed (90.9%), and with an individual income of one minimum wage (45.4%), a profile similar to that described in national and international studies,

which point to a higher occurrence of DM2 in elderly women with low education and low income¹⁴⁻¹⁸. It is worth noting the scarcity of publications that specifically address self-care for people with DM2 as applied to oral health.

Two categories emerged regarding the perceptions of people with DM2 registered in HIPERDIA of an ESF on oral self-care. In the first, "self-care applied to the oral health of people with DM2 in actions with and without the support of a health professional," self-care is understood as actions with or without the support of a dentist: brushing, use of mouthwash and dental floss, choice of toothbrush, seeking dental care, and seeking health information about DM2. The subcategory "oral self-care such as brushing, flossing, mouthwash, and toothbrush choice" gathered statements about daily brushing, regardless of the use of prostheses, flossing and mouthwash use, and choosing a soft-bristled toothbrush in the face of gingival bleeding.

In the characterization instrument, brushing three times a day (63.6%), flossing (54.5%), low use of toothpicks (90.9%), and mouthwash (72.7%) predominated. Six participants wore dentures (54.5%). The statements confirmed these hygiene practices and the preference for soft toothbrushes due to gingival bleeding. These findings are similar to the literature, which defines oral self-care as individual actions without direct support from the dentist, focused on hygiene, prevention of gum disease and cancer, through brushing, toothpaste, flossing, and toothbrush maintenance¹⁹. These practices reduce biofilm and preserve periodontal tissues and should be incorporated into one's lifestyle^{10,11}.

The statements also showed that, for the participants, self-care involves actions supported by dentists and seeking health information. In

the subcategory "oral self-care in dental care for people with DM2," they reported fear and anxiety about procedures, difficulty scheduling appointments, and the impact of the pandemic, justifying the low frequency of visits. As facilitators, they mentioned having health insurance and being treated by a dentist with a broader perspective. Procedures such as counseling, extraction, implants, root canal treatment, and cleaning were mentioned, as well as suggestions for improving the service, such as scheduling by phone and coordination between dentists for referrals.

Fear and anxiety about dental care, associated with negative experiences, insecurity about procedures and instruments, vulnerability during therapy, third-party reports, and the professional's attitude are widely documented and result in abstention from consultations and worsening oral health^{21,22}. In this study, these factors were reported and were related to lower demand for care. On the other hand, care with a broader perspective and coordination between dentists for referrals were mentioned as facilitators and suggestions for improvement, with the potential to increase demand for appointments.

The role of the dentist as an oral health educator, responsible for guiding care according to the WHO, stands out. Regular visits to the dentist are part of self-care and should include educational activities²³. The difficulty of scheduling appointments was also pointed out as a barrier, with the suggestion of scheduling by telephone, given the difficulties of mobility and dependence on family members, in addition to pain, neuropathy, and discomfort. Growing demand and difficult access to some SUS services reinforce inequalities and the need for improvements, especially since older adults are the ones who seek medical care the most and have the least immediate access to dental

care^{22,24}.

A study with dentists and oral health professionals shows that, although they recognize the need for systematic monitoring of people with DM2, care often occurs only when the user spontaneously seeks the service or is referred by other professionals^{23,26}. Since the inclusion of oral health teams in the ESF in 2000, the curative model has been replaced by a model aligned with the principles of the SUS; however, high demand, difficulties in establishing links, and gaps in training still hinder its effective consolidation^{24,26}. The actions of dentists in the ESF include training the team, collective activities, feeding information systems, reception, home visits, educational activities in schools, and comprehensive oral health care^{24,26}.

According to the Primary Care Pact (2006), the first scheduled dental appointment aims at diagnosis and a preventive-therapeutic plan; however, there was a drop in funding for this appointment and endodontic treatments between 2011 and 2018, highlighting weaknesses in primary and specialized care. Although a preventive approach that strengthens the autonomy of people with DM2 and facilitates adherence to self-care is recommended, the findings of this study show difficulties that contradict this ideal^{1-4,11,12}. The difficulty of access to the SUS, reported by the participants, contrasts with the possibility of using dental insurance plans, which appeared to be a facilitator. The reduction of the role of the State in the provision of services and the strengthening of private interests have contributed to the expansion of the private oral health market^{26,28}.

Another meaning of oral self-care identified was the search for health information, present in the subcategory "oral self-care as a search for health information by people with DM2." Participants reported seeking

information about DM2 and self-care on television, the internet, and from health professionals, but reported being unaware of the specifics of oral health in DM2 and not having received guidance from professionals on this aspect. This finding corroborates studies that point to a lack of knowledge about oral complications in people with DM2³⁻⁶. In endocrinology clinics, for example, the main sources of information were multidisciplinary teams, television, doctors, newspapers, the internet, family, and friends^{12,13}. In this study, there was no clear mention of multidisciplinary teams as a structured source of information, but rather of individual professionals and, above all, the media, reinforcing the importance of interprofessional practice in the FHS.

The literature on self-care in DM2 and multidisciplinary work often focuses on topics such as medication use, foot care, blood glucose monitoring, physical activity, general nutrition, and smoking, with little or no mention of oral health^{3,5,7,15}. A study in a province of Cuba (2019–2020) identified low levels of knowledge, unfavorable attitudes, and inadequate oral health practices among people with DM²⁰. Health practices in the FHS, which are often fragmented and focused on medical consultations, may restrict nurses' activities to renewing prescriptions for antidiabetic drugs, without broader listening or a comprehensive approach¹⁵.

Given this, there is a need for an interprofessional approach with the effective inclusion of dentists, so that professionals work together, focusing on the person and not on isolated actions by category. This broader view is particularly important for people with DM2, considering their specific oral health needs. Health education and policies aimed at changing lifestyle habits are fundamental to promoting self-care and quality of life^{15,17,19}. The statements about seek-

ing information show that interprofessional educational actions in the FHS have the potential to improve the oral health and quality of life of people with DM2.

The second category, "experiences of people with DM2: a broader view of oral self-care," although it does not contain statements strictly focused on oral self-care, brings together important meanings that, from a holistic view, have an impact on this care. The discovery of DM2 after serious signs and symptoms (urgency, amputation, vertigo) generated fear of death and complications, followed by a search for endocrinologists, ophthalmologists, and nurses from the ESF. In some cases, medications and predefined diets were prescribed, but with little listening and clarification of doubts.

DM, often silent, may remain undiagnosed in about 50% of the population. The diagnosis of DM2 interferes with life and relationships, and can trigger denial and difficulty in adopting healthy habits^{12,13}. In the elderly, a chronic disease impacts autonomy, self-care, and social dynamics, requiring lifestyle adjustments¹³. In this study, participants reported changes in self-care, such as daily use of oral antidiabetic drugs, smoking cessation, follow-up with specialists, and specific care (such as not removing cuticles), but were unaware of the importance and particularities of oral health in DM2.

Studies indicate low adherence to self-care in DM2 and even less knowledge about oral self-care, which is often absent from the guidance received^{6,7,13}. It is up to PHC to develop person-centered interprofessional strategies to strengthen autonomy, facilitate access, and promote understanding and application of the health care necessary for each individual's reality². This reinforces the potential of health education in the FHS, including oral health, and the role of the

dentist as an educator.

CONCLUSION

This study identified, from the perspective of people with DM2, perceptions, meanings, beliefs, facilities, challenges, and potentialities related to oral self-care, synthesized into two categories and three sub-categories. Oral self-care was understood as actions performed with or without the support of the dentist, involving daily oral hygiene, choice of

toothbrush, seeking dental care, and seeking health information, although barriers such as fear, previous negative experiences, insecurity, and difficulty of access persist. Experiences after the diagnosis of DM2 had an impact on autonomy, self-care, and social dynamics, requiring lifestyle adjustments.

The expansion of knowledge about the relationship between DM2 and oral health, the facilitation of access to dental care, and interprofessional educational actions in the FHS, with

a focus on prevention and health promotion, stand out as potentialities for strengthening autonomy. As limitations, we highlight the fact that the study was conducted in a single FHS, over a short period, and in the face of a scarcity of studies on the topic. Further research on self-care applied to oral health in people with DM2 is recommended. Other studies on self-care applied to oral health, especially involving people with DM2, are sug-

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