

### Dental treatment dropout in social programs from the perspective of participants and social operators: the Uruguay Trabaja case

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Uruguay Trabaja (UT) is a socio-labor integration program for unemployed adults belonging to households in socio-economic vulnerability. During nine months they receive support from experts from Civil Society Organizations (CSO), and are entitled to comprehensive dental care not routinely provided by the Health System of Uruguay. A third of beneficiaries of UT initiate the treatment, abandoning it afterwards. The phenomenon of dropping out dental treatment was studied based on the content analysis of interviews with participants and experts from CSOs. Based on the concepts of habitus de Bourdieu and Castel's individualized protections, the complexity of everyday life; absence of dentist-participant bonding and the short time of accompaniment of UT to sustain the processes of socialization, are aspects to be considered in order to understand the abandonment of this transitory right to assistance.

**Keywords:** Dental care. Public policy. Vulnerable populations. Patient dropout. Qualitative research.

## Introduction

Uruguay implemented the Equity Plan in 2008 with the purpose of ensuring the exercise of citizens's rights and especially those in a situation of socio-economic vulnerability<sup>1,2</sup>.

The Equity Plan intended to weave a social assistance and integration network through the definition of policies associated with protected work, including the *Uruguay Trabaja* (UT) Program, seeking to contribute to social integration through socio-educational strategies and improvement of their employability<sup>3</sup>. It is a time-limited program (9 months) aimed at people over 18 years old who have been unemployed for a long time, without complete basic secondary education, belonging to households living in extreme poverty measured by the index of critical needs<sup>4</sup>. Participants must perform 30 hours of temporary work activities with social value and training, receiving an approximate amount of US \$ 112 per month.

The incorporation of dental care in the program was defined due to its possible impact in overcoming barriers to the inclusion of people in the labor market, a topic still lacking sufficient evidence<sup>5,6</sup>. Oral health care is broader than the one proposed by the comprehensive benefit program (PIAS) for adult users of the National Integrated Health System<sup>7</sup>. Participants receive social support from leaders of Civil Society Organizations (CSOs) that operationalize the policy, manage the access of participants to the benefits of the program and link with dentists.

Dental care can be provided in municipal health services in Montevideo near their homes or workplaces. The weekly attention outside working hours has no direct cost to the users. The Ministry of Social Development funds it on a per capita basis, being carried out during the annual edition of the program.

Despite the fact that the program offers the opportunity of a wider range of dental services, 30% of people abandon dental treatment<sup>8</sup>.

Different authors in the literature seek to explain the reasons for dropping out dental treatment: personal situations (family, pregnancy, diseases)<sup>9,10</sup>; forgetting appointments<sup>11-13</sup>; time (duration of treatment, transfers, coincidence with work schedule)<sup>14-16</sup>; fear, previous frustrating experiences, poor relationship with professionals<sup>17,18</sup>; factors related to organization of services<sup>19,20</sup>; costs<sup>21-23</sup>; but they do not approach the phenomenon of abandonment as a contextualized social practice.

Due to the importance of dental care for participants' social integration, the objective of this study was to analyze the phenomenon of abandoning the dental treatment that affects the individuals participating in UT Montevideo - 2010-2012 editions, from the perspective of its referents and participants.

The phenomenon of abandonment will be analyzed from the theoretical contributions of Bourdieu's constructivist structuralism, particularly the concept of *habitus*; framed in a comprehensive view of the social world. The protagonists of UT as social agents occupy positions (depending on their available capitals) in the system of social world relations. They develop practices in relation to oral health care, which are part of an experienced and incorporated history regarding the conditions of their existence. The concept of *habitus* allows us to think up to what extent the new healthcare practices can be incorporated as action strategies by UT participants during the program<sup>24,25</sup>.

Castel's theoretical contributions are also used, as they relate to the individualization of social protection trends, developed in France by international organizations that were later replicated in Latin America, through temporary focused programs aiming towards social insertion objectives<sup>26-28</sup>.

## Methodology

The present work assumes the modality of a case study, using a qualitative approach whose object of research is the UT dental care program as it was carried out in municipal health centers.

The data collection was developed in two moments: 1. Identification of the universe of persons who dropped out from dental care, using the reports of the care providers and the CSOs that participated during the study period (2010-2012); 2. Performing interviews with participants and referents.

In order to select the participants to be interviewed, it was created a data bank of the people (n = 693) that was part of the 2010-2012 editions of UT. The study then filtered the data bank to select the people who dropped out (n = 340). Since the program editions are developed annually, the 'abandonment situation' was conceptualized when a person received assistance at least once and did not continue the treatment until the beginning of the next group. The sample selection of the interviewees was randomly carried out from the abandonment data bank, identifying a 'typical case' characterized by belonging to any of the program's editions, being a woman and of the oldest age group.

Those CSOs who had participated in UT were selected, choosing the referents that should have performed the follow-up of protagonists in at least one of the program's editions (n = 27).

The interviews were conducted by one researcher, following a pre-tested pattern (Chart 1).

**Chart 1.** Topics and dimensions of interview guidelines for UT participants and CSO referents.

Interviewees	Themes	Dimensions
	Participants' profiles	Sex, age, schooling, UT beginning year
Participants	Recent experiences regarding oral health	Feelings in relation to the mouth, last experience in care Possibilities of care
	First experiences in relation to oral health	Family care, first dental visits, feelings when going to the dentist
	Perceptions of the Oral Health Program in UT	Importance of dental care Relationship with the dentist Abandonment of care What do you currently need
Referents	Perceptions of the Oral Health Program in UT	Importance of dental care Work with the participants on oral health Abandonment of assistance Proposals

An active and methodical listening was carried out during the interviews<sup>29</sup>. We conducted ten interviews with the participants (eight in their homes and two in private rooms inside the health services). The interviews of seventeen referents were carried out inside health facilities, while the rest was done in the referents' workplace.

The size of the samples was defined using the saturation criterion, when the narrative contents of the subjects supplies scarce additional input to the objectives proposed in the research, becoming repetitive<sup>30</sup>.

Regarding the record of communications, it was carried out a systematic, repeated, exhaustive and fluctuating reading of the contents of the interviews of the participants and the referents as well as a content analysis based on Bardin, including the stages of pre-analysis, exploration of the material, treatment of results and interpretation<sup>31</sup>.

The study was approved by the Research Ethics Committee of the Faculty of Dentistry of the University of the Republic (091900/000270/10) and by the Research Committee of the Faculty of Dentistry (COMPESQ / FO) of the Federal University of Rio Grande do Sul (UFRGS).

## Results and discussion

From the analysis of the interviews, three emerging categories were organized to understand the phenomenon of abandonment (Chart 2).

**Chart 2.** Emerging Categories.

Categories	Category expression	Category description
Abandonment of the treatment associated with the characteristics of the UT	It is related to the difficulties of facing the proposal and organization of the program incorporating dental care	Difficulties in organizing a new life project, including work, training and dental care. Difficulties related to duration of the program
Abandonment of treatment associated with the characteristics of dentists	It is related to the dynamics and care capacity	Difficulty for the service to include a practice with a positive discrimination profile Professional-patient relationship Difficulties to respect patient's autonomy
Abandonment of the treatment associated with socialization process	It is related to the process of socialization in conditions of extreme poverty	Difficulty referred to dental care records Difficulty in reconciling the construction of the value of oral health and the opportunity of care in the program

### The abandonment of the treatment associated with UT Program

UT is a demanding program. For 9 months, protagonists must reorganize their daily lives by incorporating workdays of 6 hours plus dental care. The participants, mostly women (70%), are responsible for caring for their families. Family chores are essentially unpaid female activities (14 hours per week for child care). This has relevant gender consequences, because when female members of the families are the main providers of well-being, they must either exclude themselves from the labor market, or face greater difficulties than their male counterparts in reconciling productive and reproductive work<sup>32-34</sup>.



Family tasks cause absenteeism to dental care appointments. The abandonment is a process developed upon from the repeated absences and one of the tasks of the referents is to be attentive to their motives.

Absences are addressed, ... strategies are established ... we even go to the house ... there are very complex family life processes, situations of violence, situations of family organizations that are overwhelmed by the presence of children, of disabled people. (R10)

Informal work to increase family income, whenever it exists, must be inserted within the 'free' time of the people. [...] Sometimes coincided with the days I had a dentist with the days that I had free time in my work. (P6)

The program imposes a new pivotal time organization representing the work whose "... temporary requirements and priorities sacrifice the rest of social activities"<sup>35</sup>. Given the oral clinical situation, the average number of consultations is 12 sessions per participant; "programmed dental care" requires long-term commitments, confirming the need to overcome day-to-day survival strategies<sup>36</sup>.

During the job searching workshops in the course of the program, the referents point out the importance of dental care for the improvement of employability.

[...] it really opens up the possibilities of employability of these people and we practically know that there is not a single job at this time, not even the most unofficial domestic work, in which they accept you if you have a damaged mouth. (R13)

It is not easy to include the assistance in the life projects that are promoted. Sometimes the time available to deploy the processes of reflection and creation of habits and competences, of secondary socialization or "asocial sociability" as the Castel denominates it (relational configurations "more or less evanescent" that are registered intermittently or temporarily in the institutions and that place the subjects in "weightlessness situation") are not enough<sup>28</sup>. Sometimes people end up incorporating them only once the program has finished.

[...] there is a time of 9 months (of duration of the program), but the times and the processes of each person do not adjust to the 8 months. We have people here that we should have probably for much long, we do not know how much ... but it's too short! (R4)

### **The abandonment associated with dentists**

Once in the services, the patient-professional relationship is put into play. The previous bond has been frequently specific for pain relief, or diagnosis for the compulsory health card, evidencing the power of the profession to decide aspects of labor insertion, but not to solve the problems that are detected.

The health card... That's why the dentist decides everything. Because the dentist does not require you to have your teeth on, but instead to have your mouth clean, whether you have teeth or not, it does not matter and that's it... (P1)

In Uruguay it is demanded to have a 'clean' mouth (as a criterion of normality) to obtain a 2-year health card (Law 9696, Decree 651/90). When restoration is not accessible, the way of cleaning the mouth is extraction. The model of attention generates a mutilation and does not repair it. The dentists are invested as arbiters of health for the working class, based on their qualified knowledge, building a concrete power over people's life, ordering what they should do as part of the medicalization processes of modern society in which the State "Sees, announces, but does not intervene"<sup>37-39</sup>. In a broad sense, medicalization of social life is understood as the extension of the domain in which medicine happens to intervene, and which in the past exhibited a degree of exteriority with respect to its interference<sup>40,41</sup>. Dentistry (as part of medicine) is then also a biopolitical strategy of the modern State<sup>42</sup>.

Although the dentists in UT put on hold their traditional role of exclusively relieving pain and mutilating, the new situation carries with it the prejudices of the participants and the professionals in the consultation. Among the dropouts, there is distrust of the professionals when they are young, because they do not have enough experience, or when they are women because they are not strong enough.

We had met the dentist because they brought her for introduction. We felt a little weird, because she was so young, only 29 years old! [...] a woman, the first thing that came to my mind, was: if I need to have a tooth removed and she does not have the strength ... she will dismantle me ... (P2)

The professional role is based on the confidence of patients, and although "reliability" is given to the abstract system of dental care, the flesh-and-bone potentially fallible individuals represent them, those who operate in it and in them it is necessary to trust upon<sup>43</sup>.

Additionally, women-dentist carry the gender biases derived from the remnants of a clinical practice focused on extractions for adults performed by a man-dentist and using force (a traditionally masculine attribute). Since the clinical practice is more conservative and the workforce is mostly feminine, the changes that may be generated in the exercise and in professional social representations have not yet been sufficiently examined<sup>44,45</sup>.

The dentists have biases in their care process, related to the participants' social status. A referent affirms: ... there is a "hidden" situation of prejudice, "you arrived in this state and ... now you are worried because I have to care for you" (R10).

The moralizing attitude can be an expression of the authority of professional power that some dentists may particularly feel when they treat the poorest populations. This is expressed as a correction of behavior deviated from the central value of health and is based on the social legitimacy of their actions as health professionals<sup>46</sup>.

When dentists understand poverty as an individual characteristic depending on personal responsibility of the poor, and not from a structural perspective, they have less empathy with patients<sup>47</sup>. Dentists can experience caring in poor areas with high

levels of frustration and impotence because there are procedures that the system will not cover, because they are not lucrative or because of organizational difficulties due to the patients' absenteeism<sup>48</sup>, something that may generate lower quality assistance<sup>49,50</sup> or even exclusion strategies<sup>51</sup>.

The protagonists bring explanations of the world and knowledge that constitute the bases that guide their expectations. The expectations may be different from those proposed by professionals, especially from more normative positions.

[...] that the dentist should be kind, patient. Because there are dentists who probably do not talk to you ... but things are like that, and like that it should be, right? He did not say anything inconvenient, but I do not ... do not know how to explain ... (P2)

This new role requires professional vocational care and listening, strengthening the soft technologies of the management of health services<sup>52-55</sup>. Having a good relationship with professionals is very important for the participants; receiving orders, not being recognized or listened to, generates limitations to establish a bond that facilitates the continuity of assistance.

Many times, a strategy that allows coping with the situation consists in the support of the groupmates that offers the contention to sustain an unknown experience. "But, OK, it was good, because if you're waiting, waiting with a partner becomes more ... bearable" (P9).

These attitudes contribute to develop forms of recognition and mutual pride that enhance the solidarity of the group<sup>56</sup>.

Dialogue is needed to agree upon both the treatment plan and schedule. The participants should have the possibility to state what they consider best for their lives, for example, when the patient prefers an extraction, while the dentist does not, or vice versa.

... I had three (teeth), ... I put on the hooks (and this fang is beginning to have a cavity), a moment will come that, how do I get hold of it? Then a year or two goes by and I'm toothless again. And that was one reason why I dropped out ... (P5)

... he (dentist) told me that he wanted to remove a tooth that is healthy, but that it was better to take it out, but I told him that if it is healthy, I want to leave it; and he said to me –think about it and then you see ... and OK then I did not come anymore ... But I say: if it is healthy, why will they take it from me? Because perhaps I cannot get used to eating with false teeth and, at least as it is, I have something left to eat [Smiling]. (P1)

The texts of the participants reflect the tension resulting from the encounter between professional knowledge and patient's freedom. It is necessary to overcome the paternalistic model by a decision model already enshrined in Uruguayan legislation, which places the patients as agents with rights, as well as a broad autonomous decision-making capacity over the diagnostic and therapeutic procedures offered to them<sup>57,58</sup>.

The model of medicalization produces a conversion of health problems into strictly political problems related to public hygiene through the revaluation of the body (as workforce) and moralization, as a social control of deviance. “Medicine” [and in this case dentistry] appears “as an instituted and instituting space for broader social relationships”<sup>59</sup> (p.28) that are not directly related to the disease and its healing process or management of the disease. According to Menéndez<sup>60</sup>, “the process of medicalization involved the ideological and technical appropriation of the health/disease processes and their constant application to new forms of social behavior”(p.165). This phenomenon generated “a split between medical knowledge and popular knowledge”, legitimizing health control<sup>59</sup> (p. 28).

This encounter between dentists and patients can be an opportunity to develop a “live” professional work process (creative and innovative) that surpasses the forms of work oriented exclusively by a productive and mechanistic management<sup>61,62</sup>.

### **The abandonment of the treatment associated with the socialization process**

The daily routine of the participants and the disagreement with the professionals can activate a process of distancing from the dental services that the participants call “abstaining from doing” (P5). When consulted, they recognize that oral health care was not a priority during their childhood.

Yes I went, as a boy (to the dentist the first time). I was probably 10 years old, 9 years old, I had an extraction ... My mother was 40 years old and had just started going to the dentist. (P10)

There is evidence that early childhood is a sensitive period and that it influences health trajectories throughout life<sup>63-65</sup>.

During the process of “primary socialization”, the family as a significant group mediates the social world both from a cognitive and emotional point of view, guiding attitudes - among them those referring to oral health - that will reflect the identity of that individual<sup>36</sup>.

The participants recognize how the deterioration of the mouth can interfere in their relationship with others, albeit being necessary to differentiate to which “others” they relate. The referents warn that in the closer environment where the participants move, and even in the informal jobs they can get, oral health does not represent a problem for the person, since the process of primary socialization occurs not only from the family perspective with an “idiosyncratic coloration”, but from the broader perspective of the class to which the family belongs<sup>36</sup>. With “certain others” such as teachers, technicians, persons from less closer social circles, the appearance can be perceived as a lack or limitation to the exchange. According to the referents, this duality must be worked on “and it must be made explicit” (R2).

Yes, for everything! To talk to people, to go and talk to a teacher, a professor ... it’s like I’m ashamed. (P5)

It is as part of the processes of secondary socialization that new attitudes are produced and reproduced. This process of internalizing new institutional sub-worlds leads to opening to the family world, although strong biographical impacts will be needed in order to disintegrate reality as it was internalized in childhood<sup>36</sup>. In the institutional world as presented by the referents, oral health can assume new meanings and produce a shift and a commitment to this reality, incorporating new attitudes.

In the broader social space, oral health conditions mean that the protagonists often do not smile or hide and must manage the tension that is generated in social contacts, avoiding being discredited. To be discovered, or its possibility, discourages them.

I laugh no more (Laughs) ... in the pictures, in all the pictures I look unsmiling because ... it is ... horrible..., if I laugh or something, they say “ah you have no teeth”. And there, already I feel absolutely down. (P9)

In different social spaces, stigmatization may arise. People, knowing that they may be subject to a subsequent discredit, try to hide what discredits their own image in public life (concealment) and internally feel marked and ashamed by these stereotypes<sup>66</sup>.

The body, marked by the status of the mouth, places people in the hierarchy of classes, being a sign of their status, perhaps the most intimate - that cannot be dissociated from the person who inhabits it<sup>67</sup> and, as the referents say: “it reflects how life has treated them” (R14).

This body-made-history constitutes the *habitus*, defined by Bourdieu<sup>24</sup> as the matrix of the world is perceived, conditioning the repertoire of the individual's practices and explaining the behaviors of the UT participants in relation to their possibilities of attending to and sustaining dental care.

The mouth, as a physical crossroads of the body, produces and reproduces practices, combining functions and forms in the diet (what to eat and drink, the way of eating, the time to eat), in the aesthetics (tastes, flavors, beauty) in the expression of affection (smiling, kissing), hygiene and care<sup>68</sup>. The differentiated forms of consumption (whether in terms of hygiene or personal care) originated by the position in the economic space adjust the aspirations to objective opportunities, with the conviction that they will not have more than they deserve<sup>29</sup>.

There are unthinkable practices, perceived as they were excluded from their life.

Of course, what happens is that there was never anyone to fix the teeth for free, that did not exist, you had to have the money and did not have it, and it's not that cheap either, so I already knew that I was not going to get it. (P1)

The *habitus* tends to guarantee conformity with the practices that are usually experimented. This built-in history, the basis from which reasonable practices are produced, gives persistence and predictability to social life. This could explain the lack of mobilization by something that they believe it does not belong to them. For example, health check-ups, appearing only as a standard to be complied with, emanated from professional discourse.



She (her daughter) asked me why, if the children of the bosses had all the right teeth, whites and everything, they needed to go to the dentist? And yes, because you have to go every year I think it is, I do not know, I knew everything, but I was not going, it's my fault. (P1)

According to Boltanski<sup>67</sup> the members of the lower classes do not pay attention to their bodies, expecting mainly that the body should function. For the upper classes the disease is inscribed in time and can adopt a preventative attitude, willing to submit themselves to rules that seek to preserve them from the disease. In the lower classes, the immediateness in the management of time can lead to “energetic remedies” such as tooth extraction, (perhaps painful, but immediately attenuating the suffering) that can be the solution to their problems. The idea of prevention, in short, is based on a problematization of the future (notion of risk) that does not coincide with the immediateness of their lives<sup>69</sup>.

However, the *habitus*, despite being socially conditioned, is not immutable, but rather an open system of dispositions that can be affected by new experiences. The encounter with other social fields generates a practical sense that, as a strategy, allows adapting using personal creativity, to new experiences. One of those experiences is the passage through the UT groups.

## Final considerations

The phenomenon of dropout is analyzed in the context of the UT program. In this context some people manage to reach the dental discharge stage while others do not.

We must recognize that much is asked for a 9-months period. The achievements obtained during the course of the accompaniment of the CSOs are fundamental, because UT in dentistry generates competencies that are basically valid during the course of the program. Before UT people did not develop them, not out of negligence, but because that type of care was not available; and once the policy is finalized, these competencies will again disappear within the framework of the universal care provided by the public sector.

To be exposed to new circumstances by the program allowed some protagonists to modify their practices in oral health stemming from self-reflective work, experimented together with their partners, acknowledged by the members and the referents of the group.

Oral care is an opportunity. But there are times when people cannot take advantage of the opportunities because, as stated in the interviews, there are other more urgent priorities such as the survival of the family and children. Lives are complicated, bonding with dentists is weak, or the adaptation to the program process is not enough as it goes against the weight of history and the present of poverty. In that way, part of this population, the most vulnerable, the unemployed, subject to individualized protections, abandon care or just give up, remaining abandoned by the State without social protection once the program ends.

Participants access a transitory right of assistance within a program that pretends to address rights. In order to transform the participants in truly holders of rights,

a mechanism must be created that guarantees a transition, a bridge towards dental care in the health sector that provides them with comprehensive benefits once the promoted employment assistance program has been completed. It must also have the necessary breadth to respect that right that today does not integrate the universal policy of the National Integrated Health System, as far as dentistry is concerned.

Social integration is more than coordination and articulation of resources as it involves changes and transformations of public policies and structures of the system, in particular of the health system.

The universal health matrix should receive people after they transit through social programs, and it should process and respond in quantity and quality to their needs in oral health. It is this one of the political-healthcare problems that this work shows as needing to be addressed by the State.

### Authors' contributions

All authors actively participated in all the stages of the manuscript's elaboration.

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**Translator:** Félix Héctor Rigoli

Submitted on 09/21/18.  
Approved on 02/01/19.