Perceptions on the Factors Influencing Oral Health Care Seeking Behaviour of Communities in Randfontein, Gauteng, South Africa

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Perceptions on factors influencing oral health seeking by Randfontein residents

Key words

- Gauteng,
- South Africa,
- Oral health care seeking behaviour ,
- Perceptions,
- Socio-economic constraints ,
- Cultural factors influencing oral health care seeking behaviour,
- Common oral diseases ,
- Oral health promotion and disease prevention,
- Apartheid policies

Declaration

I declare that the study "Perceptions on the factors influencing oral health seeking behaviour of communities in Randfontein, Gauteng, South Africa" is my own work and that to the best of my knowledge it has not been submitted before for any degree, examination or other research purposes in any other institution. I further declare that all the sources I have used or quoted have been indicated and acknowledged as citations and complete references.

Full name: Mlungisi Patrick Makubalo

Signed: 

Date: November 2011

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Abstract

The negative effect of poor oral health on quality of life and financial implication of work days lost as a result of dental pain can be accepted as a rationale for inclusion of oral health in the primary health care (PHC) package for South Africa. The norms of the PHC package for oral health services are to expose at least 50% of primary schools to organized school preventive programmes and to ensure basic coverage of everybody in the catchment areas. Currently these norms are not adequately fulfilled in Randfontein.

The purpose of this study was to gather information that can be used to improve oral health services in Randfontein. The aim of the study was to gain an understanding of the factors that influence the choice of oral health care seeking behaviour as perceived by residents in different contexts and to use these perceptions to inform appropriate health planning strategies and implementation of measures that can improve health promotion in Randfontein. This qualitative study explored oral health care seeking behaviour. The study population comprised all residents of Randfontein above seventeen years old who had visited the oral health section in the Randfontein Primary Health Care (PHC) Facility. There were two focus group discussions (FGDs) from each of three separate residential areas namely Mohlakeng with mainly black residents, Toekomsrus with mainly coloured race residents and from town which is a predominantly Caucasian race area. Data collected was analysed during the data collection stage and thereafter until they made sense to the researcher. To strengthen validity, the accuracy of the interpretation of what respondents said was confirmed with them. Analysed themes were coded and categorized to enable the key researcher to interpret them for final reporting. Appropriate ethical procedures were followed. The findings were that although all focus groups preferred allopathic oral health care seeking, various barriers existed. The study concluded that there should be adequate oral health education and promotion, effective communication and an expansion of these services to Toekomsrus, where they do not exist.

Chapter 1

1.0 Introduction

This study gives an insight into factors that are perceived by Randfontein residents as influencing their oral health care seeking behaviour. The first chapter covers the introduction of the study, the setting, problem statement, purpose and the research question. Studies demonstrate that perceptions of health influence choices of treatment (Bedos, Levine and Brodeur, 2009) and explain selective uses of services (Sparks – du Preez, Griffiths and Cameron, 2005). While perceptions influencing choices of a specific behaviour, such as oral health care seeking, are important there must also be intentions to act according to the behaviour in question (Edward and Casper, 2007). There are many factors on which perceptions are based. An analytical approach based on perceptions by clients has a potential to adequately facilitate improvements in the oral health delivery system. An understanding of these perceptions can be used to influence intentions which in turn can lead to desirable behaviour by the targeted individuals and communities. Examples of strategies that can be used include a visibly installed suggestion box and a brief questionnaire before and after services to identify gaps between expected outcomes from a patient's perspective and their fulfilment by the service provider.

Oral diseases are common worldwide. Studies indicate that severe cases may result in the increase of mortality and morbidity rates. High prevalence rates of noma (an opportunistic infection of oral tissues associated with poor nutrition) and oral manifestations of HIV / AIDS in Sub – Saharan African countries result in high morbidity and mortally rates (Danfillo, 2009). Oral cancers also result in high mortality rates and dental caries and periodontal diseases create significant morbidity globally (Hobdell et al, 2003). Poor quality of life such as functional limitation, physical pain and / or disability, psychological disability and discomfort, social

disability and handicap often results from oral diseases (Lawrence et al, 2008). These adverse outcomes are a result of inadequate or lack of prompt oral health care seeking. Yet studies indicate that people tend to delay dental visits for various reasons. In South Africa more than 80% of dental caries in children remain untreated (Van Wyk and Van Wyk, 2004). A study by Lesolang, Motloba and Lallo (2009) in Winterveld, Gauteng, South Africa, found that caries accounted for 47.9% while periodontal diseases accounted for 22.6% of dental extractions. Furthermore the authors suggest that late dental attendance increases the potential for the prevalence of these treatable diseases.

In response to the prevalence and severity of oral diseases, skills and strategies are often applied to manage oral diseases. However, these must be supported by effective oral health policies which consist of rules, regulations and guidelines. These rules, regulations or guidelines will define service oriented decision making, actions to be taken and plans that should be implemented to enhance facility and service delivery improvements that can be user – friendly for oral health services. Improved services will then be measured by positive access factors and higher utilisation rates.

According to Thorpe (2006) and Ndiaye (2005), one of the problems facing Africa is the lack of national oral health policies and plans. The challenge in Africa is therefore to develop clear policy statements, implement adequate oral health policies and evaluate what has been done to address inadequate oral health systems and the subsequent use of oral health services (Thorpe, 2006). South Africa is one of the few African countries that have a national oral health policy (Thorpe, 2006).

An important policy document in relation to oral health in South Africa, is the Primary Health Care (PHC) Package (Department of Health Pretoria, 2000) which specifies norms and standards of primary healthcare. According to this document at least fifty per cent of all primary school children should be exposed to organised preventive programmes and everybody

in the catchment areas should have access to basic total treatment. The standards specified in the document emphasise oral health education. The ideal implementers are community health workers together with an interdepartmental collaboration with departments such as the Department of Education, Water Affairs, Forestry and other related sections (Department of Health, 2000).

Despite the existence of these policies in South Africa, studies suggest that they are not implemented. Reasons include a combination of inadequate supply of oral health staff, the emphasis of curative over preventive oral health services by clinicians and other barriers to policy implementation (Singh, 2005). Research is needed to establish context specific reasons for the gap between rhetoric and actual implementation of these policies.

The current study was therefore conducted with a view to understanding what respondents considered to be factors that influenced their oral health care seeking behaviour in Randfontein. The study also explored their perceptions on the impact of their choices regarding oral health care seeking in Randfontein and their suggestions on how oral health services could be improved and sustained.

1.1 Setting

The study was conducted in a primary health care facility in Randfontein. Randfontein is one of four districts in the Westrand, a region in the western part of the Gauteng Province of South Africa. Most residents of this area either live in one of two peri – urban areas or townships namely Mohlakeng and Toekomsrus or in town. Mohlakeng is inhabited mainly by so-called 'black'[1] and Toekomsrus by so-called 'coloured'[2] residents and the residential part of the town

[1] Black people are those who are perceived as of pure African parentage also previously referred to as 'Bantu' people.

[2] Coloured people were perceived as pure Khoisan, of Malay extraction or those with parents from Caucasian and other black races according to the racial classification of previous regimes before 1994. There is therefore no clear definition of 'Coloured' but people who share a Common history that is characterized by social exclusion (Legget, 2004).

is predominantly inhabited by Caucasian or "white" people whose ancestry is perceived as of "pure" European origin. Unlike in town residential areas, there is poor infrastructure in townships and most residents in these areas live in smaller or informal houses. There are also high levels of unemployment and poverty among township residents. Inequalities among residential areas within Randfontein reflect the effects of previous apartheid laws which segregated against township residents (so-called black and coloured people) and in favour of town residents (Caucasians).

Two State primary health care facilities, one of which is in town and the other, a mobile clinic in Mohlakeng Township offer oral health services in addition to other general health services. Oral health services were first offered in the town facility in January 1997 and the mobile clinic started to operate in July 2007.

The main oral health facility in town operates from Mondays to Saturdays. A dentist and a dental therapist deliver basic dental services (mostly dental extractions) in this clinic during the week and only one clinician provides oral health services on Saturdays. The mobile clinic only operates from Monday to Friday. The main clinic normally serves an average of about fifty patients per day while the mobile clinic handles about twenty.

For the purpose of this study the key researcher used the main clinic and not the mobile clinic because the former serves more patients from all areas including townships and town residents unlike the mobile clinic in Mohlakeng which serves almost none from areas other than Mohlakeng. The main clinic was also chosen because it operates over longer hours and serves even Mohlakeng residents as they frequently visit the town for shopping or are employed in town. The choice of using the main clinic for the study is deemed to be appropriate considering that the researcher intended to compare people's perceptions from the three different residential areas and who are treated in the same facility.

1.2 Problem statement

Access dimensions within all health delivery systems are acceptability, affordability and availability (Harris et al, 2011). There are policies in place in South Africa that should facilitate these dimensions, yet there remain limitations in access and provision. This applies in Randfontein as well as in the country as a whole. There is currently no objective information that is based on any research about the perceptions of patients in Randfontein about oral health care services, a perspective that could enhance service improvement.

1.3 Purpose

The purpose of this study was to gather information about perceived factors that influenced the choice of oral health care seeking behaviour by residents attending the main clinic from three different geographical areas in Randfontein, to use these perceptions to inform the design of health planning strategies, implementation of appropriate measures that can improve the delivery and acceptability of oral health care services in Randfontein and to use the information to advocate for improved resources.

1.4 Research question

What are the perceptions on factors that influence the choice of oral health care seeking behaviour in Randfontein?

Chapter 2: Literature review

2.0 Introduction

Relevant literature was reviewed to identify existing information on factors influencing oral health care seeking behaviour and perceptions on these factors in different settings. As a starting point, the review commences with a brief description of the lifestyle related aetiology, incidence and prevalence of oral diseases with a view to illustrate the extent to which oral diseases constitute a public health challenge. Literature from relevant hard cover and electronic journals, books and other sources was used for the purpose of getting the required information and to achieve an understanding of factors that generally influence oral health care seeking behaviour in different contexts. No similar study is known to have been conducted in Randfontein or South Africa. However, relevant studies from other parts of the world were found and drawn on for reference.

The State is a major player in establishing health services. However oral health services are usually not prioritised in terms of funding. For example studies indicated that the treatment of oral diseases is expensive and may be extremely inadequate in low and middle income countries (Petersen, 2004) and that dental caries and periodontal infections are common oral diseases worldwide (Vered and Sgan – Cohen, 2003). The implication of poor funding and the subsequent inadequate availability of oral health services is therefore a major economic barrier to oral health services, including outreach programmes that are focused on basic oral health educational campaigns and promotional activities.

Health and risk behaviour or lifestyles often determine incidence and prevalence levels of oral diseases. Health behaviour consists of human activities that protect, promote or maintain health or prevent disease and risk behaviour consists of behaviours that result in negative impacts on the health of individuals or communities (Petersen et al, 2008).

Studies indicate that changes associated with economic developments often influence individuals to adopt detrimental lifestyles or risk behaviours. Consumption of foods containing refined carbohydrates resulting in dental caries, alcohol abuse and consumption of tobacco are important lifestyle changes that are often associated with rapid urbanisation leading to high incidents, prevalence and severity of oral diseases (Enwonwu et al, 2004). Nurelhuda et al (2009) in a study conducted among 12 year old school children in Khartoum, Sudan, found socio – economic status (SES) to be positively associated with caries experience and the authors suggested that children from high SES tended to consume more sugary snacks than those from low SES. The use of tobacco and alcohol are considered to be leading causes of oral cancers and precancerous lesions (Ndiaye, 2005). These studies clearly demonstrate that the exposure to high consumption of refined carbohydrates leads to increasing levels of the incidence and prevalence of dental caries and both tobacco and alcohol can cause oral cancers.

2.1 Incidence and prevalence of oral diseases

A brief description of levels of oral diseases may explain the importance of understanding health and risk behaviours and the context in which these behaviours occur. Studies have found differences in the incidence and prevalence of the different oral diseases worldwide and that their high levels result in major public health problems globally (Petersen, 2004; Ndiaye, 2005; Watt, 2005). An ecological study conducted by Hobdell et al (2003) using data from the United Nations Development Programme (UNDP) and the World Bank to analyse socio-economic status, the United Nations Food and Agricultural Organisation (UNFAO) and World Atlas of History to analyse risk factors, data for oral cancers came from the Union for International Cancer Control (UICC) Globocan databases and for dental caries and periodontal diseases data were extracted from the WHO Global Epidemiology Data Bank. The study found a difference of approximately 50% in oral disease prevalence, that is, dental caries among twelve year old children and periodontal infections among the 35 to 44 years age group

between low and high socio-economic status groups and surprisingly no conclusive association of oral cancers with socio-economic status could be found in this study (Hobdell et al, 2003). Petersen and Christensen (2006) in a study conducted in Greenland also found that dental caries tended to increase with young children while it remained stable among adolescents. These studies appear to indicate that children are either more exposed or susceptible to caries causing foods especially if intervention in the progression of these diseases is lacking. Edelstein (2006) argues convincingly that due to the global distribution of oral diseases and the severity of their impact they constitute a pandemic.

Dental caries and periodontal diseases prevalence also differ among countries and although African countries are poorer than developed countries these oral diseases appear to be less common and / or severe than in the developed world (Thorpe, 2006). There is however an increase in the prevalence of dental caries even in Africa as a result of inadequate fluoride in drinking water, lifestyle changes and insufficient oral health resources (Petersen, 2004). In an earlier study Alvarez and Navia (1989) confirmed that there was a decrease in the incidence of dental caries in developed countries which could be attributed to the use of fluoride. Fluoride, a natural substance found in drinking water in parts of the world, has protective properties against dental caries.

Africa faces other more severe oral diseases than dental caries and periodontal infections possibly due to the poor opportunity to adequately seek oral health in this mainly resource restricted continent. For example 90% of 3 to 6 year old children in Africa die without having been treated for noma, HIV/AIDS oral manifestations are higher in Sub-Sahara Africa than in the rest of the continent and both oral cancers and precancerous lesions “are estimated at 25 cases per 100 000 in Africa” yearly (Ndiaye, 2005: 3). Warnakulasuriya (2009) reported lower incident rates of oral cancers and even for the highest incidence rates found in Sri Lanka the

figure was 13, 8 cases per 100 000 in 2002. Globocan recorded only 2 cases per 100 000 in Africa.

2.2 Factors influencing oral health care **seeking behaviour**

There are different facilitators and barriers that influence oral health care seeking behaviour. Studies indicate that choices made about dental health services, that is, oral health care seeking behaviour, are based on a range of demand and supply factors. Demand factors depend on the willingness of patients to use oral health services and supply factors depend on the availability of oral health services (Guay, 2004). Utilisation of services can only be absolute if services are adequately available and communities are willing and / or able to utilise them.

Different authors describe factors that influence oral health seeking in different ways but broadly these are associated with social, cultural, psychological and economic experiences of communities and individuals. Heaton, Smith and Raybould (2004) in a study conducted in three areas in Kentucky, America, found that access to care, affordability, attitudes towards dental care and fear influenced utilisation of oral health services. A study conducted in New Zealand found that the environment, finance, lack of awareness and the absence of policy for adults residing in residential homes were factors that influenced access to health services (Smith, 2010).

In the South African context, the legacy of apartheid still plays a role in that different societies who lived separately because of apartheid laws and were exposed to unequal health and other resources appear to be making different choices in line with their previous exposures (Myburgh et al, 2005). In a study conducted in South Africa, Sparks - du Preez et al (2005 found that cultural beliefs, costs and attitudes of health professionals were determining factors in the choice of health services by parents for their babies. These studies indicate that historical, socio – cultural and economic factors can influence accessibility and utilisation of oral health care services.

Andersen (1995) developed a theoretical framework, the Andersen Health Utilization Behavioural Model, which was intended to explain factors that influence health service utilization, define and measure equitable access and assist in developing policies that promote equitable access. According to this model health behaviour is determined by the environment in which it occurs and the characteristics of the population studied (Andersen, 1995). The environment consists of the health system and the external environment and population characteristics are predisposing, enabling and need factors (Andersen, 1995).
Socio-economic factors such as education and occupation, gender, ethnicity and health beliefs have an impact on the predisposition to using allopathic oral health services, enabling factors relate to personal, family or community resources which determine whether individuals or communities are able to access health services and need factors are either perceived by individuals and / or communities themselves or evaluated by experts on their behalf (Andersen and Newman, 2005). Population characteristics also determine personal health practices other than health service utilisation (Baker, 2009). Andersen's model allows for a researcher to have an insight into factors that influence health seeking behaviour in a specific context and recommend appropriate intervention strategies accordingly.

2.2.1 Social and cultural factors

Linton (undated, as cited by Haralambos and Holborn, 1992: 3) defines the culture of a society as ..."the way of life of its members; the collection of ideas and habits which they learn, share and transmit from generation to generation". Social determinants that influence human behaviour can be family, social, community, political and / or economic factors (Watt, 2005). According to Anderson et al (2003: 68) ..."culture refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups". Social and cultural influences can be viewed in terms of the Andersen Model as leading to predisposition to

behave in certain ways. Furthermore, culture and ethnicity can result in unique beliefs and perceptions of what health and/or illness means and that may have an impact on how and when individuals and communities seek health (Andersen et al, 2003).

Literature studying different cultures clearly demonstrates that beliefs often influence health care seeking behaviour including oral health care seeking behaviour and perceptions of the aetiology of diseases largely determine approaches to treatment choices including not seeking treatment. For example a study by Butani, Weintraub and Barker (2008) conducted in the United States of America (USA) among the African-Americans, people of Chinese extraction, the Filipino and the Hispanic or Latino ethnic groups found that the four races were influenced by their beliefs in different ways. African – American ethnic groups believed that the diet used during pregnancy caused dental decay and that the preferred treatment is dental extractions. Chinese people perceived the existence of teeth at the time of a baby's birth as well as at a 'late' adult stage as undesirable and also recommended dental extractions for such teeth. Obeng (2007) also conducted a study in the USA and found that 70.23 % of African immigrants believed that dental caries did not warrant dental treatment by dental professionals as individuals were expected to take responsibility for their dental health and not to rely on oral health professionals.

Hildreth and Elma (2007) found different patterns of health care seeking behaviour in the United States which are attributable to religiosity and spirituality in the choice of complementary alternative medicines. These authors found that people who rated themselves as religious (those whose beliefs are validated by institutional communities) tended to use minimum complementary and alternative medical techniques while the self-rated spiritual individuals (those with a personal inclination not associated with an institution or collective activity) tended to use more of these techniques. Olasoji et al (2008) found that in Nigeria lay models ascribed causes and treatment of illnesses to different explanations depending on

culture and beliefs unlike the modern scientific description of illness which relates to cell or organ pathology.

Traditional health practices in areas within countries such as Uganda, Kenya and Burundi involve the extraction of deciduous teeth of babies to 'treat' baby illnesses (Jamieson, 2006). This practice can have detrimental effects on the baby's oral health. Changes in cultural beliefs and lifestyles often occur as a result of social influences such as acquisition of higher education or oral health literacy and acculturation. A study by Kiwanuka, Åstrøm and Trovik (2004) found that Ugandan children whose mothers had low education levels had more caries experiences than those who had better educated mothers. Acculturation occurs when groups of people come into contact and changes in the original culture or cultures occur (Cruz et al, 2004). These changes can modify or alter adopted cultural beliefs that are detrimental to health especially if those who have acquired high levels of education or advanced oral health care knowledge share their information with those who lack the necessary knowledge to influential positive changes that subsequently occur.

Studies further suggest that there are communities and individuals in Africa who consult traditional healers for ailments affecting the mouth and others rely on spiritual and / or religious beliefs. For instance, a study conducted by Puranwasi (2006) in the Province of KwaZulu – Natal in South Africa found that traditional healers correctly identified oral disease lesions and that appears to suggest that communities were likely to have consulted traditional healers for these diseases. A study conducted by Agbor and Naidoo (2011) in Cameroon found that communities preferred traditional healers to dentists because the former were perceived to have a better understanding of community problems than the latter and were accessible to all communities since dental facilities were too far for some communities to utilise while traditional healers were living among all communities. El – Safty (2001) stated that culture and health of communities in Africa are interrelated such that it becomes impossible to understand

one without understanding the other. The literature can be useful in identifying possible shortcomings in oral health related practices and implementing strategies that can improve oral health care seeking behaviour especially in the African continent where underdevelopment is rife. .

2.2.2 Health systems factors

A national health care system consists of resources such as personnel, facilities, equipment and materials and how these are organised for effective health care outcomes (Andersen and Newman, 2005). The distribution and volume of resources together with other factors can determine the extent to which services are available and the organisation deals with what happens once the patient enters the system (Andersen and Newman, 2005). These factors are described in the literature to demonstrate the impacts of deficiencies in the delivery and / or utilisation of all health services in various contexts.

The human component has characteristics that are unique given that human beings can make decisions including organising how other resources can be utilised. Their skills and characteristics can be modified to be in line with the needs of their clients in order to improve outcomes of the dental health system. Studies have shown that poor dental attendance can be related to ineffective communication, poor attitudes of service providers, discrimination against vulnerable groups and failure to practise equity. A study conducted by Broder et al (2002) in the United States of America (USA), concluded that interpersonal communication was perceived as the most significant facilitator or barrier to oral health attendance. Language proficiency also plays an important role in communication because language barriers lead to a decrease in the likelihood of follow – up treatment, erroneous diagnosis and inappropriate treatment (Andersen et al, 2003).

Bad past experiences can have negative effects on future decisions regarding oral health care seeking behaviour. Poor attitudes by impatient dentists added to the avoidance of dental visits

by anxious clients according to a study conducted in Hong Kong, China by Ng and Leung (2007). Moore, Brødsgaard and Rosenberg (2004) found that previous unpleasant encounters with dentists in which study subjects stated feelings of powerlessness when they were young lead to anxiety even in later life. A study conducted in France by Nicolas et al (2007) found an association between long intervals between dental visits or high frequencies of cancelled dental appointments and past experiences of pain during dental treatment, negative attitudes by staff and unpleasant remarks of the dentist. A study conducted by Bayat et al (2010) in Iran indicated that clients chose to pay fully for oral health care services offered by private dentists even though free and heavily subsidised public services were available because they appreciated good relations with private dentists. On the contrary, a professional who practises empathy will encourage free disclosure of symptoms by patients (Brosky et al, 2003) and that will enable the clinician to treat and manage the relevant condition appropriately. These studies demonstrate that professionals may negatively affect health care seeking behaviour when communities do not perceive professionals as friendly, helpful or approachable.

Studies indicate that racial and other discriminatory practices exist in various contexts and lead to poor oral health services. Mitchell and Lassiter (2006) conducted a literature study in the USA and concluded that racial and ethnic minorities received poor oral health services compared to the white majority of citizens in the USA, there was lack of sound relations between dental professionals and clients who belong to minority races and that black dentists were more likely to treat black patients than white dentists. Kelly et al (2005) also found suboptimal dental care for racial minorities in the USA. Racial disparities in Brazil were evident as dental services were more available for white than for brown and black adolescents and black citizens in general were more likely to suffer from oral diseases (Bastos et al 2009; Kuhnen et al, 2009). Insensitivity to cultural needs demonstrated by service providers of a

different race may inhibit health seeking from health professionals (Jamieson, Parker and Richards, 2008).

Failure to practise equity was also shown to be a reason for poor oral health outcomes for females, people living with HIV/AIDS, poor communities, socially excluded people and / or people living under social circumstances associated with vulnerabilities. Guay (2004) identified vulnerable groups as those living in poverty, rural communities, mobility restricted or homebound people, culturally isolated groups and other people with special needs. Equity in health services means demonstrating empathy and treating people according to their emerging special needs and not to discriminate against them.

Poor gender relations may inhibit health seeking and there is a possibility that a combination of insensitivity and poor gender relations could be associated with cultural biases (Shaikh et al, 2007; Mitchell and Lassiter, 2006). A study conducted in Nigeria by Adedigba et al (2008) suggested that high levels of unmet oral health care needs that existed among people living with HIV/AIDS (PLWHA) in Nigeria were due to health care workers who offered inadequate care for PLWHA and these authors stated that there was documented evidence of discrimination against this category of oral health care seekers.

Resources other than human resources add to the determination of whether services are adequate or deficient for utilisation to occur. In Sudan low utilization of dental services in rural areas with poor resources was associated with deficiency in instruments in addition to human resources (Yousif and Miakeen, 2009). A study conducted by Mickenautsch and Frencken (2009) in South Africa lists lack of a reliable supplier of materials for performing the atraumatic restorative technique (ART), which is a painless technique used to perform teeth restorations without using anaesthetic injections, time constraints as a result of patient overloads, lack of interest on the part of dental clinicians and poor leadership by managers as

reasons for not offering this service. These studies demonstrate negative effects of poor organisational issues and poor resources.

Insufficient oral health care information may account for inadequate oral health care seeking behaviour in some instances. In a study conducted in Pakistan by Mizra et al (2007), 45% of respondents who were diabetic stated that they would increase their brushing if informed about the association of diabetes with oral health, 31.5% said they would not change their behaviour and 23% said they would consult dentists. The study clearly demonstrated that the majority of respondents did not have adequate information that would improve their oral health care seeking behaviours regarding oral hygiene.

Nowjack – Raymer (1995) identified weaknesses inherent in the traditional practices of oral health care services systems which collectively limit decision – making by professionals who often depend on higher authorities for decisions taken in their daily duties and suggested that these shortcomings may be reasons for poor oral health care delivery. This study thus demonstrates that poor organisation can negatively affect service delivery and that can result in poor oral health care seeking.

Studies demonstrate that activities within and the organisation of any oral health care system can determine oral health care seeking behaviour and outcomes thereof. The absence of sound relationships between the providers of health services and their clients contributes to the poor quality of health care (Mitchell and Lassiter, 2006) and poor dentist – patient relationship can lead to dental phobia (Peretz, Katz and Eldad, 1999). Negative perceptions may lead to anxiety, fear and feelings of powerlessness by patients and these perceptions may be transmitted to friends and acquaintances of those who had unfavourable experiences with health professionals. Anxiety and fear of being criticised by dentists for neglecting their oral health may influence choices of service providers according to studies conducted in Greece and Zimbabwe (Karydis et al, 2001; Muzondo, Muzondo and Mutandwa, 2007). A study by Moore

et al (2004) demonstrates, through illustrations of case studies, that failure to consult dentists originates from power imbalances between dentists and their patients.

In addition to a shortage of dentists and other resources, restricted physical access to dental services in areas where poor communities live makes it difficult or impossible for those communities to acquire oral health care services (Lang et al, 2008). A combination of worker demoralization, lack of proper worker training, poor communication with clients, poor resource availability and poor management can lead to poor relationships between clients and health workers. A study called "Health Workers for Change Impact" which consisted of a series of workshops which was conducted in Kenya by Onyango – Ouma et al (2001) found improvements in staff behaviours and relationships with patients at the end of the workshops. Initially clients perceived workers as uncaring and arrogant but after the final stage of the three stage workshop programme patients stated that staff attitudes and behaviours were positive in all aspects. A new manager was deployed to the facility, the project was funded by the World Health Organisation (WHO) and the staffs that had joined the project were trained for the project (Onyango – Ouma et al, 2001). This study therefore shows the importance of a holistic approach to managing and organising resources to improve oral health care seeking behaviour.

2.2.3 Economic factors

Studies demonstrate that citizens of poor countries and poor residents in rich countries suffer more from oral diseases as a result of inability to access oral health care services. The treatment of oral diseases is expensive and may be extremely inadequate in low and middle income countries (Petersen, 2004). Dental caries and periodontal infections are common oral diseases worldwide (Vered and Sgan – Cohen, 2003) yet many citizens in Africa have never consulted a dentist (Petersen, 2004). Studies indicate that costs of oral health care services to the subsidising State and to the consumers of these services are very high. It has been argued that if treatment for dental caries was available in low income countries it would cost more than the

total child health budget and in industrialized countries oral diseases are the fourth most expensive to treat (Petersen, 2004). Disadvantaged households in Canada could not access dental services as they had difficulty even meeting their most basic household needs including healthy diet (Snow and McNally, 2010). Leak and Birch (2008) found that poor people had lesser access to health services in Canada than their affluent counterparts. Another Canadian study conducted by Bedos et al (2005) found that complicated dental procedures which were not covered by insurance were avoided because of costs.

Studies demonstrate high impacts of inequity, regarding the availability of oral health care services, on the prevalence of oral diseases on poor communities. Delgado – Angulo, Hobdell and Bernabé (2009) found that poverty and social exclusion or marginalisation were associated with high prevalence of dental caries in Lima, Peru. A study conducted in the United Kingdom (UK) found a direct relationship between socioeconomic status and the number of sound teeth in adults that could not be explained by other barriers (Donaldson et al, 2008). Another study by Oliveira, Sheiham and Bonecker (2008) found an indirect association of dental caries among Brazilian preschool children with socioeconomic and nutritional status.

White people who took part in a study conducted by Myburgh et al (2005) reported more excellent service ratings than black[3] races and individuals from a high SES reported more satisfaction with oral health services offered than individuals from a low SES did. Myburgh et al (2005) further suggest that because of the legacy of apartheid in South Africa inadequate oral health promotion for rural and semi-rural inhabitants who were formerly economically disadvantaged and are still poor tend to prefer dental extractions over restorations. This study indicates the role of information deficiencies and inequity in service provision for disadvantaged communities in South Africa.

[3] 'Black' in this context refers to those who are normally referred to as not 'White' or not of the Caucasian race.

2.2.4 Psychological factors

Psychological factors are products of individual personalities. Personality is defined as "... a pattern of characteristic thoughts, feelings and behaviours that persist over time and situations that distinguishes one person from another" (Morris, 1988:458). Personality can influence an individuals' intention to act in a manner that conforms to his or her characteristic. According to Edward and Casper (2009: 1324) "... intentions are a function of three factors: attitudes toward the behaviour, subjective norms and perceived control over the behaviour".

In relation to perceived lack of control studies indicate that bad past experiences during early childhood often lead to negative expectations and may inhibit allopathic oral health care seeking. A study by Al - Madi and AbdelLatif (2002) suggests that experience of dental trauma at early stages of development of a child may lead to dental phobia in later years. A study by Stalker et al (2005) also found that survivors of previous childhood sexual abuse were anxious about dental visits because they associated dental treatment procedures with activities they encountered during sexual abuse such as loss of control or helplessness and the smell of gloves which they likened to the smell of condoms.

Inability to cope determines when a person will seek dental medication (Pau, Croucher and Marcenes, 2008). Bedos et al (2005) found, mostly among American adults of low socioeconomic status, that fear of painful dental treatment prevented participants from receiving treatment before the onset of unbearable dental pain, which occurs when medication failed to stop it and normal functioning has become impossible. At early stages of dental decay, that is, before the onset of unbearable dental pain, people used over-the-counter medicines most of which are pain killers and various home remedies including alcohol (Bedos et al, 2005).

Universal factors such as pain, feeling of helplessness, anxiety and past experiences appear to have similar effects on many individuals irrespective of the context (Heaton, Smith and

Raybould, 2004; Muzondo et al, 2007; Stalker et al 2005; Ohrn, Hakeberg and Abrahamson, 2008). A study conducted by Peretz et al, (1999) among dental phobic clients found that dental phobic[4] patients behaved in similar ways under similar situations and that a combination of expectation of pain and uncertainty about treatment may cause dental phobia.

Literature demonstrates that the type of treatment received plays a role in future oral health care seeking behaviour. In the study by Butani et al (2008) the Filipino group stated that they delay dental treatment because they were not certain that they would get anaesthetised before treatment. Studies further demonstrate that the type of treatment one receives may also lead to fear and anxiety. For example a study conducted by Al - Madi and AbdelLatif (2002) among Arab female adolescents in Riyadh, Kingdom of Arabia, found that the highest percentage of those who demonstrated fear and anxiety were those who had undergone dental extractions during their last visits to the dentist followed by those who had visited the dentist but not for dental extractions and finally those who had never been to a dentist. A study conducted by Oosterink, de Jongh and Aartman (2008) found that invasive stimuli which result from use of instruments that penetrate the soft tissue within the patient's mouth were more associated with dental anxiety than non-invasive stimuli.

Important determinants for allopathic oral health care seeking appear to include self – esteem, self – image and a feeling of attractiveness and that may indicate confidence in allopathic dental treatment (Meng, Gilbert and Litaker, 2007). According to a study by Okunseri et al (2005), aesthetics and perceived oral health related quality of life are important variables that determine oral health care seeking behaviour by individuals. Motives prompting dental health care seeking result from the belief that one is susceptible to dental diseases, dental problems are serious and / or dental treatment is beneficial (Mizra et al, 2007). People delay seeking oral

[4] Phobic from phobia is defined as "an intense, paralyzing fear of something in the absence of any real danger – a fear of something that most people find bearable".

health care because of lack of knowledge, perceived inability to receive help and low emotional response to disease symptoms (Scott, McGurk and Grunfeld, 2008).

2.3 Impact of perceptions on health care seeking behaviour

The literature studying perceptions on factors associated with oral health care seeking behaviour in various contexts show various impacts from seeking, delaying or neglecting to seek oral health care from professionals. According to Leake and Birch (2008) in a study conducted in Canada the impacts of various kinds of oral pathology are pain, reduced functioning, stigma and reduced quality of life. These impacts are results of not seeking or delaying to seek oral health care.

A study conducted in Denmark by Moore, Brødsgaard and Rosenberg (2004) found that embarrassment and other psychological developments characterized by lack of self- esteem resulted in failure to consult until advanced stages of oral disease. Ng and Leung (2007) found that anxiety is associated with a person's poor oral health quality because patients with high levels of anxiety avoided complicated root canal treatment and other complicated operations. Delaying dental attendance results in pain, swelling, inadequate functioning, lack of preferred aesthetics, cost to business or employer as a result of the suffering employee staying away from work, lack of proper nutrition as eating becomes difficult and sometimes impossible as well as a poor nutritional state (Hollander, 2007). Oliviera, Sheiham and Bonecker (2008) found an association of caries with weight loss and obesity but not with overweight. Obesity-dental caries relation may be due to frequent intake of sugary foods because of the pain causing inability to consume other nutritious diets. Similarly pain leads to difficulties in eating and weight loss occurs when one eats less (Oliviera et al, 2008).

2.4 Studies suggesting corrective measures

Studies on factors influencing oral health care seeking behaviour may assist in identifying problems and / or challenges associated with modern oral health care seeking. Health

professionals must identify the impact on the quality of life of communities they serve so that they can understand service needs of their clients and be able to monitor interventions that are implemented (Pau et al, 2008). According to Petersen (2008: 115) … "oral disease prevention and the promotion of oral health needs to be integrated with chronic disease prevention and general health promotion as the risks to health are linked". A health systems approach targeting resources and organisation for health improvement is the key to managing public oral health challenges.

2.4.1 Oral health education and promotion

Studies suggest that oral health services are not universally prioritized especially in low socio-economic countries yet oral diseases are ubiquitous globally. Heaton et al (2004) suggested that there should be a post-doctoral training of general practice residents who must be fully responsible for educating and communicating with communities to remove barriers to oral health care seeking and to promote oral health. Mikhailovich, Morrison and Arabena (2007) in a study conducted in Australia suggest that efforts to improve health promotion require that culturally appropriate models should be applied and communities must be involved and have control over those models. These studies therefore suggest that there should be professionals who are trained to conduct oral health care education and promotion. Communities must be empowered and motivated to be actively involved in their oral health promotion and there should be appropriate communication, using culturally appropriate models among relevant stakeholders regarding oral health care.

2.4.2 Service

Studies reiterate the importance of service oriented behaviours and practices by providers that are directed at serving communities rather than merely maintaining the status quo of the oral health service system. Puriene, Balciuniene and Drobnys (2008) state that the interests of the patient should be placed above those of the caregiver and high standards of health service

delivery should be established and maintained. Communication and understanding the needs of clients can be helpful if acceptable services are to be offered. For example in a study conducted in Greece, 93% of participants mentioned breath of a dentist as unacceptable suggesting their preference for the wearing of masks by dentists (Karydis et al, 2001).

Similarly the quality of services with all attributes that make it work such as building a good rapport with clients and demonstrating the required professionalism are applicable to the health industry as demonstrated by various studies. A combination of effective communication, putting efforts to satisfy client needs and being available when needed, responsiveness and reliability are the most desired expectations by patients from their dentist (Karydis, 2001). A study by Muzondo et al (2007) conducted in Zimbabwe concluded that reliability, access, credibility, security, knowledge, responsiveness, competence, courtesy and communication are important predictors of service acceptability. Adequate communication between oral health service providers and their clients has a potential to improve professional oral health care seeking by clients who have negative opinions about oral health systems (Ohrn, Hakeberg and Abrahamson, 2008).

Studies define and describe professionalism that is essential to general and oral health care services in various ways. For example Brosky et al (2003: 909) ...“define professionalism in its broadest sense as an image that promotes a successful relationship with the patient” and ...“one in which the patient feels confident in the capabilities of the health care provider”. Puriene, et al (2008) in a study conducted in Lithuania found reliability to be an important attribute as perceived by dental patients and suggested that appropriate qualifications, pain management, neatness of clothes, convenience issues, low costs and communication skills including confidentiality assurance and clear explanations could improve trust in the service provider. Christensen (2001) states that dentists must avoid excessive treatment without informing

patients, charging fees without justification, providing service only when it is convenient for the dentist to do so and refusing to accept responsibility when treatment prematurely fails.

2.4.3 Human and organizational issues

A study conducted by Harrison and Wong (2003) in Canada among Vietnamese preschool children applied client oriented strategies by taking cultural diversities into account. In that study lay Vietnamese community dental health workers were integrated in the oral health promotion system and that resulted in mothers adopting healthy feeding for their babies and caring for their children's teeth (Harrison and Wong, 2003). The study indicates that client oriented strategies involving targeted communities have a potential to improve the delivery and utilisation of oral health care services.

Nowjack – Raymer (1995) proposes that teams of health workers must learn and practise oral health promotion skills, team members must be empowered and given opportunities to play their roles in health education, effective communication must be established, teams must be maintained and be cohesive, leadership must be based on ability to lead not on seniority, each member must be accountable to his/her decisions and actions and conflicts must be resolved.

2.5 Conclusion

Studies demonstrate various reasons for factors associated with oral health care seeking in different contexts. Addressing issues associated with oral health care seeking may facilitate changes of negative perceptions and promote health behaviour in any context. Al - Madi and AbdelLatif (2002) concluded that frequent dental visits will most likely reduce the probability of dental extractions and eventually reduce the prevalence of dental caries.

Studies suggest different approaches to addressing economic, socio – cultural, psychological and service related barriers to improve chances of changing negative community and individual perceptions of oral health care services. In recognition of socio – economic disparities among communities, literature proposes the creation of effective health promotion and disease

prevention strategies and advocacy for social support in favour of the disadvantaged communities and individuals (Snow and McNally, 2010). Public health care subsidies should be increased and appropriate population wide programs such as appropriate provision of fluoride and addressing common risk factors to reduce dental caries for the most vulnerable communities and individuals must be implemented (Leak and Beach, 2008). Wamala, Merlo and Bonström (2006) in a study conducted in Sweden suggest that the State must intervene at national level to create and maintain equitable access that will enable an effective reduction of the effects of socio – economic disparities in dental health care.

The establishment of research networks appears to be ideal in addressing oral health care service challenges given their diversity which render them capable of addressing a wide range of oral health care issues and therefore offer an opportunity to improve the quality of primary oral health care by encouraging reflective practice, self – audits and performance monitoring which ultimately enhances improved clinical decision – making and informed treatment planning (Kay, Ward and Locker, 2003).

Communities and individuals must be empowered and motivating to adopt healthy lifestyles that will improve their oral health status. This can be achieved by applying the concept of motivational interviewing which is a client focused and empowering strategy to address identified needs (Treasure, 2004). Oral health professionals must deliver patient – centred services and adopt a cultural competency approach that will encourage communities and individuals to seek allopathic oral health care (Saha, Beach and Cooper, 2008).

Studies further suggest that policies should be implemented based on scientific evidence, using resources and processes that can be adapted according to emerging needs to strengthen oral health delivery and disease prevention (Nguyen, 2005). Broadbent, Thomson and Poulton (2006) suggest that positive oral health beliefs must be developed and retained to improve oral health outcomes.

Chapter 3. Research design and methodology

3.1 Aims and objectives

Aim

The study aims to gain an understanding of the factors that influence oral health care seeking behaviour as perceived by people attending the primary health care in Randfontein from three different contexts and to use these perceptions to inform health planning strategies and appropriate measures that can improve oral health promotion strategies in Randfontein.

Objectives

1. To explore the perceptions on factors influencing oral health care seeking behaviour by respondents selected from three communities in Randfontein.
2. To explore perceived facilitators and barriers to using oral health services at a primary health care facility, as well as differences in opinions as reported by participants from three different communities who use this facility.
3. To describe similarities and differences in treatment choices demonstrated by the respondents of the three communities
4. To draw on these similarities and differences to inform the planning and implementation of oral health services in Randfontein.

3.2 Research design

A qualitative explorative study was conducted to explore the perceptions on factors influencing oral health seeking by respondents from communities in Randfontein. The factors that influence oral health care seeking behaviour were investigated using focus group discussions (FGDs). FGDs were selected because through group interaction they stimulate participants to consider and reveal opinions they might not have chosen to reveal (Katzenellenbogen, Joubert and Abdool- Karim, 2002).

A qualitative approach was selected as qualitative data are perceived as richer because of their in-depth nature of inquiry which has a potential to reveal more about people's attitudes, experiences and practices than quantitative data can (Haralambos and Holborn, 1992). Furthermore, following a qualitative approach gives one an opportunity to engage in active dialogue during the data collection stage and to repeatedly check for information that conflicts with one's predetermined theory at the analysis stage (Secker et al, 1995). The choice was also influenced by the fact that there has not been any qualitative study undertaken in Randfontein before.

3.3 Study population

The study population consisted of adults above seventeen years who had lived in Randfontein for a period of six months or more and who attended the primary health care clinic for oral health services. Only those who lived in either one of the two townships or in town were included in the study. In other words farm dwellers were excluded.

3.4 Sampling procedure

Volunteers were invited to participate during their clinic visits, and practical arrangements were made with those who met the above criteria and consented to participate. The sample was purposive with the aim to ensure geographical and to some extent ethnically homogenous members within each focus group. This was because the difference in socio – cultural dynamics such as language, culture, experiences and other factors were thought to be common within each residential group. The study size comprised six FGDs, two from each of the two townships and two from among town residents. The rationale for the choice of six FGDs, two from each site, was to ensure adequate data from each population group. Each FGD consisted of between five and nine individuals.

The discussions within each FGD were based on a research schedule that was developed to meet the objectives of the study (See questions in Appendix 4).

3. 5 Data collection

The researcher contacted the facility manager of the primary health clinic and the local director of clinical services for permission to conduct FGDs. Suitable dates and times agreeable to potential respondents were arranged with all of them.

Questions asked were open-ended and focused on perceived factors that influence oral health seeking behaviour, perceptions about these factors and their perceived impacts. Additional questions triggered by emerging information were asked and the researcher checked his understanding during discussions by asking for clarifications when in doubt. FGDs were conducted in the local languages and translated into English. FGDs were tape recorded and the texts transcribed into English. Views expressed are available on tape.

The key researcher is the author of the study and was assisted by one research assistant for each FGD. The role of the assistant was to take notes during the FGDs, observe cues and help with language interpretation and / or translation where it became necessary. Field notes in the form of memos and diaries were also taken by the key researcher and the assistant researcher.

3.6 Data analysis

The researcher started to analyse data during data collection in order to build on issues raised during subsequent focus group discussions. He categorised data from the different FDGs according to place of residence to facilitate an understanding of the different perceptions of the different residential groups. Data were then collated and coded according to content drawing on recurrent themes that related to perceptions on oral health seeking behaviours as well as differences that emerged between and within focus group discussions.

The process was facilitated by the inclusion of notes taken by the assistant researcher, and the discussion with her on the interpretation of data. A final analysis was completed when the researcher was satisfied that theme categories made sense for the final report to be written.

3.7 Rigour

To strengthen rigour, field notes taken during the data collection stage indicating what was observed during FGDs, were compared with the transcribed text emanating from FGDs. Comparisons between each pair of focus group for each community provided data source triangulation and so increased the validity of the study. The researcher confirmed the contents of each interview with the respondents after each interview to be sure that his understanding of their responses was correct.

He took additional notes after each interview to record aspects that could not be captured on tape such as body language, events that might have influenced the responses or actions that took place on the day of each FGD. He compared the notes he had taken with the assistant's notes and other observation she had made during discussions with the relevant group. Because the researcher has worked in the clinic for a number of years, he needed to be reflective about his role in the data collection and data analysis processes. His notes therefore included his reflections during the research progress, and he drew on the measures noted above to counter any potential bias. All opinions or views from the FDGs were treated equally. Finally the researcher compared the data from the focus group discussions with the information gathered from the literature. Respondents were not paid for taking part in FGDs. However they were reimbursed for transportation costs incurred. A meal was also provided for them after each FGD.

3.8 Limitations

One limitation is the small number of focus groups in each community which could not lead to saturation[5]. Secondly, because the researcher is employed by the clinic, he tended to have his own interpretation of oral health care seeking behaviour of the clients. Care was taken to

[5] Saturation is achieved only when no new information emerges from FGDs and/or interviews in a qualitative study.

ensure that this was minimised and that respondents were not subject to the researcher's influence. However the attention to rigour, noted above assisted in limiting bias.

3.9 Ethical considerations

The study was conducted after getting ethical approval from the University of the Western Cape (UWC) Ethics Committees. As anticipated the research did not create harm to participants nor were they unduly influenced to take part in the research. However, measures were in place to provide support for respondents had any of them felt the need. Respondents were informed that they were free to withdraw from participating in the interview during or before the end of the interview and that there was no loss of benefits resulting from participation in the study. A letter explaining the research purpose and process, requesting consent and assuring confidentiality (see Participant Information Sheet in Appendix 3) was made available to all respondents. Consent forms were signed by all participants who were willing to take part in the study. Participants were made aware that signing the consent form indicated that the participant agreed to take part in the research. Participants who did not speak or read English had the contents of the letter and consent form translated for them.

All participants were requested to observe confidentiality both verbally and in writing. They were made aware that whatever they heard, discussed and shared among themselves in FGDs should not be disclosed to persons outside the respective FGs or even with persons in FGs after each session. The lack of anonymity had a potential to interfere with endeavours to ensure confidentiality. There was no guarantee that respondents were all strangers to one another and the researcher continued with the research based on subjective trust that respondents would exercise caution not to divulge one another's identity and contributions. The nature of discussions also did not appear to have a potential harmful effect during and after the research. Participants from all FGs demonstrated trust in the key researcher and harmony among themselves.

Chapter 4: Results

4.0 Introduction

This chapter describes the views of the respondents on facilitators and barriers to using dental facilities, as well as the impacts of the choices made. Contributions by respondents from the three geographical areas under study were compared in order to identify similarities and differences of perceptions regarding treatment choices for oral diseases. The results also highlight suggestions on what ways respondents believed oral health services could be improved. Some of the direct quotes expressed by respondents are included in this chapter to corroborate the findings of the study.

4.1 Preference for use of state dental health facilities

The overall view was that allopathic dental services were preferable to home remedies for various reasons discussed under different headings below.

Respondents stated that free services and an opportunity to be educated about oral health encouraged them to visit State facilities.

> "*The service is free and one gets the opportunity to get advice on oral health issues"* (Mohlakeng resident).

Although the reason for suggesting regular dental visits did not come out clearly among Toekomsrus residents there was an inference that dental consultations were important.

> *"You have to come to the dentist regularly not just when you have a toothache"* (Toekomsrus resident).

4.2 Staff attitudes, knowledge, skills and the overall performance of facilities

Members of the oral health staff were described as caring and thus encouraging for clients[6] to visit the oral health facility in Randfontein. Examples of these staff attributes included friendly communication, explanation of what clients should do to heal completely and commitment that was not motivated by financial gains.

"*They* [dental staff] *treat you with care, they ask you and talk and laugh with you and that is a good"* (Mohlakeng resident).

Respondents also stated that state facilities offer the same level of care as that offered in private practices.

> "*They do extremely good work… facilities are the same* [in PHC Clinic] *as in private doctors … doctors of this place makes you come*" [visit dental clinic] (Toekomsrus resident).

The preference for public sector dentists and dental therapist was made clear. The opinions were based on their trust for oral health clinicians as well as the disincentive of the costs of private dentistry.

> "*Private doctors*[7] [clinicians] *treat you because they want money. State doctors treat you because they are human as well*" (Town resident).

Respondents expressed their confidence in allopathic dentistry as being due to the knowledge and skills that oral health professionals possess. Respondents demonstrated their trust and reliance on dentist for removal of a severely painful tooth which appeared to be perceived as a necessary treatment in instances of severe pain.

[6] The word "client" is used to denote patients and / or their next of kin who represent them as parents or guardians.

[7] In this context the word "doctors" is used by respondents to refer to dentists, dental therapists and oral hygienists.

"*When the pain is too heavy – when you have a toothache you must come to the dentist and have your tooth extracted*" (Toekomsrus resident).

Apart from technical skills demonstrated in dental facilities other skills were mentioned. These are described below. Prevention of infections resulting from oral diseases and spreading to other parts of the body is one of such skills.

"*It is important to go to the dentist because with a rotten tooth you can get infections in your body*" (Mohlakeng resident).

The perception on the efficacy of allopathic dentistry was also based on the fact that professionals ask questions about other poor health conditions before treating their clients. It was felt that inquiries help prevent potential infections after dental extractions and this may indicate that respondents believed that there are illnesses that weaken the human body's immunity against infections.

"*When you get there what I know is that doctors will ask you about other illnesses. I used to wonder why they ask you such questions when all you want is to remove a tooth but I realized that they want to know because you may get infection after removing your tooth*" (Mohlakeng resident).

A respondent expressed his frustration of losing a tooth because he delayed dental consultation suggesting that an early dental visit could have been the only solution to prevent tooth loss. This statement indicates an understanding that dentists are capable of preventing tooth loss if early treatment is sought and that this is a preferred treatment for a decayed tooth.

"*To my point of view … I would say 'prevention is better than cure' … I left it* [my decayed tooth] *for the last minute…I could have saved my tooth …but because I put up and put and put up I lost my own tooth. It is hurting me more for not coming to the dentist*" (Town resident).

Being able to diagnose illnesses such as cancers was also mentioned as a skill that oral health professionals possess.

> "*People are stereotyped* [in assuming that dentists are not able to diagnose other illnesses] *but it is up to an individual to make a visit* [to the dentist]. *A dentist discovered that my friend had cancer … after consulting many specialists*" (Town resident).

Respondents also mentioned the knowledge demonstrated by professionals when confronted with complications that need referral to specialists. Specialists were perceived as having more advanced skills and knowledge than general professionals in primary health care facilities. In other words nothing is left to chance if one seeks oral health from dental professionals, even in primary health facilities, because expertise is always available through referrals to facilities that have the necessary resources.

> "*When you have a dental problem I believe you should go to the clinic because when the dentist sees that your tooth needs to be operated on* [procedures performed by specialists only] *he/she will refer you to the nearest hospital"* (Mohlakeng resident).

4.3 Inadequacy of other forms of treatment

Respondents expressed a view that allopathic dentistry is superior because other health seeking strategies were perceived as providing no solution or at best provide temporary relief of oral diseases.

> "*Traditional and alternative ways will result in no solution to the problem*" (Mohlakeng resident).
>
> "*They* [home remedies] *just help for two months or a few weeks but you will still have a toothache after that*" (Toekomsrus resident).
>
> "*Somebody told me to put shoe-polish in the hole* [cavity in my aching tooth]…*that night I never slept*" (Town resident).

Allopathic dentistry was also perceived as the only effective strategy to treat oral diseases.

> "*The more you wait* [instead of consulting dentists] *the more infection will progress*" (Toekomsrus resident).

4.4 Barriers to State dental health provision

Not all experiences of dental services were described as having been positive. Respondents also mentioned various factors that lead to non-attendance and / or delays in seeking allopathic dental care. The existence of deterrent factors or barriers to prompt oral health care seeking did not however indicate a lack of preference for allopathic dentistry. Instead respondents offered suggestions on how to address different barriers so that allopathic oral health care seeking in state facilities can be improved. Some respondents mentioned having experienced bad staff attitudes and unpleasant outcomes of dental treatments. These bad experiences appeared to discourage clients from seeking allopathic oral health care services in State facilities.

Being discharged before completing treatment is one of these barriers.

> "*When you are done they say go go go and you have to leave before you are finished* [treatment is completed]. *Yeah! They chase us away. I came to the clinic one day and that lady was not nice to me*" (Toekomsrus resident).

A respondent mentioned being turned away for not having the expected documents one needs to bring when visiting the facility for consultation.

> "*When I came here about three weeks ago I did not have proof of identity because I was robbed and my identity book was taken from me. So I came to the receptionist and told the lady I was really in pain …she said she cannot help because I have no ID*[8] *so that make me feel unhappy*" (Town resident).

[8] An official document showing identity details of a client.

Respondents also stated that poor outcomes of dental extraction discourage dental revisits. Examples of these outcomes were teeth that broke during dental extraction, pain during dental extraction and removal of teeth not supposed to be removed.

> "*If you have a problem you are supposed to go to the clinic … my tooth broke a long time ago but I fear going to the hospital. They removed it badly and at the end, the treatment was not good. That experience? The second time the same thing happened, my tooth broke*" (Mohlakeng resident).
>
> "*I went to the dentist but when they extracted* [my tooth] *it* [the procedure] *was very painful I thought the injection was diluted*" (Toekomsrus resident).

There were inferences that professionals neglect to prevent anxiety or alleviate fear before and during dental operations. Respondents expressed fear and anxiety associated with instruments often displayed in dental trays, poor staff attitudes demonstrated in previous dental visits and crying children.

Interestingly no comment on fear or anxiety was made by Mohlakeng residents. However anxiety was expressed by respondents from the other two residential areas.

> "*I don't feel comfortable because I am scared it's going to be painful. Even though I am in pain and I don't sleep at night I fear going to the dentist…instrument**s** make me scared*" (Toekomsrus resident).
>
> "*It's not the injection … I am afraid of* [anxious about] *but holes* [gaps after removing teeth] *in the mouth*" (Town resident).

The psychological trauma of experiencing a child forced to cooperate during dental procedures was also mentioned as a source of anxiety for a mother.

> "*When coming to the dentist you have to think twice. You cannot just say I am coming to the dentist. At the end of the day it is scary …and for me as a mother it is traumatic as*

well to bring my child …to be held down as if it's a goat being slaughtered" (Toekomsrus resident).

Anxiety and fear were also associated with not knowing what will happen during the process of dental treatment.

"*I'm scared I don't know what's happening behind doors*" (Toekomsrus resident).

The fear influenced by previous staff behaviour and screams from inside the surgery was mentioned as a source of dental treatment avoidance.

"*When we got here they told us to come tomorrow and my friend never came again … she was scared - every patient was screaming in the clinic when they take out their teeth*" (Toekomsrus resident).

The issue of race and age of service provider preferences emerged in response to probing questions by the researcher in the last focus group of town residents. The perception about race emerged when a black female respondent stated that black people do not adequately care about their teeth.

"*You have to take care of your teeth …I don't want to …like taking the colour bar.*…[I do not want to use race or colour in this discussion] *for our side that part* [going for dental check-ups] *has not been fulfilled on our black side*" [we black people do not visit oral health facilities on regular basis] (Town resident).

As a follow-up to the comment about race, a white male respondent stated that some white patients do not accept services from black service providers.

"*Most of the white people when they go to the dentist they turn back and say I will not let a black dentist touch my teeth*" (Town resident).

Perceptions about gender emerged as a theme in several focus groups. Although there were different views about gender some female respondents in Mohlakeng and town FDGs perceived female staff as less caring than their male counterparts.

"*Generally male doctors are good but females sometimes say things which are not good*" (Mohlakeng resident).

"*Some men have more patience than ladies…they have more patience than the ladies does"* (Town resident).

Respondents had subjective and conflicting perceptions about age and the power of the service provider. Some respondents stated that there were no influences based on these characteristics while others thought there were influences associated with them,

A view by those who perceived age as an important factor was that older service providers were perceived as more competent because of their experiences in oral health care service delivery.

"*I would prefer an older dentist because he has been through it for many years but the younger one will first consult a colleague for advice*" (Town resident).

There were perceptions that information about the services in Randfontein does not reach some members of the public. People were either not aware that oral health care services exist or that these services are offered free of charge.

"*There was no* [oral health] *service before as a result many people still don't know* [that] *there are free services but now I am happy with services. I would encourage others to come to clinics"* (Mohlakeng resident).

"*People should be told that there is a dentist because most people don't know about the dental clinic in town. So it should be advertised well to the people"* (Toekomsrus resident).

"*People still use these medicines* [traditional medicines and other remedies] *because people don't know that there are free services in State clinics"* (Town resident).

Some Toekomsrus residents mentioned physical access as a challenge especially for the elderly or physically compromised residents but none from the other two areas did so.

> "*We in Toekomsrus… we have a clinic but there is no doctor who works with teeth … there are other people who cannot afford the* [transport] *costs of coming to town for dental extractions*" (Toekomsrus resident).

Another respondent reinforced the view about the lack of oral health care services in Toekomsrus and mentioned that if such services could be made available people would make use of them.

> "*Dental facility in Toekomsrus will be appropriated because there are people – say for instance an old lady, she can't walk from here* [Toekomsrus] *to town but if maybe there is a dentist or a facility for a dentist I believe we* [in Toekomsrus] *will all go to the dentist*" (Toekomsrus resident).

Respondents also indicated that private dental services are expensive and therefore were not an option. In addition to other challenges inaccessibility of dental services because of financial constraints appeared to lead to the use of alternative means albeit these may neither be efficacious nor preferred to allopathic services.

> "*If you are unemployed just like me… friends will suggest brandy or spirits"* [as a remedy for pain relief] (Mohlakeng resident).
>
> "*Firstly* [private] *dental services are expensive. You use other means until you have money to go to the dentist … the more you tell the doctor about oral health problems the more doctors tell you about high prices of treating dental problems"* (Town resident).

A town resident who needed restorations could not receive this service because the necessary equipments had broken down. No other respondent mentioned resource challenges.

> "*I have been here about three months ago so that they can fix my tooth and then they said the light*[9] *must be fixed and every time I come here the light is not fixed*" (Town resident).

Professionals were alleged to be offering services they do not properly disclose to their clients and that clients felt obliged to accept the service offered without question because they feel powerless to make decisions freely.

> "*Doctors may remove the teeth even if it's not necessary* … [and as a patient] you *can't argue with someone who is a specialist"* (Toekomsrus resident).

4.5 Strategies used instead of allopathic dentistry

Respondents stated that they use other methods instead of allopathic dentistry as a result of the barriers mentioned above. For example lack of money for transport mentioned above and fear played a role in the choice of home remedies.

> "*Our parents use home remedies for those who are scared to come to the dentist*" (Toekomsrus resident).

Although respondents in all focus groups mentioned use of pain killers for treating dental pain they also mentioned different remedies. Some of these appeared to be common in all areas and others unique in certain areas. These remedies include certain household products, allopathic medicines other than painkillers and raw plant products.

Respondents mentioned plant based traditional remedies that are used to 'heal' various ailments including oral diseases. However perceptions were that even after a long period of well-being dental caries will re-emerge. Respondents stated that they use these remedies either because they have trust in their efficacy or to remove pain for a short period after which they will consult a professional service provider.

[9] The 'light' referred to is an instrument used to direct a curing light that hardens the material used during the process of restoring teeth.

"*I know of a traditional medicinal plant. You mix it with warm water and the worm will come out*" (Mohlakeng resident).

"*I do not have oral disease problems but when my children had these problems, I used a* [type of] *green fruit and they became well*" (Toekomsrus resident).

"*Use garden rue to kill the tooth…so it does not pain…the youngsters does not believe* [that garden rue can relieve the pain] *but the elders use it*" (town resident).

Respondents mentioned use of other home remedies besides traditional medicinal plants to treat various oral conditions. The most widely used over- the -counter medicines appeared to be pain killers which demonstrates that pain rather than other oral health challenges were the main reasons for seeking oral health.

"*Sometimes we use disprins [*aspirins] *to calm the pain*" (Toekomsrus resident).

Besides pain killers a number of medicinal products bought over the counter are used to relieve pain and to remove infective agents.

"*I suggest the use of alum crystals … they help with tonsils, gums and teeth within ten minutes. They stop the pain for five days or more. However it is best to visit the doctor once the pain has disappeared*" (Mohlakeng resident).

"*You buy drops from the chemist …they work to delay the* [disease] *process but do not stop it*" (Toekomsrus resident).

"*When I have a problem with my mouth, first thing I go to the chemist (pause) then I buy some mouthwash … it's called 'Plax' … it kills all the germs*" (Town resident).

Residents also mentioned household products which are normally used for purposes other than healing. Use of these products appeared to be associated with desperation when one is unable to seek immediate help to relieve pain.

"*I put a drop of brandy in the hole of the tooth to relieve pain when there is no dentist within reach*" (Mohlakeng resident).

"*When the baby has a sore throat I clean the mouth with soap*" (Toekomsrus resident).

There was a perception that whisky and warm water with dissolved salt should be used after dental extractions.

"*Use dry whisky to clean blood after dental extraction.… an old remedy used by rural farming communities …use warm water with salt and spool with whisky*" (town resident).

4.6 Suggested approaches to improve oral health services

Respondents mentioned various strategies that could be implemented to improve oral health services. It was felt that communities should be educated and informed about oral health issues. It was felt that health education and promotion could be achieved by involving communities in oral activities that are organised and / or lead by dental professionals. The use of the words "health promotion" by respondents followed from the key researcher's use of these words as he was probing and explaining their meaning.

"*It is better to have oral health promotion and to educate many people… say if I have pamphlets that explain issues relating to oral diseases I can share my knowledge with people who live in faraway areas with no oral health promotion*" (Mohlakeng resident).

"*Services must expand to areas where they are not offered and oral health education should be promoted from preschool ages in crèches*" (Toekomsrus resident).

Respondents also suggested that direct information propagation should be implemented through mass campaigns and other strategies whose aim must be to actively educate communities.

"*Dentists must use road shows to make people aware of dental services*" (Mohlakeng resident)

"*Another thing I want to comment on is advertising, letting people know that there is a doctor there especially in Toekomsrus*" (Toekomsrus resident).

> "*That* [oral health education] *has to be implemented in schools and then be taken out to communities*" (Town resident).

Respondents expressed a view that the impact of positive past experiences can be used by individuals to spread positive messages.

> "*I had a gum infection – I got a chance to be healed and to educate my family that they must not take dental treatment lightly – they must be aware and go to the dentist if they have a dental problem*" (Toekomsrus resident).

Respondents expressed a need to create partnerships between service providers and communities in order to improve rapport that exists between dental staff and their patients.

> "*Promote hospital visits … doctors must ensure cooperation* [with communities] *to stop anxieties. Communities should be included to create confidence that even if treatment is free it is perceived as* [valuable and appropriate] *good quality*" (Mohlakeng resident).

Respondents also suggested better ways in which services should be provided to create a patient friendly environment. For example there were perceptions that screams by children may cause panic among other patients. One respondent suggested that the working area within the clinic should be divided into an adult section and a children's section.

> "*Why not separate children from the people* [adults]? *The moment that child screams for* [because of] *the injection people move out*" [leave before receiving treatment] (Town resident).

Chapter 5: Discussion

5.0 Preference for allopathic dentistry

The findings of the current study were grounded in the perceptions of respondents which indicated a general preference for allopathic oral health care seeking in Randfontein's primary healthcare facility. This was despite them also having several criticisms of the services offered there. These views are largely consistent with studies in other contexts. For example a study on patient satisfaction conducted in Nigeria by Sowole (2007) also found high levels of patient satisfaction with dental care although respondents in that study also noted that there were aspects that needed to be addressed to improve patient satisfaction. Similarly Luzzi and Spencer (2008) in their study conducted in Australia found that barriers to oral health care seeking were weaker compared to the facilitators and therefore did not significantly hinder oral health care seeking. This study was undertaken in a developed country context, so it is not surprising that there were more facilitators than barriers to oral health care seeking. It is encouraging however that despite the developing country context, a study in South Africa by Myburgh et al (2005) showed the existence of similar preferences. In that study, Myburgh et al (2005) found that 89% of respondents indicated satisfaction with allopathic oral health care services despite the limited capacity of the services. Given that the findings in the current study are supported by other studies on the preference for allopathic dentistry, including one in South Africa, it can be assumed that most communities in Randfontein prefer allopathic dentistry.

5.1 Factors influencing oral health seeking

The health behavioural model described by Andersen (1995), and noted in the literature review, suggests that utilization of health services can be explained by predisposing, need and enabling factors. The interrelationship among the three factors will also determine personal health practices (Baker, 2009). The observed general preference for allopathic dentistry noted above,

seems to be based on various factors influencing oral health care seeking behaviour which are often products of a mix of individual and community experiences with dental services, including people's own intentions, expectations, fears and anticipation. These factors may act as facilitators or barriers to allopathic oral health care seeking. Although these factors are discussed separately and individually they are interconnected.

5.1.1 Predisposing factors

Respondents indicated that preference for using public dental care services was related to several factors. These included an opportunity to gain knowledge and to use it to influence families and friends to seek oral health care. They also described having more confidence in allopathic dentistry than in non – allopathic treatment methods. Home remedies were perceived by almost all respondents as inferior to conventional allopathic dentistry.

The literature has shown that socioeconomic factors play an important role in oral health care seeking in terms of access and relevant information the clients have. The description of socio - demographic factors is associated with levels of education, ethnicity, occupation or other related characteristics of the community as well as demographic biological factors such as age and gender (Andersen, 1995). These, according to Andersen's framework, may lead to strategies of health care seeking that may differ according to the social and biological characteristics of communities and individuals. The focus group data collection method in this study did not enable sufficient clarification of the role of demographic influences on oral health care seeking. However, there were inferences to the role played by social structures and attitudes of respondents that may be associated with socio – economic and cultural circumstances of those attending the primary health care facility.

For example some of the respondents mentioned instances in which the uses of home remedies such as the use of plant portions to treat oral diseases were learnt from rural adults, implying that indigenous knowledge and / or beliefs may have influenced decision making. The converse

should be true of urban dwellers that have been influenced by their environment to practice positive oral health care seeking and are therefore, more likely to influence their children and other community members to do the same. This positive behaviour was seen as being influenced by the information that they, as community members have received from the oral health services. Respondents in two focus groups, one from Mohlakeng and the other from Toekomsrus residents, expressed a view that oral health care seeking behaviour can improve if sufficient information is made available because people can share such knowledge with those who may not have the necessary information. The influence of community members on others was reflected in other literature as well. Adair et al (2004) in a study conducted in seventeen countries from four continents reported that positive parental attitudes to oral health behaviour resulted in the establishment of favourable oral health behaviours. A study by Ogundele and Ogunsile (2008) conducted in Nigeria also shows the value of providing knowledge, as they found that knowledge that influences positive health attitudes and practices can reduce oral disease occurrence.

There were indications that the use of home remedies did not result in desired outcomes, that is, successful healing of oral diseases in both the study and the literature. This perception indicated that barriers to accessing services were the main reason for using these remedies. Studies indicate that many commonly used herbs could be toxic and that since most of these plant medicines have never been evaluated and are poorly packaged and / or preserved, caution must be exercised when people use them (Bisi – Johnson et al, 2011, Argbo and Naidoo, 2011). One respondent in the current study who used shoe polish to relieve dental pain actually suffered more after using the shoe polish which may suggest the presence of toxicity in the ingredients of the polish used. It is sensible to conclude that once people acquire the knowledge about the negative effects of home remedies they would generally cease to use them.

There were, however, some respondents in the current study who appeared to believe in the efficacy of traditional medicines as a result of traditional influences that encouraged the use of home remedies. The findings of this study demonstrate that these community and family influences appeared to influence oral health care seeking in different ways. Users of home remedies mentioned traditional medicinal plants and other remedies which were recommended by elders or acquaintances to use. In the current study there were perceptions that old traditional methods can offer relief for up to five years. These perceptions appeared to imply that delays are, in some instances, a function of trust in alterative remedies resulting in a predisposition to delay or not to seek allopathic oral health care.

5.1. 2 Enabling factors

Enabling factors either relate to individual or community circumstances, the nature of available health systems, organisational issues or any combination of these variables and these are often associated with accessibility. Accessibility to oral health care services can be explained by their acceptability, affordability and availability which together define enabling factors. In order to improve health coverage, Harris et al (2011) suggest that access challenges should be understood from the user's perspective. Respondents in the current study mentioned caring staff attitudes, knowledge and skills of professionals, ability to diagnose potential complications, advices on oral health issues and kindness of staff which they perceived as encouraging them to attend dental services in the primary health care clinic.

Various studies agree with most of these findings in terms of professionalism and skills associated with scientific professional qualifications. For example regarding accessibility of services, a study by Kikwilu et al (2009) in Tanzania found that 68% of respondents were satisfied with urgent oral care delivery, 83% with hospitality of the dentist and 82% with cleanliness of the facility. A further discussion of these follows under health systems factors.

Oral health care system enablers other than staff attributes were cost – free services, and competitive resources which were described as of the same quality as those found in private practices. In other words, respondents were motivated to use public dental facilities when there are no financial constraints. These views are reflected in the two studies conducted in South Africa and Tanzania referred to in the literature reviews which demonstrate the effects of service affordability on utilization. In South Africa, Bhayat (2003) reported an increase in attendance in Soweto public clinics after the introduction of free oral health care services by the new South African State since 1994. Those findings were consistent with those of a Tanzanian study which identified a 33% drop in dental attendance as a result of the introduction of in public health institutions (Kikwulu et al, 2008).

Indirect costs were however, a factor. Transport costs were referred to by Toekomsrus residents who emphasised the difficulty old people face when they need oral health care services. Borreani et al (2008) in a study conducted in the United Kingdom (UK) reported that the highest indirect cost of accessing dental services was transport costs. In South Africa, Harries et al (2011) reported that transportation costs and travel distance to health facilities were key barriers to health seeking.

Economic factors were also mentioned in terms of being unable to buy pharmaceutical products intended to stop the pain. This was described as eventually leading one respondent to the use of freely available alcohol offered by friends. This is supported by studies that indicate that because of financial constraints people resort to using traditional medicines and other remedies which may be less expensive than dental visits (Agbor and Naidoo, 2011).

5.1.3 Need

Needs to respond to a health condition can either be perceived by an individual or be explained to the individual by a health practitioner who has evaluated such needs on other patients. The need for oral health care services is expressed by seeking these services. Regarding oral

pathologies respondents indicated that they generally consult oral health professionals for pain relief, dental extractions and to a lesser extent dental restorations. The response to need as a rationale for dental attendance demonstrated that in the absence of pain respondents generally did not prioritise dental attendance. A study conducted in Sudan by Verenne et al (2005) found that problem oriented dental attendance was mainly due to pain.

Realisation of a need to seek oral health care did not always lead to allopathic oral health care seeking as those respondents who expressed trust in alternative therapies for dental pain did not perceive the need for prompt allopathic dental attendance. It was apparent that in some instances delays in oral health care seeking could be a function of trust in traditional medicine. Butani et al (2008) found that Chinese people in America believed that their traditional medicine was more effective in treating oral mucosal lesions and periodontal diseases while allopathic medicine is considered to be good for the treatment of symptoms and that perception lead to delays in allopathic oral health seeking.

Notably in the absence of pain people did not prioritise dental attendance although access barriers were also responsible for these delays. Studies demonstrate that pain is an important indicator of a perceived need for dental attendance and that when communities and individuals do not perceive a need to seek oral health care they are unlikely to attend dental services even if there is an actual need. Varenne et al (2005) in a study they conducted in Burkina Faso found that 60% of respondents reported that dental attendance was mainly because of pain. Al-Shamrany (2006) found that absence of any perceived need for oral health care seeking is the main cause of not consulting dentists. These studies demonstrate that there is a need for oral disease awareness campaigns to improve dental consultations by communities.

5.2 Barriers to oral health seeking

As noted above the respondents in this study and in the examples drawn from the literature were supportive of allopathic dentistry. Yet this was not sufficient to guarantee that the services

were used. Hence in an assessment of the factors that influence oral health care seeking, barriers must be considered. In this study respondents gave accounts of reasons for either delaying dental visits or not seeking oral health care at all even when they realised the consequences of their actions. All users of home remedies indicated that their beliefs in the efficacy of alternative therapies and other barriers to prompt oral health care seeking influenced them to use alternative treatment. In addition to costs, lack of perceived needs, trust in alternative remedies, race and gender related factors and factors related to health services were mentioned as barriers to oral health care seeking.

Race appeared to be associated with preference for treatment by own race for white people and a lack of predisposition to oral health seeking by black people. Studies in various contexts suggest that race does play a role in the delivery and utilisation of oral health services. There were allegations that some Caucasian people did not want to be treated by people who belong to other races. Black people were described as generally not predisposed to attending dental services because of lack of knowledge about the consequences of delaying oral health care seeking. Racial diversity challenges in the United States (US) indicated presence of poor relationships between clients and service providers where there is a lack of racially diverse workforce (Mitchell and Lassiter, 2006). Participants in a study by Jamieson, Parker and Richards (2007) among aborigines in Australia indicated the existence of a culture of dependency that originated from not being allowed to do anything without permission or approval by white colonial authorities. In the South African context with a history of racial disharmony and inequality in health service delivery and accessibility, race is an important factor to consider in the choice and / or utilisation of oral health services (Myburgh et al, 2005). There were also attitudes that were based on perceived gender differences. Respondents mentioned instances where they alleged that female professionals did not treat them well. There were disagreements in one focus group where different views expressed indicated that female

clinicians were as good as their counterparts. Studies that refer to perceived gender differences in health care give conflicting accounts of experiences by patients. A study by Adedigba et al (2005) conducted in Nigeria among oral health care workers in public dental clinics found that male health personnel demonstrated better attitudes, behaviours and practices in the management of patients living with HIV / AIDS than females. Smith and Dundes (2008) in a study conducted in America reported different preferences between genders. The authors reported that females were viewed as more caring and patient than males and the latter were perceived as more devoted to their profession but the majority of respondents in that study perceived no differences between male and female dentists.

Oral health care service related factors appeared to play a role in oral health care seeking. Instances were highlighted where people demonstrate preferences for allopathic oral health care seeking and recognise the need to use oral health services, yet they do not do so. In the current study service related reasons for delaying dental attendance were previous bad experiences with dental staff such as teeth breaking during dental extraction, not knowing what happens in the dental surgery, fear caused by crying patients and instruments displayed in the dental surgery. They also described poor staff attitudes, the lack of control by the patient and children not being handled appropriately. Studies demonstrate that the effects of traumatic dental experiences especially when these occurred during childhood can play a major role in causing anxiety, even in adulthood (Moore, Brødsgaard and Rosenberg, 2004; Hmud and Walsh, 2009). It was made clear that previously unmet expectations that lead to a lack of hope for a better future experience during and after dental treatment also contributed to whether one either delayed or neglected to visit oral health facilities. Luzzi and Spencer, (2008) clarified this when they stated that it is unlikely for individuals to carry out behaviour change or persevere with it if they believe that it will not lead to outcomes they desire. Previously unmet expectations that lead to a lack of hope for a better future experience contribute to whether one

either delays or neglects to visit oral health facilities. Respondents who had experienced problems during and after dental operations felt reluctant to visit dental facilities promptly. Respondents expressed similar experiences in many respects and their oral health care seeking did not differ according to the place of residence. This suggests that similar access to oral health care services and information is likely to have similar results even among people from different cultural backgrounds. Barriers to prompt oral health care seeking appeared to be mainly related to poor staff attitudes and bad past experiences in the dental facility.

6. Conclusion

The current study indicated that communities in Randfontein prefer allopathic dental services but face barriers to accessing these services. Facilitators and barriers to oral health care seeking emerged as important themes on which to draw conclusions and suggest recommendations. Although services may not be described as ideal in Randfontein, respondents emphasised their satisfaction with allopathic dentistry in the local primary oral health care clinic. In all focus groups, respondents mentioned staff attributes that they perceived as good. However, there were instances when staff performed poorly in terms of communication and the overall treatment of patients. Respondents were turned away before being treated and some claimed to be turned away after starting but before completing their treatment. It was alleged that dentists sometimes failed to explain what patients should do to facilitate the healing process after dental extractions.

Barriers to desired treatment were also described in relation to insufficient and inadequate instruments used to restore decayed teeth which led to clients resorting to dental extractions even though that would not be their ideal choice. Private dentistry was not a choice for most of the respondents who could not afford the high fees charged by private dentists. The impact of any barriers to oral health care services can exacerbate what is already poor oral health care as it can lead to the use of home remedies some of which could be toxic.

7. Recommendations

Most factors that facilitate positive oral health seeking behaviour in Randfontein can be improved. These include professional development of staff mainly in communication and patient centred care, acquisition and maintenance of equipment, health education and promotion, community participation and employing more oral hygienists.

Turning patients away is an example of poor communication and absence of patient centred care, and that must be corrected. All staff should act professionally and in a manner that will improve their repertoire with communities. This includes demonstrating care, empathy, skills and courtesy to their clients. Communities should be involved and empowered. This can be fulfilled if health committees who are members of different committees within Randfontein are established and communicate their needs with oral health professionals and managers. Oral health education should be expanded to reach schools and other public places.

Although this study was not about personnel it is clear that more attention should be paid to this important resource. Existing perceived positive staff behaviours and attitudes should be acknowledged, maintained and reinforced / strengthened in Randfontein. Personnel needs such as acquisition of equipment when needed, rewarding achievement and generally creating a sound working environment are some of the ways in which oral health staff can be motivated. There should be continuous monitoring and evaluation of personnel needs with the intension to satisfy them.

General health workers who are responsible for managing diseases that share the same risk factors as oral diseases must be encouraged to emphasise the importance of oral health care while promoting general health. They should have basic knowledge of diagnosing abnormalities in the oral cavity (mouth) and take responsibility for making referrals to oral health care professionals on detecting these conditions.

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Appendix 1

Information supplied by an official from (based on his records) Department of Housing, Randfontein: breakdown of housing units per area.

Area	Number of houses
Mohlakeng	14000
Toekomsrus	6000
Town suburban areas	8000
Total	28000
Other – farm areas and informal settlements outside townships and town areas	7600
Difference (28000 – 7600)	20400
Total population (28000+7600)	35600

Figures supplied by data-capturer in Randfontein catchment areas

Area	Number of people in catchment areas in 2008.
Mohlakeng	69829
Toekomsrus	21626
Town	55875
Total	147330
Other	27254
Difference (147330 – 120076)	120076
Total population (147330 + 27254)	174584

This is an indication of the catchment volume of clinic attenders in different areas.

Appendix 2

Participant Information Sheet

RECORD OF INFORMED CONSENT TO CONDUCT AN INTERVIEW BY THE STUDENT OF THE UNIVERSITY OF THE WESTERN CAPE (UWC)

Date:

Interviewer: Mlungisi Patrick Makubalo

UWC Student Number: 2637295

Tel: 0732089001 Fax 0116934104

Email: phopho.makubalo@hotmail.com

Institution: University of the Western Cape

Interviewee's pseudonym:

Place where interview is conducted: Primary health care facility in Randfontein.

Thank you for agreeing to allow me to interview you. What follows is an explanation of the purpose and process of this interview. You are asked to give your consent to me on tape when we meet to conduct the interview.

I am Mlungisi Patrick Makubalo, a student at the School of Public Health, University of the Western Cape. As part of my Master's degree in Public Health, I am required to do a mini-thesis research. I will be focusing on a study that will explore Randfontein communities' perceptions on the factors that influence their dental and oral health seeking. I am accountable to doctor Ruth Stern who is contactable by email at rstern@uwc.ac.za, by phone at 0219592809 and by fax at 021959 2872

Perceptions on factors influencing oral health seeking by Randfontein residents

Here is some information to explain the purpose and usage of my interview.

2. **Purpose and contents of interview**

The purpose of the interview is to gather information that can be used to better design, plan and implement effective oral and dental health promotion. The contents of the interview will be questions about factors that influence oral health seeking by communities in Randfontein and to understand the impact of these factors as well as of oral health seeking.

3. **The interview process**

Six focus group discussions will be held at the primary health care clinic commonly known as the Municipality Clinic in Randfontein. Groups will be allocated according to where they reside because the study hopes to elicit issues that are common among residents within each geographical area of residence however issues that are perceived as not common will not be discarded. Those issues viewed as "not common" may widen the insight into the needs of all communities. The other reason is to enable all participants to understand one another as this will be a discussion among participants.

4. **Anonymity of contributors**

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. See "name" above. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected.

Things that may affect your willingness to participate

The interview may touch on issues which you do not want to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive or unacceptable to you. You will be completely free to withdraw from the interview at any stage of this process.

6. **Agreement**

6.1 **Interviewee's agreement**

Dear sir/madam,

You are requested to participate on the research on "perceptions on the factors that influence oral health care seeking behaviour of communities in Randfontein, Gauteng Province, South Africa". You will freely discuss as a respondent who will assist with information and knowledge generation for the purpose of a mini-thesis. You will be free to discontinue the discussion or withdraw from it whenever you want to do so. You are not obliged to answer questions you are not comfortable with.

Should you want more clarification on any aspect regarding the research please ask for it. All information in this interview will be kept strictly confidential. If you choose to participate in this research kindly sign below as indicated. Your signature means that you give me permission to involve you in the focus group discussion. I can only start the focus group discussion involving you after you have consented and signed as in the box below:

Interviewee's agreement

I have read and understood the contents of this research, alternatively the contents of this research has been explained to me to my satisfaction. I voluntarily give consent to the researcher to include me as a participant in the group discussion on the topic stated above. I understand that I may choose to participate, refuse to answer questions or to discontinue at any time during the group.

I give consent to participate in the research and this I indicate with my signature. I understand that my signature means that I consent to participate.

Participant's name……(printed)

Participant' signature ……Date…….

Researcher' s name: Mlungisi Patrick Makubalo

Researcher's signature: 

6.2 **Interviewer's agreement**

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purpose referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be negotiated with you.

Signed by interviewer. 

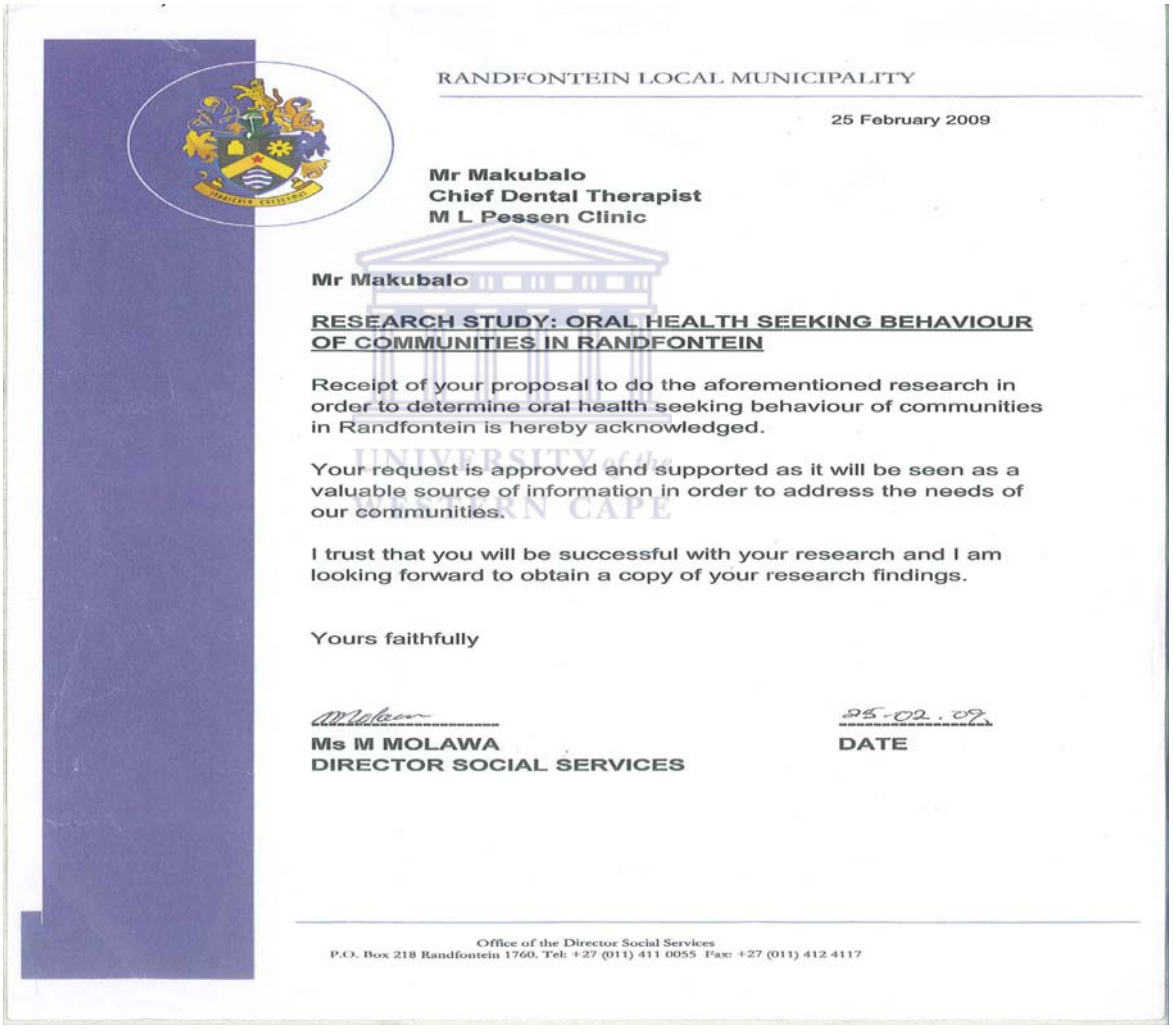
Signed by participant

Date;

Place: Randfontein, Gauteng.

Appendix 3

Proof of permission to do research in a Randfontein primary health facility



RANDFONTEIN LOCAL MUNICIPALITY

25 February 2009

Mr Makubalo
Chief Dental Therapist
M L Pessen Clinic

Mr Makubalo

RESEARCH STUDY: ORAL HEALTH SEEKING BEHAVIOUR OF COMMUNITIES IN RANDFONTEIN

Receipt of your proposal to do the aforementioned research in order to determine oral health seeking behaviour of communities in Randfontein is hereby acknowledged.

Your request is approved and supported as it will be seen as a valuable source of information in order to address the needs of our communities.

I trust that you will be successful with your research and I am looking forward to obtain a copy of your research findings.

Yours faithfully

Ms M MOLAWA
DIRECTOR SOCIAL SERVICES

25-02-09
DATE

Office of the Director Social Services
P.O. Box 218 Randfontein 1760. Tel: +27 (011) 411 0055 Fax: +27 (011) 412 4117

Appendix 4: Questions intended to guide FGD themes

1. What do you do when you have a dental problem or any discomfort in your mouth?
2. What is the best thing to do when one has a dental problem?
3. What reasons could or has lead you or anyone you know not to visit a dentist even though you believe you should do so?
4. Tell me about strategies that are sometimes used to relieve dental pain.
5. What effects do these have on the disease and how long is the effect?
6. What experiences did you have since you started visiting dentists?
7. Let us discuss suggestions that you believe could help people and communities that are in need of dental services. The key researcher found it necessary to use the words “oral health promotion” and to explain them in the latter FGDs to probe perceptions and behaviors participants considered to be oral health promotion.
8. What are the short – comings of the present oral health services in the public health system in Randfontein?

   The key researcher was satisfied that the expected themes came out in these discussions.