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Thaís Gioda Noronha

EFEITO MODERADOR DO SENSO DE COERÊNCIA NA RELAÇÃO ENTRE PERCEPÇÃO DE DISCRIMINAÇÃO RACIAL E QUALIDADE DE VIDA RELACIONADA À SAÚDE BUCAL DE ESCOLARES

Santa Maria, RS
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Dissertação apresentada ao Curso de Mestrado do Programa de Pós-Graduação em Ciências Odontológicas, Área de Concentração em Odontologia, ênfase em Odontopediatria, da Universidade Federal de Santa Maria (UFSM, RS), para a obtenção do grau de **Mestre em Ciências Odontológicas.**

Orientadora: Profª. Drª. Fernanda Tomazoni
Co-orientador: Prof. Dr. Thiago Machado Ardenghi

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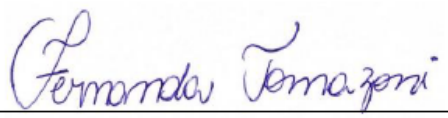

Fernanda Tomazoni, Drª, UFSM
(Presidente/Orientadora)

Marília Leão Goettems, Drª. (UFPel)

Jessye Melgarejo do Amaral Giordani, Dr. (UFSM)

Santa Maria, RS
2021

DEDICATÓRIA

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RESUMO

EFEITO MODERADOR DO SENSO DE COERÊNCIA NA RELAÇÃO ENTRE PERCEPÇÃO DE DISCRIMINAÇÃO RACIAL E QUALIDADE DE VIDA RELACIONADA À SAÚDE BUCAL DE ESCOLARES

AUTORA: Thaís Gioda Noronha
ORIENTADORA: Fernanda Tomazoni
CO-ORIENTADOR: Thiago Machado Ardenghi

A discriminação racial pode atuar como um estressor psicossocial que fundamenta as desigualdades raciais em saúde bucal. A percepção de eventos discriminatórios pode começar na infância e refletir na adolescência e vida adulta e, através de diferentes privações sociais, pode influenciar na qualidade de vida dos indivíduos. A qualidade de vida relacionada à saúde bucal (QVRSB) se refere ao quanto as condições de saúde bucal interferem na vida cotidiana e no bem-estar das pessoas. Muitos estudos têm avaliado os determinantes clínicos, socioeconômicos, sociais e ambientais que possivelmente melhorariam a saúde bucal de indivíduos e populações e entre esses determinantes está o senso de coerência (SDC). O SDC é utilizado para explicar por que algumas pessoas continuam bem apesar das situações de estresse que enfrentam. Dessa forma, considerando que a discriminação racial envolve situações estressantes que impactam na percepção de saúde bucal, o objetivo desse estudo foi avaliar o efeito moderador do SDC na relação entre discriminação racial e QVRSB em escolares. Esse é um estudo transversal aninhado em uma coorte com 10 anos de acompanhamento. A QVRSB foi avaliada usando a versão brasileira reduzida do *Child Perception Questionnaire* (CPQ11-14). A percepção da discriminação racial foi avaliada por meio de uma questão contida no Questionário de Bullying de *Olweus* - Vítima e para medir o senso de coerência, os alunos responderam à versão reduzida da Escala de Senso de Coerência de 13 itens (SOC-13). Dados relacionados a sexo, idade, cor da pele, condições socioeconômicas e cárie dentária também foram mensurados como covariáveis. Os dados foram analisados através da análise de regressão de Poisson, a fim de testar o efeito moderador do SDC na relação entre discriminação racial e QVRSB. Os resultados são apresentados em Razão de Médias (RM) e intervalo de confiança de 95% (95% IC). Um total de 429 escolares foi considerado neste estudo. A média de idade foi de 12,5 (erro padrão 0,1) anos. Considerando as variáveis preditoras separadamente, os indivíduos que perceberam discriminação racial apresentaram pior QVRSB (RM 1,38; IC95% 1,25-1,52); e indivíduos com maior SDC apresentaram melhor QVRSB (RM 0,54 IC 95% 0,51-0,57). No modelo ajustado, considerando a interação entre discriminação racial e SDC, escolares que perceberam discriminação racial, mas apresentavam alto SDC, relataram menor impacto sobre QVRSB (RR 0,70; IC 95% 0,55-0,89) em comparação com àqueles com baixo SDC. Com isso, o SDC pode ser considerado uma variável moderadora na relação entre discriminação racial e QVRSB. Esses resultados destacam a potencial importância do senso de coerência na redução dos efeitos nocivos da discriminação racial na QVRSB.

Palavras-chave: Discriminação racial. Senso de coerência. Qualidade de vida. Saúde bucal.

ABSTRACT

MODERATING EFFECT OF THE SENSE OF COHERENCE IN THE RELATIONSHIP BETWEEN PERCEIVED RACIAL DISCRIMINATION AND ORAL HEALTH-RELATED QUALITY OF LIFE IN SCHOLARS

AUTHOR: Thaís Gioda Noronha
ADVISOR: Fernanda Tomazoni
CO-ADVISOR: Thiago Machado Ardenghi

Racial discrimination can act as a psychosocial stressor that underlies racial inequalities in oral health. Perception of discriminatory events can start in childhood and reflect in adolescence and adulthood and, through different social deprivations, can influence the individuals´ quality of life. The oral health-related quality of life (OHRQoL) refers to how much oral health conditions interfere with people´s daily life and well-being. Many epidemiological studies have evaluated the clinical, socioeconomic, social and environmental determinants that could possibly improve the oral health of individuals and populations, and among these determinants is the sense of coherence (SOC). The SOC is used to explain why some people continue to do well despite the stressful situations they face. Thus, considering that racial discrimination brings on stressful situations that impact on oral health perception, the aim of this study was to evaluate the moderating effect of SOC on the relationship between racial discrimination and OHRQoL in schoolchildren. This is a cross-sectional study nested in a cohort with 10 years of follow-up. OHRQoL was assessed using the reduced Brazilian version of the Child Perception Questionnaire (CPQ11-14). Perceived racial discrimination was assessed using a question contained in the Olweus Bullying Questionnaire – Victim, and to measure the sense of coherence, students answered the reduced version of the 13-item Sense of Coherence Scale (SOC-13). Data related to sex, age, skin color and socioeconomic conditions were also assessed. Poisson regression analysis was performed to test the moderating effect of SOC on the relationship between racial discrimination and OHRQoL. A total of 429 students were considered in this study. Considering the predictor variables separately, individuals who perceived racial discrimination had worse OHRQoL (RR 1.38; 95%CI 1.25-1.52); and individuals with higher SOC had better OHRQoL (RR 0.54 95%CI 0.51-0.57) than their counterparts. In the adjusted model, considering the interaction among racial discrimination and SOC, students who perceived racial discrimination, but had high SOC, reported less impact on OHRQoL (RR 0.70; 95% CI 0.55-0.89) than those with low SDC. Thus, the SOC can be considered a moderating variable in the relationship between racial discrimination and OHRQoL. These results highlight the potential importance of SOC in reducing the harmful effects of racial discrimination on OHRQoL.

Keywords: Racial discrimination. Sense of coherence. Quality of life. Oral health.

SUMÁRIO

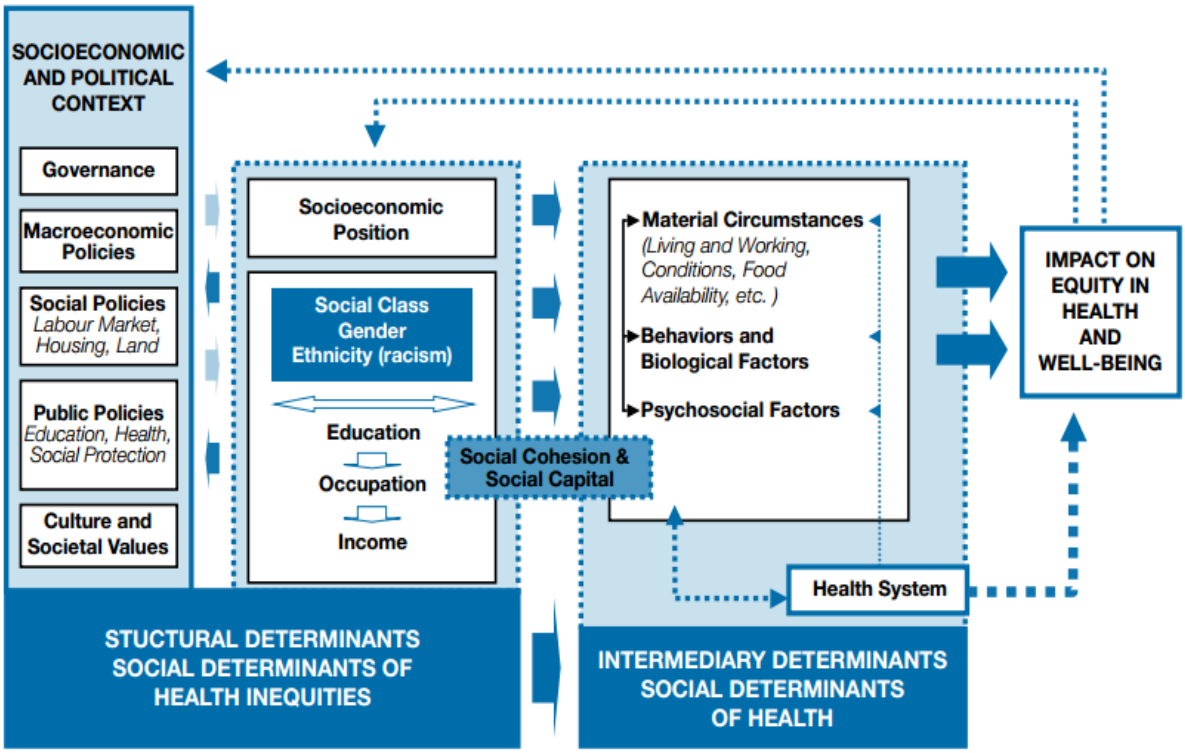
1 INTRODUÇÃO

Durante muito tempo, as doenças que acometem a saúde bucal foram reduzidas a processos exclusivamente orgânicos e comportamentais (WATT, 2007). A concepção ampliada de saúde, em contraponto ao mecanicismo do modelo biomédico vigente, entende que os determinantes sociais, culturais, econômicos, políticos e a disponibilidade/acesso aos serviços se manifestam no corpo biológico e, dessa forma, modificam o processo saúde/doença (MARCENES, 2013; KASSEBAUM, 2015; SOLAR, 2010; WILLIAMS, 2011). Assim, fatores comportamentais, socioeconômicos, psicossociais e contextuais podem atuar como determinantes na etiopatogenia destas doenças.

Alguns modelos teóricos foram desenvolvidos para a melhor compreensão da relação existente entre os fatores individuais e contextuais e os desfechos em saúde (DAHLGREN; WHITEHEAD, 1991; CSDH, 2007). O primeiro modelo proposto foi o de Dahlgren e Whitehead (1991), que sugere a existência de uma rede de relações entre fatores em diferentes níveis, demonstrando que características individuais são influenciadas pelas redes sociais e estas afetadas por condições socioeconômicas, culturais e ambientais nas quais os indivíduos se estabelecem. (DAHLGREN, WHITEHEAD, 1991). Posteriormente entrou em evidência o modelo proposto pela Comissão dos Determinantes Sociais de Saúde (Figura 1), o qual se diferencia por acrescentar características que se relacionam ao contexto político e socioeconômico em que as pessoas se inserem. Esse modelo também incluiu um novo componente transversal, que representa o capital social e a coesão social (CSDH, 2007).

Ao longo do tempo, houve muitas mudanças na ocorrência das doenças e nos fatores de risco que poderiam estar associados a elas. Mesmo diante dessas mudanças, tem-se observado que a associação entre nível socioeconômico e morbidade/mortalidade se mostra persistente. Dessa maneira, existem evidências de que, de fato, o baixo nível socioeconômico é uma causa fundamental de piores condições de saúde, onde as situações desfavoráveis em relação a riscos e tratamentos se mostram mais frequentes. (LINK, 1995; PHELAN, 2015). Assim, as melhorias nas condições das causas fundamentais das doenças devem fazer parte das políticas de saúde, e envolvem, por exemplo, o salário mínimo, uma habitação para pessoas sem-teto, programas de avanço ou outras iniciativas dessa natureza. (LINK, 1995).

Figura 1 – Modelo conceitual proposto pela Comissão sobre os Determinantes Sociais de Saúde



Fonte: (SOLAR; IRWIN, 2010, p. 6).

Uma característica que tem sido apontada como determinante social e estrutural relacionado a diferentes desfechos de saúde é a raça do indivíduo. A raça, diferente da cor da pele, é um conceito que está relacionado a grupos sociais que compartilham as mesmas características culturais, identidade individual e acesso a recursos. Dessa forma, raça não é apenas uma característica pessoal, mas um conceito socialmente construído (FORD, 2010). Segundo Jary & Jary (2005), no *"Collins Dictionary of Sociology"*, os cientistas sociais atualmente reconhecem que raça é uma categorização construída socialmente que especifica regras para a identificação de um determinado grupo, mas consideram o conceito como um termo cientificamente desacreditado, usado para descrever grupos biologicamente distintos de pessoas que têm características de natureza inalterável. Dessa forma, pode ser considerado preferível referir-se à etnia ou grupos étnicos, principalmente para distanciar essa categorização de suas conotações históricas e biológicas (JARY, 2005).

Disparidades raciais são observadas no mundo inteiro (especialmente na América Latina) e refletem as piores condições socioeconômicas e de saúde para os indivíduos de pele negra (WILLIAMS, 2001; PHELAN, 2015; HUNT, 2015; FRANKS, 2006). No Brasil, o rendimento médio mensal, segundo o IBGE (2010), de homens brancos e amarelos é aproximadamente o dobro do valor relativo encontrado de homens pretos, pardos e indígenas e

os negros correspondem a 72% dos 10% mais pobres da população (IPEA, 2011). Essas disparidades nas condições socioeconômicas, podem ajudar a explicar boa parte das diferenças na distribuição de doenças: Nas mulheres pretas entre 40 e 69 anos de idade, a taxa de mortalidade no Brasil por doenças cerebrovasculares é aproximadamente duas vezes maior do que entre brancas, e a mortalidade por hipertensão e diabetes mellitus é muito mais expressiva entre as mulheres pretas (CHOR, 2005). Atualmente, os estudos que avaliam os resultados de raça/etnia na pandemia da COVID-19 relatam que indivíduos afro-americanos carregam uma carga desproporcional de casos (HOOPER, 2020; YANCY, 2020).

Ao se tratar de saúde bucal, as disparidades em saúde persistem. As pesquisas sobre os seus determinantes sociais são sustentadas por evidências de que as doenças bucais, incluindo a doença periodontal e a cárie dentária, são mais comuns em grupos populacionais em maior desvantagem social (MOIMAZ, 2016; AIDA, 2008; ANTUNES, 2006; BAGGIO, 2015; PERES, 2007, VETTORE, 2013). Além disso, a dor dentária também se apresenta mais prevalente entre adolescentes brasileiros não-brancos (COSTA, 2021). Em um estudo que avaliou a população brasileira entre 35 e 44 anos, foi observado que em comparação a indivíduos brancos, indivíduos pardos apresentaram probabilidade 50% maior de apresentar doença periodontal, enquanto os indivíduos pretos tinham probabilidade 59% maior. (PERES, 2007). Nessa mesma perspectiva, a maioria dos estudos incluídos na revisão sistemática publicada por Boing (2014) encontrou uma incidência mais elevada de cárie dentária entre pretos e pardos (BOING, 2014).

As disparidades raciais encontradas nos diferentes desfechos de saúde bucal são demonstradas também quando se avalia o acesso a serviços de saúde e a indicação de tratamentos odontológicos. No estudo de Cabral (2005), foi possível observar que profissionais da saúde, ainda que inconscientemente, indicam diferentes tratamentos de acordo com a cor da pele do paciente (CABRAL, 2005). O mesmo se observou no estudo de Chisini (2018), em que cirurgiões-dentistas escolheram opções de tratamento menos complexas e mais baratas para pacientes negros, mesmo com total liberdade para decidir a melhor opção de tratamento (CHISINI, 2018). Além disso, também é possível perceber que indivíduos pretos, pardos ou indígenas tem mais dificuldade no acesso aos serviços odontológicos (HERKRATH, 2018).

Embora a literatura tenha documentado importantes e persistentes lacunas raciais na saúde, a maioria dos estudos atribui essas disparidades ao nível socioeconômico dos indivíduos. Entretanto, é possível perceber que em muitas situações, quando o nível socioeconômico é controlado, essa discrepância continua para diferentes desfechos (PHELAN, 2015). Dessa forma, as explicações teóricas das associações entre disparidades raciais e desfechos em saúde

envolvem, além de questões socioeconômicas, fatores psicossociais, comportamentais, culturais e biológicos (MARMOT, 2011; PERREIRA, 2014).

Em estudos prévios que avaliam raça especificamente, pacientes não-brancos apresentaram piores desfechos subjetivos de saúde bucal (SFREDDO, 2019; PIOVESAN, 2010; EMMANUELLI, 2015, HUANG, 2015; ABANTO, 2017). Essa diferença se apresenta não apenas em crianças e adolescentes, mas também é observada em adultos (SOUZA, 2016). Em adição, alguns autores afirmam que a raça pode ter influência na autopercepção da saúde bucal por meio da discriminação e da exposição a um baixo nível socioeconômico, no entanto, a literatura ainda apresenta diversas lacunas acerca desse aspecto (PERREIRA, 2014).

Nesse sentido, alguns autores têm apontado que a discriminação pode atuar como um estressor psicossocial que fundamenta e perpetua as iniquidades em saúde bucal; a distribuição desigual de maus-tratos, ambos dentro e entre os grupos, dá origem não apenas a padrões específicos da saúde bucal, mas também às desigualdades raciais nos desfechos odontológicos (CELESTE, 2013; JAMIESON, 2013; BEM; JAMIESON, 2014; BEM; PARADIES, 2014; LAWRENCE, 2016; FINLAYSON, 2018; JUNIOR, 2020). Ainda que a maioria dos estudos que associam raça e cor da pele a diferentes desfechos de saúde bucal apresentem uma tendência em relação às suas conclusões – que indivíduos não-brancos apresentam piores condições –, a discriminação racial e suas consequências ainda é pouco explorada na literatura odontológica. As poucas evidências disponíveis apontam uma relação entre discriminação racial e condições clínicas e subjetivas de saúde bucal (BASTOS, 2018; SCHUCH, 2020; ALI, 2021; JAMIESON, 2021).

A discriminação, definida como "tratar injustamente", foi vista inicialmente pelos sociólogos como uma expressão do etnocentrismo (SCOTT, 2014). As formas de discriminação internalizadas, interpessoais e estruturais dão origem não apenas a padrões específicos de diferentes desfechos, mas também a desigualdades em saúde (HARNOIS; BASTOS, 2018). A discriminação pode impactar nos desfechos de saúde através das experiências diretas de atos discriminatórios, de uma maior exposição a substâncias tóxicas e a ambientes mais deletérios, e de uma inferior assistência à saúde. (CHOR, 2005; PERREIRA, 2014; KRIEGER, 2005). O estudo de Pascoe e Smart Richman (2009) expõe que as experiências discriminatórias são consideradas imprevisíveis e apresenta os mecanismos causais que ligam essas experiências a comportamentos e condições adversas de saúde geral. Nesse estudo, eles relatam que esses mecanismos podem causar efeitos diretos sobre a saúde (sintomas depressivos, ansiedade e bem-estar), alterações psicofisiológicas (aumento da frequência cardíaca, maior produção de hormônios em resposta ao estresse, etc) ou influenciar comportamentos em saúde (através da

adoção de comportamentos não saudáveis ou menor comprometimento com comportamentos benéficos para a saúde) (PASCOE; RICHMAN, 2009).

A literatura aponta também que alguns grupos raciais e étnicos apresentam riscos maiores de experimentar situações adversas na infância (como a discriminação racial e a violência doméstica) e isso influencia em desfechos de saúde. (KABANI, 2018). Além disso, essas situações adversas são cumulativas ao longo da vida, iniciando na infância, e podem influenciar em desfechos subjetivos, como a qualidade de vida em diferentes estágios de vida. Estudos sobre discriminação em crianças indicam que a exposição a eventos discriminatórios pode começar nessa fase e gerar importantes consequências para a saúde na infância e adolescência, podendo também refletir na vida adulta (COGBURN, 2011; COKER, 2009; PACHTER; COLL, 2009; SANDERS-PHILLIPS, 2009; BRODY, 2014; MATTHEWS, 2005; PRIEST, 2013; ZEIDERS, 2014; LEWIS, 2015).

Uma vez que as privações sociais durante a vida podem levar a um acesso reduzido aos cuidados e a piores hábitos de saúde bucal, também podem influenciar na qualidade de vida dos indivíduos expostos a elas (PERES, 2007). A qualidade de vida envolve uma sensação subjetiva de bem-estar acerca da sua saúde, não se restringindo apenas aos efeitos físicos e psicológicos, mas também a questões fisiológicas, familiares e ambientais (SISCHO; BRODER, 2011). Nesse sentido, é evidente que a saúde bucal não pode ser dissociada da saúde e bem-estar geral, uma vez que uma pior saúde bucal pode impactar em diversos âmbitos da vida dos indivíduos (MCGRATH, 2004).

Assim, um desfecho subjetivo de saúde bucal que vem sendo amplamente avaliado é a qualidade de vida relacionada à saúde bucal (QVRSB). A QVRSB é definida como um constructo multidimensional que se refere à extensão com que as condições de saúde bucal interferem na vida cotidiana e bem-estar dos indivíduos (SISCHO; BRODER, 2011). O modelo proposto por Sischo e Broder reconhece os efeitos de fatores contextuais (por exemplo, fatores socioculturais) e o acesso aos cuidados na percepção da saúde bucal e na qualidade de vida (SISCHO; BRODER, 2011).

Muitos estudos epidemiológicos têm avaliado os determinantes clínicos, socioeconômicos, psicossociais e ambientais que possivelmente melhorariam a QVRSB de indivíduos e populações (SHEIHAM, 2000; WATT, 2007; SCHEERMAN, 2016). Entre esses determinantes, pode-se destacar o senso de coerência (SDC) (BAKER, 2010; LINDSTROM, 2006). O SDC é utilizado para explicar por que algumas pessoas continuam bem, apesar das situações de estresse que elas enfrentam (ANTONOVSKY, 1987). Ele representa o constructo central do modelo da teoria salutogênica, destacando a capacidade de resposta dos indivíduos

a condições estressantes. É considerado um dos fatores mais importantes que determinam a satisfação com a vida e a capacidade de lidar com situações mais complexas (ERIKSSON; LINDSTROM, 2007). Os indivíduos com um alto senso de coerência têm uma capacidade de perceber que consegue gerenciar situações adversas, independente dos acontecimentos da vida e do dia-a-dia, e apresentam melhores desfechos de saúde geral e saúde bucal (LINDSTROM; ERIKSSON 2006; BAKER, 2010; ERIKSSON; LINDSTROM, 2007).

Com base no que foi exposto, pode-se verificar que tanto as experiências autorreferidas de discriminação, quanto o SDC estão associados a condições clínicas e subjetivas de saúde. Diferentes argumentos têm sido propostos para explicar a influência do SDC na saúde. Um deles é que o SDC pode estar associado com atitudes e comportamentos relacionados a melhores condições clínicas e subjetivas (ERIKSSON; LINDSTROM, 2007). Além disso, características psicossociais como o SDC podem influenciar os desfechos subjetivos de saúde, como a QVRSB, através da moderação de condições estressantes e adversas (GUPTA, 2015). Nesse sentido, o SDC é um atributo individual que pode servir como um recurso pelo qual os efeitos negativos da discriminação percebida podem ser reduzidos.

A literatura tem sugerido que estudos futuros se concentrem na identificação de fatores individuais e/ou contextuais que promovam resiliência e atenuem os efeitos da discriminação em saúde (LEWIS, 2015). Em um estudo que avalia saúde física e mental, os autores observaram que altos níveis de SDC podem reduzir os efeitos negativos da discriminação em saúde em grupos minoritários, podendo servir como um recurso de enfrentamento (BARON-EPEL, 2016). Entretanto, nenhum estudo avaliou esse possível efeito moderador do SDC na relação entre discriminação racial e desfechos de saúde bucal. Dessa maneira, fica evidente a importância de um estudo pioneiro que considere essas relações e as avalie utilizando ferramentas estatísticas apropriadas. Assim, o objetivo desse estudo foi avaliar o efeito moderador do senso de coerência na relação entre discriminação racial e qualidade de vida relacionada à saúde bucal em escolares.

2 ARTIGO - SENSE OF COHERENCE MODERATES THE RELATIONSHIP BETWEEN PERCEIVED RACIAL DISCRIMINATION AND ORAL HEALTH-RELATED QUALITY OF LIFE IN SCHOLARS

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Title page

Sense of coherence moderates the relationship between perceived racial discrimination and oral health-related quality of life in scholars

Authors

Thaís Gioda Noronha[2], Jessica Klöckner Knorst[2], Bruno Emmanuelli[1], Leonardo da Silva Godois[2], Thiago Machado Ardenghi[1], Fernanda Tomazoni[1].

[1]Department of Stomatology, School of Dentistry, Federal University of Santa Maria, Santa Maria, Brazil

[2]Post Graduate Program in Dental Sciences, Federal University of Santa Maria, Santa Maria, Brazil

Corresponding Author:

Fernanda Tomazoni

Curso de Odontologia da Universidade Federal de Santa Maria, Av. Roraima, 1000, Cidade Universitária - 26F, Departamento de Estomatologia, 97015-372, Santa Maria, RS, Brazil. Phone - Fax: +55.55. 3220-9272. E-mail: fernanda.tomazoni@ufsm.br.

ORCID:

Thaís Gioda Noronha: 0000-0002-7690-3930

Jessica Klöckner Knorst: 0000-0001-7792-8032

Bruno Emmanuelli: 0000-0002-9226-0832

Leonardo da Silva Godois: 0000-0001-7341-8369

Thiago Machado Ardenghi: 0000-0002-5109-740X

Fernanda Tomazoni: 0000-0001-6291-552X

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Compliance with Ethical Standards

Conflicts of interest: The authors declare that they have no conflict of interest.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the Human Research Ethics Committee of the Federal University of Santa Maria (protocol number 11765419.1.0000.5346), Brazil.

Informed consent: Informed consent was obtained from all individual participants included in the study.

Abstract

Purpose: Self-reported experiences of racial discrimination and sense of coherence (SOC) have been found to be associated with oral health outcomes. The study aimed to evaluate the moderating effect of the SOC in the relationship between racial discrimination and oral health-related quality of life (OHRQoL) in scholars.

Methods: This is a cross-sectional study nested in a cohort performed in southern Brazil. OHRQoL was assessed using the short version of the Child Perceptions Questionnaire 11-14 (CPQ11-14). The perception of racial discrimination was measured using a question contained in the Bullying Questionnaire by Olweus, and SOC through the shortened version of the 13-item Sense of Coherence Scale (SOC-13). Data related to demographic, socioeconomic, and dental caries characteristics were also collected. A simple slop test and Poisson regression analysis were performed to test the interaction effects of the predictors on OHRQoL. The results are presented in Rate Ratio (RR) and 95% confidence interval (95% CI).

Results: A total of 429 scholars were included in this study. About 6.7% reported had perceived racial discrimination. The simple slope test indicated that the negative effects of racial discrimination on OHRQoL were significant under different SOC levels. Among scholars who suffered racial discrimination, those who had higher SOC reported lower impact on OHRQoL (RR 0.70; 95%CI 0.55-0.89) when compared to those with low SOC.

Conclusion: SOC can be considered a moderating variable in the relationship between racial discrimination and OHRQoL. These findings highlight the potential importance of the SOC in reducing the harmful effects of racial discrimination on OHRQoL.

Keywords: Racial discrimination. Sense of coherence. Quality of life. Oral health. Adolescent.

Introduction

Discrimination is defined as “treating unfairly” and may rise specific patterns of health outcomes and health inequalities [1]. A wide body of research has investigated the association between perceived ethnic discrimination and different general and oral health conditions [2, 3, 4]. Most findings show that discrimination can impact health through direct experiences of discriminatory acts, greater exposure to toxic substances and more harmful environments, and lower health care [5, 6, 7].

Previous studies that evaluated discrimination in children indicate that exposure to discriminatory events can start in childhood and have important health consequences in childhood and adolescence, and may also affect adulthood [8-16]. Thus, since social deprivation throughout life can also lead to reduced access to oral health care and worse oral health habits, they can also influence the quality of life of the individuals [17].

Oral health-related quality of life (OHRQoL) is defined as a multidimensional construct that refers to the extent to which oral health conditions interfere in the individual's daily life and well-being. It evaluates the impact of oral diseases and disorders on daily life aspects, which are considered important for the individual, occurring with an adequate magnitude in terms of frequency, severity or duration to affect their self-perception as a whole [18]. The model proposed by Sischo and Broder (2011) recognizes the effects of contextual factors (e.g., sociocultural factors) and access to care on the perception of oral health and quality of life. Thus, the OHRQoL is an important subjective outcome resulting from an interaction between oral health conditions, general health, social and contextual factors [19, 20].

Studies have tried to identify individual and social attributes that may serve as a resource for resilience and improve the oral health of individuals and populations [21, 22, 23]. The sense of coherence (SOC) is one such individual attribute that can be highlighted [24, 25]. SOC represents the central construct of the salutogenic theory model, emphasizing the individual's responsiveness to stressful conditions. Thus, this construct is considered one of the most important factors that determine satisfaction with life and the ability to deal with more complex situations [26, 25]. An argument that has been proposed is that SOC can influence subjective health outcomes, such as OHRQoL, through the moderation of stressful and adverse conditions [27]. Moreover, it can be associated with health-related attitudes and behaviors [25].

In this context, taking into account that individuals who suffer racial discrimination can be subjected to stressful situations, which may impact their perception of general and oral health, the SOC could exert an important moderating role, attenuating this effect. Moreover, the literature has suggested that future studies focus on identifying individual and/or contextual factors that mitigate the effects of discrimination on health. [16]. In a

study that assesses general health, it was possible to observe that high levels of SOC can reduce the negative effects of discrimination on health and can serve as a coping resource [28]. However, there are no evidences accessing these effects on oral health outcomes. Thus, the aim of this study was to evaluate the moderating effect of SOC in the relationship between racial discrimination and OHRQoL among schoolchildren. The conceptual hypothesis is that a high sense of coherence could protect individuals from the effects of perceived racial discrimination on OHRQoL.

Methods

This study is reported according to STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines. [29]

Study design, participants and data collection

This is a cross-sectional study nested in a 10 years cohort. The first cohort's assessment was undertaken in 2010 in Santa Maria, a southern city in Brazil. In 2010, the city had an estimated population of 263,403, which included 27,520 children under 6 years old. A sample group was selected from all children who attended health centers in the municipality on the National Children's Vaccination Day. The sampling points were all 15 health centers with dental chairs, which were located in different administrative regions and neighborhoods of the city. Each health center was responsible for vaccinating children living in that area. A total of 639 children aged 1–5 years were examined for the assessment of their oral health status. The baseline (T1) was conducted in 2010 and three follow-ups (T2, T3 and T4) were conducted in 2012, 2017 and 2020, respectively. This study considers data from the last assessment (T4). Full details about the methodology used in the epidemiological survey were published elsewhere [30, 31, 32].

Data collection of T4 started in November, 2019. All adolescents who participated in the epidemiological survey at baseline were again invited to participate in this follow-up and were aged between 11 and 14 years old. Due to the COVID-19 pandemic, the data collection was interrupted in March 2020 [33]. Thereafter, as soon as possible, the continuation of this stage began in October 2020 and ended in January 2021.

Some strategies were adopted to reach the largest possible number of participants at T4. Before the COVID-19 pandemic, individuals were initially contacted in the school they studied during the T3 or using information from updated listings of students enrolled in public schools in the city of Santa Maria. As a second strategy, parents or caregivers were contacted by phone calls, to schedule an evaluation. Finally, home visits were

carried out to find the missing individuals, using the addresses previously registered. With the closing of schools due to the COVID-19 pandemic, phone calls were performed to contact those participants who had not been previously assessed, and home visits were scheduled. Some individuals were also contacted through social networks (Facebook or WhatsApp).

For evaluating the sample size, we performed a power test. The calculation considered an alpha error probability of 0.05, a mean score of CPQ11-14 of 10.3 (SD 8.3) for the non-exposed group (absence of racial discrimination), and a mean score of 14.3 (SD 8.8) for the exposed group (presence of racial discrimination), resulting in a sample power of 70%.

Racial discrimination

The perception of racial discrimination was measured using the item “Somebody insulted me because of my color or race” contained in the Bullying Questionnaire by Olweus – Victim [34], which was previously adapted and culturally transcribed to be used in Brazilian scholars [35]. The answer was obtained through the options 0 = “never”, 1 = “once or twice a month”, and 2 = “once or more a week”. For the analysis, was considered the absence (score 0) or presence (scores 1 and 2) of racial discrimination. A similar question was used in other study [36].

Oral health related quality of life (OHRQoL)

OHRQoL was assessed using the short version of the Child Perceptions Questionnaire 11-14 (CPQ11-14) [37]. It was previously adapted and culturally transcribed to be used in Brazilian children in that age group [38]. The reduced version of CPQ11-14 has 16 questions, equally divided into 4 domains: oral symptoms, functional limitation, social well-being, and emotional well-being. Five answer options are given for each question in the questionnaire: “never” = 0; “Once or twice” = 1; "Sometimes" = 2; “Frequently” = 3; and “every day / almost every day” = 4. The final score is made up of the sum of all items. The total result of the questionnaire can vary from 0 to 64 points. The higher the score, the greater the impact of oral health conditions on the child’s quality of life.

Sense of Coherence

Participants answered the shortened version of the 13-item sense of coherence scale (SOC-13), which was originally developed by Antonovsky (1987) and posteriorly translated, adapted and validated in Brazil to access individual SOC [39, 40, 41]. In the SOC-13, questions are divided into three components:

comprehensibility, manageability, and meaning. The answer options are presented according to a 5-point Likert scale, varying according to the item in the questionnaire, coded from 1 to 5. The items are added together to calculate the final score, and the result can vary from 13 to 65 points. Higher scores represent higher SOC. For data analysis, the SOC-13 was dichotomized according to the median in low (SOC-13 score ≤ 38) and high (SOC-13 score > 38).

Covariates

Data about sex (girls or boys), age (in years), skin color, and socioeconomic conditions were also measured. For the classification of skin color, the criteria established by the Brazilian Institute of Geography and Statistics (IBGE) were used, using the following question: "What race do you consider yourself? 0 = white; 1 = brown; 2 = black; 3 = yellow or 4 = indigenous?" [42]. For analysis purpose, the variable was categorized in white (0) or non-white (1, 2, 3 and 4). The monthly household income was collected in Brazilian currency and subsequently dichotomized according to Brazilian Minimum Wages (BMW) in ≤ 1 BMW or > 1 BMW (1 BMW is equivalent to US$220.0 approximately).

Dental caries was evaluated by six calibrated examiners following the International Caries Detection and Assessment System (ICDAS) [43]. The examination was performed with natural illumination, using a plane dental mirror, gauze pad, and periodontal probes (CPI; "ballpoint"). For the analysis, the absence (scores 0,1,2, and 4) or presence (scores 3, 5, and 6) of untreated dental caries was considered. The intra and inter-examiner agreement were verified through the Kappa coefficients and the values ranged from 0.70 and 0.92.

Data analysis

Data analysis was performed using STATA 14.0 statistical software (StataCorp. 2014. Stata Statistical Software: Release 14.0. College Station, TX: StataCorp L). A descriptive analysis of the demographic, socioeconomic, psychosocial, and oral health characteristics of the sample was performed. These analyzes were performed considering the sample weight ('svy'). The comparison between followed-up and dropouts, to confirm the representativeness of the sample over time, was assessed using the chi-square test (qualitative variables) and the t-test (quantitative variables). Comparison between individuals evaluated before and during the COVID-19 pandemic was also performed.

The study outcome was the overall CPQ11-14 scores. The moderating effect of SOC on the relationship between racial discrimination and CPQ11-14 (Figure 1) was tested using unadjusted and adjusted Poisson

regression analysis, considering the interaction between racial discrimination (RD) and SOC, in different categories (0= presence of RD x low SOC; 1= absence of RD x low SOC; 2= absence of RD x high SOC; and 3= presence of RD x high SOC). Demographic, socioeconomic and clinical variables related to the outcome were included in the adjusted model as possible confounders (variables with $p < 0.20$ in the unadjusted analysis). The results presented the Rate Ratio (RR) and its respective 95% confidence interval (95% CI).

Posteriorly, when hypothesized moderation effects were statistically significant, we performed the simple slope test, obtaining the simple margins of predicted values by each level of the categorical moderator. This procedure allows the calculation of the conditional effect of X (racial discrimination) on Y (CPQ11-14) according to levels of the moderator (SOC), generating a confidence interval and p-values. In order to understand the interaction in the interest group, the contrast test to obtain the differences of predicted values was also performed [44, 45]. A significance level of 0.05 was considered.

Ethical Issues

This cohort study was approved by the Committee for Ethics in Research of School of Dentistry, Federal University of Santa Maria (protocol number 11765419.1.0000.5346) and the parents' participants signed a consent form.

Results

A total of 429 scholars were considered in this study (representing 67.1% of the individuals assessed at baseline of the cohort). Losses in follow-up occurred due to inability to find the child (n = 184), moving to another city (n = 19), or refusal (n = 7). There were no significant differences in sample characteristics between adolescents followed or dropouts, nor among those assessed before or during the COVID-19 pandemic ($p > 0.05$).

Table 1 shows the descriptive characteristics of the sample. The mean age was 12.5 (SE 0.1) years. The sample was balanced between boys and girls, and most individuals were white. Regarding socioeconomic variables, most individuals presented household income higher than one BMW (70.8%). In regard to the psychosocial characteristics, 50.1% of the children presented a high sense of coherence, and 6.7% reported racial discrimination. The overall mean CPQ11-14 score was 11.2 (SE 0.6).

Table 2 displays the unadjusted analysis of the interaction between racial discrimination and SOC on overall CPQ11-14 scores. Considering the predictor variables separately, individuals who suffered racial discrimination presented poorer OHRQoL (RR 1.38; 95%CI 1.25-1.52); and individuals with higher SOC had

better OHRQoL (RR 0.54 95%CI 0.51-0.57). Considering the interaction between RD and SOC level, all groups had lower CPQ11-14 scores compared to those who suffered RD and presented low SOC.

Moderation analysis after adjusting for confounders is shown in Table 3. Among adolescents who suffered RD, those who had higher SOC reported lower impact on OHRQoL (RR 0.70; 95%CI 0.55-0.89) when compared to those with low SOC. Regarding those who did not suffer RD, regardless of the SOC level, the impacts on CPQ11-14 were also lower compared to the counterparts (presence of RD and low SOC). Although SOC demonstrated a protective role for the association between perceived racial discrimination and OHRQoL, its protection effect was higher among individuals who did not report racial discrimination episodes (30% lower scores versus 52%).

Figure 2 displays the predictive marginal effects between racial discrimination and overall CPQ11-14 scores according to different SOC levels. The simple slope test (Table 4) indicated that the negative effects of racial discrimination on OHRQoL were statistically significant under different SOC levels (low and high). The greatest margin effect was observed in individuals that reported RD and presented low SOC (15.8; $p<0.01$). Contrast analysis among adolescents that suffered RD showed a difference of 4.80 in overall CPQ11-14 scores according to SOC level (low versus high) (Table 5).

Discussion

Our findings support the hypothesis that a high sense of coherence could attenuate the effects of perceived racial discrimination on OHRQoL. Children who presented a high SOC showed a lower impact of racial discrimination on OHRQoL. A recent study has reported this moderating relationship and protective effect of SOC, considering general health [28]. However, to the best of our knowledge, this issue has not been explored with oral health outcomes yet.

In our study, individuals who reported racial discrimination had a worse OHRQoL. Previous studies have shown similar results in different populations, and suggested that this relationship is due to direct experiences of discriminatory acts, greater exposure to toxic substances and more harmful environments, in addition to lower health care. [5, 6, 7] However, it is necessary to look deeper. While racial equity is not a reality, it is important to look for different individual and/or contextual factors that promote more resilience and can mitigate the negative effects of discrimination on health outcomes, such as the SOC. [16]

Our results showed that a high sense of coherence attenuated the effects of perceived racial discrimination on OHRQoL. It has been shown that SOC establishes the responsiveness of individuals to stressful conditions and

may moderate the relationship between racial discrimination and health. [28]. A previous study demonstrated that high levels of SOC can reduce the negative effects of discrimination on general health in minority groups. [28]. These moderating effects may be explained by the Salutogenic Theory, developed by Antonovsky (1987) [39]. The Salutogenic framework describes that SOC and general resistance resources may help people to cope with a stressful situation, improving the ability to perceive the environment as comprehensible, manageable, or meaningful. [39]. In this sense, the main concept of the salutogenic approach is to explain why some individuals remain healthy even after experiencing stressful circumstances in life [39]. Thus, subjects with a high SOC envisage life events and problems as challenges worthy of effort, perceive the available resources, and are able to use them to deal with stress [39]. Thus, it is suggested that individuals who suffered racial discrimination but who had high SOC were less likely to have their OHRQoL affected than individuals with low SOC.

In counterpart, in another study that evaluated the moderating effect of SOC and social support on the relationship between racial discrimination and psychological well-being, it was not possible to observe the moderation of SOC [46]. However, the authors could verify that social support, also a psychosocial characteristic, had this moderating effect. [46]. Thus, social support has also received a lot of attention as a resource for dealing with stress [47]. It has been suggested that SOC interacts with a person's natural coping style and social support. That is, the extent to which these elements are available is one of the main determinants in the development of a strong or weak SOC [27].

It is important to make clear that the SOC has mitigated the effect of racial discrimination on OHRQoL, but has not eliminated it. Both groups that perceived racial discrimination (high and low SOC) had a worse OHRQoL than those who did not report it. In addition, the individuals involved in this study are between 11 and 15 years of age, and we understand that the social environment in which young people are raised shapes the development of children and adolescents, who can be significantly impacted by racial discrimination. Consequently, young adults may still suffer consequences on their well-being and on different health outcomes due to discriminatory acts experienced in earlier stages of life and that is why it is so important to study individuals at this age and seek alternatives to mitigate these impacts [48].

This study has some limitations. The perception of racial discrimination was assessed using a single question. It is important that future studies are carried out taking into account that racial/ethnic discrimination is complex and multidimensional. It is also appropriate to consider more sensitive measures, for example, those assessing the different forms of racial discrimination. It is evident that racial discrimination is difficult to measure, and no instrument would be able to fully capture all instances of discriminatory experiences [49]. In the United

States, it is possible to see a large body of studies in search of instruments that assess discrimination more accurately, but in other parts of the world this is not yet a reality [50]. Although instruments already exist in Brazil, such as the Explicit Discrimination Scale, we did not find validated instruments that measure racial discrimination in the age group of this study [51]. Thus, it would be important to seek instruments that can assess racial discrimination in greater depth and that also take into account the complex intersections between different forms of discrimination, to help build evidence of the effects of discrimination on health. Another limitation that could be considered is that collections started before the onset of the pandemic and ended during the isolation period. However, we emphasize that there were no significant differences in sample characteristics among adolescents assessed before or during the COVID-19 pandemic.

Even so, we emphasize that our results are important because this is a pioneer study that assesses this relationship in oral health and should open paths for further research to be carried out on this issue. In addition, studies on discrimination in children indicate that exposure to discriminatory events can start at this stage and generate important health consequences in childhood, adolescence and can also reflect in adulthood [12]. Therefore, these findings may be considered in the planning of public interventions to promote SOC and enable the strengthening of this population. Finally, it would also be important to evaluate this relationship longitudinally, so that we can understand at which times through life these discriminatory acts are occurring, in addition to allow to establish a cause-and-effect relationship. However, as this is a cross-sectional nested within a cohort study, it is possible to evaluate the same individuals again in the future.

Conclusions

Our findings support the hypothesis that SOC may have a moderating effect on the relationship between perceived racial discrimination and OHRQoL. Schoolchildren with a high sense of coherence had a lower impact of racial discrimination on OHRQoL. This knowledge is important because it allowed us to start identifying factors that can reduce the harmful effects of racial discrimination on OHRQoL.

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Tables

Table 1. Demographic, socioeconomic, psychosocial and oral health variables of the sample, Santa Maria, (n=429).

Variables	**n = 429***
Demographic and socieconomic	
Sex [n (%)]	
Boys	209 (49.8)
Girls	220 (50.2)
Age [mean SE)]	12.5 (0.1)
Skin color	
White	215 (48.5)
Non-white	211 (51.5)
Household income in BMW [n (%)]	
≤ 1BMW	110 (29.2)
> 1BMW	264 (70.8)
Psychosocial	
Sense of coherence [n (%)]	
Low	222 (49.9)
High	207 (50.1)
Racial discrimination [n (%)]	
No	398 (93.3)
Yes	31 (6.7)
Oral health	
Untreated dental caries [n (%)]	
Absent	300 (69.4)
Present	128 (30.6)
CPQ11-14 [mean (SE)]	11.2 (0.6)

*Taking into account the sampling weight; BMW, Brazilian minimum wage; SE, standard error.

Table 2. Unadjusted analysis of the interaction of racial discrimination and sense of coherence on overall CPQ11-14 scores, (n=429)

Variables	**CPQ11-14**	
	RR (95% CI)	**p-value**
Sex		
Boys	1 (reference)	
Girls	1.25 (1.18-1.33)	<0.01
Age	0.91 (0.86-0.97)	<0.05
Skin color		
White	1 (reference)	
Non-white	1.09 (1.03-1.16)	<0.01
Household income in BMW		
≤ 1BMW	1 (reference)	
> 1BMW	0.77 (0.72-0.82)	<0.01
Sense of coherence		
Low	1 (reference)	
High	0.54 (0.51-0.57)	<0.01
Racial discrimination		
No	1 (reference)	
Yes	1.38 (1.25-1.52)	<0.01
Untreated dental caries		
Absent	1 (reference)	
Present	1.18 (1.11-1.25)	<0.01
Racial discrimination x Sense of coherence		
Presence of RD - Low SOC	1 (reference)	
Absence of RD – Low SOC	0.84 (0.56-0.86)	<0.01
Absence of RD – High SOC	0.45 (0.40-0.81)	<0.01
Presence of RD – High SOC	0.69 (0.75-0.94)	<0.01

BMW, Brazilian minimum wage; RR, rate ratio; CI, confidence interval; RD, racial discrimination; SOC, sense of coherence.

Table 3. Adjusted analysis of the interaction of racial discrimination and sense of coherence on overall CPQ11-14 scores

	CPQ11-14	
Interaction variable	**RR (95% CI)***	**p-value**
Racial discrimination x Sense of choerence		
Presence of RD - Low SOC	1 (reference)	
Absence of RD – Low SOC	0.89 (0.79-1.01)	0.07
Absence of RD – High SOC	0.48 (0.44-0.54)	<0.01
Presence of RD – High SOC	0.70 (0.55-0.89)	<0.01

RR, rate ratio; CI, confidence interval; RD, racial discrimination; SOC, sense of coherence; *Adjuested by sex, skin color, age, household income and untreated dental caries.

Table 4. Predictive marginal effects between the racial discrimination and overall CPQ11-14 scores according to different levels of sense of coherence, (n=429)

	CPQ11-14	
Racial discrimination x Sense of choerence	**Margin (95% CI)***	**p-value**
Presence of RD - Low SOC	15.8 (14.1-17.6)	<0.01
Absence of RD – Low SOC	13.4 (12.9-13.9	<0.01
Absence of RD – High SOC	7.2 (6.8-7.6)	<0.01
Presence of RD – High SOC	11.1 (9.03-13.1)	<0.01

RR, rate ratio; CI, confidence interval; RD, racial discrimination; SOC, sense of coherence. *Delta-method.

Table 5. Contrast analysis of overall CPQ11-14 scores according to SOC level among individuals' victims of racial discrimination, (n=31)

	CPQ11-14	
Racial discrimination x Sense of choerence	**dy/dx* (SE)**	**p-value**
Presence of RD - Low SOC x High SOC	-4.80 (1.36)	<0.01

RD, racial discrimination; SOC, sense of coherence. *dy/dx for factor levels is the discrete change from the base level.

Figures

Figure 1. The logic map of the moderation effects

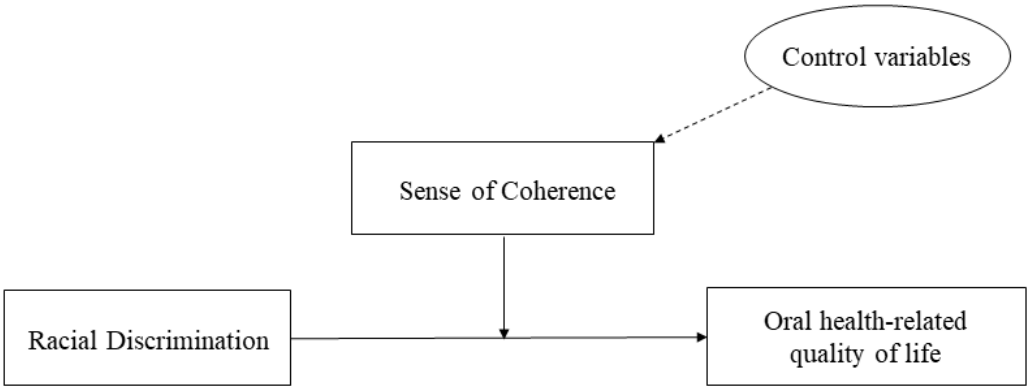
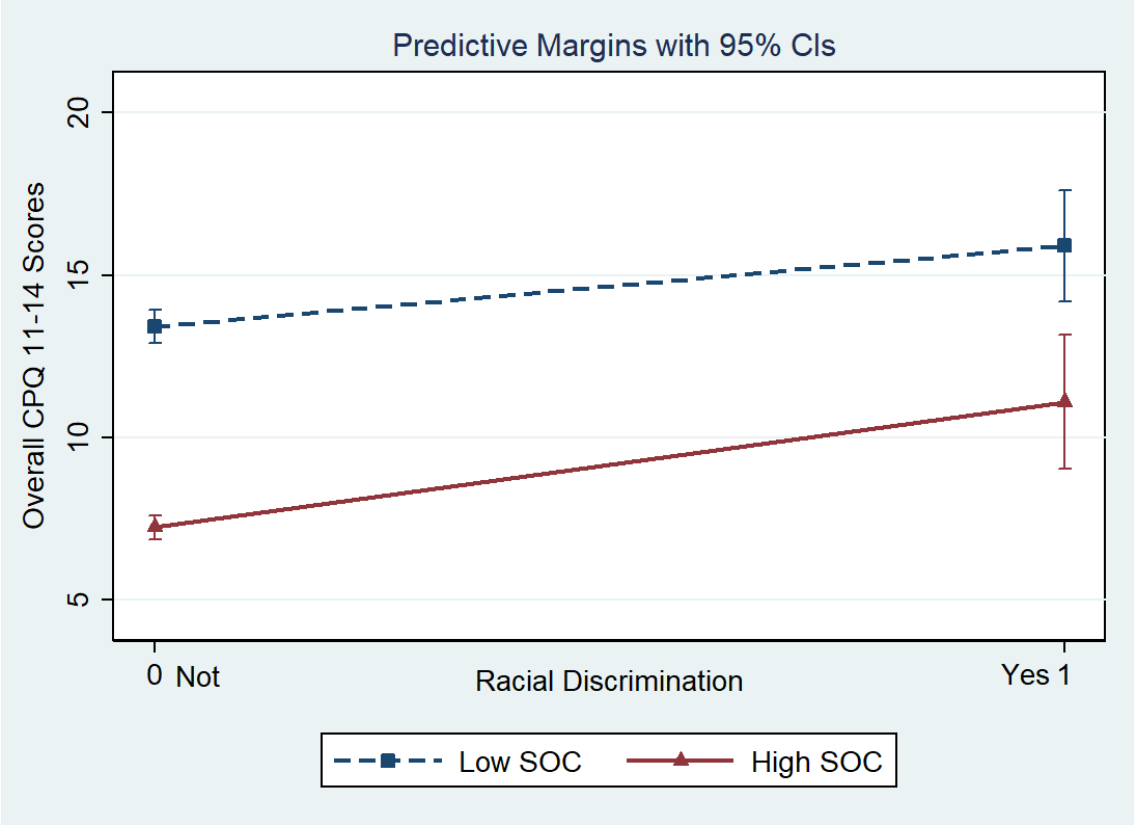


Figure 2. Predictive marginal effects between racial discrimination and overall CPQ11-14 scores according to different levels of sense of coherence



3 CONSIDERAÇÕES FINAIS

O presente estudo avaliou o efeito moderador do senso de coerência (SDC) na relação entre percepção de discriminação racial e qualidade de vida relacionada à saúde bucal (QVRSB). Para isso, foi realizado um estudo transversal aninhado a um estudo de coorte com acompanhamento de 10 anos, que avaliou no ano de 2020 escolares entre 11 e 15 anos de idade. Investigar essa relação é extremamente importante, pois um alto SDC pode atenuar os efeitos nocivos da discriminação racial e servir como um recurso de enfrentamento, através da melhora da capacidade de perceber as situações como compreensíveis, gerenciáveis e significativas.

Em nosso estudo, indivíduos que perceberam a discriminação racial apresentaram pior QVRSB. Ao avaliarmos o efeito moderador do SDC, foi possível observar um efeito protetor do SDC na relação entre percepção de discriminação racial e QVRSB. Isso indica que escolares que perceberam a discriminação racial e apresentaram um maior SDC, apresentaram um menor impacto sobre a QVRSB quando comparados àqueles que reportaram discriminação, mas tinham um baixo SOC.

É importante que estudos futuros sejam realizados levando em consideração que a discriminação racial / étnica é complexa e multidimensional, e, portanto, é oportuno considerar medidas mais sensíveis para mensurar, por exemplo, as diferentes formas de discriminação racial sofridas. Além disso, pode ser importante avaliar essas relações ao longo do tempo, permitindo estabeler relações de causa e efeito. No entanto, esse é um assunto que ainda está em desenvolvimento e o nosso estudo constitui parte importante desse processo. Além disso, o delineamento desse estudo permite que no futuro reavaliemos esses mesmos escolares e identifiquemos essa relação.

Os presentes achados suportaram a hipótese de que o SDC pode produzir efeito moderador na relação entre discriminação racial e QVRSB em escolares. Como sabemos que a discriminação racial pode iniciar na infância e gerar importantes consequências para a saúde na adolescência e na vida adulta, é extremamente importante apresentarmos formas de minimizar esses impactos, a fim de reduzir os efeitos dos atos discriminatórios em diferentes desfechos de saúde bucal ao longo da vida.

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ANEXO A – CARTA DE APROVAÇÃO DO COMITÊ DE ÉTICA EM PESQUISA

UNIVERSIDADE FEDERAL DE SANTA MARIA/ PRÓ-REITORIA DE PÓS-GRADUAÇÃO E

PARECER CONSUBSTANCIADO DO CEP

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: Influência do capital social no desenvolvimento do senso de coerência e nas condições bucais de escolares: uma coorte de 10 anos

Pesquisador: Thiago Machado Ardenghi

Área Temática:

Versão: 2

CAAE: 11765419.1.0000.5346

Instituição Proponente: Departamento de Estomatologia

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 3.425.591

Apresentação do Projeto:

O objetivo deste estudo é explorar as inter-relações longitudinais entre fatores sociais individuais e comunitários no senso de coerência e nas condições de saúde bucal de escolares no município de Santa Maria, RS, Brasil. Esta pesquisa trata-se de uma coorte iniciado no ano de 2010 com 639 pré-escolares (1-5 anos) no qual se propõe uma quarta etapa de avaliação dos indivíduos que compõe a amostra, totalizando 10 anos de acompanhamento. As questões referentes aos fatores demográficos, condições socioeconômicas e fatores comportamentais serão obtidas através de um questionário semiestruturado aplicado aos pais/responsáveis dos escolares. Além disso, os escolares responderão questões referentes ao senso de coerência e outros medidas subjetivas. Os dados a respeito das condições bucais serão obtidos através de exames clínicos realizados por examinadores previamente treinados e calibrados. As variáveis clínicas consideradas serão cárie, traumatismo dentário, sangramento gengival, presença de placa visível, maloclusão e dor dentária. Modelagem de equações estruturais (MEE) será utilizada para testar as inter-relações entre o capital social individual e comunitário (como principais preditores) com SDC e resultados de saúde bucal (desfechos).

Objetivo da Pesquisa:

Explorar as inter-relações longitudinais entre fatores sociais individuais e comunitários no senso

Endereço: Av. Roraima, 1000 - prédio da Reitoria - 2º andar
Bairro: Camobi **CEP:** 97.105-970
UF: RS **Município:** SANTA MARIA
Telefone: (55)3220-9362 **E-mail:** cep.ufsm@gmail.com

de coerência e nas condições de saúde bucal de escolares no município de Santa Maria, RS, Brasil.

Avaliação dos Riscos e Benefícios:

Considerando-se as características do projeto, a descrição de riscos e benefícios apresentada pode ser considerada suficiente.

Comentários e Considerações sobre a Pesquisa:

.

Considerações sobre os Termos de apresentação obrigatória:

Os termos de apresentação obrigatória podem ser considerados suficientes.

Recomendações:

Veja no site do CEP - http://w3.ufsm.br/nucleodecomites/index.php/cep - na aba "orientações gerais", modelos e orientações para apresentação dos documentos. ACOMPANHE AS ORIENTAÇÕES DISPONÍVEIS, EVITE PENDÊNCIAS E AGILIZE A TRAMITAÇÃO DO SEU PROJETO.

Conclusões ou Pendências e Lista de Inadequações:

.

Considerações Finais a critério do CEP:

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_DO_PROJETO_1331113.pdf	27/06/2019 15:35:37		Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TermoAssentimento_mod.pdf	27/06/2019 15:32:32	Thiago Machado Ardenghi	Aceito
Outros	Carta_ao_CEP.pdf	27/06/2019 15:29:54	Thiago Machado Ardenghi	Aceito
Outros	Autorizacao_munic.pdf	27/06/2019 15:29:33	Thiago Machado Ardenghi	Aceito

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Continuação do Parecer: 3.425.591

Outros	autorizacao_estad.pdf	27/06/2019 15:28:57	Thiago Machado Ardenghi	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TCLE_mod.pdf	27/06/2019 15:25:36	Thiago Machado Ardenghi	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TermoConfidencialidadenovo.pdf	22/05/2019 12:11:40	Thiago Machado Ardenghi	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TermoConfidencialidade.pdf	12/04/2019 12:14:19	Thiago Machado Ardenghi	Aceito
Cronograma	cronograma.pdf	10/04/2019 09:49:59	Thiago Machado Ardenghi	Aceito
Declaração de Instituição e Infraestrutura	Autorizacao.pdf	10/04/2019 09:45:32	Thiago Machado Ardenghi	Aceito
Projeto Detalhado / Brochura Investigador	projeto.pdf	10/04/2019 09:45:02	Thiago Machado Ardenghi	Aceito
Folha de Rosto	folharosto.pdf	10/04/2019 09:44:43	Thiago Machado Ardenghi	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

SANTA MARIA, 28 de Junho de 2019

Assinado por:
CLAUDEMIR DE QUADROS
(Coordenador(a))

Endereço: Av. Roraima, 1000 - prédio da Reitoria - 2º andar
Bairro: Camobi **CEP:** 97.105-970
UF: RS **Município:** SANTA MARIA
Telefone: (55)3220-9362 **E-mail:** cep.ufsm@gmail.com

ANEXO B - NORMAS PARA PUBLICAÇÃO NO PERIÓDICO QUALITY OF LIFE RESEARCH

ARTICLE TYPES

Quality of Life Research welcomes scientific articles in the following categories:

• Original Articles

Original articles are a maximum of 4,000 words, exclusive of a 250-word structured abstract, figures, tables, and references. We encourage submissions of shorter length if the empirical study can be presented concisely. We also make authors aware of the option to publish additional detail as online appendices. We are particularly interested in studies that utilize patient-reported outcomes, focusing on clinical and policy applications of (health-related) quality-of-life research; showcasing quantitative and qualitative methodological advances; and/ or describing instrument development.

Original articles describe work that is not already published elsewhere or directly uses statements from previously published materials without appropriate acknowledgement or referencing. For example, if the submitted work forms part of a thesis dissertation or the abstract was published as part of conference proceedings, these should be acknowledged. If taking direct statements from published sources, these should be appropriately referenced.

• Registered Reports

The journal is pleased to offer Registered Reports for authors submitting to the journal. To learn more about this article type, please see the full instructions here.

• Letters to the editor

Quality of Life Research accepts on occasion letters to the editor. These letters are published at the Co-Editors in Chief's discretion. Letters would be expected to make a substantial informative point and usually cover material such as responses to published articles or viewpoints (usually of more than an individual, e.g. patient groups, scientific societies, stakeholder organizations, international research consortia). As with commentaries, letters can also be submitted on invitation of the editors. Letters are not for general news sharing or to summarize results of articles published elsewhere. Letters to the editor will be reviewed by the Co-Editors in Chief, and if necessary, by drawing on additional editorial board members. In the case of letters that are in direct response to work published in Quality of Life Research, the original handling Associate Editor will be invited to review.

The submission format for a letter is a maximum length of 1000 words; no abstract; no sections; no graphs/figures; and no tables are permitted. The manuscript should have at most 5 references. A maximum of three authors are permitted, and only first author's main affiliation should be included

• Other Types of Articles

The journal also publishes commentaries and editorials; reviews of the literature; reviews of recent books and software advances; and abstracts presented at the annual meeting of the

International Society of Quality of Life Research conference. These articles should be as long as needed to convey the desired information, and no more than 4,000 words in length. To the extent that it is possible, a structured abstract is appreciated.

Language

We appreciate any efforts that you make to ensure that the language usage is corrected before submission using standard United States or United Kingdom English. This will greatly improve the legibility of your paper if English is not your first language.

PLAIN ENGLISH SUMMARY

All submitting authors in Quality of Life Research have the opportunity to include a Plain English summary in addition to the Abstract. The plain English summary is a brief summary of the study written for the general public rather than for specialists. It is not a scientific abstract. Use clear and simple language, avoiding jargon, abbreviations, technical terms, uncommon words, and long sentences wherever possible.

Please address the following questions in your summary paragraph:

1. Why is this study needed?

2. What is the key problem/issue/question this manuscript addresses?

3. What is the main point of your study?

4. What are your main results and what do they mean?

The recommended length for the summary is 100-200 words and it should not exceed 250 words. Each question above should be addressed briefly (i.e., 1-2 sentences).

Please include your plain English summary as a separate submission file, and additionally within the main body of your manuscript file. The plain English summary should be inserted immediately after the official scientific abstract within the manuscript file under the heading "Plain English summary".

By adding a plain English summary, we hope to broaden the reach of the article and bring it to the attention of a more general audience. Researchers are trained to be highly focused, specific, and conservative with extrapolation and speculation. These attributes are useful for scientific publications, but not for wider public understanding. Many non-scientists have difficulty understanding technical terms and jargon, and the public requires more context-setting by way of introduction and more help drawing a conclusion.

An Example from the Journal of Eating Disorders

Original Manuscript

www.jeatdisord.biomedcentral.com/articles/10.1186/s40337-019-0264-0

Binge Eating Disorder is the most common eating disorder. Still, this disorder is often not addressed by the health care system, and current treatment shows poor results on a large group of these patients. Difficulties in relating to own body are linked to the development and maintenance of eating disorders in previous research and seem to influence treatment results and the risk of relapse. Basic Body Awareness Therapy is a psychomotor physiotherapeutic treatment addressing the relation to one's own body. In this study, we have explored in-depth the experiences of two patients with Binge Eating Disorder during their treatment-process with Basic Body Awareness Therapy. This study indicates that changes in how these patients related to their own bodies during the treatment processes were meaningful to them and implied a movement toward well-being and accepting one's own body. Findings from this study inspire more research on body awareness raising approaches in the treatment of patients with Binge Eating Disorder.

MANUSCRIPT SUBMISSION

Manuscript Submission

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

Permissions

Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

Online Submission

Please follow the hyperlink "Submit manuscript" on the right and upload all of your manuscript files following the instructions given on the screen.

Please ensure you provide all relevant editable source files. Failing to submit these source files might cause unnecessary delays in the review and production process.

EDITORIAL PROCEDURE

Single-blind peer review

This journal follows a single-blind reviewing procedure.

TITLE PAGE

Title Page

Please make sure your title page contains the following information.

Title

The title should be concise and informative.

Author information

The name(s) of the author(s)
The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
A clear indication and an active e-mail address of the corresponding author
If available, the 16-digit ORCID of the author(s)
If address information is provided with the affiliation(s) it will also be published.

For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.

Abstract
Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

Purpose (stating the main purposes and research question)
Methods
Results
Conclusion
For life science journals only (when applicable)

Trial registration number and date of registration

Trial registration number, date of registration followed by “retrospectively registered”

Keywords
Please provide 4 to 6 keywords which can be used for indexing purposes.

Declarations
All manuscripts must contain the following sections under the heading 'Declarations'.

If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

To be used for all articles, including articles with biological applications

Funding (information that explains whether and by whom the research was supported)

Conflicts of interest/Competing interests (include appropriate disclosures)

Availability of data and material (data transparency)

Code availability (software application or custom code)

Authors' contributions (optional: please review the submission guidelines from the journal whether statements are mandatory)

Additional declarations for articles in life science journals that report the results of studies involving humans and/or animals

Ethics approval (include appropriate approvals or waivers)

Consent to participate (include appropriate statements)

Consent for publication (include appropriate statements)

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

Please note:
The Title Page should also state the word count for the manuscript (exclusive of abstract, figures, tables, and references.

TEXT

Text Formatting
Manuscripts should be submitted in Word.

Use a normal, plain font (e.g., 10-point Times Roman) for text.
Use italics for emphasis.
Use the automatic page numbering function to number the pages.
Do not use field functions.
Use tab stops or other commands for indents, not the space bar.
Use the table function, not spreadsheets, to make tables.
Use the equation editor or MathType for equations.
Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).
Manuscripts with mathematical content can also be submitted in LaTeX.

LaTeX macro package (Download zip, 190 kB)

Headings
Please use no more than three levels of displayed headings.

Abbreviations
Abbreviations should be defined at first mention and used consistently thereafter.

Footnotes
Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

SCIENTIFIC STYLE

Please always use internationally accepted signs and symbols for units (SI units).
Generic names of drugs and pesticides are preferred; if trade names are used, the generic name should be given at first mention.

REFERENCES

Citation

Reference citations in the text should be identified by numbers in square brackets. Some examples:

1. Negotiation research spans many disciplines [3].

2. This result was later contradicted by Becker and Seligman [5].

3. This effect has been widely studied [1-3, 7].

Authors are encouraged to follow official APA version 7 guidelines on the number of authors included in reference list entries (i.e., include all authors up to 20; for larger groups, give the first 19 names followed by an ellipsis and the final author's name). However, if authors shorten the author group by using et al., this will be retained.

Reference list

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

The entries in the list should be numbered consecutively.

Journal names and book titles should be italicized.

If available, please always include DOIs as full DOI links in your reference list (e.g. "https://doi.org/abc").

Journal article

Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. Psychology of Popular Media Culture, 8(3), 207–217. https://doi.org/10.1037/ppm0000185

Article by DOI

Hong, I., Knox, S., Pryor, L., Mroz, T. M., Graham, J., Shields, M. F., & Reistetter, T. A. (2020). Is referral to home health rehabilitation following inpatient rehabilitation facility associated with 90-day hospital readmission for adult patients with stroke? American Journal of Physical Medicine & Rehabilitation. Advance online publication. https://doi.org/10.1097/PHM.0000000000001435

Book

Sapolsky, R. M. (2017). Behave: The biology of humans at our best and worst. Penguin Books.

Book chapter
Dillard, J. P. (2020). Currents in the study of persuasion. In M. B. Oliver, A. A. Raney, & J. Bryant (Eds.), Media effects: Advances in theory and research (4th ed., pp. 115–129). Routledge.

Online document
Fagan, J. (2019, March 25). Nursing clinical brain. OER Commons. Retrieved January 7, 2020, from https://www.oercommons.org/authoring/53029-nursing-clinical-brain/view

TABLES

All tables are to be numbered using Arabic numerals.
Tables should always be cited in text in consecutive numerical order.
For each table, please supply a table caption (title) explaining the components of the table.
Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

ARTWORK AND ILLUSTRATIONS GUIDELINES
Electronic Figure Submission
Supply all figures electronically.
Indicate what graphics program was used to create the artwork.
For vector graphics, the preferred format is EPS; for halftones, please use TIFF format. MSOffice files are also acceptable.
Vector graphics containing fonts must have the fonts embedded in the files.
Name your figure files with "Fig" and the figure number, e.g., Fig1.eps.

Line Art

Definition: Black and white graphic with no shading.
Do not use faint lines and/or lettering and check that all lines and lettering within the figures are legible at final size.
All lines should be at least 0.1 mm (0.3 pt) wide.
Scanned line drawings and line drawings in bitmap format should have a minimum resolution of 1200 dpi.
Vector graphics containing fonts must have the fonts embedded in the files.

Halftone Art

Definition: Photographs, drawings, or paintings with fine shading, etc.
If any magnification is used in the photographs, indicate this by using scale bars within the figures themselves.
Halftones should have a minimum resolution of 300 dpi.

Combination Art

Definition: a combination of halftone and line art, e.g., halftones containing line drawing, extensive lettering, color diagrams, etc.
Combination artwork should have a minimum resolution of 600 dpi.

Color Art
Color art is free of charge for online publication.
If black and white will be shown in the print version, make sure that the main information will still be visible. Many colors are not distinguishable from one another when converted to black and white. A simple way to check this is to make a xerographic copy to see if the necessary distinctions between the different colors are still apparent.
If the figures will be printed in black and white, do not refer to color in the captions.
Color illustrations should be submitted as RGB (8 bits per channel).

Figure Lettering
To add lettering, it is best to use Helvetica or Arial (sans serif fonts).
Keep lettering consistently sized throughout your final-sized artwork, usually about 2–3 mm (8–12 pt).
Variance of type size within an illustration should be minimal, e.g., do not use 8-pt type on an axis and 20-pt type for the axis label.
Avoid effects such as shading, outline letters, etc.
Do not include titles or captions within your illustrations.

Figure Numbering
All figures are to be numbered using Arabic numerals.
Figures should always be cited in text in consecutive numerical order.
Figure parts should be denoted by lowercase letters (a, b, c, etc.).
If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc."
Figures in online appendices [Supplementary Information (SI)] should, however, be numbered separately.

Figure Captions
Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

Figure Placement and Size
Figures should be submitted separately from the text, if possible.
When preparing your figures, size figures to fit in the column width.
For large-sized journals the figures should be 84 mm (for double-column text areas), or 174 mm (for single-column text areas) wide and not higher than 234 mm.
For small-sized journals, the figures should be 119 mm wide and not higher than 195 mm.

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Accessibility
In order to give people of all abilities and disabilities access to the content of your figures, please make sure that

All figures have descriptive captions (blind users could then use a text-to-speech software or a text-to-Braille hardware)
Patterns are used instead of or in addition to colors for conveying information (colorblind users would then be able to distinguish the visual elements)
Any figure lettering has a contrast ratio of at least 4.5:1

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Springer accepts electronic multimedia files (animations, movies, audio, etc.) and other supplementary files to be published online along with an article or a book chapter. This feature can add dimension to the author's article, as certain information cannot be printed or is more convenient in electronic form.

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Submission
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ANEXO C – ESCALA DE SENSO DE COERÊNCIA (SOC-13)

Senso de Coerência (SOC- 13)

INSTRUÇÕES

Aqui estão 13 perguntas sobre vários aspectos da sua vida. Cada pergunta tem cinco respostas possíveis. Escolha a opção que melhor expresse a sua maneira de pensar e sentir em relação ao que está sendo falado. Dê apenas uma única resposta em cada pergunta. Não existem respostas certas ou erradas.

		Um enorme sofrimento e aborrecimento	Um sofrimento e aborrecimento	Nem aborrecimento nem satisfação	Um prazer e satisfação	Um enorme prazer e satisfação
01	Aquilo que você faz diariamente é:					

		Sem nenhum objetivo	Com poucos objetivos	Com alguns objetivos	Com muitos objetivos	Repleta de objetivos
02	Até hoje a sua vida tem sido:					

		Nunca	Poucas vezes	Algumas vezes	Muitas vezes	Sempre
03	Você tem interesse pelo que se passa ao seu redor?					
04	Você acha que você é tratado(a) com injustiça?					
05	Você tem ideias e sentimentos confusos?					
06	Você acha que as coisas que você faz na sua vida têm pouco sentido?					
07	Já lhe aconteceu ter ficado desapontada com pessoas em quem você confiava?					
08	Você tem sentimentos que gostaria de não ter?					
09	Você tem dúvida se pode controlar seus sentimentos?					
10	Já lhe aconteceu de ficar surpreendida com o comportamento de pessoas que você achava que conhecia bem?					
11	Em algumas situações, as pessoas sentem-se fracassadas. Você já se sentiu fracassado(a)?					
12	Você sente que está numa situação pouco comum, e sem saber o que fazer?					

		Totalmente errada	Errada	Nem correta e nem errada	Correta	Totalmente correta
13	As vezes acontecem coisas na vida da gente que depois achamos que não demos a devida importância. Quando alguma coisa acontece na sua vida, você acaba achando que deu a importância:					

ANEXO D – CHILD PERCEPTION QUESTIONNAIRE (CPQ 11-14)

CPQ-11-14

Você diria que a saúde de seus dentes, lábios, maxilares e boca é:
( ) Excelente ( ) Boa ( ) Regular ( ) Ruim

Até que ponto a condição dos seus dentes, lábios, maxilares e boca afetam sua vida em geral?
( ) De jeito nenhum ( ) Um pouco ( ) Moderadamente ( ) Bastante ( ) Muitíssimo

PERGUNTAS SOBRE PROBLEMAS BUCAIS

Nos últimos 3 meses, com que frequência você teve?

	nunca	1 ou 2 vezes	algumas vezes	frequentemente	todos os dias ou quase todos
1. Dor nos seus dentes, lábios, maxilares ou boca?					
2. Feridas na boca?					
3. Mau hálito?					
4. Restos de alimentos presos dentro ou entre os seus dentes?					
5. Demorou mais que os outros para terminar sua refeição?					
6. Dificuldade para morder ou mastigar alimentos como maçãs, espiga de milho ou carne?					
7. Dificuldades para dizer algumas palavras?					
8. Dificuldades para beber ou comer alimentos quentes ou frios?					
9. Ficou irritado (a) ou frustrado (a)?					
10. Ficou tímido (a), constrangido (a) ou com vergonha?					
11. Ficou chateado?					
12. Ficou preocupado com o que as outras pessoas pensam sobre seus dentes, lábios, boca ou maxilares?					
13. Evitou sorrir ou dar risadas quando está com outras crianças?					
14. Discutiu com outras crianças ou pessoas de sua família?					
15. Outras crianças lhe aborreceram ou lhe chamaram por apelidos?					
16. Outras crianças fizeram perguntas sobre seus dentes, lábios, maxilares e boca?					

ANEXO E – QUESTIONÁRIO DE BULLYING DE OLWEUS – VÍTIMA

Questionário de Bullying de Olweus – Vítima

Instruções: você vai encontrar abaixo uma lista de situações nas quais pode ter se envolvido na escola. Assinale com um X a resposta que melhor representa a frequência com que você se envolveu nessa situação *no último mês*.

		Nenhuma vez	Uma ou duas vezes por mês	Uma ou mais vezes por semana
01	Me deram socos, pontapés ou empurrões	☐	☐	☐
02	Puxaram meu cabelo ou me arranharam	☐	☐	☐
03	Me ameaçaram	☐	☐	☐
04	Fui obrigado(a) a entregar dinheiro ou minhas coisas	☐	☐	☐
05	Pegaram sem consentimento meu dinheiro ou minhas coisas	☐	☐	☐
06	Estragaram minhas coisas	☐	☐	☐
07	Me xingaram	☐	☐	☐
08	Me insultaram por causa da minha cor ou raça	☐	☐	☐
09	Me insultaram por causa de alguma característica física	☐	☐	☐
10	Fui humilhado(a) por causa da minha orientação sexual ou trejeito	☐	☐	☐
11	Fizeram zoações por causa do meu sotaque	☐	☐	☐
12	Deram risadas e apontaram para mim	☐	☐	☐
13	Colocaram apelidos em mim que eu não gostei	☐	☐	☐
14	Fui encurralado(a) ou colocado(a) contra a parede	☐	☐	☐
15	Fui perseguido(a) dentro ou fora da escola	☐	☐	☐
16	Fui sexualmente assediado(a)	☐	☐	☐
17	Não me deixaram fazer parte de um grupo de colegas	☐	☐	☐
18	Me ignoraram completamente, me deram "gelo"	☐	☐	☐
19	Inventaram que peguei coisas dos colegas	☐	☐	☐
20	Disseram coisas maldosas sobre mim ou sobre minha família	☐	☐	☐
21	Fizeram ou tentaram fazer com que os outros não gostassem de mim	☐	☐	☐
22	Fui forçado(a) a agredir outro(a) colega	☐	☐	☐
23	Usaram da internet ou celular para me agredir	☐	☐	☐

APÊNDICE A – QUESTIONÁRIO DEMOGRÁFICO E SOCIOECONÔMICO

Questionário demográfico e socioeconômico

1) Estrutura familiar - você mora com? ( ) Pai e mãe ( ) Só com a mãe ( ) Só com o pai ( ) Outro
2) Quantos cômodos tem na sua casa (exceto banheiro)? _____
3) Contando com você, quantas pessoas moram na sua casa ou apartamento? _____
4) Qual é o rendimento mensal, em reais, de todos que moram na casa? _____
5) De que raça você se considera? ( ) Branco ( ) Parda ( ) Preta ( ) Amarela ( ) Indígena
6) Escolaridade materna: ( ) Não estudou ( ) 1° grau incompleto ( ) 1° grau completo ( ) 2° grau incompleto ( ) 2° grau completo ( ) 3° grau incompleto ( ) 3° grau completo

Questionário comportamental (higiene, uso de serviços, dieta e hábitos nocivos)

7) Como você considera ser desempenho escolar? ( ) Excelente ( ) Bom ( ) Regular ( ) Ruim
8) No último mês, quantas vezes por dia você escovou os seus dentes? ( ) Não escovo os dentes diariamente ( ) Uma vez por dia ( ) Duas vezes por dia ( ) Três vezes por dia ( ) Quatro ou mais vezes por dia
9) Você utiliza fio dental? ( ) Não utilizo ( ) Menos de uma vez ao dia ( ) 1 vez por dia
10) Quanto medo você tem de visitar um dentista? ( ) De jeito nenhum ( ) Um pouco ( ) Muito
11) No último ano (12 meses) quantas vezes você foi ao dentista? ( ) Nenhuma vez ( ) 1 vez ( ) 2 vezes ( ) 3 vezes ou mais
12) Qual foi o motivo da última consulta? ( ) Dor de dente ( ) Dor na boca ( ) Batidas e quedas ( ) Rotina ( ) Aparelho ( ) Outros:_____ ( ) Nunca fui.
13) Qual foi o tipo de serviço que você procurou na última consulta? ( ) Dentista particular ( ) Público
14) Você acha que necessita de tratamento dentário atualmente? ( ) Não ( ) Sim
15) Com que frequência você consome alimentos ou bebidas açucaradas? ( ) Três ou mais vezes por dia ( ) Duas vezes por dia ( ) Pelo menos uma vez por dia ( ) Menos de uma vez por dia; ( ) Nunca/quase nunca
16) Você range seus dentes enquanto dorme? ( ) Sim ( ) Não
17) Como você classificaria a qualidade do seu sono? ( ) Eu durmo bem/boa qualidade ( ) Eu durmo mal
18) No último mês, quantos dias você fumou cigarros? ( ) Nunca experimentei ( ) ____ dia(s)
19) No último mês, quantos dias você consumiu bebida alcoólica? ( ) Não bebi ( ) _____dia(s)
20) Qual droga você já experimentou? ( ) Nenhuma ( ) Nome da droga: _____