UNIVERSIDADE ESTADUAL PAULISTA – UNESP

Faculdade de Odontologia de Araraquara

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PERCEPÇÕES E ATITUDES DE ESTUDANTES DE ODONTOLOGIA SOBRE A POBREZA

Dissertação apresentada ao Programa de Pós-Graduação em Ciências Odontológicas - Área de Odontopediatria da Faculdade de Odontologia de Araraquara da Universidade Estadual Paulista, para o título de Mestre em Ciências Odontológicas.

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"De modo suave, você pode sacudir o mundo."

Mahatma Gandhi

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Dedico este trabalho....

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"Há escolas que são gaiolas e há escolas que são asas."

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Resumo

Ferraz-Santos B. Percepções e atitudes dos estudantes de odontologia sobre a pobreza [Dissertação de Mestrado]. Araraquara: Faculdade de Odontologia da UNESP; 2011.

RESUMO

Doenças bucais são prevalentes em pessoas que vivem na pobreza. Esse fenômeno complexo pode ser explicado por diversos fatores, sendo as barreiras no acesso aos serviços de saúde bucal uma das princípais causas. Além da falta de recursos, pessoas pobres também subutilizam os serviços odontológicos devido às experiências negativas na clínica odontológica. Uma possível razão é que a conceituação, percepção e atitude dos profissionais em relação a pobreza geram impactos diretos sobre a qualidade do cuidado em saúde bucal bem como na relação com os pacientes desfavorecidos. Entendendo que os estudantes serão os futuros profissionais, o objetivo desse estudo foi desvelar a percepção e as atitudes de estudantes de Odontologia sobre a pobreza e as pessoas pobres. Para isso foi realizada uma *survey descritiva* com os alunos regularmente matriculados no curso de graduação em Odontologia de Universidades Públicas do Estado de São Paulo. Um questionário semi-estruturado foi respondido pelos alunos que aceitaram participar da pesquisa a fim de identificar: 1) os dados gerais dos estudantes; 2) a prática profissional futura pretendida por eles; 3) a percepção e as atitudes dos mesmos com relação a pobreza e as pessoas pobres; 4) e dados sócio-econômicos. Análise descritiva dos dados, cross-tabs e regressão logística com intervalo de confiança de 95% (IC) foram usadas para avaliar a diferença entre os grupos. A análise estatística foi complemetada pela análise fatorial. Foi demonstrado que a prática profissional intencionada pelos estudantes de Odontologia é a de se tornar especialista. Associações foram observadas entre gênero, nível sócio-econômico, universidade e ano de graduação e a intenção de seguir a carreira no serviço público de saúde. O senso de responsabilidade profissional para prestar atendimento as populações marginalizadas, bem como as percepções quanto as atitudes do estudantes de odontologia com relação as pessoas

pobres foram consideradas moderadamente positivas. Foi observada uma tendência entre os estudantes em atribuir a pobreza a fatores individuais, além da existência da crença em diferença de valores entre as pessoas pobres e os demais membros da sociedade. Fatores individuais, como sexo e nível socioeconômico, universidade e ano de graduação foram significantemente associados com o senso de responsabilidade profissional dos estudantes de odontologia. Além disso, características individuais, como genêro e idade, foram possíveis preditores relacionados com as percepções sobre as pessoas pobres. Este estudo demonstrou importantes questões relacionadas com a prática intencionada pelos estudantes as quais contribuem para planejamentos eficientes para adequar e melhorar a força de trabalho no setor odontológico e no ensino de odontologia.

Palavras-chave: saúde bucal, pobreza, acesso aos serviços de saúde, desigualdades em saúde, educação em saúde.

Abstract

Ferraz-Santos B. Perceptions and attitudes of dental students towards poverty [Dissertação de Mestrado]. Araraquara: Faculdade de Odontologia da UNESP; 2011.

ABSTRACT

Oral diseases are prevalent amongst people living in poverty. This complex phenomenon can be explained by several factors. The barriers preventing access to oral health services is a major cause. Poor people underutilize dental services due to negative experiences in clinical dentistry. One possible reason is that the conception, perception and attitude of professionals towards poverty generate direct impacts on the quality of care in oral health as well as in relation to disadvantaged patients. Understanding that students are future professionals, the aim of this study was to examine the perceptions and attitudes of dental students about poverty and poor people. A cross sectional study was carried out with students enrolled in the undergraduate program in dental public universities in the state of São Paulo. A semi-structured questionnaire was answered by the students who agreed to participate in the research to identify: 1) the profile of the students, 2) the desired future practice for them, 3) the perception and attitudes of dental students towards poverty and poor people, 4) and socioeconomic data. Descriptive analysis, cross-tabs and logistic regression with confidence interval 95% (CI) were used to evaluate the differences between the groups. Statistical analysis was supplemented by factor analysis. Our study has shown that the practice intended by the dental students is to become a specialist. Associations were observed between gender, socioeconomic status, university and graduation year and students' intentions to pursue a career in public health service. The sense of professional responsibility to provide care for disadvantaged populations as well as the perceptions and attitudes of dental students about the poor were considered moderately positive. We observed a tendency among students to attribute poverty to individual factors, besides the existence of the gap between values of poor and the other members of society. Individual factors such as gender and socioeconomic level, university and graduation year were risk factors associated with the sense of

professional responsibility for dental students. In addition, individual characteristics such as gender and age are predictors related to perceptions of poor people. This study showed important issues related to practices intended by the students contributing to an efficient planning of the emergent workforce in the dental sector. However, further studies are needed to identify the possible factors involved in the dental students' perceptions and attitudes toward poor people and their influence on future practice intended for them.

Keywords: oral health, poverty, health service accessibility, dental education, health status disparities.

Introdução

Pobreza é um fenômeno multidimensional e dinâmico e não se restringe apenas ao bem-estar sócio-econômico mas envolve, também, padrões como exclusão social, que pode ser entendida como a marginalização dos estrados sociais inferiores pela sociedade; e capacidade, decorrente da falta das competências individuais, como saúde, educação e condições de moradia, considerados essenciais para alcançar um nível de bem-estar[51].

Apesar da melhoria nos índices de saúde da população mundial, a existência de iniquidades em saúde já foram bem reportadas[19,22] e constituem um dos principais desafios para a saúde pública. Piores condições de saúde e pobreza se articulam numa causalidade bidirecional, onde as pessoas inseridas em posições sociais menos privilegiadas apresentam maior vulnerabilidade a fatores de risco do que os indivíduos de setores sociais mais pivilegiados[36,44].

Estudos demonstram a estreita relação entre pobreza e problemas de saúde bucal[47,49]. Com a existência das disparidades em saúde, bem como do gradiente social, os indivíduos inseridos nos estrados sociais inferiores apresentam índices significativamente maiores de doenças bucais[34,52]. Esse fenômeno complexo pode ser explicado por diversos fatores, tais como, condições individuais - nível sócio-econômico[45,46], renda familiar[38], nível educacional da mãe[40]; distribuição desigual de fatores de risco na população[24,26]; e barreiras no acesso aos serviços de saúde bucal[4,25].

As doenças bucais geram impactos funcionais, psicológicos e sociais. Pessoas pobres carregam marcas impressas na dentição que exprimem suas realidades e seus modos de vida, interferindo em sua auto-estima, relações sociais e profissionais e em sua saúde mental[7,28,39]. Assim a aparência bucal precária de populações vulneráveis amplifica as desigualdades e a exclusão social.

Nos países em desenvolvimento a influência da desigualdade sócio-econômica na saúde bucal é semelhante a dos países desenvolvidos[1]. Fatores como privação social, desigualdade de renda e coesão social apresentam reflexos diretos no processo saúde-doença e determinam, por exemplo, as diferenças na distribuição da cárie dentária na população[42].

No Brasil, apesar do grande contingente de cirurgiões-dentistas e do avanço na área preventiva e tecnológica, dados do último estudo epidemiológico em saúde bucal de base populacional realizado pelo Ministério da Saúde[12] em 2003, reafirmam o paradoxo das iniquidades em saúde bucal, pois revelam a maior prevalência das doenças bucais nas regiões mais pobres do país (Nordeste, Centro-Oeste e Norte).

A associação entre pobreza e condição bucal precária é potencializada pela dificuldade de acesso aos serviços de saúde. Assim como em países desenvolvidos, estudos nacionais[3,20] apontam desigualdades no acesso e utilização dos serviços de saúde bucal no país.

Diante deste contexto, as diferentes barreiras no acesso aos serviços odontológicos pelos grupos desfavorecidos tem sido objeto de investigação de muitos pesquisadores[5,14,43]. Vários fatores explicam as desigualdades no acesso incluindo financiamento público insuficiente no setor, questões estruturais relativas a abastecimento, produtividade e distribuição geográfica dos dentistas[48]. Além disso, a desigualdade no acesso tem sido associada também a fatores individuais tais como barreiras psicológicas, baixo nível educacional e a pouca procura dos grupos desfavorecidos aos serviços de saúde [4,25].

Atualmente a barreira no acesso aos serviços tem sido relacionada principalmente no nível das relações entre os prestadores de serviços odontológicos (profissionais) e os pacientes carentes. As pessoas pobres subutilizam os serviços odontológicos devido as

experiências negativas vivenciadas na clínica, onde os pacientes relatam sentimentos de rejeição e estigmatização[5,6,30]

A conceituação, percepção e atitude dos profissionais em relação a pobreza geram impactos diretos sobre a qualidade do cuidado em saúde bucal bem como na relação com os pacientes desfavorecidos. Estudos mostram que os dentistas apresentam dificuldades em se relacionar com pacientes de baixa renda, e essas nuances estão relacionadas as diferenças sócio-culturais, presença irregular no tratamento e barreiras de comunicação[33,35,43].

Entendendo que prestar atendimento odontológico é essencial para a melhoria dos índices de saúde bucal das populações desprovidas e, que as percepções e atitudes dos profissionais com relação a pobreza refletem diretamente no relacionamento com os pacientes que vivem nesta condição, é de suma importância que essa temática seja abordada durante os anos formativos dos profissionais.

A Odontologia, enquanto núcleo de conhecimento, pela sua concepção flexneriana e sua conformação ao modelo assistencial curativo, privilegia, de modo geral, a formação centrada no indivíduo e nas práticas curativas, onde é enfatizado o tratamento das sequelas das doenças bucais, a tecnificação do ato de curar e o desinteresse pelas ações de promoção e prevenção das doenças, distanciando o profissional de uma prática odontológica socialmente dirigida[18].

No tocante da formação laboral odontológica, já foi constatada a existência de uma crise educacional mundial, um esgotamento entre o paradigma da formação e da saúde bucal da população[2,9,18,21].

Neste contexto, trabalhos discutem a importância da reestruturação curricular dos cursos de Odontologia[8,13,17,29]. Smith et al[50], encontraram relação positiva entre a estrutura do currículo odontológico com foco no tratamento de pacientes de diversos níveis sociais e a

intenção dos estudantes de Odontologia em prestararem atendimento as populações socialmente marginalizadas em sua prática futura. Outros estudos[14,16,27,31,32,37] demostram que a introdução de programas comunitários no currículo odontológico contribuem positivamente para o conforto e a disponibilidade dos estudantes de Odontologia em prestarem futuramente atendimento para as pessoas pobres.

As percepções e atitudes dos estudantes de Odontologia com relação a pobreza e as pessoas inseridas em posições sociais menos privilegiadas ainda não foram estudas em grande profundidade. Um estudo realizado nos Estados Unidos com os estudantes de Odontologia demonstrou que 70% deles acreditam que garantir e prestar assistência a todos os segmentos da sociedade é uma obrigação ética e profissional[41]. Contudo não revelou as pecepções dos estudantes sobre a temática da pobreza.

Dessa forma, o objetivo deste estudo é avaliar as percepções e atitudes dos estudantes de Odontologia sobre a pobreza, assim como suas intenções com relação a prática profissional, contribuindo assim para um melhor entendimento de como os futuros prestadores de cuidados bucais irão lidar com esta problemática e com seus pacientes pobres

Proposição

Proposição Geral

O objetivo do presente estudo é desvelar e comparar a percepção e as atitudes dos estudantes de Odontologia sobre a pobreza e suas intenções quanto a futura prática profissional.

Proposições Específicas

Estudo 1: Access to oral health care: an analysis of dental students' intentions and motivations towards professional career.

Identificar a motivação dos estudantes pela escolha do curso de Odontologia, bem como a prática profissional intencionada por eles. Avaliar os possíveis fatores associados quanto da intenção de seguir carreira no serviço público de saúde.

Estudo 2: Inequalities in oral health and social justice: how dental students perceive the poor?

Analisar a intenção dos estudantes de odontologia em prestar atendimento as populações carentes após concluírem o curso de graduação e identificar fatores envolvidos com as percepções e atitudes dos mesmos com relação as pessoas pobres.

Estudo 1

ACCESS TO ORAL HEALTH CARE: AN ANALYSIS OF DENTAL STUDENTS' INTENTIONS AND MOTIVATIONS TOWARDS PROFESSIONAL CAREER.

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ABSTRACT

Investigating career choices and future career intentions of dental students allows a better understanding of their role in society and adds to the debate on dental education and practices. This study aimed to describe the profile, career choice motivations and future career intentions of Brazilian dental students. In addition, we evaluate whether students' socio demographic background and the university where they were trained influence their future intentions to pursue a public services career. A cross-sectional study was carried out among all dental students enrolled in three Brazilian Universities in 2010 (N=905). A total of 766 students responded to a self-administered questionnaire (response rate= 83.7%) comprising of 21 questions related to socio-demographic factors, reasons for choosing dentistry as a career, and future career intentions. Following descriptive statistics, we carried out logistic regression to evaluate the associations between the university training, socio-demographic factors, and students' intentions to work in the public services. Our descriptive results show that the main reason for choosing dentistry as a profession was job conception. In addition, most students intended to become specialists and work in both public and private sectors. Gender (female vs. male students (OR) 2.23 95% confidence interval (CI): =1.62-3.08), socioeconomic background (low income vs. high income level (OR) 1.86 95% (CI) = 1.10-3.13) university (university A vs. university B and C (OR) 0.59 95% (CI) = 0.40-0.89) and year enrolled in the university (first and second year vs. third and fourth (OR) 1.87 95% (CI) = 1.22-2.85) were the factors influencing dental students' intention to work in the public sectors.

Keywords: dental education, student, career choice, professional practice, access to oral health care, oral health care workforce.

INTRODUCTION

The existence of the social gradient in oral health leading to oral health inequality has sparked research in public health that aims at identifying and understanding the primary causes of the problem[1,2]. Differences in access to oral health care services[3] is one of the major contributions to these inequalities. While people in the high socioeconomic strata have abundant access to private or insured dental care, those in the low strata cannot afford the high fees and are dependent solely on the public system. In addition, current characteristics of the dental workforce such as over-specialization and business-oriented professionals result in the lack of oral health providers with a broad understanding of the society in which they work.[4]

To better understand the above situation and, in the long term, find the means for a change, several studies have investigated students' motivation for choosing the dental career and their future career intentions [5-14]. Among the factors identified are the assurance of employment opportunities, the conception of dentistry as a profession, the influence of family members and the perception of dentistry as a profitable carrier. Taken together, these results indicate that students generally choose dentistry for personal fulfillment and for the high professional status. Rarely altruism and empathy towards population oral health status explain dental students' career choices. Individual background and experiences, personal values and beliefs[15] as well as socio-economic factors seem to have an impact on the decision to study dentistry[7,12,13,16].

The Ministry of Health in Brazil[17,18] has recently adopted new policies to increase access to health care for disadvantaged populations. However, the success of these policies is largely dependent on the willingness of dental professionals to work in the public health service and with socially deprived patients, which in turn is directly related to the dental

students' profiles and their future career intentions. In other words the selection and training of dental students are essential stages which determine whether dental schools produce professionals tailored to the needs of the population or not. The purpose of this study was, to describe the profile, career choice main motivation and future career intentions of the emerging dental workforce in Brazil. In addition, we evaluated whether students' socio demographic background and the university they were trained influenced their future intentions to pursue a public services career.

METHODS

In 2010, we carried out a cross sectional survey aimed at evaluating dental students' perceptions of poverty, future career choices and intentions. Three out of 7 public dental schools located in the state of São Paulo State, Brazil were conveniently selected to be part of this survey. All students regularly enrolled in these schools in 2010 were invited to participate in this project (N=915). The study was approved by the Ethics Committee of Araraquara Dental School and all the participants signed a consent form. Participation was voluntary and anonymous.

The research instrument was a self-administered questionnaire. This survey was completed during regularly scheduled class sessions in an average time of 10 minutes. The questionnaire, designed to maximize response rate and minimize missing data, consisted of 21 closed and open questions concerning socio-demographic factors, reasons for choosing dentistry as a career, and future career intentions. The latter included type of practice intended after graduating (private, public or both), the reasons for this choice and intentions to pursue specialist career. An open-ended question addressed reasons for choosing dentistry. The questions were selected from previous similar studies[5-8,10] and adapted to the Brazilian context. We conducted a pilot study among graduate dental students (22 males and females)

to evaluate the questions' format and sequence which led to minor modifications (e.g., clarity of the questions).

Data were analyzed using the statistical software program PASW Statistics version 18.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics were used to report percentages of respondents for selected socio-demographic variables and to describe aspects related with career choice. To evaluate differences in the students' responses a Pearson's chi-square test was performed. For the open-ended question on reasons for choosing dentistry, responses were classified into categories using a content analysis technique[19]. Associations between the university training, socio demographic factors, and students' intentions to work in the public system were evaluated using a logistic regression. Our dependent variable, intention to work in the public sector, was defined as students intending to work only in the private sector against those intending to work either in the public sector only or in both the public and private sectors. Statistical significance was based on probability values of less or equal 0.05.

RESULTS

Out of 915 students enrolled in the studied schools, 766 participated in our survey representing an overall response rate of 83.7%. The majority of participants were female (n=518, 67.6%) and the age of the students ranged from 18 to 34 (mean= 21; SD= 2) (Table 1). More than half of the students' had parents with university degrees and were from high-income families (Table 1).

As can be seen in Table 2, professional conception was the primary students' motivation for choosing dentistry as a career (37.4 %), followed by the applied aspect of this health science (19.3%), personal fulfillment (15.9 %) and the influence of others (11.4 %). Professional conception answers were related to knowledge of dentistry, involvement with manual abilities, professional fulfillment, admiration for dentistry, career flexibility and

vocation. Dentistry was not the first career choice for 3.2% of students. Furthermore, only 4.3% of the total sample chose dentistry with the desire of contributing to people's health. The choice of dental career based on lucrative reasons was given by 1.9% of students.

The majority of students revealed their intention to work as a specialist (80.2%), whereas 11% intended to become general dentists and 8.9% intended to work in the academic area. University B had the highest number of responses for intention to become general dentist and University A had the highest number of responses for intention to work in the academic area (Table 3).

The type of practice that the students intended to have after graduating also varied among universities. More than half of students intend to work in both public services and private clinics (59.5 %). The intention to work only in private clinics received the highest number of responses among students at University C (47%). The main reason given by those who intend to work in public services was job security (80.3%, Table 3).

Odds ratios and 95% confidence intervals (CI) from logistic regression models were conducted to assess the associations between selected characteristics (e.g., sociodemographic, the university the students attended) and students' intentions to work only in the public service or in both public and private sectors. The results showed that female students (OR 2.23 95% CI=1.62-3.08) and those from a low income level (OR 1.86 95% CI= 1.10-3.13) were more likely to report that they intend to work in public services when compared to males students and those from high income groups (Table 4). Students at University C were 60% less inclined to work in public service compared to students at University A. Similarly, first and second year dental students, compared to fourth year dental students, were more likely (OR 1.54 95% CI= 1.01-2.34) and (OR=1.87 95% CI= 1.22-2.85) respectively to report their intention to work either only in the public sector or both public and private.

DISCUSSION

Before discussing our findings, it is important to provide some information for readers who are not familiar with the dental education and profession in Brazil. The public dental universities included in this study are among the most renowned in Brazil and therefore admission is an extremely competitive process. To pass the exam and be admitted to these schools, applicants need a strong secondary education, which is usually achieved in private and expensive colleges. These colleges' high fees are a strong selective factor towards high family income. It is well recognized that social economic position plays an important role in educational attainment and accessing higher education. This fact explains the homogeneity of our sample regarding social background, which includes students with high family income, private previous education and high parents' education level.

Similar to previous Brazilian studies, our results showed that the number of female dental students has exceeded that of men[5,8]. These findings have been also observed in other countries including the United States[12], Denmark[20], France[21], and the United Kingdom[13]. The dental profession is attractive to women as it allows a balance between personal and professional lives. In addition, women see dentistry as a way to work with others, achieve financial gain and professional prestige [12,22,23].

Large differences may exist in attitudes about educational issues and career choices among dental students. We evaluated dental students' motivation for choosing dentistry as career and explored whether students' future career intentions may be influenced by their cultural and social background. Our findings regarding the reasons for choosing dentistry are in agreement with many previous studies[8,16,24-27]. In general, the main reason for studying dentistry in this sample was related to the characteristics of the profession (38%). Other

reasons chosen by a quarter of the sample was the influence of others and personal fulfillment.

There is considerable evidence in the literature that financial reasons influence the occupation decision making process of dental students[20,28,29]. However, in our study financial motives were chosen least often as a career choice motivation. These findings are likely to reflect the increase in the number of dentists. Although the profession was known to be highly profitable two decades ago, there has been a substantial increase in the number of dental schools in Brazil leading to exponential increase in the dentist/population ratio[30]. Consequently, dentists have been forced to lower their fees to competitive levels to attract patients in addition to having continuously fewer patients and lower incomes. Therefore, it is likely that Brazilian dental students have a more realistic financial expectation of the profession and do not count on a future income level as high as it was a few decades ago. The fact that we explored the issue with an open-ended question further ensures a meaningful and honest answer from the students.

The present situation of the dental profession in Brazil, which resulted in lower incomes for dentists probably explains in part the wish of most dental students' to pursue further specialty training after graduating, even at an early stage in their studies. A further explanation also supported by previous studies[26,31] reflects the aspiration of higher earnings in combination with a higher professional status compared to general dentists. Given that the general population has high demands for basic oral treatments, the large numbers of students who plan to become specialists are in contradiction with the expectations and needs of society.

The majority of dental students surveyed intend to work both in public services and private sectors, although the main reason for this planning to work in public services was job

security (80.3 %). In fact, Brazilian public health services usually pay modest salaries, but it provides job stability and several other benefits in addition to allowing professionals to work in private practices. A high percentage of dental students (38 %) stated a preference to work entirely in a private clinic, with only 3 percent planning to work exclusively within the public services. Our finding confirms those of similar studies in the United Kingdom[10,23], and may be of considerable importance in predicting possible workforce patterns for the National Health System in the future.

It is worth commenting that despite equity of access to care being a principle of the National Health System in Brazil, the distribution of dental care providers towards the most profitable markets, private services, creates a gap in the access to oral health care for the majority of population that continues to live in poverty. Our findings concerning dental students' intentions support the existence of the inverse care law in dentistry, which states that "Those with the least need of health care use the health services more, and more effectively, than do those with greatest need" [32].

There are a myriad of reasons for career aspirations of dental students and personal factors are perceived as key influences on future careers. The regression analysis model showed an important effect of socio-economic position in the students' future intentions to work in public services after graduating. Dental students from lower income groups are more inclined to work in public services. Considering the high prevalence of dental students coming from higher social backgrounds, this finding is at odds with the concern of the National Health System for an effective public accessibility and dental treatment. The problem may be slightly alleviated by the findings that female students, which make almost 70% of our sample, are more likely to work in public services. However, women dentists tend to have more career interruptions due to family care and therefore contribute less to public care in the long-term[12,23].

Future intention to work in public services was also significantly affected by the university in which students are enrolled and year of graduation. The differences found suggest that the educational philosophy and dental curriculum which can vary among schools may influence the students' future career intentions to work in public services. Although it is beyond the scope of this study to evaluate differences in curricula between schools, it is worth mentioning that recent guidelines have been set by the Brazilian Ministries of Education and Health [17,18] with the aim to regulate the training and education of health professionals based on the principles of the National Health System. These principles emphasize universality, equity and holistic health care for all citizens and schools have been gradually adapting their program in accordance with these principles. Interestingly, of the evaluated schools University A and B had their program adapted while University C has not changed its curriculum yet, which could may partly explain our results. Similar to other studies year of graduation also had a significant impact on the intention to work in public services, with students in years 1 and 2 having higher chances to respond positively than students in years 3 and 4. Senior students could be more concerned about their future financial situation than junior students, influencing their decisions toward working in private clinics. Furthermore, due to the educational system in Brazil students apply to university studies at a very young age (18) on average, many without ever having had to worry about personal finances. Indeed, dental students in the initial years of their studies, tend to have a more idealistic view of the profession compared to final year students who progressively build throughout the course a positive view of the private practice[33]. However, research on the impact of years spent in dental school in the students' career intentions is lacking and should be thoroughly explored with a cohort study design.

A few study limitations merit mention. First, the cross-sectional study design used does not allow us to establish whether dental students' future career intentions change over

time. Second, the sample was recruited from three public dental universities located in São Paulo State and results cannot be generalized to all dental students in Brazil. However, our study had a high response rate and included renowned institutions and all Brazilian public universities located in the northwest region of São Paulo State. Therefore it provides an overview of the future dental workforce trained by these institutions.

CONCLUSION

In conclusion, the findings of our study raise important issues about the students' professional motivations and highlight future career intentions of dental students which could contribute to a more efficient planning of the workforce in the dental sector. This study also has implications for the Educators' responsibility to help students developed an acquisition of public service values and reinforce altruistic motives in its students in order to develop the oral health care to the public need. Our findings also highlight the importance of current efforts to improve and standardize a socially competent curriculum in Brazilian dental schools. However, it should be noted that there could be potential differences in knowledge and attitudes between students at the schools evaluated compared with other Brazilian dental schools. Future research should be encouraged to explore the factors that may be involved in dental students' career decisions. More studies are therefore needed to evaluate whether current dental curricula changes will impact the development of the dental workforce in Brazil.

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Table 1. Profile of students, by number and percentage of total at each school and total of three schools

Variables	University A N(%)	University B N(%)	University C N(%)	Total (N=766)
Age				
< 20 yrs	132 (37.7)	112 (44.3)	79 (48.5)	323 (42.2)
21 - 24 yrs	195 (55.7)	130 (51.4)	78 (47.9)	403 (52.6)
> 20 yrs	23 (6.6)	11 (4.3)	6 (3.7)	40 (5.2)
Gender				
Female	252 (72)	165 (65.2)	101 (62)	518 (67.6)
Male	98 (28)	88 (34.2)	62 (38)	248 (32.4)
Family Income				
R$ 510 - 3060,00	76 (21.7)	69 (27.3)	26 (16)	171 (22.3)
R$ 3060- 7650,00	87 (24.9)	69 (27.3)	50 (30.7)	206 (26.9)
R$ 7650 - 10200,00	100 (28.6)	77 (30.4)	41 (25.2)	218 (28.5)
> R$ 10200,00	87 (24.9)	38 (15)	46 (28.2)	171 (22.3)
Mother's education				
Elementary	24 (6.9)	19 (7.5)	8 (4.9)	51 (6.7)
High school	127 (36.3)	86 (34)	46 (28.2)	259 (33.8)
University	199 (56.9)	148 (58.5)	109 (66.9)	456 (59.5)
Father's education				
Elementary	28 (8)	27 (10.7)	8 (4.9)	63 (8.2)
High school	119 (34)	76 (30)	41 (25.2)	236 (30.8)
University	203 (58)	150 (59.3)	114 (69.9)	467 (61)
Students' Previous Education				
Public school	42 (12)	36 (14.2)	16 (9.8)	94 (12.3)
Private school	308 (88)	217 (85.8)	147 (90.2)	672 (87.7)

Table 2. Reasons for choosing destistry as a career

Reason	
Job conception	287 (37.4)
Health Science	148 (19.3)
Personal fulfillment	122 (15.9)
Influence of others	88 (11.4)
I don't know	48 (6.2)
Contribution to peoples' health	33 (4.3)
Second option	25 (3.2)
Finantial motives	15 (1.9)
Total	766 (100)

Table 3. Type of practice intended, by number and percentage of total respodents at each dental school

Variables	University A N(%)	University B N(%)	University C N(%)	p-value	Total (N=766)
Professional Goal					
General	35 (10)	36 (14.2)	13 (8)	0.037	84 (11)
Specialist	267 (76.3)	208 (82.2)	139 (85.3)		614 (80.2)
Professor/ Research	48 (13.7)	9 (3.6)	11 (6.7)		68 (8.9)
Type of practice					
Public services	14 (4)	5 (2)	2 (1.2)	0.000	21 (2.7)
Private clinics	122 (34.9)	91 (36)	76 (46.6)		289 (37.7)
Both	214 (61.1)	157 (62.1)	85 (52.1)		456 (59.5)
Public Service Motivation					
Job security	192 (84.2)	121 (74.7)	70 (80.5)	0.066	383 (80.3)
Find likeable	36 (15.8)	41 (25.3)	17 (19.5)		94 (19.7)

Table 4. Logistic regression model for students intention to work in public services (N=766)

Variables	Type of practice N(%) public service&both	private	Unadjusted Odds Ratio (95% Cl)	Adjusted Odds Ratio (95% Cl)
Gender				
Male	121 (25.4)	127 (43.9)	Reference	
Female	356 (74.6)	162 (56.1)	2.30 (1.69 - 3.14)	2.23 (1.62 - 3.08)
Parents' Education Level				
Both parents with elementary school	20 (4.2)	7 (2.4)	Reference	
At least one of the parents with elementary	37 (7.6)	23 (8)	0.56 (0.20 - 1.53)	0.61 (0.21 - 1.73)
No one with elementary	420 (88.1)	259 (89.6)	0.56 (0.23 - 1.36)	0.62 (0.25 - 1.55)
Family Income				
R$ 7000.00	89 (18.7)	80 (27.7)	Reference	
R$ 4561.58	165 (34.6)	109 (37.7)	1.36 (0.92 - 2.00)	1.30 (0.87 - . 1.95)
R$ 2677.50	146 (30.6)	63 (21.8)	2.08 (1.36 - 3.17)	2.03 (1.31 - 3.16)
R$ 892.50	77 (16.1)	37 (12.8)	1.87 (1.14 - 3.06)	1.86 (1.10 - 3.13)
University				
University A	228 (47.8)	122 (42.2)	Reference	
University B	162 (34)	91 (31.5)	0.95 (0.67 - 1.33)	0.90 (0.63 - 1.29)
University C	87 (18.2)	76 (26.3)	0.61 (0.42 - 0.89)	0.59 (0.40 - 0.89)
Student graduation year				
4rd yr	135 (28.3)	102 (35.3)	Reference	
3rd yr	89 (18.7)	70 (24.2)	0.96 (0.64 - 1.44)	1.00 (0.65 - 1.53)
2nd yr	130 (27.3)	56 (19.4)	1.75 (1.17 - 2.63)	1.87 (1.22 - 2.85)
1sr yr	123 (25.8)	61 (21.1)	1.52 (1.02 - 2.27)	1.54 (1.01 - 2.34)

Estudo 2

INEQUALITIES IN ORAL HEALTH AND SOCIAL JUSTICE: HOW DENTAL STUDENTS PERCEIVE THE POOR?

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ABSTRACT

The purpose of this study was to analyze dental students' future intentions in treating disadvantage patients after completing undergraduate dental school and their perceptions and attitudes toward poor people. Moreover, this study explore whether students' socio demographic background and the university where they were trained influence their future intentions of treating disadvantage people and their beliefs towards the poor. A total of 766 dental students were surveyed. All participants were enrolled in three dental universities in the state of São Paulo, Brazil, in 2010. Descriptive analyses, Pearson's chi-square, factor analysis and logistic regression were performed for the statistical analysis of the data. Statistical significance was based on probability values of less or equal 0.05. The results of the surveys revealed that dental students had positively sense of professional responsibility to treat disadvantage population. Moreover, dental students had a positive feeling toward the characteristics of poor. The findings of this study raise important insights towards the disparities in oral health in the future which could contribute to a more efficient planning to improve access to oral health care for disadvantage patients. Overall this study shows that improvements in dental education are needed to build an effective health care workforce to meet the oral health needs for all.

Keywords: access to oral health care, oral health inequalities, social responsibility, poverty, dental education.

INTRODUCTION

Due to the well documented existence of disparities in health as well as the social gradient (Locker, 2000; Watt & Sheiham, 1999), disadvantaged and socially marginalized populations have higher prevalence of oral diseases (Sanders, Spencer & Slade, 2006; Sgan-Cohen & Mann, 2007). This complex phenomenon is explained in part by individual conditions and barriers to access to oral health care. The growth of the specialized dental workforce and individualistic dental approaches may have increased the deficient access to oral health care for the underserved people (Dal Poz, Quain, O'Neil, McCaffery, Elzinga & Martineau, 2006). Dental schools have an important role to educate the future workforce concerning the provision of oral health care for all (Bertolami, 2001; Davis, Stewart, Guelmann, Wee, Beach, Crews et al. 2007; DePaola & Slavkin, 2004). Students should be prepared and sensitized to understand the needs and perspectives of diverse populations and their responsibilities as future health professionals (Graham, 2006). In this context changes in dental education policies could contribute with the education of the future oral health providers with understanding a variety of humanistic themes, development of personal and professional values about social justice and also affect students' willingness to provide care for underserved patients.

Studies about perspectives of dental students' to provide care for patients from diverse backgrounds after completing undergraduate are lacking. Little data exist concerning the dental students' career intentions and, particularly about perspectives of dental students' to provide care for patients from diverse background after completing the undergraduate course (Kuthy, Heller, Riniker, McQuistan & Qian, 2007; Kuthy, McQuistan, Riniker, Heller & Qian, 2005; Rubin, Rustveld, Weyant & Close, 2008; Smith, Ester & Inglehart, 2006). The literature suggests that giving dental students varied experiences like working in community settings with disadvantage populations helps to form in dental students a basis of social

responsibility and improve significantly students' intentions to provide care for these patients in their future practice. Moreover, studies showed that the introduction of community-based experiential learning programs have been contributing to the level of comfort and future willingness of dental students to treat underserved patients (Davidson, Carreon, Baumeister, Nakazono, Gutierrez, Afifi et al. 2007; Holtzman & Seirawan, 2009; McQuistan, Kuthy, Heller, Qian & Riniker, 2008).

Dental students' intentions to treat underserved patients after their graduation may be influenced by their concepts, perceptions, experiences and attitudes towards poverty and poor people. In this context, an understanding of dental students' perceptions and attitudes towards low-income and minority communities is needed because it may have an impact on the relationship between dental providers and patients and can act as a barrier for deprived patients. And also deepening our understanding of students is crucial for community planning proposes, particularly when these groups are the future dental workforce.

This study aims to describe dental students' future intentions to treat poor people and their perceptions and attitudes toward poverty. In addition, we aim to evaluate to what extent gender, social background and dental education influence students' future intentions to treat poor people and their perceptions and attitudes toward poverty.

METHODS

The study received approval from the Ethics Committee of Araraquara Dental School (#20/10). Survey data were collected from all dental students of three public dental universities located on São Paulo State, Brazil, in 2010. Students regularly enrolled in these three undergraduate dental courses in 2010 participated in this study after signing informed consent forms. The choice of dental courses was convenience. All students received an

information sheet explaining the study and they were instructed to answer honestly. Participation was voluntary and anonymous.

The data presented in this article came from a descriptive study aimed to explore dental students' perceptions and attitude towards poverty. The research instrument was a self-administered questionnaire. This survey was completed during regularly scheduled class sessions in an average time of 10 minutes. The questionnaire was designed to maximize response rate and minimize missing data. The dental students responded survey that included fifty closed questions. The instrument consisted in four sections: demographic data (age, gender, and previous education), dental students' future intention for treat poor people and their perceptions and attitudes towards poverty, and socioeconomic data (family income, socioeconomic background, parents' education level). The questions were selected from previous similar studies and adapted to the Brazilian context.

The section on student's perception and attitudes towards poverty comprised of 32 questions derived from studies by Atherton & Gemmel (1993) and Gilens (1999). The items evaluated several issues related to poverty and were grouped in four main categories to structure the presentation of items in the instrument. These categories were: poverty and social issues (10 items); characteristics of poor people (8 items); poverty and employment (5 items); and poverty and public policies (9 items). Students evaluated statements on a five-point Likert scale where 1 represented strong agreement and 5 represented strong disagreement. A low score defined a more positive perception/attitude towards disadvantage population. Some of the items had to be reverse-coded. In order to have a comprehensive assessment of students' perceptions of poverty we build our research instrument using several sources. Although we did not use any specific theoretical framework, we guide our selection of items on the relevance of the aims of the study and the Brazilian context. Therefore, to evaluate the conceptual constructs within the questionnaire, we conducted a principal

component factor analysis with varimax rotation. This method groups variables that are highly correlated into factors.

The factor analysis reveals that the items revolve around eight central themes or dimensions. In this study we will present the results from two these central themes which we labeled as: professional obligation to care for the disadvantage populations (3 items) and professional beliefs towards poverty (7 items).

The first theme -*professional responsibility*- addressed students' future intentions to treat disadvantage populations and students beliefs towards health as a right for all. The second theme -*professional belief towards poverty*- addressed characteristics of poor people. Two discrete variables were constructed by summing up the scores of items loaded in each component from each subject. The scores for sense of *professional responsibility* ranged from 3 to 15 while the scores for *beliefs towards poverty* ranged from 7 to 35, with greater figures meaning lower sense of professional responsibility and negative view of poverty respectively. The variables were dichotomized in low and high considering the mean as a cut-off point.

All analyses were conducted using the statistical software program PASW Statistics version 18.0 (SPSS Inc., Chicago, IL, USA). The analysis proceeded in three stages. First, descriptive analyses were used to report percentages of respondents on select variables and to describe aspects related with students' profile. Second, differences in the students' responses were testing using a Pearson's chi-square test. Third, logistic regression model were used to assess the influence between socio demographic status and dental education in the sense of professional responsibility which was defined as students who have strong sense of professional responsibility to treat disadvantage populations vs. who has low sense of professional responsibility. Belief towards poverty was defined as students who have positive perception vs. those who have negative perception. Statistical significance was based on probability values of less or equal 0.05.

RESULTS

There were 915 students regularly enrolled in these three dental public universities located in São Paulo state, Brazil, 2010. Seven hundred sixty-six students responded our survey for an overall response rate of 83.71 percent. Responses rates of three universities ranged from 91.62% (n=350) university A, 76.89% (n= 253) university B and 79.9% (n=163) university C. Of the total, 518 (67.6 percent) were female and 248 (32.3 percent) were male. The age of the students ranged from eighteen to thirty-four years (mean= 21; SD= 2) (Table 1). Table 1 also shows students' social background and the absolute and the percentage distribution of the responding students enrolled in each university.

The first objective in this study was to analyze dental students' future intentions for treating disadvantage patients after completing undergraduate. Table 2 displays number and percentage of students for each university in the component professional obligation to care for disadvantage populations. In overall, the majority of dental students enrolled in those dental courses have a positively perception that dental providers have an obligation to offer dental care for the poor (70%). University B had the highest number of students with low perception in this component (32.4%, Table 2). The differences between universities were statistically significant. The mean score for this component was 5.42 (SD= 1.91).

The second objective was to describe dental students' perceptions, attitudes and beliefs toward poor people. In this component, denominated beliefs about characteristics of the poor, the stereotype items were predominantly negative and included beliefs that the poor are, for example, less honest, lazy or less intelligent. Table 3 shows the number and percentage of students for each university. In this sample, students' beliefs towards the poor were, on average, moderately positive (mean score= 13.06; SD= 3.53). University A had the

highest number of students with positively perception towards poor people and University C had the highest number of students with negatively perception towards the poor (Table 3).

Logistic regression were performed to explore whether gender, social background and dental education may influence students' ethics and professional responsibility towards disadvantage population and students' beliefs towards poor people. As shown in table 4, students' ethics and professional responsibility concerning treating disadvantage patients were associated with four predictors: year enrolled in the graduation, students' gender, university and family income. The sense of obligation concerning treating disadvantage patients were stronger amongst female students (OR = 1.5, 95% CI = 1.0–2.1), students enrolled in the first and second year of graduation (OR = 1.6, 95% CI = 1.0–2.6), students having lower family incomes (OR = 1.9, 95% CI = 1.0–3.6) and students enrolled in University A and C (OR = .88, 95% CI = .55–1.4).

As can be seen in table 5, students' beliefs towards poor people were influenced by two predictors. Female students are 1.74 times more likely to have a positive belief towards the poor than male students. Dental students enrolled in the first year of graduation are 1.67 times more likely to have a positive believe toward poor than students enrolled in others years.

DISCUSSION

The concept of social responsibility has been discussed in different fields. In health sciences the idea is related to social conscience of health professionals which are originally based on interpersonal relationships and individual moral and ethical values overtake individualism and private interests (Dharamsi, Pratt & MacEntee, 2007; Nortvedt, Hem & Skirbekk, 2011). Based on disparities in oral health, we explored in this study, first, how the

emerging dental workforce perceives their social responsibility to care the disadvantage population.

An evaluation of the results from this study suggests that dental students' sense of professional obligation for treat underserved populations was, in general, moderately positively. However a high percentage of students having low perception towards the professional obligation for treat the poor were also observed. Possibly, this finding may be reflecting the business characteristics of dentistry which include over-specialization and private clinical practice that delivers oral health care as a service. In fact, recent studies showed that dental students desire to enter dentistry are largely motivated by professional and financial expectations (Crossley & Mubarik, 2002; Hallissey, Hannigan & Ray, 2000). Likewise dental students were shown to be less motivated by altruism than medical students (Coulter, Wilkes & Der-Martirosian, 2007).

Turning to the logistic regression analyses of professional obligation to treat disadvantage populations, we found four predictors variables correlated with dental students' practice intentions. Our results suggest individual-level predisposing characteristics, such as sex and socioeconomic status are most highly correlated with sense of professional responsibility to treat disadvantage population. In particular, dental students from lower socioeconomic status and female students are highly motivated to provide care to underserved populations and have a stronger sense of professional responsibility to treat the needy. Our findings are in accordance with previous studies (Carreon, Davidson, Andersen & Nakazono, 2011; Kuthy et al., 2005; Smith et al., 2006). Assuming that dental students' willingness result in practice decisions to improve access to oral health care for underserved patients our finding may be of considerable importance in predicting possible workforce patterns in the future.

Furthermore, university in which they are enrolled was also associated with stronger sense of professional responsibility to treat underserved patients. One possible reason could be that the educational philosophy and dental curriculum which can vary among schools may have a influence in the students' sense of professional responsibility to care the poor. Year of graduation also had a significant impact on sense of professional responsibility to care underserved patients, with students in years 1 and 2 having higher chances to respond positively than students in years 3 and 4. Senior students could be more concern about future financial situation than junior students, influencing their sense of responsibility treating patients from lower socioeconomic groups with less capacity to pay for services. In addition we hypothesized that the years spent in dental school have also influence in students' behavioral intentions. Likewise it has been shown previously that dental students become less altruistic during school (Coulter et al., 2007). Although it is beyond the scope of this study to evaluate differences in curricula between schools, this finding should also alert the dental educators about the lack of education concerning the dental students/dentists responsibility to societal and community needs. Dental students' sense of professional responsibility to treat disadvantage population reflects their understanding of the importance to improving oral health for all, and should be developed and reinforced during undergraduate training.

Dental education has an important role in development emerging dental workforce with sociocultural competency and social values (Graham, 2006). As well, build dental students sensitize towards oral health disparities and committed with their reduction. There is considerable evidence in the literature that educational experience with underserved patients has been favorable for the students' future willingness and comfort to treat such group (Kuthy et al., 2007; Kuthy et al., 2005; Smith et al., 2006). Comfort highlights sentiments, which are in general assumptions of beliefs and values and play an important role in the health providers-patient interactions. Cultural differences, barriers due to language and/or values

may explain why some underserved populations do not receive dental care. Studies have indeed shown that dental providers report difficulties in treating people on poverty because of cultural differences (Loignon, Allison, Landry, Richard, Brodeur & Bedos, 2010; Pegon-Machat, Tubert-Jeannin, Loignon, Landry & Bedos, 2009). In this context, the second objective of this study was explored dental students' beliefs and attitudes toward poor people. Additionally, we still recognize that dental students' values are highly reflective of societal values.

Overall, dental students' responses concerning beliefs towards the poor were moderately positive. However, an expressive percentage of dental students had a negatively perception concerning the poor. Such negative beliefs open the possibility that future dental providers will present difficulties in establishing or maintaining positive rapport with disadvantage patients. In sum, our results helped to expose the recurrence of positive and negative stereotypes on the part of the emergent dental workforce towards people living on poverty. Perceptions of poverty are likely to be positively correlated to attitudes toward poverty (Cozzarelli C, Wilkinson AV & Tagler MJ, 2001). Assuming that individual values and beliefs correlate with future practice, these findings are clearly important because may reflect the future barrier of care for disadvantage populations.

This study suggests that perceptions of poverty can be linked to individual characteristics, such as gender and age. Our finding confirms previous studies (Clarke G & Sison M, 2003; Cozzarelli C et al., 2001; Mikko Niemela, 2008). Although some authors have suggested that sociodemographic factors may influence the perceptions of poor (Cozzarelli C et al., 2001; Forma P, 2002), our results not support those findings. However, the results from this study must be interpreted with caution because, first, we have analyzed self-reported, cross-sectional data and, second, the homogeneity of our sample regarding

social background, may be influenced our results. Most dental students are members of economically privileged class.

A number of limitations exist in our study. First, the fact that this study was a cross-sectional study the data cannot provide an opportunity to infer whether dental students' perceptions and beliefs over time. In addition, changes over time cannot be evaluated. However, this study provides recent data concerning students' ethics and beliefs towards disadvantage population. Further longitudinal studies could thus to be encouraged to evaluate students over time. A second limitation is the issue of generalizability of the results. Our sample was convenience sample and the results of this study are limited to dental students surveyed from three dental universities located in São Paulo state. Therefore, our results cannot be generalized of dental students elsewhere in Brazil, whereas the context and characteristics may be different. However, despite this fact our findings showed important aspects that could be involved in the students' perceptions and beliefs towards disadvantage populations. Third, because this was not a randomly select sample of students participants, biases may be occurred.

Despite these limitations, we were able to identify significant associations in our data. Our findings raise important issues about the predictors related with dental student's sense of professional responsibility to treat disadvantage populations. Further, this research provides possible predictors that influence the dental students' perceptions and beliefs toward the poor. This emphasizes the need for future studies, using qualitative and quantitative approaches to explore the factors that may be involved in dental student's decision to treat disadvantage population. Moreover, future research should be encouraged to explore more in-depth whether dental students' perceptions toward poor people actually result in practice decisions to improve access to oral health care for disadvantage patients. In conclusion, these data showed that improvements in dental education are needed to build an effective health care

infrastructure to meet the oral health needs for all. In addition, insights from this study may be useful for reducing oral health care disparities.

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Table 1. Profile of students, by number and percentage of total at each school and total of three schools

Variables	University A N(%)	University B N(%)	University C N(%)	Total (N=766)
Age				
< 20 yrs	132 (37.7)	112 (44.3)	79 (48.5)	323 (42.2)
21 - 24 yrs	195 (55.7)	130 (51.4)	78 (47.9)	403 (52.6)
> 20 yrs	23 (6.6)	11 (4.3)	6 (3.7)	40 (5.2)
Gender				
Female	252 (72)	165 (65.2)	101 (62)	518 (67.6)
Male	98 (28)	88 (34.2)	62 (38)	248 (32.4)
Family Income				
R$ 510 - 3060,00	76 (21.7)	69 (27.3)	26 (16)	171 (22.3)
R$ 3060- 7650,00	87 (24.9)	69 (27.3)	50 (30.7)	206 (26.9)
R$ 7650 - 10200,00	100 (28.6)	77 (30.4)	41 (25.2)	218 (28.5)
> R$ 10200,00	87 (24.9)	38 (15)	46 (28.2)	171 (22.3)
Mother's education				
Elementary	24 (6.9)	19 (7.5)	8 (4.9)	51 (6.7)
High school	127 (36.3)	86 (34)	46 (28.2)	259 (33.8)
University	199 (56.9)	148 (58.5)	109 (66.9)	456 (59.5)
Father's education				
Elementary	28 (8)	27 (10.7)	8 (4.9)	63 (8.2)
High school	119 (34)	76 (30)	41 (25.2)	236 (30.8)
University	203 (58)	150 (59.3)	114 (69.9)	467 (61)
Students' Previous Education				
Public school	42 (12)	36 (14.2)	16 (9.8)	94 (12.3)
Private school	308 (88)	217 (85.8)	147 (90.2)	672 (87.7)

Table 2. Frequencies and percentages of responses concerning the component professional obligation to care for the disadvantage populations (N=766)

Survey	Low perception N(%)	High perception N(%)	p-value
University A	75 (21.4)	275 (78.6)	0.009
University B	82 (32.4)	171 (67.6)	
University C	39 (23.9)	124 (76.1)	

Table 3. Frequencies and percentages of responses concerning the component beliefs toward characteristics of poor people (N=766)

Survey	Low perception N(%)	High perception N(%)	p-value
University A	108 (30.9)	242 (69.1)	0.484
University B	81 (32)	172 (68)	
University C	59 (36.2)	104 (63.8)	

Table 4. Logistic regression model for students' sense of professional obligation to treat disadvantage population (N=766)

	Unadjusted		Adjusted	
Variables	Odds Ratio (95% Cl)	p-value	Odds Ratio (95% Cl)	p-value
Student graduation year				
4rd yr		0.00		0.00
3rd yr	0.81 (0.53 - 1.25)	0.35	0.79 (0.50 - 1.23)	0.30
2nd yr	1.94 (1.21 - 3.10)	0.00	1.99 (1.22 - 3.23)	0.00
1st yr	1.55 (0.99 - 2.44)	0.05	1.63 (1.02 - 2.61)	0.03
Gender				
Male				
Female	1.65 (1.17 - 2.31)	0.00	1.54 (1.08 - 2.19)	0.01
University				
University A		0.00		0.00
University B	0.56 (0.39 - 0.82)	0.00	0.52 (0.35 - 0.77)	0.00
University C	0.86 (0.55 - 1.34)	0.52	0.88 (0.55 - 1.40)	0.60
Parents' Education				
Elementary		0.17		0.24
1 Elementary and 1 High school	0.36 (0.11 - 1.20)	0.09	0.33 (0.09 - 1.16)	0.08
1 Elementary and 1 University	0.75 (0.20 - 2.87)	0.68	0.78 (0.19 - 3.14)	0.73
High School	0.99 (0.31 - 3.07)	0.98	0.86 (0.26 - 2.79)	0.80
1 High School and 1 University	0.52 (0.18 - 1.44)	0.21	0.52 (0.17 - 1.51)	0.23
University	0.70 (0.25 - 1.89)	0.48	0.68 (0.24 - 1.94)	0.47
Family Income				
R$7212.49		0.42		0.15
R$4561.58	1.03 (0.66 - 1.58)	0.89	1.06 (0.68 - 1.67)	0.76
R$2677.50	1.04 (0.66 - 1.65)	0.84	1.08 (0.66 - 1.75)	0.73
R$ 892.50	1.56 (0.88 - 2.78)	0.12	1.95 (1.04 - 3.64)	0.03

Table 5. Logistic regression model for students' beliefs toward characteristics of poor people (N=766)

	Unadjusted		Adjusted	
Variables	Odds Ratio (95% CI)	p-value	Odds Ratio (95% CI)	p-value
Student graduation year				
4rd yr		0.07		0.07
3rd yr	1.02 (0.67 - 1.57)	0.89	1.11 (0.71 - 1.71)	0.63
2nd yr	0.94 (0.62 - 1.40)	0.76	0.97 (0.64 - 1.47)	0.89
1st yr	1.63 (1.06 - 2.51)	0.02	1.67 (1.07 - 2.60)	0.02
Gender				
Male				
Female	1.73 (1.29 - 2.44)	0.00	1.74 (1.26 - 2.41)	0.00
University				
University A		0.48		0.58
University B	0.94 (0.66 - 1.34)	0.76	0.94 (0.66 - 1.35)	0.75
University C	0.73 (0.53 - 1.16)	0.23	0.80 (0.53 - 1.21)	0.30
Parents' Education				
Elementary		0.81		0.82
1 Elementary and 1 High school	1.04 (0.35 - 3.06)	0.93	1.00 (0.33 - 3.02)	0.99
1 Elementary and 1 University	2.10 (0.59 - 7.41)	0.24	2.09 (0.57 - 7.66)	0.26
High School	1.00 (0.39 - 2.54)	1.00	0.93 (0.35 - 2.42)	0.88
1 High School and 1 University	1.08 (0.45 - 2.36)	0.85	1.08 (0.44 - 2.65)	0.85
University	1.00 (0.44 - 2.28)	0.99	1.02 (0.44 - 2.43)	0.95
Family Income				
R$7212.49		0.41		0.38
R$4561.58	0.86 (0.57 - 1.30)	0.48	0.82 (0.54 - 1.25)	0.36
R$2677.50	1.19 (0.77 - 1.86)	0.42	1.16 (0.73 - 1.84)	0.51
R$ 892.50	1.08 (0.65 - 1.81)	0.74	1.05 (0.61 - 1.82)	0.84

Considerações Finais

CONSIDERAÇÕES FINAIS

A existência da desigualdade social em saúde bucal tem sido objeto de investigação em saúde pública[34,52]. Muitos fatores têm sido associados as iniquidades em saúde bucal, sendo a diferença no acesso aos serviços de saúde uma das principais causas[25]. O crescimento da mão de obra odontológica especializada e a abordagem de cuidado individualista e tecnicista podem ter contribuído para o acesso deficiente das populações em desvantagem aos serviços de saúde bucal[15]. Além disso, estudos demostram que pessoas pobres subutilizam os serviços devido a experiências negativas vivenciadas na clínica odontológica[6,30]. Uma possível razão para este fato é que as percepções e atitudes dos profissionais em relação a pobreza geram impactos diretos sobre a qualidade do cuidado em saúde bucal bem como na relação com os pacientes desfavorecidos. Neste contexto, um entendimento da prática profissional intencionada pelos estudantes de Odontologia, bem como, a sua percepção e atitude sobre as pessoas pobres são necessários para desvelar as disparidades de acesso ao cuidado no futuro e as suas implicações éticas.

Apesar da população em geral ter alta demanda por tratamentos básicos[12], pode-se observar no primeiro estudo que a prática profissional intencionada pelos estudantes de Odontologia é a de se tornar especialista, não respondendo, assim, as necessidades de saúde bucal da população. Este estudo demonstrou que a maioria dos estudantes escolheram a odontologia como carreira devido ao conceito que eles fazem da profissão. Além disso, foi demonstrado neste estudo que mais da metade dos estudantes de odontologia tem a intenção de trabalhar tanto nos serviços públicos de saúde quanto na clínica privada, uma vez que estes relacionam o primeiro com estabilidade profissional. Pode-se observar também que gênero, nível sócioeconômico, universidade e ano de graduação foram preditores relacionados com a intenção dos estudantes em trabalhar nos serviços públicos de saúde após a graduação.

O descompasso entre a formação profissional e as necessidades de saúde da população é um desafio para o setor público brasileiro. Neste contexto, recentes reformas curriculares dos cursos da saúde foram realizadas pelo Ministério da Saúde e Ministério da Educação[10,11] a fim de aumentar o acesso aos cuidados de saúde para as populações desfavorecidas. As faculdades de Odontologia têm um papel fundamental na formação e sensibilização dos alunos para as disparidades em saúde bucal, além de ampliar a compreensão de suas responsabilidades profissionais como a futura força de trabalho[23].

O senso de responsabilidade profissional para prestar atendimento às populações marginalizadas, bem como as percepções e as atitudes dos estudantes de odontologia com relação as pessoas pobres ainda são foram esclarecidos, fato este que instigou a realização do segundo estudo. Este estudo demonstrou que, de uma forma geral, os estudantes de odontologia apresentaram senso de obrigação profissional em prestar atendimento aos pacientes pobres moderadamente positivo. Nossos resultados sugeriram também que fatores individuais, como sexo e nível socioeconômico, universidade e ano de graduação são fatores significantemente associados com o senso de responsabilidade profissional.

As percepções e atitudes dos estudantes com relação às pessoas pobres também se apresentaram moderadamente positivas. No entanto, foi observada uma tendência entre os estudantes em atribuir a pobreza a fatores individuais, além da existência da crença em diferença de valores entre as pessoas pobres e os demais membros da sociedade. Este estudo sugere, ainda, que características individuais, como gênero e idade, são possíveis preditores relacionados com as percepções sobre as pessoas pobres. Assumindo que os valores e crenças individuais se relacionam diretamente com a futura prática profissional, estes resultados podem refletir futuras disparidades no acesso para as populações desfavorecidas.

Em suma, este estudo demonstrou importantes questões relacionadas com a prática intencionada pelos estudantes contribuindo para um planejamento eficiente da força de

trabalho no setor odontológico. Estes resultados destacaram, também, a importância dos esforços atuais para construir o currículo socialmente dirigido nas universidades de odontologia, a fim de incutir um senso de responsabilidade profissional e social nos futuros profissionais. Dessa forma, será possível construir uma força de trabalho odontológico responsiva a sociedade, comprometida com a diminuição das iniquidades e proporcionando maior justiça social.

Considerando o caráter transversal desse estudo é relevante investigar em trabalhos futuros o impacto das mudanças atuais nos currículos odontológicos para o desenvolvimento da força de trabalho odontológica no Brasil.

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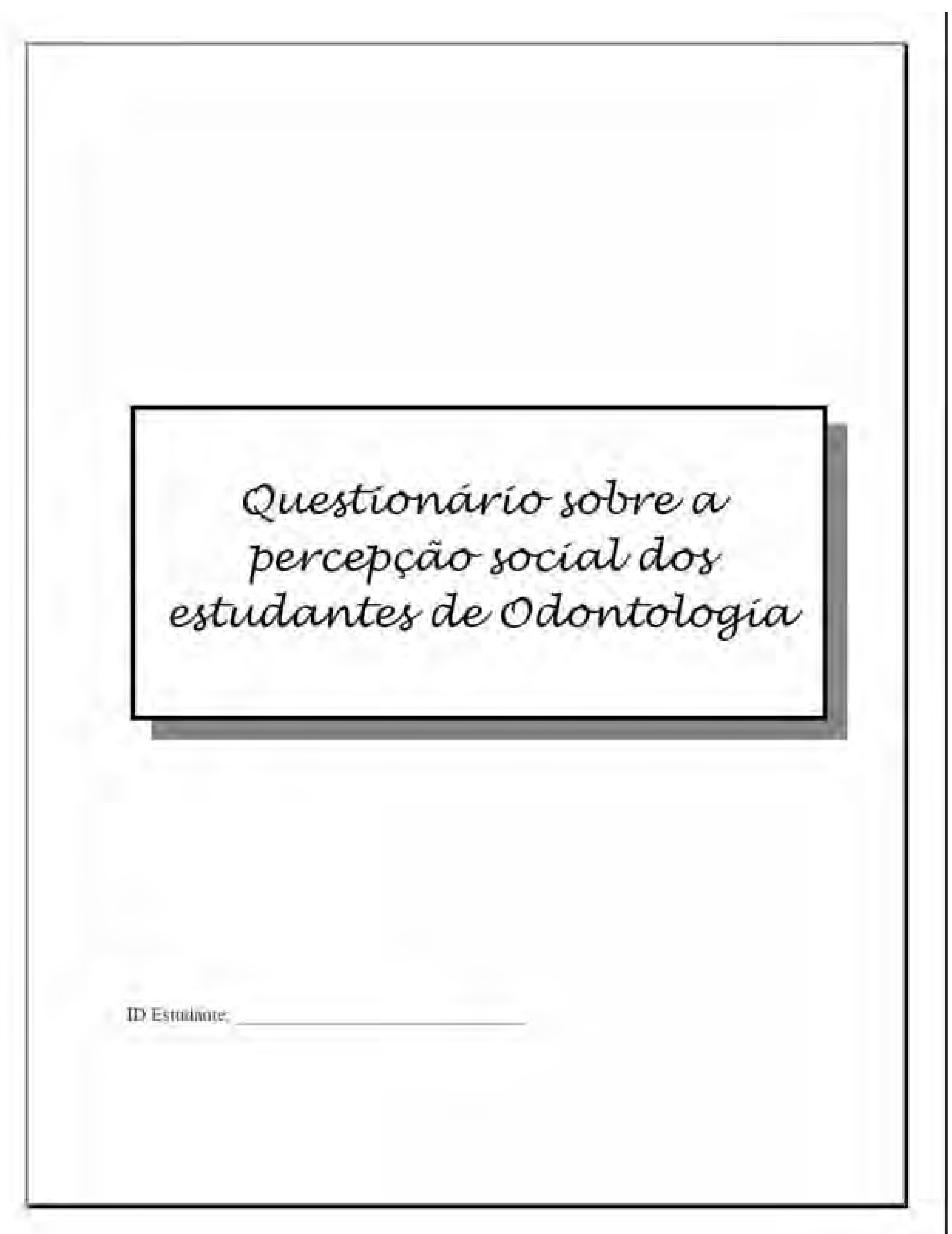
Apêndice

APÊNDICE A

QUESTIONÁRIO SOBRE A PERCEPÇÃO SOCIAL DE ESTUDANTES DE ODONTOLOGIA


Questionário sobre a percepção social dos estudantes de Odontologia

ID Estudante: ______________________________

O presente questionário é parte integrante de um projeto de pesquisa para a obtenção do título de mestrado. Esclarecemos que a sua participação é voluntária e o sigilo de sua identidade está assegurado. Agradecemos a sua disposição em conceder-nos as informações desse questionário e estamos abertos a qualquer dúvida ou esclarecimento.

Data de preenchimento do questionário

a) Dia ________ (1 a 31)
b) Mês ________ (1 a 12)
c) Ano ________ (XXXX)

DADOS PESSOAIS

1) Sexo

Masculino ☐ 1
Feminino ☐ 2

2) Data de nascimento

a) Dia ________ (1 a 31)
b) Mês ________ (1 a 12)
c) Ano ________ (XXXX)

3) Local (cidade e estado) de nascimento ______________________________

4) Onde você cursou a maior parte do ensino médio?

Escola pública ☐ 1
Escola particular ☐ 2

5) Em qual estado você concluiu o ensino médio? ____________________

6) Qual o ano de Odontologia você esta cursando?

1º ☐ 1
2º ☐ 2
3º ☐ 3
4º ☐ 4
5º ☐ 5 → (quando se aplica)

7) Por que a escolha pela Odontologia? ______________________________

PRÁTICA PROFISSIONAL FUTURA

1) Você pretende trabalhar como:

Clínico geral ☐1 → CLÍNICO GERAL, ***seguir para a questão 3***
Especialista ☐2
Professor/Pesquisador ☐3

2) Qual especialidade/residência/mestrado você pretende seguir?

Cirurgia Oral ☐1
Endodontia ☐2
Ortodontia ☐3
Periodontia ☐4
Odontopediatria ☐5
Prótese ☐6
Implantodontia ☐7
Saúde Pública ☐8
Outra ☐9 → Especificar ______

Marque apenas uma opção

3) Você pretende trabalhar no serviço público de saúde?

Não ☐1 → ***NÃO, seguir para a questão 6.***
Sim ☐2

4) Você pretende trabalhar no serviço público de saúde

Exclusivamente ☐1
Juntamente com o consultório particular ☐2

5) Por que você pretende trabalhar no serviço público?

salário ☐1
estabilidade ☐2
comodidade ☐3
gosta do trabalho publico ☐4

Marque apenas uma opção

Leia as afirmações abaixo e assinale:
(1) Se você concordar totalmente
(2) Se você concordar
(3) Se você está neutro
(4) Se você discordar
(5) Se você discordar totalmente

	Concordo totalmente	Concordo	Sem opinião	Discordo	Discordo totalmente
6) Os dentistas tem a responsabilidade de atender as pessoas pobres.	1	2	3	4	5
7) Todas as pessoas tem direito de receber tratamentos odontológicos independentemente da sua capacidade de pagar por eles.	1	2	3	4	5
8) Eu irei tratar pacientes de diversos níveis sociais.	1	2	3	4	5

POBREZA E QUESTÃO SOCIAL

Leia as afirmações abaixo e assinale:

(1) Se você concordar totalmente
(2) Se você concordar
(3) Se você está neutro
(4) Se você discordar
(5) Se você discordar totalmente

	Concordo totalmente	Concordo	Sem opinião	Discordo	Discordo totalmente
1) O governo é o maior responsável por gerar desigualdade social.	1	2	3	4	5
2) A pobreza é o maior problema social do Brasil.	1	2	3	4	5
3) No Brasil as diferenças de renda são muito grandes.	1	2	3	4	5
4) Os indivíduos são os maiores responsáveis por ajudar as pessoas pobres.	1	2	3	4	5
5) Pobreza é determinante da saúde.	1	2	3	4	5
6) As pessoas são pobres devido a circunstâncias alheias a sua vontade.	1	2	3	4	5
7) Pessoas pobres são discriminadas.	1	2	3	4	5
8) Pessoas pobres não devem ser responsabilizadas por sua condição.	1	2	3	4	5
9) Pessoas pobres tem mais problemas de saúde do que as outras pessoas.	1	2	3	4	5
10) Pessoas pobres não tem acesso aos serviços de saúde.	1	2	3	4	5

CARACTERÍSTICAS DAS PESSOAS POBRES

Leia as afirmações abaixo e assinale:

(1) Se você concordar totalmente
(2) Se você concordar
(3) Se você está neutro
(4) Se você discordar
(5) Se você discordar totalmente

	Concordo totalmente	Concordo	Sem opinião	Discordo	Discordo totalmente
1) As pessoas pobres continuarão pobres independentemente do que é feito por elas.	1	2	3	4	5
2) As pessoas pobres são menos honestas que as outras pessoas.	1	2	3	4	5
3) As pessoas pobres são diferentes do resto da sociedade.	1	2	3	4	5
4) Muitas pessoas pobres estão satisfeitas com o seu padrão de vida.	1	2	3	4	5
5) Pessoas pobres são menos inteligentes que as outras pessoas.	1	2	3	4	5
6) Pessoas pobres têm valores diferentes das outras pessoas.	1	2	3	4	5
7) As pessoas pobres criam as suas próprias dificuldades.	1	2	3	4	5
8) As pessoas pobres não se preocupam com a saúde.	1	2	3	4	5

EMPREGO E POBREZA

Leia as afirmações abaixo e assinale:

(1) Se você concordar totalmente
(2) Se você concordar
(3) Se você está neutro
(4) Se você discordar
(5) Se você discordar totalmente

	Concordo totalmente	Concordo	Sem opinião	Discordo	Discordo totalmente
1) Se as pessoas pobres trabalhassem mais elas poderiam sair da pobreza.	1	2	3	4	5
2) As pessoas pobres desempregadas poderiam encontrar emprego se tentassem mais.	1	2	3	4	5
3) As pessoas pobres desempregadas deveriam aceitar qualquer emprego que lhes é oferecido.	1	2	3	4	5
4) Eu poderia confiar em uma pessoa pobre que trabalhasse para mim.	1	2	3	4	5
5) Não trabalhar e ganhar auxílios é uma escolha.	1	2	3	4	5

POBREZA E POLÍTICAS PÚBLICAS

Leia as afirmações abaixo e assinale:

(1) Se você concordar totalmente
(2) Se você concordar
(3) Se você está neutro
(4) Se você discordar
(5) Se você discordar totalmente

	Concordo totalmente	Concordo	Sem opinião	Discordo	Discordo totalmente
1) Os auxílios concedidos pelo governo (Bolsa Família, auxílio gás, auxílio reclusão, entre outros) tornam as pessoas preguiçosas.	1	2	3	4	5
2) As pessoas que recebem os auxílios devem ser capazes de gastar o seu dinheiro como quiserem.	1	2	3	4	5
3) Os auxílios encorajam as pessoas a terem mais filhos.	1	2	3	4	5
4) As pessoas que recebem os auxílios deveriam trabalhar para consegui-la.	1	2	3	4	5
5) Se eu fosse pobre eu aceitaria os auxílios.	1	2	3	4	5
6) O governo gasta muito dinheiro com os programas para a pobreza.	1	2	3	4	5
7) Algumas pessoas pobres vivem melhor do que eu por conta de todos os benefícios.	1	2	3	4	5
8) Os auxílios concedidos para as pessoas pobres consomem a maior parte do orçamento federal.	1	2	3	4	5
9) Eu apoiaria um programa de suporte social para os pobres em que eu tivesse que pagar mais impostos.	1	2	3	4	5

DADOS SOCIOECONÔMICOS

1) Nível de escolaridade do pai:

- 1º grau incompleto ☐ 1
- 1º grau completo ☐ 2
- 2º grau incompleto ☐ 3
- 2º grau completo ☐ 4
- Superior incompleto ☐ 5
- Superior completo ☐ 6
- Pós-graduação ☐ 7

2) Nível de escolaridade da mãe:

- 1º grau incompleto ☐ 1
- 1º grau completo ☐ 2
- 2º grau incompleto ☐ 3
- 2º grau completo ☐ 4
- Superior incompleto ☐ 5
- Superior completo ☐ 6
- Pós-graduação ☐ 7

3) Renda familiar (salário mínimo – R$ 510,00)

- 1 a 3 (R$ 510 a R$ 1530) ☐ 1
- 3 a 6 (R$ 1530 a R$3060) ☐ 2
- 6 a 9 (R$ 3060 a R$ 4590) ☐ 3
- 10 a 15 (R$5100 a R$7650) ☐ 4

15 a 20 (R$7650 a R$10200) ☐ 7
Mais de 20 (mais de R$10200) ☐ 8

4) Ocupação do pai: ____________________

5) Ocupação da mãe: ________________

6) Quantas pessoas vivem na casa? ______

7) Quantos quartos tem na sua casa? _______

8) Quantos banheiros tem na sua casa? _______

9) Você ou sua família tem carro?

Sim ☐ 1 → Quantos? _______
Não ☐ 2

Obrigada pela sua colaboração!

APÊNDICE B

ANÁLISE FATORIAL

Component Matrix

	Component									
	1	2	3	4	5	6	7	8	9	10
As pessoas pobres continuarao pobres independentemente do que é feito por elas	,290	,436	-,168	,186	-,058	,001	,012	-,013	,229	,029
As pessoas pobres sao menos honestas	,480	,540	-,060	,193	-,054	,125	-,010	,033	,047	-,005
As pessoas pobres sao diferentes do resto da sociedade	,421	,544	-,067	,043	,070	,050	,069	-,076	,045	,145
Muitas pessoas pobres estão satisfeitas com seu padrão de vida	,323	,014	,080	-,316	,369	-,178	,070	-,092	,496	,197
Pessoas pobres sao menos inteligentes que as outras pessoas	,512	,504	-,077	,078	,024	,159	,035	,008	,032	-,077
Pessoas pobres tem valores diferentes das outras	,388	,235	-,105	-,258	,301	-,024	,402	-,067	-,253	-,009
Pessoas pobres criam suas proprias dificuldades	,599	,218	-,027	-,204	-,048	-,100	,099	-,033	-,080	,138
Pessoas pobres nao se preocupam com a saude	,458	,401	-,091	-,125	-,017	,030	,118	-,028	-,224	,136
Os auxilios tornam as pessoas preguiçosas	-,603	,484	,085	-,136	-,119	-,013	-,017	,058	-,047	-,046
Os auxilios encorajam as pessoas a terem mais filhos	-,496	,417	,203	-,058	-,143	-,188	-,033	,165	-,063	-,081
Pessoas que recebem auxilios deveriam trabalhar	-,449	,484	-,003	,085	-,050	-,167	-,173	,252	-,086	,005
O governo gasta muito dinheiro com os programas para a pobreza	-,574	,358	-,013	-,247	-,175	,067	-,074	-,097	,101	,078
Pessoas pobres vivem melhor que eu por conta dos auxilios	-,423	,210	,082	-,423	-,090	,253	,156	,003	,143	-,050
Os auxilios consomem a maior parte do orçamento federal	-,544	,259	,048	-,381	-,011	,139	,046	-,194	,289	,150
Se as pessoas pobres trabalhassem mais sairiam da pobreza	-,568	,060	-,013	,390	,232	,171	,315	,029	-,039	,117
Pessoas pobres desempregadas poderiam encontrar emprego se tentassem mais	-,613	,100	-,059	,371	,186	,167	,221	,019	-,141	,170
Pessoas pobres desempregadas deveriam aceitar qualquer emprego	-,415	,020	,066	,183	,240	-,071	-,056	-,090	-,132	,558
Pobreza é determinante de saude	,007	,080	,464	,186	,154	-,333	,454	-,004	,195	-,113
Pessoas pobres tem mais problemas de	,014	-,042	,512	,238	-,210	-,346	,262	-,038	,082	-,119
Pessoas pobres não tem acesso aos serviços de saude	,051	,010	,496	-,044	-,207	-,106	,146	-,150	-,117	,006
Governo é responsavel por gerar desigualdade social	-,025	,125	,442	-,198	,356	,167	-,333	-,109	-,175	-,304
Pobreza é o maior problema social do Brasil	,006	,057	,513	-,118	,480	-,007	-,141	-,157	-,263	,010
No Brasil diferenças de renda grandes	,111	,297	,398	,181	,248	,196	-,193	,071	,106	-,236
Pessoas são pobres devido a circunstancias alheias a sua vontade	,095	-,099	,474	-,187	-,151	,222	,003	,172	,072	,413
Pessoas pobres não devem ser responsabilizadas por sua condição	,317	-,089	,364	-,205	-,322	-,052	-,073	-,007	-,369	,269
Não trabalhar e ganhar auxílios é uma escolha	,278	-,091	-,033	-,052	,191	-,146	-,259	,466	,177	,196
Pessoas que recebem auxilios devem ser capazes de gastar o dinheiro como quiserem	,081	-,243	,171	,048	-,149	,586	,129	-,238	,149	-,083
Eu apoiaria um programa de suporte social para os pobres	,263	-,256	,113	,014	-,022	,368	,227	,181	-,085	,046
Pessoas pobres são discriminadas	,170	,001	,473	,157	-,241	-,064	-,127	-,049	,226	,057
Se eu fosse pobre aceitaria os auxilios	,142	,005	,156	,447	,058	,102	-,323	-,252	,150	,211
Individuos responsaveis por ajudar as pessoas pobres	,066	-,016	,278	-,020	,071	,255	,127	,678	,049	-,025
Poderia confiar em uma pessoa pobre que trabalhasse para mim	,243	,376	,079	,310	-,257	,130	-,075	-,039	-,100	,029

Extraction Method: Principal Component Analysis

a. 10 components extracted

Rotated Component Matrix

	Component									
	1	2	3	4	5	6	7	8	9	10
As pessoas pobres continuarao pobres independentemente do que é feito por elas	,567	,008	-,046	,015	-,138	-,163	-,060	,079	,122	-,018
As pessoas pobres sao menos honestas	,748	-,073	-,087	,000	,022	-,037	-,007	-,043	,062	,068
As pessoas pobres sao diferentes do resto da sociedade	,699	-,004	,010	-,013	,036	,041	-,037	,149	-,063	-,040
Muitas pessoas pobres estão satisfeitas com seu padrão de vida	,121	-,043	-,145	,080	,068	-,022	,005	,790	-,041	,011
Pessoas pobres sao menos inteligentes que as outras pessoas	,716	-,075	-,146	-,031	,083	-,066	,053	,006	-,060	,063
Pessoas pobres tem valores diferentes das outras	,363	-,135	-,005	,018	,120	,060	,042	,176	-,633	-,047
Pessoas pobres criam suas proprias dificuldades	,469	-,192	-,257	,010	-,042	,286	-,028	,194	-,227	-,034
Pessoas pobres nao se preocupam com a saude	,570	-,072	-,079	-,078	,013	,235	-,040	,021	-,281	-,038
Os auxilios tornam as pessoas preguiçosas	-,003	,703	,169	,048	,078	-,054	-,254	-,219	-,017	-,004
Os auxilios encorajam as pessoas a terem mais filhos	-,029	,547	,094	,205	,084	-,008	-,376	-,232	,024	,072
Pessoas que recebem auxilios deveriam trabalhar	,089	,431	,193	-,006	,045	-,096	-,503	-,246	,097	,100
O governo gasta muito dinheiro com os programas para a pobreza	-,061	,725	,112	-,091	-,031	-,001	-,104	-,052	,070	-,124
Pessoas pobres vivem melhor que eu por conta dos auxilios	-,107	,672	-,008	-,032	,028	-,012	,172	,042	-,153	,092
Os auxilios consomem a maior parte do orçamento federal	-,120	,748	,140	-,062	,010	-,019	,076	,241	,018	-,120
Se as pessoas pobres trabalhassem mais sairiam da pobreza	-,138	,182	,713	,105	-,030	-,272	,068	-,146	-,026	,071
Pessoas pobres desempregadas poderiam encontrar emprego se tentassem mais	-,136	,217	,729	,006	-,028	-,199	-,005	-,221	-,012	,020
Pessoas pobres desempregadas deveriam aceitar qualquer emprego	-,156	,092	,663	-,084	,040	,201	-,210	,125	,136	-,118
Pobreza é determinante de saude	,028	-,027	,132	,748	,091	-,106	-,040	,185	-,088	,082
Pessoas pobres tem mais problemas de saude	-,061	-,056	-,030	,733	-,015	,098	-,037	-,072	,119	,002
Pessoas pobres não tem acesso aos serviços de saude	-,015	,066	-,062	,441	,133	,352	,091	-,077	,007	-,064
Governo é responsavel por gerar desigualdade social	-,050	,111	-,127	-,020	,786	,020	,024	-,032	,014	,018
Pobreza é o maior problema social do Brasil	-,064	-,043	,153	,118	,714	,208	-,053	,135	-,082	-,039
No Brasil diferenças de renda grandes	,267	,033	-,011	,153	,522	-,158	,042	-,025	,234	,224
Pessoas são pobres devido a circunstancias alheias a sua vontade	-,031	,110	,039	,084	,041	,551	,205	,192	,174	,347
Pessoas pobres não devem ser responsabilizadas por sua condição	,043	-,129	-,181	,089	,056	,728	,009	-,104	-,024	,011
Não trabalhar e ganhar auxílios é uma escolha	,027	-,262	-,127	-,181	-,021	,052	-,306	,317	,133	,409
Pessoas que recebem auxilios devem ser capazes de gastar o dinheiro como quiserem	-,031	,013	-,024	,006	,040	,025	,731	-,063	,151	,031
Eu apoiaria um programa de suporte social para os pobres	,009	-,236	,015	-,015	-,029	,162	,408	-,044	-,121	,333
Pessoas pobres são discriminadas	,085	-,026	-,143	,367	,067	,222	,068	,051	,430	,060
Se eu fosse pobre aceitaria os auxilios	,182	-,232	,199	-,003	,146	,032	,088	,062	,554	-,159
Individuos responsaveis por ajudar as pessoas pobres	,006	,003	,009	,071	,077	,041	,050	-,031	-,051	,783
Poderia confiar em uma pessoa pobre que trabalhasse para mim	,506	-,029	,014	,074	-,001	,111	,023	-,287	,214	-,016

Extraction Method: Principal Component Analysis

Rotation Method: Varimax with Kaiser Normalization

- Componentes

1) Crenças sobre as características dos pobres – descrição das pessoas pobres

2) Atitudes com relação aos auxílios e aos recebedores dos benefícios

3) Percepções sobre as causas da pobreza – Causas individuais

4) Percepções sobre a relação entre pobreza e condições de saúde

5) Percepções sobre as causas da pobreza no Brasil – Causas sociais/externas

6) Percepções das causas da pobreza – Explicação individual/culpa

7) Percepções e atitudes sobre as políticas públicas de combate a pobreza - auxílios

- Questões **CPP4, PQS4, PPP5, PQS7** e **EP4** foram excluídas do estudo.

Component Matrix

	Component
	1
Todas as pessoas tem direito de receber tratamentos odontologicos independentemente da sua capacidade de pagar por eles	,663
Os dentistas tem a responsabilidade de atender as pessoas pobres	,666
Eu irei tratar pacientes de diversos niveis sociais	,707

Extraction Method: Principal Component Analysis

a. 1 component extracted

- Componente

1) Senso de responsabilidade profissional em prestar atendimento as pessoas pobres

Anexos

ANEXO A

CERTIFICADO DE APROVAÇÃO DO COMITÊ DE ÉTICA EM PESQUISA – FOAr/UNESP

UNIVERSIDADE ESTADUAL PAULISTA " JÚLIO DE MESQUITA FILHO"

FACULDADE DE ODONTOLOGIA DE ARARAQUARA

Comitê de Ética em Pesquisa

Certificado

Certificamos que o projeto de pesquisa intitulado ***"PERCEPÇÕES E ATITUDES DOS ESTUDANTES DE ODONTOLOGIA SOBRE A POBREZA: UM ESTUDO QUANTITATIVO"***, sob o protocolo nº **20/10**, de responsabilidade do Pesquisador (a) *ÂNGELA CRISTINA CILENSE ZUANON*, está de acordo com a Resolução 196/96 do Conselho Nacional de Saúde/MS, de 10/10/96, tendo sido aprovado pelo Comitê de Ética em Pesquisa–FOAr, com validade de 01 (um) ano, quando será avaliado o relatório final da pesquisa.

Certify that the research project titled "***PERCEPTIONS AND ATTITUDES OF DENTAL STUDENTS ABOUT POVERTY: A QUANTITATIVE STUDY***", protocol number **20/10**, under *Dr ÂNGELA CRISTINA CILENSE ZUANON*, responsability, is under the terms of Conselho Nacional de Saúde/MS resolution # 196/96, published on May 10, 1996. This research has been approved by Research Ethic Committee, FOAr-UNESP. Approval is granted for 01 (one) year when the final review of this study will occur.

Araraquara, 4 de maio de 2010.

Prof. Dr. Maurício Meirelles Nagle
Coordenador

ANEXO B

TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO (TCLE)

"Percepções e atitudes dos estudantes de Odontologia sobre a pobreza: um estudo quantitativo"

Eu:____idade_______
RG__________________morador(a)____
_______________________________________ cidade_________________________________,
concordo, voluntariamente, em participar da pesquisa intitulada "Percepções e atitudes dos estudantes de Odontologia sobre a pobreza: um estudo quantitativo", sob responsabilidade da Profª. Drª. Angela Cristina Cilense Zuanon.

Estou ciente de que tenho a liberdade de me recusar a participar da pesquisa ou de retirar meu consentimento em qualquer fase desta, sem penalização. Autorizo que os dados sejam utilizados para pesquisa e sejam publicados em revistas científicas especializadas e/ou apresentados em congressos científicos, desde que minha identidade seja mantida em sigilo.

Declaro ainda, que tenho assistência integral em caso de danos decorrentes de riscos previstos, não terei despesas financeiras e que todas as minhas dúvidas acerca do assunto da pesquisa serão esclarecidas sempre que desejar.

Para reclamações: Comitê de Ética em Pesquisa (16)3301-6432/6434.

Ciente, ____________________, ___ de _________ de 20___.

Assinatura ____

Nome por extenso ____

Autorizo a reprodução deste trabalho.

(Direitos de publicação reservados ao autor)

Araraquara, 09 de agosto de 2011

BEATRIZ FERRAZ DOS SANTOS