A STUDY ON CULTURAL BARRIERS INFLUENCING DENTAL CARE UTILIZATION IN KANPUR

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Manika Tewari

Under the Supervision and Guidance of

Dr. Seema Mehta

2025

where smile comes alive
CHAUHAN'S
DENTAL SOLUTIONS

Dr. SHIV KUMAR CHAUHAN
BDS, MDS (Gold Medalist)
Reg. No. 15115

125, NEW CIVIL LINES, BEHIND GURUDEV PALACE, VINAYAKPUR, KANPUR-24 | chauhansdentalsolutions@gmail.com

TO WHOMSOEVER IT MAY CONCERN,

This is to certify that **Dr. Manika Tewari**, a student at IIHMR University, was associated with us from **March 18, 2025, to June 04, 2025**, as a part of her dissertation experience.

The overall performance shown by her during the period was excellent.

This certificate is being issued to meet the requirements of the IIHMR University

Dr. Shiv Kumar Chauhan

Dr. Shiv Kumar Chauhan
BDS, MDS
Reg. No. 15115

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **A study on cultural barriers influencing dental care utilization in Kanpur** is a record of the research work undertaken by **Manika Tewari** in partial fulfilment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Dr. Seema Mehta
Faculty Guide
IIHMR University, Jaipur
Date: 10-06-2025

Dr. Sanjay Gupta
School Dean
IIHMR University, Jaipur
Date: 10-06-2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **A study on cultural barriers influencing dental care utilization in Kanpur** is the bona fide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

M Tewari

Dr. Manika Tewari

10-06-2025

ACKNOWLEDGEMENT

I wish to extend my sincere gratitude to the individuals who helped me during the dissertation writing process.

First and foremost, I would like to express my sincere gratitude to Dr. Seema Mehta, my mentor for her invaluable guidance, expertise, and support throughout this research project. Her insights and encouragement were crucial to the completion of this work.

I would like to express my sincere gratitude to Dr Shiv Kumar Chauhan, my mentor in the organization, for the opportunity. Navigating the practical parts of this study has been made possible by his unfailing support, practical insights, and insightful advice.

Furthermore, I would like to express my gratitude to the entire staff and associates for their indispensable help, collaboration and support during my project.

Finally, I would want to express my gratitude to my family and friends for their support, whose endurance and inspiration have given me strength.

Dr. Manika Tewari

Table of Contents

ABSTRACT

Title – A study on cultural barriers influencing dental care utilization.

Background – Oral health is a key and integral part of overall health, but arguably the most neglected health issue in much of India. With increasing knowledge and access to dental care, however, the vast majority of Indians continue to delay treatment. While cost, access, and awareness are repeatedly cited as reasons, we are told little about the cultural and social values that underlie seeking dental care.

India is a nation characterized by an abundance of cultures in which long-standing traditions, religious beliefs, gender roles, and family dynamics play important roles in influencing health-related behavior. In local communities, especially rural and semi-urban areas, gargling with clove oil, turmeric, or salt solutions is the most preferred home remedy, and visiting a dentist is seldom practiced. Dental problems are considered a matter of fate or, in other cases, a manifestation of imbalance in the spiritual realm by a section of the population, with senior members or male members of a family typically deciding whether and when individuals, particularly women, are allowed to be treated medically.

Additionally, cultural stigma, shame, and the absence of culturally specific dental care are also key determinants to the ineffective utilization of available services. In normal times, aside from pain, dentistry falls behind other health areas, and routine preventive dental visits are not practiced. Cultural identity, religious fasting, ritual prohibition, or gender roles can deter patients from attending clinic visits at specific occasions or for specific groups.

While scientific studies have typically been directed towards economic and infrastructure impediments, cultural aspects of dental health are often poorly managed in the clinical setting and difficult to surmount. These specific and complex cultural impediments must be comprehended in order to create culture-

sensitive, representative, and efficient public health interventions in a given local setting.

This research tries to fill the existing gap by exploring the cultural misconceptions and impediments to the delay in dental care among the residents of a Tier-2 Indian town, both the urban, semi-urban, and rural. Through this method, we seek to provide pragmatic suggestions for culturally adapted oral health education and dental programs at the community level.

Objectives-

1. To assess the prevalence of cultural beliefs and misconceptions influencing dental visits.

2. To examine the relationship between these beliefs and key sociodemographic factors.

3. To identify barriers preventing preventive dental care among various population segments.

Methodology - This cross-sectional study was conducted in Kanpur, involving participants from urban, semi-urban, and rural areas. Data was gathered for three months from March to June 2025. The study sample consisted of individuals aged eighteen years and above who attended outreach dental camps.

Results- Results show that patterns of belief at the cultural level had a significant impact on the behavior of seeking care for dental issues. A large proportion of participants considered dental issues as serious only if painful, and in most cases, they would seek home remedies or traditional healers rather than professional dental care. Gender-based inequalities were also uncovered by the analysis: especially in rural settings, women also had more barriers, often needing permission from male relatives to be treated or being reluctant to be treated by male dentists because of prevailing gendered expectations. Low education and

income were associated with lower awareness of dental health and lower use of formal dental care. In conclusion, most participants delayed care until dental issues were serious, demonstrating high levels of shortfall in preventive awareness and access.

Keywords- Cultural barriers, Dental care utilization, Oral health literacy, Traditional beliefs, Health-seeking behavior

INTRODUCTION

India offers a rich and varied environment to study the patterns of use of healthcare, mainly due to the fact that it is so hugely diverse in customs, religions, languages, and social customs. While oral health is obviously a part of overall health, it is a neglected aspect of public health ideology, particularly in low- and middle-income countries like India.

Oral disease affects nearly 3.5 billion people globally, and the most prevalent health condition is untreated dental caries. The situation in India is particularly grim: over 95% of adults harbor gum disease, and dental caries are present in 50% to 80% of children. These statistics reflect a widespread but largely neglected public health crisis, exacerbated by a lack of preventive treatment and persistent oral disease cultural taboo.

Despite technological developments in dentistry, access to professional dental care remains incredibly low. Just 28% of urban residents and a measly 12% of rural residents avail themselves of professional dental care, according to India's National Oral Health Survey 2019. This difference reflects systemic inequalities entrenched deep within and highlights the imperative for addressing barriers to treatment, given the prevalence of dental caries, periodontal diseases, and oral cancers throughout the nation.

A close look at the socio-cultural background reveals the multi-dimensional nature of the issue. Economic constraint, infrastructural inadequacies, and limited access are core issues, but cultural factors exert an equally potent—but often overlooked—influence on health-seeking behavior, with specific reference to dental care. The Indian context is one where there is a dynamic interplay between traditional and conventional outlooks, health being widely understood in moral and spiritual terms. Traditional medical systems like Ayurveda, Unani, and Siddha still shape attitudes towards illness and health, particularly in semi-urban

and rural India. In these systems, disease often comes to be aligned with spiritual imbalance or with derangement of body humors, and not with the biomedical notions that form the basis of modern dentistry. This difference in understanding can lower the perceived importance of oral health and the importance of professional dental care.

Additionally, health decisions in India are more familial than individual, mirroring the powerful role of family and community frameworks. In these societies, attitudes towards dental care are shaped by the intergenerational transmission of cultural values. Distrust of allopathic medicine or reliance on word-of-mouth advice can lead family members to discourage professional dental care, opting instead for vernacular or traditional treatments. Oral health practice in India is determined by an interplay of complex economic, infrastructural, and—most importantly—cultural forces. Solving this issue requires subtle approaches that acknowledge and appeal to these socio-cultural forces.

TRADITIONAL BELIEFS AND ORAL HEALTH

Traditional treatments continue to shape public dental care procedures across India. The majority of people utilize neem sticks, oil of cloves, turmeric, or salt for cleaning the mouth or to ease toothache, often turning to such practices prior to visiting a professional dentist. Although some of the treatments are antibacterial, overuse is certain to lead to delayed dentist visits for prompt dental care, particularly worsening gum and other mouth ailments. The majority of people are still uncertain that bleeding gums and toothaches are medical conditions that require clinical attendance but are simply mere slight nuisances that can be treated at home.

The past lack of access or skepticism regarding traditional healthcare services is another cause for such dependence. Due to their experiences in times when medical facilities did not exist, the older generations were often denied access to

trained dental experts, and thus self-medication became common. Such strong beliefs that find their way to the younger generations also contribute to cultural perceptions that undervalue expert dental care.

Religious practices have the ability to influence health behavior in direct and indirect ways. Most Indians fast or do not attend for medical treatment on certain religious days, as they consider invasive treatment or contact with blood to be unlucky. Additionally, cultural and religious practices have extreme impacts on people's desires for dental care. For instance, it is not unusual for patients to delay dental visits during fasting periods, like Ekadashi, Ramadan, or Navratri. Additionally, in certain conservative cultures, women are prevented from dental treatment during menstruation, cutting off further access to their sources of care. Religious beliefs have the potential to heighten these barriers; some people blame disease on karma or God's plans, so they consider issues of oral illness to be spiritual tests instead of medical issues. Therefore, they might attribute less importance to rituals or prayer rather than medical treatment, leading to delays in obtaining essential care.

Gender norms play a strong role in access to healthcare in India, and dental care is no different. Patriarchal structures tend to withhold control over decisions around their health from women and ask for their family members' permission, preferably the male ones, before they can visit a dentist—particularly if the dentist is male. These cultural norms together add strong impediments to fair and timely dental care. Due to cultural norms around modesty and decency, women may also feel shy or embarrassed to speak in front of male dentists in conservative environments. Moreover, males and children are frequently prioritized over women in health affairs at home. Women's dental needs are more likely to be delayed or neglected if they lack adequate financial means. Women's socialization also makes them put others' needs before themselves. Preventive dental care for women is not taken seriously in most Indian homes, and oral health problems are

typically neglected unless there is severe pain. This practice is strongly driven by social stigma around dental afflictions—diseases like bad breath, tooth decay, or sight of tooth loss are frequently associated with personal shortcomings, e.g., poor hygiene or illiteracy. Thus, individuals, especially adolescents and young adults, are likely to feel shy or embarrassed and therefore avoid seeking professional dental treatment out of fear of ridicule or social stigma.

There is also a shared perception that attending dental clinics is an indicator of poor self-regulation with regard to personal hygiene activities. This perception pushes individuals to hide or deny oral complications until they are critical. The uneven growth between urban and rural India contributes to the complexity of accessing dental services. Urban regions are better equipped with dental centers and specialized care; however, cultural barriers—that encompass fatalism, stigma, and a following of traditional beliefs—still persist, especially with migrant groups that originate from rural areas. In semi-urban and rural regions, the shortage of dental health workers and weak infrastructural support compound these challenges. Communal values override individual choices, and therefore many resort to seeking recommendations from local healers or community leaders instead of dental workers. A prevailing sense of cultural fatalism, coupled with low awareness and poor health literacy, further compound the overall disregard for oral health.

Linguistic and cultural disparities are key impediments to accessing dental care. Effective communication is required in the healthcare sector; yet, most dentists, particularly those practicing in urban settings, are not conversant in the indigenous languages of their patients, thereby establishing a feeling of unease and distrust. In addition, culturally insensitive conduct, including reprimanding patients or ignoring conventional beliefs, further expands the chasm between dental professionals and the societies they cater to.

In marginalized communities, both collective and individual histories of discrimination, neglect, or unaffordable expense lead to a widespread lack of trust in the healthcare system. Bad experiences deter not only the individual but also their broader community from seeking dental care. Lack of cultural competence in dental education and practice is ultimately a significant structural barrier to improving oral health.

In the Indian context, family units are likely to have collective decision-making processes in health issues. This can either ease or hinder access to dental care. Conservatism within the family system can restrict health-seeking behavior, yet family support can, in turn, ease early dental visits. In most families, especially in older generations, there is a strong reliance on conventional home remedies or spiritual healing for dental issues. The practice tends to discourage young women and children from professional dental services. In addition, oral issues are seldom open topics in families unless a person is in unbearable pain, leading to the issue being left untreated. The behavior of parents towards dental care is a key influencer in the oral health behavior of children; when neglect is culturally entrenched, it becomes a chain of poor oral hygiene and delayed treatment throughout generations.

Health behavior is strongly influenced by the dynamic interaction between formal and informal education. The more educated people are, the less they are controlled by cultural norms and the more they recognize the value of preventive dental care. Oral health is, however, rarely included fully in educational programs, and public health messages frequently fail to challenge harmfully embedded cultural stereotypes.

Advertising carried by mass media can reshape attitudes on a cultural level, if well-planned. The majority of advertisements, nonetheless, usually address urban areas, are in Hindi or English, and do not reach multilingual and multicultural populations. In order to change attitudes towards tooth care, successful ad

campaigns need to use regional dialects, use cultural stories, and involve influential community leaders.

Cultural barriers to dental care in India can be broken only by more than just additional expanded financial aid or facilities. It requires a paradigm shift in the healthcare model towards culturally appropriate treatment modalities. This entails the implementation of community health workers who can effectively negotiate cultural barriers, the development of communication skills, cultural sensitivity training for dentists, all ultimately ending in a change in the populace's behavior. Initiating such a program is itself a multifaceted process and requires an in-depth knowledge of the issues at hand, as well as the interrelated factors and regional variability involved. One single strategy is not likely to prove effective in this culturally diverse country; however, several fundamental strategies can be explored: 1. Giving a high priority to integrating cultural competence into curricula for dental education should be one of the priorities of policy initiatives. 2. Utilization of local languages and culturally adapted symbols to create oral health communications specifically localized for particular regions. 3. Coalition efforts in dental health education with participation by religious and community leaders. 4. The development of dental education programs that offer attention to the family's needs. 5. Offering incentives to dentists who choose to practice among disadvantaged and culturally diverse populations.

REVIEW OF LITERATURE

S.No.	TITLE	AUTHOR/ YEAR	DESCRIPTION	FINDINGS
1.	Utilization of dental care: An Indian outlook	Ramandeep Singh Gambhir et al., 2013	Literature review of articles pertaining to use of dental services in India.	Fear, ignorance, and lack of access, particularly in rural regions, limit the use of dental services in India. To improve people's attitudes toward dental treatment, it is essential to address dental fear and provide public education. Initiatives such as dental camps, mobile clinics, and school-based programs have proven effective in increasing awareness and motivating individuals to utilize dental services.

				Importantly, the establishment of affordable dental clinics in rural regions is vital to meet the needs of lower socioeconomic communities. It should be noted that there is a significant lack of data regarding dental service utilization in Northeast India. Such data must be gathered in order to plan effectively, distribute dental resources more effectively, and guarantee that the populations most in need of care receive them.
2.	Perceived barriers to the provision of	Ramesh Nagarajappa et al., 2015	A cross-sectional survey of 120 dentists	The study highlights three primary barriers to

	preventive care among dentists in Udaipur, India		of Udaipur city, Rajasthan. The questionnaire included demographic questions and specific research questions.	preventive dental care: a prevailing focus on treatment rather than prevention among dental professionals, financial limitations, and patient attitudes. Specifically, many dentists are discouraged from offering preventive care due to perceived inadequate financial compensation. Additionally, dentists often make assumptions about their patients' financial capacity, influencing the type of care provided. Furthermore, despite the recognized

				effectiveness of basic oral health education, most dental practitioners continue to rely exclusively on these methods, and more comprehensive strategies—such as the Common Risk Factor Approach—remain underutilized. Professional Education Needed: In order for dentists to confidently offer preventive counsel and comprehend the importance of health promotion, they need further training and motivation. Systemic Shift Needed: To enhance oral health outcomes, the

				Indian dentistry profession must abandon its curative, specialist-driven model and adopt a more public health and prevention-focused strategy.
3.	Cultural and socioeconomic barriers in utilization of dental services: A cross-sectional questionnaire based study	Khyati H Patel et al., 2016	A cross-sectional questionnaire-based study to assess the perspectives and beliefs towards oral health and correlate this to their socio-economic status.	1. Perception of Dentist's Skill: People in the higher socioeconomic category have high expectations and a low threshold for discomfort. They demand painless dental care and associate pain with inadequate training. 2. The lower socioeconomic groups often hold the following beliefs: a. Following the extraction of an

				upper tooth, vision loss may occur. b. Teeth that ache cannot be saved. 3. Attitude Based on Fate: Regardless of care, 68% of respondents think teeth will eventually fall out and 61.32% of people think dental care is too costly. 4. Absence of a Prevention Mentality: 35% believe that several dental appointments are superfluous. Lower socioeconomic groups do not prioritize scheduled visits. 5. Oral and General Health Disconnect: A lack of knowledge

				regarding the systemic effects of oral health is evident in the 49% of people who think dental problems have nothing to do with general medical concerns.
4.	Oral health beliefs, attitudes, and practices of South Asian migrants: A systematic review	Mehak Batra et al., 2019	A systematic review of studies that included South Asian adult migrants residing in high-income countries.	Adult South Asian migrants have low oral health knowledge, and gender, religion, and customs have a big impact on preventative behavior. For educational initiatives to be as effective as possible, cultural diversity and religion must be taken into account. To determine whether acculturation has

				any effect on dental health, more thorough research is required. The first step toward bettering oral health may be to implement focused oral health education initiatives that target women in these communities.
5.	Parental knowledge, attitudes and cultural beliefs regarding oral health and dental acre of preschool	N.Chhabra et al., 2012	Cross-sectional questionnaire-based study with parents of 620 preschool children	It was discovered that early preventative dental care for preschool-aged children was hampered by parents' dental anxiety, their ignorance of the significance of the primary teeth, and the myths surrounding dental procedures. Transmission of Streptococcus

				mutans, coupled with the vital importance of fluoride, underscores the need for effective dental hygiene and feeding practices—areas that remain inadequate. Family elders, particularly grandparents, exert significant influence over parental choices regarding children's oral health. If parental awareness, attitudes, and beliefs about dental health are not addressed and improved, meaningful progress will be difficult

6.	Barriers and facilitators to dental care among culturally and linguistically diverse carers: A mixed-method systematic review	Kanchan Marcus et al., 2022	This study utilized a mixed-method systematic review, with both qualitative and quantitative research.	Cultural beliefs, attitudes, and knowledge serve as either catalysts or barriers to seeking dental care. Due to widespread misconceptions, preventive care is frequently undervalued, with many individuals favoring an illness-driven approach—only seeking treatment when symptoms become severe. This highlights the ongoing need for targeted education and culturally sensitive interventions. It's possible that immigrant populations, such as Canadian African

				mothers, are not aware of public dentistry services. On the other hand, mothers from Pakistan and Bangladesh in the UK expressed interest in preventive care. Behavior was influenced by cultural customs such as gender roles in Mexico, the use of miswak in Iraq and Lebanon, and family hierarchy in China. Relationships between Faith and her frequent dentist encouraged drive and trust. Children's dental behaviors were greatly influenced by the oral health

				practices of their mothers.
7.	Barriers to Dental Services utilization among adult population in India: A scoping review	Sudhakar Vundavalli et al., 2025	Scoping review used a methodology suggested by Joanna Briggs institute's framework	1. The most frequently mentioned barrier is the high expense of dental care. 2. Financial burden of OOP as most dental procedures aren't covered by insurance schemes like Ayushman Bharat. 3. People avoid dentists because they are afraid of pain, extractions, and dental instruments. 4. A lower degree of education is associated with less use of dental care. 5. Men tend to postpone dental appointments, whereas women use

				them more frequently. 6. Due to misunderstandings and mobility challenges, the elderly and children under ten underutilize services. 7. Dental care is less important to people with general illnesses. 8. People visit dental clinics only when they need tertiary care and not preventive care 9. Traditional Beliefs like tooth loss impairs vision prevent people from obtaining help.
8.	Needs and Barriers to access oral healthcare	S Yoga Abirami et al., 2023	Cross-sectional door-to-door study involving 436 subjects	Dental caries and periodontal disorders were equally distributed

	services among the rural population in Chengalpattu, Tamil Nadu		and a structured questionnaire	among those who felt a need and those who did not. Additionally, the rural populace faces substantial obstacles to receiving dental care, especially for rural women. This demonstrates unequivocally that the rural populace is ignorant of the significance of oral diseases and their own oral health status. Thus, programs and policies that try to reduce the demands and obstacles to rural residents' access to oral healthcare services should be prioritized.

9.	Oral hygiene practices and knowledge on periodontal diseases and therapy	S Sakthi Devi et al., 2022	A cross-sectional questionnaire study on gypsy Narikuvars in Puducherry including 100 participants	The study emphasizes how the Narikuravars' low educational and economic standing in Puducherry has a major impact on how they use healthcare. With no discernible correlation to sociodemographic characteristics, the majority of participants knew very little about periodontal disease and its treatment. Poor oral hygiene habits were prevalent, with many people using brick powder, neem sticks, or their fingers in place of toothbrushes. Just 13% of people switched their

				toothbrushes every three months. The results highlight the necessity of mobile dentistry services, oral health education, and periodontal screening. Strategies should take into account the sociocultural views of the society. In order to enable future focused actions, this data attempts to close gaps between the Gypsy community and healthcare providers.
10.	Prevalent dental myths and practices in Indian population- A systematic review	Sakshi Joshi et al., 2020	A systematic review of literature.	The review's findings demonstrated that individuals' awareness and knowledge levels were insufficient,

				and that dental myths were more common in India's rural areas. To gather useful information about the nation's oral traditions and myths, more research is necessary. Additionally, the dentist must dispel the fallacies to treat patients successfully and avoid a lot of dental issues.

METHODOLOGY

Research Question

What are the cultural beliefs that shape access to dental care in India, and how do these intersect with demographic variables such as age, gender, education, occupation, residence, and income?

Study Design

To investigate these cultural beliefs and their associations with demographic factors, a cross-sectional descriptive study design was utilized.

Study Setting

This research was conducted at dental outreach camps located in urban, semi-urban, and rural regions of Kanpur, Uttar Pradesh. This methodology was chosen to ensure representation across a broad spectrum of socioeconomic and cultural backgrounds

Study Population

The focus was on individuals aged 18 and older who attended the dental camps during the data collection phase and agreed to participate in the study.

Inclusion Criteria

- Adults aged 18 years or older.

- Reside in the chosen urban, semi-urban and rural areas.

- Provide consent to take part in the study.

- Be physically and mentally capable of understanding and responding to the questionnaire.

Exclusion Criteria

- People under 18 years of age.

- Refused to give informed consent.

- Had cognitive impairments or communication issues that would prevent them from comprehending or completing the survey.

- Medical professionals.

Study Tool

A questionnaire was designed for data collection. This tool aimed to gather ddemographic data, including age, gender, marital status, educational background, occupation, income bracket, and residential area. Additionally, the study explored participants' beliefs and perceptions about dental health, including attitudes toward dental pain, the use of home remedies, reliance on traditional healers, cultural restrictions, and emotional barriers such as shame or embarrassment

Duration of Study

The research was conducted over a three-month period, from March 2025 to May 2025.

Sampling Technique

Sampling was conducted using a convenience sampling approach. Individuals were invited to participate based on their availability and willingness during dental outreach events and clinic visits. In total, 10 camps were conducted.

Sample Size

A total of 100 respondents participated in the study. The sample size was determined by practical considerations, including the number of individuals available during outreach activities and the need to ensure sufficient demographic representation

Ethical Considerations

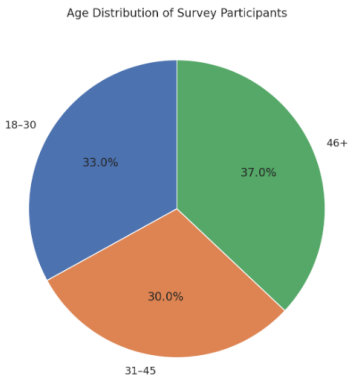
Verbal consent was obtained from all participants prior to data collection. Participants were assured that their confidentiality and anonymity would be maintained, and they were informed that participation was entirely voluntary. No personal identifiers were recorded in the dataset, which was stored securely and used exclusively for research purposes.

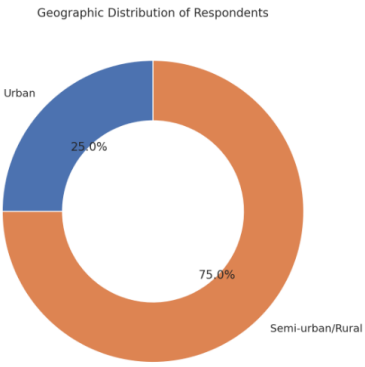
RESULTS

This chapter presents significant outcomes of a survey that investigates the impacts of cultural beliefs on the delivery of dental care to people from different backgrounds. The results are outlined to demonstrate the interaction between variables such as age, sex, level of education, occupation, place of residence, and income with cultural attitudes towards oral health and oral health practices.

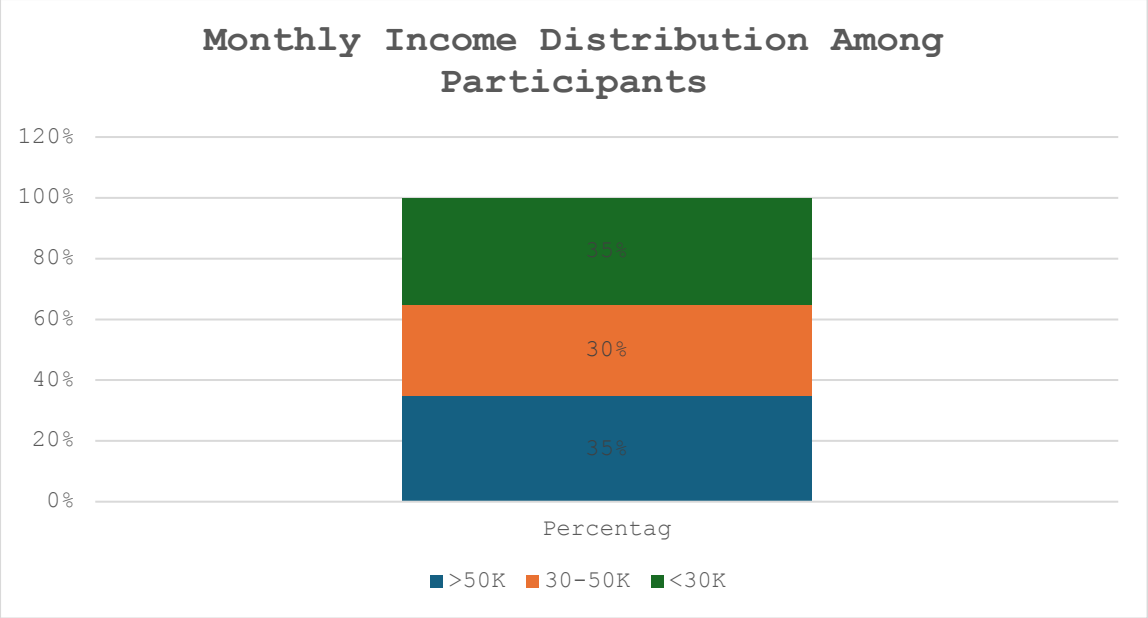
Demographic Profile of Participants

The sample of the participants was demographically representative. Among the respondents, 33% were 18 to 30 years old, 30% were 31 to 45 years old, and 37% were 46 years old and older. Females comprised 54% of the sample, while males comprised 46%, indicating a moderate female dominance. The marital status was varied: 55% were married, 29% were single, and 16% were widowed or separated. Educational level was varied: 34% had graduate studies or higher, another 34% had completed secondary, and 25% had primary education or no schooling at all.





In terms of residence, 25% of respondents lived in urban areas and 75% in semi-urban or rural regions. Family income distribution was relatively even, with 35% earning over ₹50,000 monthly, 35% below ₹30,000, and 30% between ₹30,000 and ₹50,000.

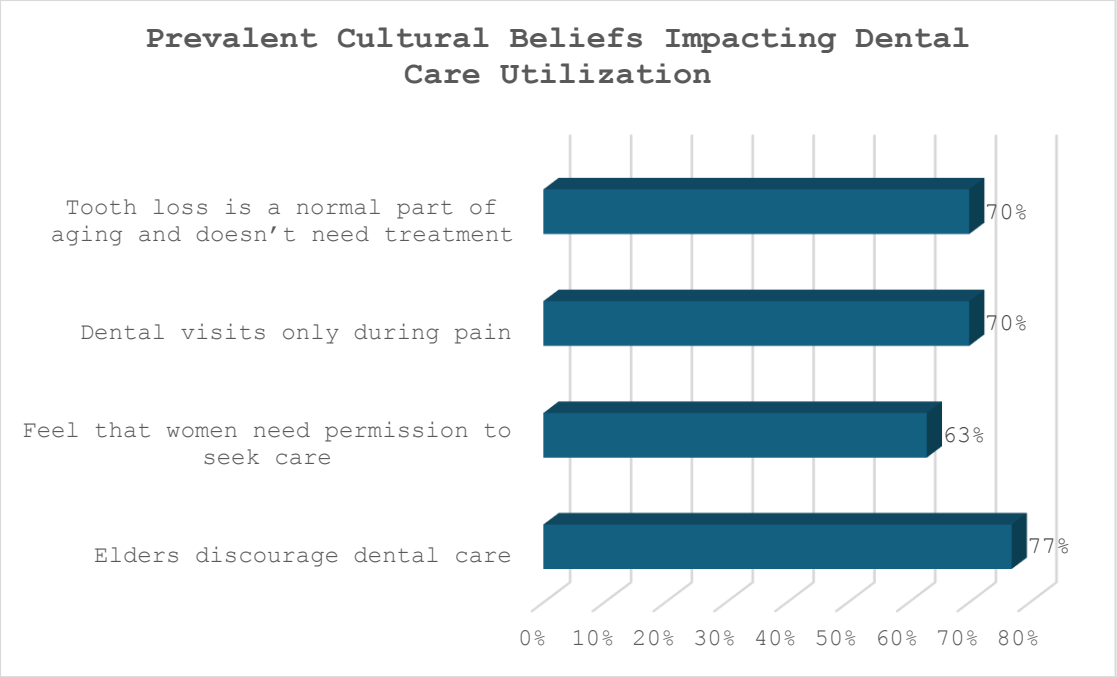


Cultural Beliefs Influencing Dental Care Behaviour

The survey provided a detailed examination of cultural beliefs that might impact dental care practice. Notably, 70% of the respondents indicated that they only took dental conditions seriously when they were painful, showing a reactive mindset towards the mouth and not a preventive one. By contrast, 22% mentioned preventive dental care as important, while the remaining ones were unsure. This suggests that cultural attitudes play a significant role in dental health behavior, with the tendency, most of the time, being towards treatment and not prevention.

Interestingly, more than half of the population (58%) opted to seek home remedies first, which is an indication of high dependence on informal or customary healthcare. Trust in traditional healers was also evident, with 47% of them having greater faith in them than registered dentists. Interestingly, 77% of the interviewees reported that elder relatives actively discouraged them from seeking dental treatment, thus indicating the high cultural influence on health practices. Further, 23% of the interviewees reported that they shunned male

dentists because of traditional beliefs, and 63% of the female population reported that they needed the approval of male relatives before seeking dental treatment. These observations highlight the central role of gender relations and family authority in the selection of healthcare.



Embarrassment emerged as a notable barrier, with 43% of individuals admitting discomfort with showing their teeth to a dental professional. This emotional factor potentially delays or prevents necessary treatment. A majority(79%) came from communities/households that believed dental visits are considered only in severe situations. Additionally, 70% believed tooth loss is a normal part of aging and doesn't need treatment.

Cross-Demographic Patterns and Beliefs

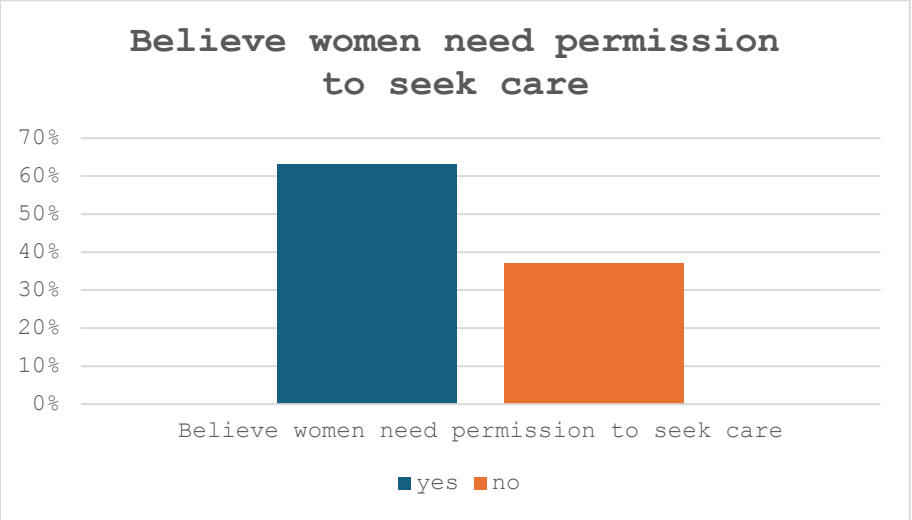
1. Age-Based Differences

There were also age differences. Younger patients (18–30 years) underplayed dental complaints unless painful, and many expressed shame during their visits. Older patients, especially those over 45, mentioned more cultural barriers, such

as embarrassment with male providers and unwillingness to seek care unless given outright permission by family members.

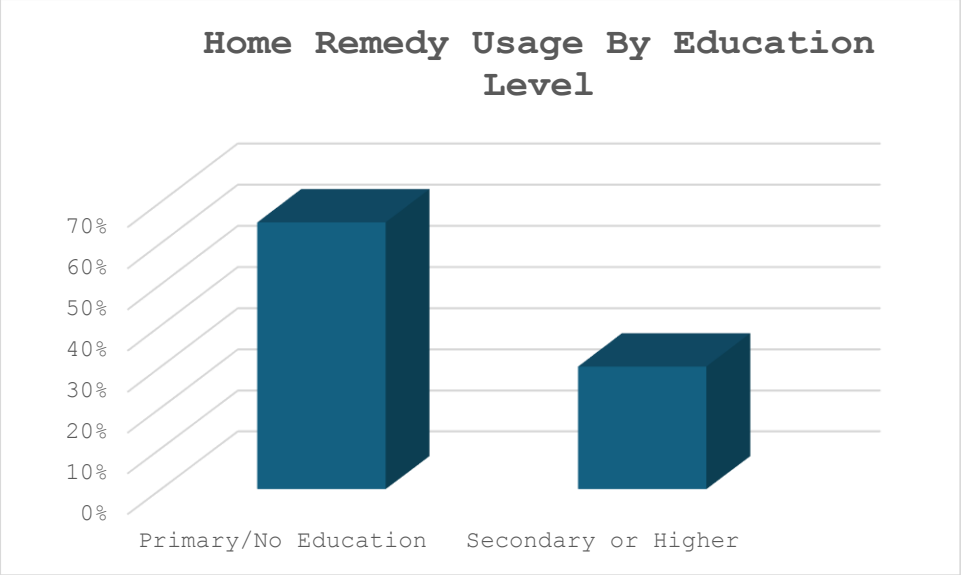
2. Gender Variations

Gender differences were quite pronounced. Female respondents were more likely to feel embarrassed (30%) and to face restrictions for seeking care. While some male respondents also reported avoiding dental visits due to traditional beliefs, fewer women resonated with the same. These findings underscore both internalized and external barriers related to gender.



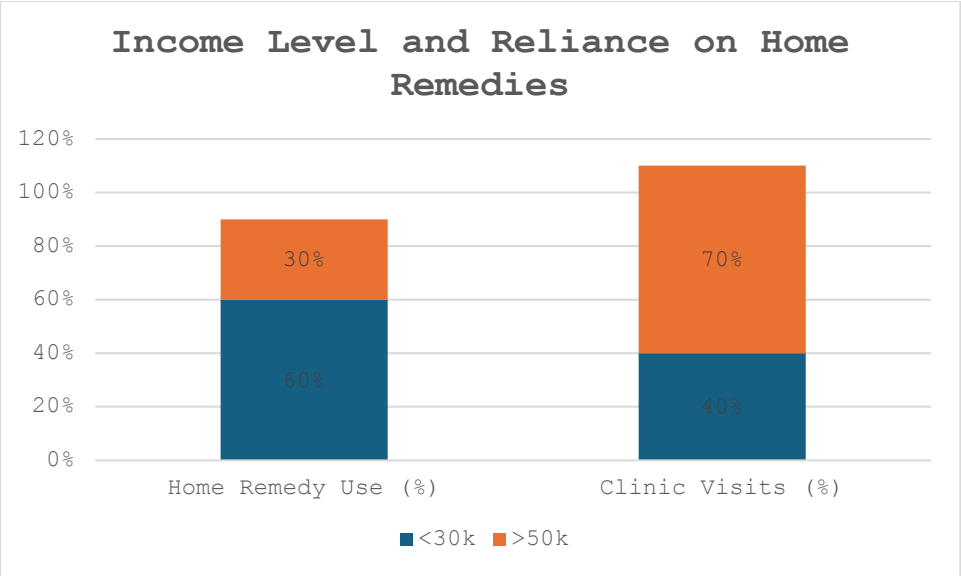
3. Role of Education

Education played a pivotal role in shaping perceptions and behaviours. Only 30% of individuals with graduate-level education or higher relied on home remedies, compared to 65% among those with only primary or no formal education. Furthermore, 70% of respondents with lower education believed dental care was necessary only when pain occurred, a belief much less common among those with advanced education.



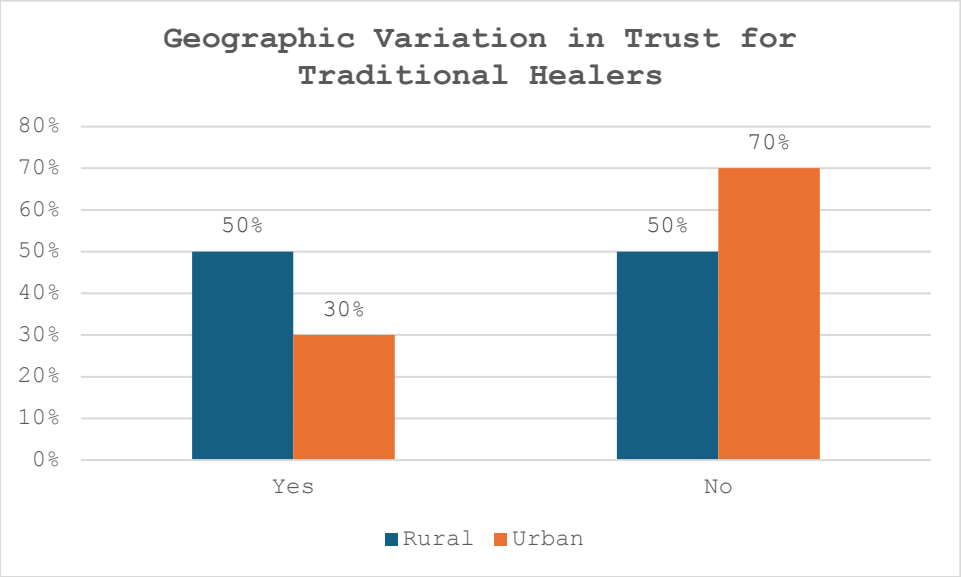
4. Socioeconomic Disparities

Lower-income groups (earning less than ₹30,000) showed a greater reliance on home remedies (60%) and cultural beliefs (50%) that hindered them from seeking formal care. Among those earning over ₹50,000, only 30% exhibited similar attitudes regarding dental care, suggesting that financial stability and education together help mitigate cultural and economic barriers.



5. Geographic Influence

Geographic disparities further complicated access. Urban residents expressed greater confidence in formal dental services, with only 30% relying on traditional healers, versus 50% in rural or semi-urban areas. Additionally, 35% of rural participants noted that women required male permission to visit a dentist—a figure significantly higher than in urban settings—demonstrating the continued strength of traditional norms outside metropolitan areas.



Summary of Key Observations

The findings reveal a few common beliefs across all demographics, like tooth loss being a normal part of ageing, and delaying care until the condition becomes severe. Additionally, many participants were discouraged from seeking dental care by their elders.

A few differences were observed in age-related behaviors, like young adults being embarrassed about their teeth and delaying care, while older people relying more on home remedies.

Gender and cultural norms created additional barriers for women, especially in non-urban areas.

A strong reliance on traditional healers and home remedies was particularly evident among rural, low-income, and less-educated groups. Also education and income levels were closely linked to greater awareness and utilization of dental care services.

DISCUSSION AND RECOMMENDATIONS

Influence of Age on Dental Beliefs and Practices

Age appears to play a substantial role in shaping attitudes toward dental care. Among younger adults (18–30), there is a notable tendency to treat dental issues reactively, often seeking professional care only when pain becomes significant. This pattern, supported by various studies both within India and internationally, suggests that routine dental checkups are often neglected by this demographic unless acute symptoms arise. Additionally, a significant portion of younger participants either did not perceive or were uncertain about the existence of cultural or familial barriers to dental care, indicating a possible lack of awareness or reflection on these influences.

In contrast, individuals over the age of 45 displayed a heightened sensitivity to cultural constraints, such as the preference for female dental practitioners and the perceived requirement for family approval prior to seeking dental treatment. These findings align with broader generational differences in health beliefs, whereby older adults are more likely to adhere to traditional norms and practices. Such distinctions emphasize the necessity for age-sensitive health promotion strategies—ones that address misinformation and complacency among younger individuals, while also acknowledging and respectfully challenging the cultural inertia observed among older adults.

Gender Barriers in Dental Care Access

The data further reveal significant gender disparities in dental care utilization. Female respondents frequently reported feelings of embarrassment regarding their dental health and encountered cultural obstacles such as the need for permission from male relatives or discomfort with male dental professionals. These patterns reinforce findings from existing research on gender norms in

South Asian healthcare, which documents both structural and interpersonal barriers to timely care for women.

Male participants, meanwhile, tended to rationalize their barriers internally, demonstrating a preference for home remedies and traditional healers. This suggests that while women's barriers are often externally imposed by societal expectations, men's reluctance is more closely linked to personal belief systems. Addressing these gendered divisions requires targeted interventions—empowering women through education and community support, while encouraging men to reconsider reliance on traditional, non-evidence-based approaches.

Educational Attainment as a Determinant of Oral Health Beliefs

Education emerged as a critical determinant of dental health beliefs and practices. Participants with higher education levels were markedly less likely to depend on home remedies or to view pain as the sole indicator of serious dental issues. They also expressed reduced confidence in traditional healers, reflecting a broader shift toward evidence-based care.

Conversely, those with limited or no formal education were more inclined to rely on home-based treatments and maintained several misconceptions regarding dental health. The link between low educational attainment and poor dental care utilization underscores the importance of prioritizing literacy within public health initiatives. Community-based education programs, particularly those offered in local languages and dialects, are essential for dispelling misinformation and improving oral health outcomes across diverse populations.

Economic Factors and Access Inequity

Economic realities play a significant role in shaping how people perceive and approach dental care. For individuals from lower-income backgrounds, there's a noticeable tendency to rely on home remedies, harbor skepticism toward modern

dental practices, and postpone seeking professional help until dental pain becomes severe. These patterns aren't isolated—they echo findings from research across India and other low- and middle-income countries, where financial insecurity frequently leads people to put dental care on the back burner.

Furthermore, those earning under ₹30,000 a month face not only financial hurdles but also cultural challenges. Many must seek permission before pursuing dental treatment or may feel embarrassed about needing care at all. This combination of economic and cultural obstacles creates a "double burden" for marginalized communities, with poverty amplifying experiences of social exclusion. Addressing these complex challenges calls for integrated policy solutions—ones that blend affordable dental care options with targeted community outreach and awareness initiatives.

Urban-Rural Divide

There are also clear urban-rural differences in dental health behavior. People in urban areas generally access formal dental care more often and are less likely to depend on traditional healers, likely due to greater exposure to and comfort with modern healthcare services. In contrast, those in rural and semi-urban settings tend to place more trust in traditional remedies and encounter cultural barriers, particularly for women. These disparities underscore the need for context-sensitive approaches when designing interventions to improve oral health outcomes.

This divide highlights significant gaps in both infrastructure and information between urban and rural communities. The absence of nearby dental clinics, combined with limited access to oral health education, likely keeps many in rural areas reliant on informal care. Moreover, women in these regions may be especially at risk of neglect due to the compounded effects of geography and

gender. To bridge this gap, it's essential to invest in mobile dental clinics, tele-dentistry options, and local oral health workers who can reach these communities.

Cultural Beliefs as Systemic Barriers

One of the most eye-opening findings from this analysis is how deeply ingrained cultural beliefs can delay or even prevent people from seeking dental treatment. Almost half of the respondents expressed a greater trust in traditional healers or opted for home remedies. While it's important to respect cultural traditions, relying solely on these practices instead of seeking clinical care can pose serious health risks, and many quacks also pose a serious risk to the public's health.

Feelings of embarrassment about dental appearance, cultural taboos regarding male dentists, and family dynamics that dictate health decisions all point to broader issues of stigma, misinformation, and patriarchal norms.

Beliefs can change with increased exposure, education, and community discussions. Therefore, public health messaging should go beyond just clinical advice and engage with cultural narratives. For instance, involving respected local figures or incorporating oral health themes into religious and cultural events can help make dental care more socially acceptable.

Recommendations-

The intricate relationship between cultural beliefs and demographic factors highlights the need for multifaceted strategies:

- Culturally Sensitive Outreach: Public health campaigns should reflect local beliefs, languages, and customs. Partnering with community leaders can significantly enhance credibility.
- Gender-Inclusive Strategies: Dental programs need to foster safe and supportive environments for women, which could include hiring female practitioners in rural areas and establish women only dental camps.

- Education-Focused Interventions: Boosting oral health literacy, especially in rural and low-income areas, has the potential to create lasting change. School-based dental education can even have a ripple effect that benefits entire families.
- Affordable and Accessible Care Models: Initiatives like subsidized clinics, community dental vans, and tele dentistry can greatly improve access, particularly for underserved populations.
- Incentivizing Preventive Care: Linking dental visits to existing welfare programs, such as health insurance reimbursements, could encourage people to seek early intervention.

Limitations and Scope for Future Research

While this study provides some insights, it's important to acknowledge some limitations. The sample does not fully represent all Indian states or socio-cultural groups, and self-reported beliefs might be influenced by a desire to present oneself in a favorable light. Future research should consider longitudinal approaches to track behavioral changes over time and include qualitative methods, like interviews or focus groups, to understand deeper into the motivations behind certain beliefs.

INFERENCE

This study underscores how deeply cultural beliefs are woven into the way people approach dental health. It's evident that many individuals still see oral care primarily as a reaction to pain, not as a preventive measure and tooth loss as a normal part of ageing. Cultural factors—such as reliance on home remedies, trust in traditional healers (often quacks disguised as healers), gendered expectations,

and the influence of elders—form significant obstacles to seeking timely professional dental care.

Socioeconomic status and education only amplify these barriers. Rural, lower-income, and less-educated populations are especially susceptible to misinformation and limited access. For women, particularly in non-urban areas, patriarchal norms and standards of modesty further restrict access to necessary treatment.

Moreover, the research highlights a striking gap between knowledge and behavior. Even when people understand the importance of dental health, longstanding cultural habits often discourage them from acting on that awareness. The findings clearly indicate that building more clinics, by itself, will not resolve these issues. Culturally informed education and behavior change strategies are essential if we hope to make a meaningful difference. Unless public health initiatives take these cultural dynamics seriously, improvements in dental infrastructure alone are unlikely to shift entrenched patterns of behavior.

REFERENCES

1. Gambhir RS, Gupta T. Utilization of dental care: An Indian outlook. *J Nat Sci Biol Med.* 2013;4(2):292–7.

2. Nagarajappa R, Sahare P, Sharda AJ, Asawa K, Tak M, Pujara P. Perceived barriers to the provision of preventive care among dentists in Udaipur, India. *Oral Health Prev Dent.* 2015;13(5):451–9.

3. Patel KH, Chawla S, Jain M, Kataria D. Cultural and socioeconomic barriers in utilization of dental services: A cross-sectional questionnaire based study. *J Int Oral Health.* 2016;8(1):40–4.

4. Batra M, Baker DL, Gerald L, Arora A. Oral health beliefs, attitudes, and practices of South Asian migrants: A systematic review. *J Immigr Minor Health.* 2019;21(2):373–89.

5. Chhabra N, Chhabra A, Shetty A. Parental knowledge, attitudes and cultural beliefs regarding oral health and dental care of preschool children. *J Dent Oral Hyg.* 2012;4(6):74–9.

6. Marcus K, Slack-Smith L, Lopes M. Barriers and facilitators to dental care among culturally and linguistically diverse carers: A mixed-method systematic review. *Community Dent Oral Epidemiol.* 2022;50(3):216–26.

7. Vundavalli S, Ramakrishna Y. Barriers to Dental Services utilization among adult population in India: A scoping review. *J Family Med Prim Care.* 2025;14(1):12–9.

8. Abirami SY, Thangadurai K, Tamilselvan B. Needs and barriers to access oral healthcare services among the rural population in Chengalpattu, Tamil Nadu. *J Indian Assoc Public Health Dent.* 2023;21(2):174–9.

9. Devi SS, Narayanasamy S. Oral hygiene practices and knowledge on periodontal diseases and therapy. *J Educ Health Promot.* 2022;11:276.

10. Joshi S, Bhaskar DJ, Jain A, Khurana R. Prevalent dental myths and practices in Indian population—A systematic review. *J Int Soc Prev Community Dent.* 2020;10(3):247–52.