Cultural Barriers Influencing Utilization of Dental Care In Kanpur: A Cross-Sectional Study

A DISSERTATION SYNOPSIS

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Submitted by

Dr. Manika Tewari

Under the guidance of

Dr. Seema Mehta

Title

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Introduction

Despite advancements in dental science and the availability of services, dental care remains underutilized in India. While economic and structural factors are well-recognized, cultural beliefs and social norms often shape attitudes and behaviors toward oral health. These influences lead many to delay care, rely on home remedies, or avoid treatment due to stigma, gender norms, or traditional practices. Understanding these cultural dimensions is crucial for improving oral health outcomes and equity in access.

Literature Review

Oral health is slowly coming to be understood as a part of overall wellness, yet it remains woefully underprioritized in much of the world, particularly in low- and middle-income countries such as India. Despite much advancement in dental science and the development of infrastructure, dental service use remains less than optimal. While economic and logistical factors contribute to this disparity, traditional cultural beliefs and social mores also play a role.

Gambhir et al. stressed that a significant section of the Indian population fails to avail themselves of dental care regularly, several of whom due to a lack of proper awareness and misconceived ideas about oral health and its correlation with the maintenance of overall health. Patel et al. also noted that cultural and socioeconomic beliefs such as reliance on traditional remedies, religious etiology of disease, and suspicion of professional dental care are extremely important in the delay in treatment.

Chhabra et al. surveyed parent attitudes and found that family systems of belief contributed to decisions regarding child oral care behaviors, which were also influenced by societal norms and cultural practices. Further, a systematic review of Batra et al. among South Asian migrants found that cultural meanings assigned to oral diseases, fear of treatment, and a preference for alternative healing options normally gained precedence over biomedical counseling.

Studies have also documented how cultural myths propagate dental neglect. Joshi et al. observed that many individuals view tooth loss as a natural part of aging and believe that procedures like scaling can weaken the teeth, reinforcing avoidance of preventive care \[5]. These beliefs are particularly prevalent in rural

populations and among those with limited formal education. Also, gender limitations function as cultural restrictions. Marcus et al. reasoned that in most communities, women required the permission of men to receive dental care and issues of modesty forbade visits to male dentists—limitations that limit access for a significant portion of the population.

Although these studies give some initial insight into the cultural context of dental care delivery in India, the vast majority have been conducted in urban populations or confined settings. A second key need, however, is for data from mixed demographic groups—namely, rural and semi-urban communities—to determine how beliefs cross-react with age, gender, education, and income.

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?

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.

Keywords

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

Methodology

The study employed a cross-sectional, questionnaire-based survey design conducted over a period of three months. It was carried out across mixed community settings, including urban, semi-urban, and rural areas, to capture a diverse demographic. The study population comprised adults above the age of 18 years from varied socioeconomic backgrounds. A sample size of 100 participants was selected using convenience sampling. Data was collected using a structured

questionnaire that included demographic details and Likert-scale statements to assess cultural beliefs and attitudes influencing dental care utilization.

Implications

Findings from this study can inform targeted oral health campaigns, culturally sensitive interventions, and community-based strategies. It emphasizes the need for educational outreach and policy reform to integrate cultural awareness into dental care delivery, especially for underserved groups.

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.

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