Understanding Oral Health Help-Seeking: Beliefs, Barriers and Facilitators Among Middle Eastern Refugees and Asylum Seekers

Isadora Aldam

This thesis is submitted in partial fulfillment of the Honours degree of Bachelor of Psychological Science

School of Psychology

University of Adelaide

October, 2018

Word Count: 9,000

Table of Contents

List of Figures

List of Tables

Abstract

Oral health is a significant health issue with marked inequalities for people of refugee and asylum seeking backgrounds. However, despite evidence of oral health disparities and unequal service access for this population, there is limited research exploring help-seeking behaviours among people with refugee and asylum seeking backgrounds, particularly in Australia. Andersen's Model of Healthcare Utilisation (1968; 1995) has frequently been employed to explore use of health services, but has not been applied to oral health help-seeking behaviours among this population. To address these research gaps, the aims of this study were to improve understandings of Middle Eastern refugees' and asylum seekers' oral health help-seeking behaviours and the barriers and facilitators to their dental service use, and to determine the utility of Andersen's Model in this context. Semi-structured interviews were conducted with 20 people from Syria, Iran and Afghanistan who had recently arrived as refugees or asylum seekers, and six oral health practitioners with professional experience with this population. Results were analysed using a combination of inductive and deductive thematic analysis, and provided some support for the use of Andersen's Model in relation to oral health help-seeking for this population, but also identified some limitations with this approach. Results of this study support a revised version of Andersen's Model, and highlight the need for a tailored approach to understanding oral health help-seeking among peoples with diverse refugee and asylum seeking backgrounds, with greater consideration of the impacts of health and resettlement policies, service experiences and migration experiences on oral health outcomes.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through the web search engines, unless permission has been granted by the School to restrict access for a period of time.

Isadora Aldam

October, 2018

Acknowledgements

Firstly, I would like to thank my supervisor, Dr. Clemence Due, for introducing me to such a meaningful research topic, and for her guidance, generosity and support throughout every research stage. I have greatly benefited from her expertise in working with vulnerable populations, and the learning experiences encountered throughout this study under her supervision.

I wish to acknowledge the generosity of organisations and individuals who assisted in promoting this study for participant recruitment, and introduced me to invaluable networks. It was a privilege to meet such knowledgeable individuals and gain insights into their work. Special thanks are extended to Shaista Kalaniya, Project Manager at the Muslim Women's Association of South Australia, and Margie Steffens (Director) and colleagues at the Adelaide Community Outreach Dental Program, as well as the Australian Refugee Association, Migrant Resource Centre of South Australia and SA Dental Services.

I would also like to thank my family for their continual support and words of encouragement throughout this and every year of study, and my Dziadek for inspiring me.

Finally, great appreciation is owed to all of the participants in this study. Not only would this study not have been possible without you, but it was a privilege to listen to your experiences. You have provided me with invaluable insights, and taught me many things beyond the scope of the results of this study. Thank you.

CHAPTER ONE: INTRODUCTION

1.1 Overview

Since 2015, more than 60 million people worldwide have become displaced from their homes (UNHCR, 2018). This includes 25.4 million people classified as refugees and 3.1 million as asylum seekers (UNHCR, 2018). Most new arrivals to Australia with refugee or asylum seeking backgrounds are from the Middle East, with people from Afghanistan, Iraq, Iran and Syria among the top ten nationalities granted protection under Australia's Humanitarian Settlement Program (ABS 2017; Department of Social Services, 2018; Refugee Council of Australia, 2018).

Upon resettlement, people from refugee and asylum seeking backgrounds face significant barriers to healthcare access, which contribute further to poor mental, physical and social outcomes (Davison et al., 2004; Lamb & Smith, 2002; Riggs, Rajan, Casey & Kilpatrick, 2017). People arriving as refugees or asylum seekers from the Middle East in particular have experienced extensive persecution, war and displacement, making it essential to understand their unique health needs (Renzaho & Dhingra, 2017). Oral health has been identified as a crucial issue and source of health inequality (COAG Health Council, 2015; Davison et al., 2004; Renzaho & Dhingra, 2017; Riggs et al., 2017). However, there is little research regarding oral health outcomes and service access for people with refugee or asylum seeking backgrounds, especially from the Middle East (Kiang & Paxton, 2017). Using Andersen's Behavioural Model of Healthcare Utilisation (Andersen, 1968; 1995), this thesis aimed to: (1) improve understandings of oral health help-seeking behaviours, barriers and facilitators among this population, and (2) determine the utility of Andersen's Model in this context.

1.2 Terminology

People referred to the Australian Government for resettlement as 'refugees' by the United Nations High Commissioner for Refugees (UNHCR) are granted one of four categories of permanent protection visas (PR) (Department of Home Affairs, 2018). People who arrive by alternative means (including via boat or plane) and whose claims to asylum are yet to be processed are referred to as 'asylum seekers'. Initially, they may be granted a Bridging Visa (BV) for temporary residence in Australia (Department of Home Affairs, 2018). Following application processing, they may receive a Temporary Protection Visa (TPV) which grants protection for three years, or a Safe Haven Enterprise Visa (SHEV) granting five years of protection (provided their commitment to work or study in Australia; Refugee Council of Australia, 2018). Different visas permit varying access to healthcare in Australia, including oral healthcare.

While migration experiences are not the sum of individuals' identities (of which it is their choice to identify or be identified by), and categorisation by immigration status can essentialise such complex experiences, for brevity within this thesis, participants of refugee and asylum seeking backgrounds are referred to as 'refugees' and 'asylum seekers'.

1.3 Oral Health Status and Impacts on Health

'Oral health' refers to oral and related tissues, and concerns individuals' ability to eat, speak and socialise without disease, discomfort or embarrassment (COAG Health Council, 2015). Oral health problems are among the most common health issues experienced in Australia, with over 63,000 hospitalisations each year due to preventable dental conditions (COAG Health Council, 2015). Oral health also impacts other health and social outcomes, including physiological (e.g. chronic pain, infection), psychological (e.g. lowered self-esteem), social (e.g. exclusion, isolation), and functional outcomes (e.g. eating, sleeping, speech) (Al-Harthi et al., 2013; Gerritsen, Allen, Witter, Bronkhorst & Creugers, 2010).

These issues extend to immigrant populations in Australia and overseas (Mariño, Schofield, Wright, Calache & Minichiello, 2008; Quandt, Hiott, Grzywacz, Davis & Arcury, 2007), and are particularly pertinent for refugees and asylum seekers who face marked health inequalities compared to the broader Australian population (Davison et al., 2006; Pani et al., 2017).

1.4 Oral Health Among Refugees and Asylum Seekers

Refugees and asylum seekers frequently face poor oral health outcomes including untreated dental decay, gum disease and physical dental trauma (Davidson et al., 2004; Høyvik, Lie, Grjibovski & Willumsen, 2018). These are exacerbated by stressors of resettlement, such as poor English proficiency, community and social exclusion, poverty, unemployment, and inadequate housing (Riggs et al., 2015), and may vary by ethnic background (Høyvik et al., 2018). However, diverse populations, including refugees and asylum seekers, are often under-represented in research resulting in skewed data and ineffective service and policy recommendations (Riggs et al., 2017).

Internationally, oral health-related research with refugee or asylum seeking populations has focused primarily on children (e.g., Hoover, Vatanparast & Uswak, 2017; Pani et al., 2017; Reza et al., 2016; Riggs et al., 2017). Few studies have been conducted concerning adults – the subject of this study. One study reported higher rates of untreated decay, gingivitis and gum disease among Bhutanese adult refugees living in Nova Scotia than non-immigrants (Ghiabi, Matthews & Brillant. 2014), and another identified dental problems and need for dental services as crucial resettlement issues for Syrian refugees in Jordan (Ay, González & Delgado, 2016). Some international research has suggested culture and acculturation (changes to individuals' original cultural patterns following contact with another culture; Berry, 1992) contribute to refugees' oral health beliefs and associated

outcomes, although specific pathways are unclear (Gao & McGrath, 2011; Geltman et al., 2013; Reza et al., 2016).

In Australia, research concerning refugees' and asylum seekers' health has typically examined physical or mental health rather than oral health specifically (Davidson et al., 2004). Australian oral health research has focussed primarily on oral status disparities (Davidson et al., 2006; Gibbs et al., 2014; Gibbs et al., 2015; Lamb, Michaels & Whelan, 2009), particularly among refugee children (Nicol, Al-Hanbali, King, Slack-Smith, & Cherian, 2014; Nicol, Anthonappa, King, Slack-Smith & Cirillo, 2015; Quach, Laemmle-Ruff, Polizzi & Paxton, 2015; Riggs et al., 2015). Regarding adult refugees, some studies have analysed associations between acculturation (concerning new cultural values, preferences and identification post-resettlement) and positive oral health outcomes (Marino et al., 2001), systemic and personal barriers to accessing dental services and impacts to oral health status (Davidson, Skull, Calache, Chesters, & Chalmers, 2007), and understandings of cultural differences for improving dental service attendance (Cheng et al., 2015).

Currently, newly arrived refugees and asylum seekers to Australia are eligible for only basic health examinations (Department of Home Affairs, 2018; Department of Health, 2014), and subsidised service availability heavily differs between states, with only 20% of those eligible for dental services actually receiving care (Oral Health Monitoring Group, 2015). In South Australia, visa criteria restrict access to concession cards for some refugees and asylum seekers, impacting their health service eligibility (Department of Health, 2012; Primary Health Network, 2017) and, without health insurance, the affordability of private services permits only basic pain relief (Davidson et al., 2007; COAG Health Council, 2015). These systemic issues compound with personal challenges including poor transportation and communication, service mistrust, trauma, differing cultural norms, social isolation and low health literacy (Lamb & Smith, 2002). However, understandings of barriers and facilitators

and pathways explaining refugees' and asylum seekers' dental health service use are limited, with potential program interventions underpinned by a paucity of appropriate research.

1.5 Oral Health Help-Seeking and Andersen's Model

Given the gap between refugee and asylum seekers' oral health needs and service access, understanding the underlying reasons for low help-seeking is essential. Help-seeking (a psychological construct) is a coping mechanism involving recognition of a health problem and the search for professional assistance, or the link between problem onset and provision of care (Gourash, 1978; Lloyd, Rogler & Dharma, 1993). Among refugee populations, help-seeking research has predominantly concerned mental – rather than oral – health (De Anstiss & Ziaian, 2010), and few studies have evaluated help-seeking models for use among refugee and asylum seeker populations (Joshi et al., 2013).

Andersen's Model of Healthcare Utilisation (1968; 1995) is the primary framework proposed to understand healthcare use; created to define, measure and develop its equitable access (Andersen, 1995), and expandable to specific health contexts and populations (Babitsch, Gohl & Lengerke, 2012). Andersen's Model originally conceptualised health service use as the result of complex, interrelated factors, and as a function of individuals' predisposition of use, enabling or impeding factors, and need (Andersen, 1968). It originally focused on families' health service use and was amended to reflect individuals' help-seeking behaviours (See Figures 1 and 2).

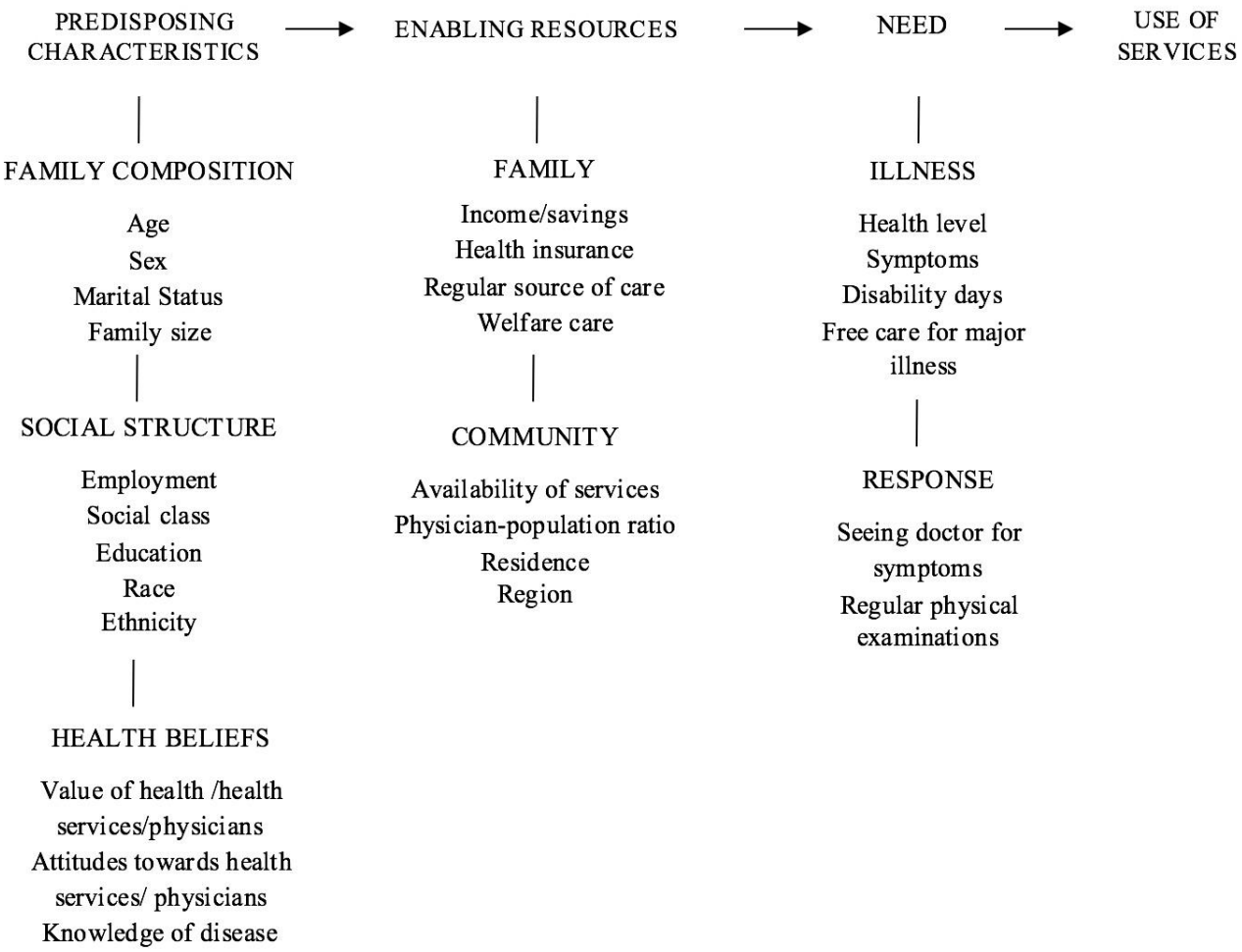

Figure 1. Andersen's (original) Behavioural Model (1968)

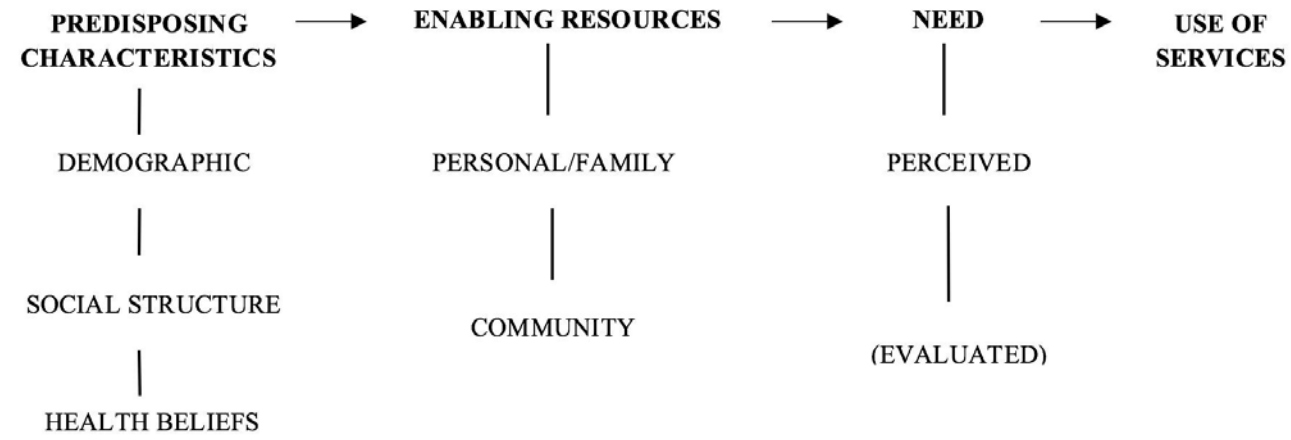

Figure 2. Andersen's (amended) Behavioural Model (1995)

Few studies have employed Andersen's Model to investigate health service engagement among people of culturally diverse backgrounds, including a qualitative study exploring African- and White-American participants' long-term healthcare service use (Bradley et al., 2002), and quantitative research regarding help-seeking for stigma-related healthcare services among African refugee women in Western Australia (Drummond et al., 2011). Regarding oral health, Andersen's Model has been used for secondary analyses of UK survey data identifying mediation effects of enabling resources (Baker, 2009), as an explanatory framework to understand children's regular and preventive service use in Beijing (Xu et al., 2018), and for gum disease outcomes in adults in Brazil, showing age to impact predisposing and enabling factors (Valente & Vettore, 2018). Aside from Davidson and Andersen's (1997) analysis of dental service access among ethnic minority groups in the US, and Brzoska, Erdsiek and Waury's (2017) preventive dental service research among migrants and non-migrants in Germany, few studies have applied Andersen's Model to explore cross-cultural dental use, and none with refugee and asylum seeker populations. This evidence highlights a paucity in understanding oral health help-seeking behaviours from a theoretical lens. In this study, analysis of the suitability of Andersen's Model (1968), as amended by Andersen (1995), informed suggested improvements to increase its explanatory power among this population.

1.5.1 Andersen's Behavioural Model of Healthcare Utilisation

Andersen's Model – considered applicable to any specific disease, need, or health service type – depicts a causal-ordering explanatory process where predisposing characteristics are exogenous, enabling resources are necessary but not sufficient facilitators of service access, and need is required (Andersen, 1995). Although Andersen (1968; 1995) specified components of each Model domain (predisposing, enabling and need factors), their utility is yet to be determined for oral health help-seeking among Middle Eastern refugees

and asylum seekers. The following sections provide an overview of each domain and component of Andersen's (1968; 1995) Model, accompanied by discussions of potentially influential variables for refugee and asylum seeker populations, as informed by previous literature.

1.5.1.1 Predisposing characteristics

Predisposing characteristics represent exogenous imperatives that predict people's likelihood of requiring health services (Andersen, 1995). While not directly responsible for service use, they can catalyse use together with enabling and need variables (Andersen, 1968). Concerning dental service use, Andersen originally suggested that predisposing and enabling domain variables were most explanatory of American families' help-seeking (Andersen, 1968). Subsequent amendments to Andersen's Model (Andersen & Newman, 1973; Andersen, 1995) to reflect variables influencing individuals' health service use (such as demographics) are more suitable for this study.

1.5.1.1.2 Demographics

Age and gender are well-established predisposing characteristics that contribute to help-seeking, including across some ethnically diverse groups (Andersen, 1968; Andersen & Newman, 1973). Recent studies of Andersen's Model reported that dental service use among general populations was associated with age and gender, with people of female gender and middle-age more likely to seek help (e.g., Babitsch et al., 2012; Baker, 2009). However, no studies have considered this in populations from the Middle East, nor refugees or asylum seekers specifically.

1.5.1.1.3 Social structure

Andersen (1968) coined social structure to represent associations between health service use patterns and families' location in society, with measures including employment, education, social class, occupation, education, race and ethnicity, and to correlate with

enabling resources (Andersen, 1968). Studies of ethnically diverse peoples confirmed social structure as a determinant of health service contact (Andersen & Newman, 1973; Andersen, 1995). Education has been extensively studied with regards to dental service access in North America among diverse ethnic groups (Davidson & Andersen, 1997), and in immigrants and refugees in a scoping review, with higher education related to greater help-seeking (Reza et al., 2016).

Other than Davidson and Andersen (1997) and Andersen and Davidson's (1997) US studies, race and ethnicity have rarely been examined regarding oral health using Andersen's Model. However, studies have reported ethnic and cultural diversity to influence general health outcomes (Cheng et al., 2015), dental service use (Lamb et al., 2009), and uptake of public oral health messages (Riggs et al., 2012). Race, ethnicity and culture are particularly complex constructs when applied to displaced peoples (Desmet, Ortuno-Ortin & Wacziarg, 2017). This study focused on people from the Middle East in an attempt to identify their impacts.

1.5.1.1.4 Health beliefs

Health beliefs comprise people's values and attitudes toward health care and services, practitioners and health status (Andersen, 1968; 1995). They influence enabling resources and perceived need as a product of social structure and may explain inclination towards service use (Andersen, 1995). Culture and ethnicity may determine oral health beliefs and perceived imperative to seek professional help (Lamb et al., 2009); especially relevant to this study.

1.5.2 Enabling resources

Enabling resources measure potential service access following individuals' predisposition to seek help (Andersen, 1968). Andersen (1968; 1995) posited that geographic accessibility and means to attain services must be present to enable use. Enabling

components were originally distinguished as family and community resources, and subsequently altered to include personal resources (Andersen, 1995). Andersen (1968) originally found enabling resources to correlate higher with families' use of dental services than predisposing or need components, although inter-correlations between predisposing and enabling components were reported.

1.5.2.1 Personal/family

Financial resources, health insurance, and welfare support have been reported as central components of Andersen's Model (Andersen, 1968; 1995). In studies with refugee and asylum seeker populations, financial constraints (including access to health insurance) have hindered access to dental services (Brzoska, Erdsiek & Waury, 2017; Lamb & Smith, 2002; Xu et al., 2018; Brzoska, Erdsiek & Waury, 2017). In Australia, eligibility for government financial assistance based on visa type for dental services may also be influential.

1.5.2.2 Community

Community resources traditionally encompassed service availability, travel means and waiting times, region of residence, practitioner-population ratios, and community health education levels (Andersen, 1968; 1995). Previous Australian research with refugee populations found transport and logistical complexities influenced decisions to access general healthcare services (Lamb & Smith, 2002; Drummond et al., 2011), and are also pertinent to this study.

1.5.3 Need

The 'need' component of Andersen's Model considers how people experience their health state, pain, symptoms of illness, and the necessity of seeking help (Andersen, 1968; 1995). Need was originally separated by 'illness' (self-reports of clinically verified conditions) and 'response' (actualised use of health services), but subsequently categorised by

'perceived need' (subjectively determined by social structure and health beliefs) and 'evaluated need' (reliant on biological and physical imperative, and professional judgement of health status; Andersen, 1968; 1995).

Analysing dental needs among refugees and asylum seekers is essential given ranging conceptualisations of oral 'wellbeing' and detrimental oral experiences including untreated problems, disrupted hygiene, and persistent trauma (Lamb et al., 2009). Oral symptoms such as pain are prominent indicators of need, as they often prompt help-seeking regardless of ethnicity or background (Andersen, 1995).

1.5.4 Use of health services

Andersen (1968) distinguished service use as discretionary (considerable choice involved) or non-discretionary (dictated by the physical condition); positing that the more discretionary the behaviour, the more important predisposing and enabling components will be in its explanation. Dental service use was considered to involve greater discretion compared to other types of medical care; correlating higher with social structure and enabling variables than need (Andersen, 1968).

For refugees and asylum seekers, successful help-seeking and access to dental services are essential in reducing adverse oral health outcomes and disparities (Riggs et al., 2017; Buset et al., 2016; Bennadi & Reddy, 2013). Whether the same discretionary pattern is present in oral health help-seeking among this population is considered in this study.

1.6 The current study

As discussed, there is a paucity in the literature regarding oral health help-seeking among Middle Eastern refugees and asylum seekers both internationally and in Australia. As such, the primary aim of this study was to address this gap to improve understandings of Middle Eastern refugees' and asylum seekers' oral health help-seeking behaviours and the barriers and facilitators to service utilisation. This qualitative research also aimed to explore

whether Andersen's Model of Healthcare Utilisation had utility in understanding oral health help-seeking for this population, and to determine appropriate variables of analysis. Research questions were: (1) What were participants' beliefs regarding oral health and how oral health services are and should be used?; (2) To what extent do participants' beliefs and experiences regarding oral health, and barriers and facilitators to service use fit with Andersen's Model?

CHAPTER TWO: METHOD

This study formed one component of a larger study concerning oral health and quality of life for people with refugee and asylum seeking backgrounds from the Middle East. As part of this larger quantitative study, participants completed a survey translated into Arabic, Dari or Farsi, and left contact details if they wished to participate in a follow-up interview. The interview data formed the bases of two projects; this study, exploring help-seeking, and another concerning oral healthcare experiences.

2.1 Participants

Two groups of participants were included in this study: people with refugee and asylum seeking backgrounds from the Middle East, and oral health practitioners. Eligibility criteria for the first group included being over 18 years of age and having come to Australia from Afghanistan, Iran, Iraq or Syria as either a refugee or asylum seeker in the last ten years (to consider impacts of migration). Eligibility criteria for the second group included having worked as an oral health practitioner with experience in the past two years with patients of refugee or asylum seeking backgrounds from Afghanistan, Iran, Iraq or Syria. The inclusion of oral health practitioners was used to bolster understandings of help seeking through both patients' and practitioners' perspectives, and to enable triangulation of findings (Tracy, 2010).

Twenty interviews were conducted with refugees (n = 17) and asylum seekers (n = 3); eight males and 12 females, aged between 18 and 52 (M = 32.85, SD = 9.26). Participants had lived in Australia from one to six years (M = 3.35, SD =1.53). At the time of interviewing, two participants held Safe Haven Enterprise Visas (SHEV), one had a Bridging Visa (BV), two were Australian Citizens, and 15 held permanent Refugee or Humanitarian Visas (PR). Three participants had lived in an alternate country to their origin for a significant period

before resettlement in Australia, and were identified by their chosen cultural background. More information about participants (with pseudonyms) is presented in Table 1.

Table 1

Demographic Information of Refugee and Asylum Seeker Participants (n = 20)

Participant	Gender	Age	Visa/Status	Years in Australia	Cultural Background	Interpreter Present
[redacted]	M	23	BV	5.5	Iranian/Ahwazi	No
[redacted]	M	32	SHEV	5.5	Iranian	No
[redacted]	F	35	SHEV	5	Iranian	No
[redacted]	F	52	PR	5	Afghani/Hazara	Yes
[redacted]	F	21	PR	4	Afghani/Hazara	No
[redacted]	F	19	Citizen	5	Afghani/Hazara	No
[redacted]	F	29	Citizen	6	Afghani/Hazara	No
[redacted]	F	34	PR	3.5	Afghani	No
[redacted]	M	42	PR	3.5	Afghani	No
[redacted]	M	36	PR	2	Syrian	Yes
[redacted]	F	36	PR	2	Syrian	Yes
[redacted]	F	29	PR	3.5	Syrian	No
[redacted]	M	43	PR	3.5	Syrian	No
[redacted]	F	30	PR	1.5	Syrian	Yes
[redacted]	M	37	PR	1.5	Syrian	Yes
[redacted]	M	45	PR	2	Syrian	Yes
[redacted]	F	35	PR	2	Syrian	Yes
[redacted]	F	18	PR	2	Syrian	Yes
[redacted]	M	40	PR	2	Syrian	Yes
[redacted]	M	21	PR	2	Syrian	Yes

Six interviews were conducted with oral health practitioners: four of whom were female and two males. Practitioners were employed by one public and one community organisation across four clinics throughout metropolitan Adelaide. Years worked with patients of refugee and asylum seeker backgrounds ranged from four to 16 years (M = 8.33, SD= 4.27). Practitioners' vocations included dentist, dental hygienist, dental assistant, clinic director and practice manager. For anonymity, no further identifying information of practitioners is provided.

2.2 Procedure

The University of Adelaide Human Research Ethics Committee approved the study ([redacted]). At the time of interviewing (May 2018), all participants who had left contact details in the survey were contacted (N = *25*), and seven agreed to an interview, providing informed consent (see Appendix A and B for ethics documents). These participants included six people from Syria and one from Iran. Subsequently, researcher IA extended recruitment to a more diverse sample by advertising the survey through the Muslim Women's Association of South Australia, Australian Migrant Resource Centre of South Australia and the Australian Refugee Association, leading to 13 interviews; resulting in a dataset of 20 for this study. For practitioner recruitment, oral health clinics and practitioners with a known history of working with refugees or asylum seekers were contacted by phone and email, followed by snowball sampling.

Interview questions were semi-structured and used open-ended questions to allow for unique conversation direction and flow determined by each participant (Braun & Clarke, 2006). Based on existing literature (as discussed in the introduction), interview questions explored refugees' and asylum seekers' oral health history, status, practices, beliefs,

experiences with dental services, and determinants of help-seeking as proposed by Andersen's Model (Andersen, 1968; 1995), as well as practitioners' experiences and challenges working with refugees and asylum seekers, and perceptions regarding their help-seeking behaviours (see Appendix C for interview schedule). A pilot interview (Zaynah) was conducted by researcher IA and her supervisor to assess the applicability of the interview questions. No changes were made, and the piloted data were included in the study.

Interviews were conducted individually by two researchers but shared for the two studies as noted above (the present study exploring help-seeking and a second concerning oral health service provision; IA = 15 interviews, BB = 11). All participants were offered the use of a professional interpreter (with 10 participants requesting an interpreter as noted in Table 1), and in cases of distress were offered information on mental health, oral health, and refugee support services (see Appendix D). Refugee and asylum seeker participants received a $45 voucher for their contribution. All interviews were conducted face-to-face at locations convenient to participants. Interview lengths ranged from 17 to 70 minutes (M = 42.35, SD = 10.59). With perspectives gathered from diverse cultural backgrounds (ensuring broad ranging cultural insights) and no new themes evident, refugee and asylum seeker interviews ceased at 20 participants. Practitioner interviews ceased at six participants where continued data collection was believed to no longer result in the identification of new themes (Braun & Clarke, 2006).

Interviews were recorded and transcribed verbatim by IA or BB, and cross-checked. Researchers maintained an audit trail throughout interviewing to ensure self-reflexivity and transparency by documenting critical notes on methodology and self-impact as a qualitative tool, as suggested by Tracy (2010). While not themselves refugees or asylum seekers, this process assisted the researchers to consider the impacts of their position and interests in refugee studies. Notes were also taken between interviews to document research activities

and decisions, including modification of interview questions such as relocating demographic questions from the end to the beginning of interviews to enhance flow and participant-researcher rapport.

2.3 Analysis

Thematic analysis (TA) was used to analyse the data, typically involving the identification, analysis and interpretation of patterns of meaning in relation to the research question, and leading to rich, detailed, and complex data interpretation via theoretical freedom and flexibility (Braun & Clarke, 2006). In this analysis, TA took a predominantly realist approach where interview questions captured participants' lived experiences, whilst underpinned by constructionist epistemology where participants' cultural norms, contexts, and the structural conditions of Australia's resettlement and healthcare environments shaped their experiences (Braun & Clarke, 2013). Braun and Clarke's (2006) six steps to TA were adopted throughout this study. Interview transcriptions were repeatedly studied and initial thoughts noted during the data familiarisation phase. Data were then coded and categorised by grouping initial ideas via systematic organisation of data extracts and key points. These formed the bases for broad themes and subthemes that captured important aspects of understanding refugees' oral health help-seeking (Braun & Clarke, 2006). Data coding was conducted both manually and using the program NVivo 12. Searching for themes was assisted by creating visual representations of the codes, as presented in the results section. Reviewing, defining and naming themes (phases four and five) were conducted collaboratively between researchers, and findings were triangulated between refugee and asylum seeker participants and practitioners to increase trustworthiness (Tracy, 2010). For the most part, identified themes were consistent between participant groups, although there were some cases where themes were only relevant to one group or the other.

Theme identification took two investigative avenues. Firstly, inductive, latent theme identification enabled exploration of participants' underlying conceptualisations of oral health help-seeking (Braun & Clarke, 2006). Secondly, a deductive, theoretical approach considered the relationships between themes and Andersen's Model (1968; 1995). Overarching, semantic themes guided by Andersen's 'predisposing', 'enabling' and 'need' domains were applied to the data to understand their overlap. Where themes did not fit these domains, they were conceptualised as external to Andersen's Model and are presented at the end of the Results chapter.

CHAPTER THREE: RESULTS

3.1 Overview

This section is organised according to Andersen's Model's (1968; 1995) three domains (predisposing, enabling and need) with conceptualised themes identified under each domain. Themes new and independent to Andersen's Model are subsequently presented. The tool of thematic networks, as advocated by Attride-Stirling (2001), was used to organise theme structure, visualise their interrelations between each other and Andersen's Model, and to assist in organising this results section (see Figure 3).

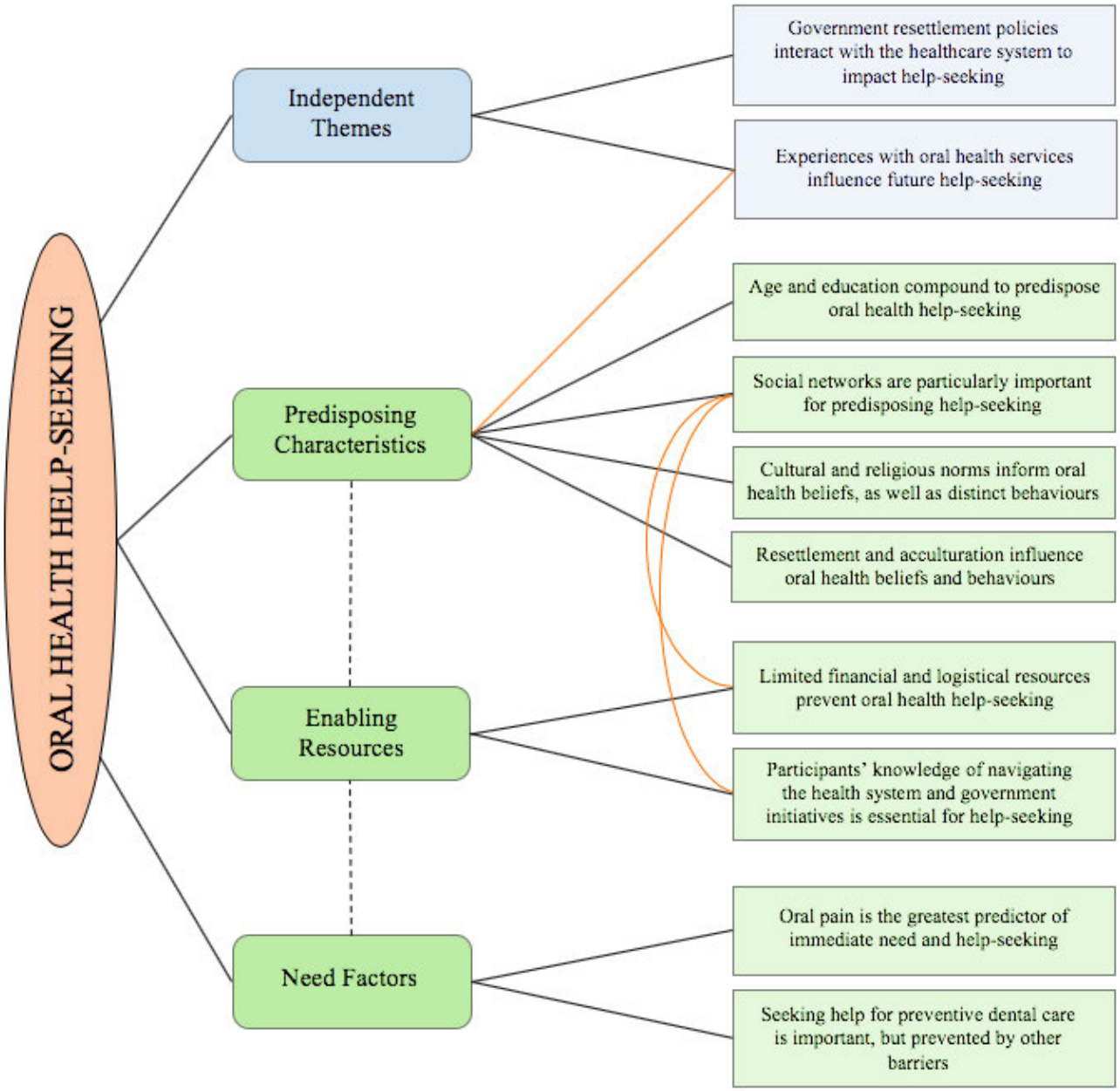

Figure 3. Thematic network of identified themes, as advocated by Attride-Stirling (2001)

3.2 Themes Reflected by Andersen's Model

TA led to the identification of eight themes (see Figure 3); some of which reveal oral health beliefs, behaviours and help-seeking that mirror aspects of Andersen's Model, including age, education, culture, finance, logistics, and oral symptoms. Themes also encompassed additional variables of religion, resettlement and acculturation, system knowledge, and barriers to preventive dental care; presented under each of the Model's relevant domains.

3.2.1 Predisposing characteristics

Identified themes consistent with Andersen's predisposing characteristics encompass demographic ('age and education compound to predispose oral health help-seeking'), social structure ('social networks are particularly important for predisposing help-seeking'), and health belief variables ('cultural and religious norms inform oral health beliefs, as well as distinct behaviours'). Data analysis identified two additional predisposing characteristics; health behaviours (discussed in the aforementioned theme), and resettlement and acculturation ('resettlement and acculturation influence oral health beliefs and behaviours').

3.2.1.1 Age and education compound to predispose oral health help-seeking

Revealing interactions between demographic and social structure components, the first theme identified age and education to compound, informing participants' predisposition to seek dental help. This theme was only relevant to refugee and asylum seeker data (not mentioned by practitioners). In particular, some participants considered education as essential to their communities' oral health literacy and beliefs:

> Most of the people are with very low or none education background so they don't have much information about health in general, and the same with the teeths, so they don't really care about teeth and this

> stuff because they don't have any knowledge. ([redacted] Afghanistan, Australian citizen, lines 284-286)

Additionally, some participants reported education to compound with age, with younger community members with higher education more capable of accessing dental services:

> The young generations um… well it's easier for them in many different ways first they know English, second they work, they have something in their pockets, … easy for them and they can pursue it they can go after it before the older people. ([redacted] Afghanistan, PR, lines 460-464)

3.2.1.2 Social networks are particularly important for predisposing help-seeking

Many participants cited social networks and support as predisposing oral health help-seeking, particularly by overcoming barriers. For example, language barriers often led to participants' apprehension regarding seeking dental help:

> It's in English and the terms and everything are very new so you don't even know what services do you need and what services are they performing on you like when you first like when you first go to a dentist it's a hard to explain your situation. ([redacted] Afghanistan, PR, lines 286-289)

Multiple participants described strong social networks to mitigate these barriers and encourage help-seeking via translation assistance:

> When I came here I would help a lot of my friends (.) my uh brother and his family and um you know, going with them doing a lot of

> interpretation you know, translate for them. ([redacted] Iran, SHEV, lines 185-186)

Social support encompassing logistical assistance also improved individuals' dental help-seeking:

> If somebody's just new arrival, it's for me happened a couple of times I took the person to the dentist from because I was working volunteer in the charity office, because when they don't know where they are <laugh> you have to take them. (Zaynah, Iran, SHEV, lines 141-143)

Therefore, social networks within Middle Eastern refugee and asylum seeker communities are important predisposing characteristics, in accordance with Andersen's Model's social structure component.

3.2.1.3 Cultural and religious norms inform oral health beliefs, as well as distinct behaviours

Health beliefs constituted a key theme in the predisposing domain and were informed by cultural and religious norms, which in turn affected oral health behaviours and help-seeking. All participants described oral health and caring for their teeth as important:

> Teeths are the part of the body that you need to take care of. You need to take care of the oral health of teeth. So we need to go there and see the dentist just to make sure there is no issue that comes up. So if there is an issue, a small issue maybe so the dentist fix that because it gets bigger. ([redacted] Afghanistan, PR, lines 152-155)

Connections to the Islamic faith also notably contributed to some participants' oral health beliefs, particularly concerning the importance of oral hygiene:

> Our Prophet Mohammad said that we have to care about our oral health … he means the bacteria or the microbes that live in the mouth so yeah like I can remember first gift I receive from my family was toothpaste and one brush. ([redacted] Iran, BV, lines 18-23)

> You need to brush all of your teeth before each prayer … I used to brush my teeth, and during the day just to make this [miswak] because we believe that it's good for health. ([redacted] Syria, PR, lines 92-93)

Furthermore, some participants' norms in their country of origin concerning food contributed to their oral health beliefs:

> I believe in like you know food so if you eat health food you know you have like healthy body and teeth as well … Iran we tend not to have much sugar… when I came here I was shock because so much sugar … sugar was everywhere so I was like 'I've gotta be careful'. ([redacted] Iran, SHEV, lines 5-12)

However, some participants' strong connections to their traditional cultural norms accounted for oral health behaviours *contrary* to their reported beliefs, as discussed by both participant groups in relation to food:

> I just feel bad because I always drink tea with sugar. I feel like, I stop it for two months, but I feel (.) I can't just something (.) make me mood just (.) I need to drink … The tea put stains. So I can't stop drinking tea! It not same just drinking water. ([redacted] Syria, PR, lines 699-702)

> [It is] Very hard um (.) when someone has (.) had to leave their country and then all of a sudden you're telling them like [don't eat sugar] (.) it's like us traveling overseas like when I went overseas for twelve months and I was writing … 'Mum send me vegemite!' you know so really hard (.) um for a displaced person just to (.) food's a comfort and it sort of grounds it to your (.) you, ya know what you're used to how you've grown up so really hard to say … 'don't eat that sugar!'. ([redacted] practitioner, lines 184-189)

Thus, health beliefs were clearly informed by religious and cultural norms from participants' country of origin, in turn impacting their oral health behaviours.

Additionally, both participant groups discussed the availability of oral health resources and services in the Middle East as contributing to oral health beliefs and resulting behaviours in Australia, as the following practitioner suggested:

> A lot of [refugees and asylum seekers] don't come back for regular sort of checks afterwards because that's not within their frame of reference that's not what they're used to. ([redacted] practitioner, lines 647-648)

Notably, some participants from Afghanistan, in particular, had used fewer dental services in Australia compared to those from Syria or Iran (despite positive attitudes towards receiving dental care), and recounted poorer access to oral health resources and services in Afghanistan:

> [In Afghanistan] Just rinsing your mouth, lately just people started brushing their teeth but before there was… you rarely would see brushes around. ([redacted] Afghanistan, Australian citizen, lines 132-133)

> Because we're living in like a countryside [in Afghanistan] we didn't have any dentist over there at all … tha facility are not very okay and provided in countryside … they are people like hairdresser … I went to see hairdresser when (.) while they're doing the shaving my kids' hair, he could take my tooth out. ([redacted] Afghanistan, PR, Lines 359-279).

This theme highlights the complex connections between oral health beliefs in informing participants' help-seeking (determined by religion, culture and country of origin), and distinct oral health behaviours.

3.2.1.4 Resettlement and acculturation influence oral health beliefs and behaviours

An inductively identified theme – additional but relevant as a predisposing characteristic – concerns resettlement influences on participants' oral health. Some discussed changed oral health attitudes, beliefs, practices and help-seeking following familiarity with Australian health norms. Some changes were positive in nature:

> Back in Pakistan or Afghanistan [brushing your teeth] was like not to be honest it was not like an everyday thing…now that I think about it it's kinda gross, but it wasn't to be honest but here when we came it's like uh everybody cleans their teeth twice a day it's important you should do it. ([redacted] Afghanistan, PR, lines 5-8)

However, negative consequences were also revealed by some, especially concerning the easy access and availability of high-sugar foods and resulting dietary changes that also influence dental practices:

> When they come here our Western diet is not healthy and I think that if they have come here and been here for a little while and come to

> see us if I find it's quite progressed. Because they have access to soft drinks and stuff, they probably didn't get back where they were from. So I think that has a huge impact, ah diet. ([redacted] practitioner, lines 215-218)

Together with the previous theme, this highlights the interplay between culture and resettlement on oral health beliefs and behaviours; potentially explained by acculturative mechanisms (e.g., the adoption of new norms associated with resettlement country). Including acculturation as a predisposing characteristic may improve understandings of help-seeking among this population.

3.2.2 Enabling resources

Identified themes revealed key factors enabling or impeding participants' oral health help-seeking; one reflecting Andersen's original Model components ('limited financial and logistical resources prevent oral health help-seeking'), and one new ('participants' knowledge of navigating the health system and government initiatives is essential for help-seeking'), strengthening the Model's conceptualisation of enabling resources in this context.

3.2.2.1 Limited financial and logistical resources prevent oral health help-seeking

While most participants wished to utilise dental services, many were limited by logistical and financial constraints, validating Andersen's personal financial and community enabling resources.

Poor logistical resources disadvantaged participants including [redacted] (Afghanistan, PR), who reported, "the main thing was transport … being like a single mum and then not having access to transport" (lines 219-221). However, logistical assistance via social networks (previously discussed as a predisposing characteristic) was reported to overcome such barriers, emphasising interconnections between the Andersen's Model domains.

Secondly, cost hindered most participants' oral health help-seeking:

> Dentistry and the procedure are really really expensive and we can't afford that … it's really too much for us and that's why I didn't go anywhere to see a dentist. ([redacted] Afghanistan, PR, lines 81-84)

The price of dental treatment was considered unreasonable and a major burden for many participants balancing other priorities:

> I like to yeah for check-up if there is any issue something but (.) the problem … the expenses because um you know, sometimes they have to get x-ray and plus you wanna see the doctor so it become at least 150, 160 [dollars], and I'm a student. ([redacted] Iran, BV, lines 80-83)

Participants revealed that some community members had resorted to seeking dental treatment overseas for affordability:

> A lot of people are making the trip to Iran and Pakistan to get the treatment done for their teeth because they just not capable financially to pay for their treatment. ([redacted] Afghanistan, PR, lines 431-433)

> One of my friend … went to Pakistan a few days ago, he actually got all of his teeth needing replaced … he paid $5000, $6000 for all of the teeth back in Pakistan, where in Australia he was given a cost of one tooth (.) $5000. ([redacted] Afghanistan, PR, lines 439-445)

While most practitioners acknowledged dental cost concerns, some did not believe that cost hindered dental help-seeking for people from the Middle East:

> I think it's [the cost] for everyone more or less the same. I don't think it's more or less difficult. I think if they were in any other country it would be more difficult for them, they're not paying much as they

> come along, most of them are seen not to have any trouble when money is payable as well. ([redacted] practitioner, lines 168-170)

3.2.2.2 Participants' knowledge of navigating the health system and government initiatives is essential for help-seeking

Although not an original component of Andersen's Model, participants' knowledge and understandings of eligibility, availability and means of accessing the healthcare system, dental appointments and government initiatives enabled or inhibited their oral health help-seeking. Firstly, some participants found it difficult to obtain relevant health information upon arrival in Australia, inhibiting their help-seeking:

> When we came to Australia we, actually we haven't got much information about health, even Medicare we…I found it myself … what's the gap is or which services has to pay a gap or which GP is not bulk bill, all (.) I found out myself. Nobody explained it. ([redacted] Syria, PR, lines 155-158)

> A lot of people [in my community] would just think that there's no extra help they'd just maybe maybe pay out of pocket expenses or (.) either choose not to go. ([redacted] Afghanistan, Australian citizen, lines 218-219)

Without sufficient service knowledge, some participants utilised informal networks, including community word-of-mouth, to seek help. However, for others new to Australia without community ties, this was difficult:

> We don't have like anyone to ask (.) and we were like early here (.) our case manager told us we were the first Syrian family to come to Adelaide. ([redacted] Syria, PR, lines 298-299)

Such informal knowledge exchange is facilitated by social networks, reiterating the connections between Andersen's predisposing and enabling factors.

Another reported means of overcoming dental system navigation barriers was using charity assistance. However, many participants were unaware of how to reach charities, and some felt uncomfortable using their services, as [redacted] (Iran, BV) explained, "I don't like to use this sort of assist to be honest yeah I feel bad … I'm taking from someone else" (lines 94-100).

In addition, participants reported confusion over eligibility and enactment of government dental schemes which help to facilitate dental access, resulting in help-seeking barriers:

> He had a a problem like he receive a letter that they offer him a cheque, but like he (.) we we just like don't know that you need to just straight away go, like he went to say I have letter they say 'oh, you are too late'. Oh my god, they destroy it and say 'you need to wait another one year'. ([redacted] lines 637-639)

Relatedly, some participants felt their autonomy was diminished when dental appointments and practitioners were pre-arranged without patient consultation, fueling dissatisfaction and mistrust:

> The second problem is that it is not we that specify the dates and the times of the appointment it's normally the the doctor that specifies the time and date and sometimes when there's a problem they they shift or they move without consulting us so that's a problem. ([redacted] Syria, PR, lines 146-148)

As such, with only temporary formal assistance and without sufficient information dissemination to equip participants' with knowledge to access services independently, many felt helpless:

> When we arrived here we had a case manager and… and he organised all the referral and the all the GPs, x-rays and all the initial test and uh treatment … so it was really good but after six month because that's case manager was just working for six month … I can't find anything myself. ([redacted] Afghanistan, PR, lines 178-192)

Some practitioners corroborated this, attributing poor help-seeking among Middle Eastern refugees and asylum seekers to poor information dissemination and transitioning between public, government-operated services and independent, private service use.

This theme signifies the importance of enabling resources for oral health help-seeking among this population, which interestingly served as facilitators *and* barriers. Participants' personal and family resources, plus additional system knowledge, navigation and autonomy were particularly pertinent.

3.2.3 Need Factors

Identified need-related themes pertained to 'perceived', rather than 'evaluated' need, and pain symptoms largely determined help-seeking. However, many participants also aspired to utilise regular preventive dental services, although reported barriers to acting on such needs. This formed two themes: 'oral pain is the greatest predictor of immediate need and help-seeking', and 'seeking help for preventive care is important, but prevented by other barriers'.

3.2.3.1 Oral pain is the greatest predictor of immediate need and help-seeking

Many participants reported oral pain affecting their oral health practices:

> In morning I'm brushing with toothbrush and toothpaste but in afternoon I'm going to wash because as I said my gums are very very painful and tender just with salty water. ([redacted] Afghanistan, PR, lines 37-38)

> No, I don't [brush my teeth] because it's I've got, my teeth are very painful. ([redacted] Syria, PR, line 14)

Some participants used their personal perceptions of oral pain to determine when to seek professional help, as [redacted] (Afghanistan, PR) relayed, "once we have a tooth ache, at that time we realise we need to go see the dentist" (line 151).

Some practitioners also believed that pain informed refugees' and asylum seekers' help-seeking, with perceived priority for oral treatment proportional to experienced pain:

> I'm sure they've got so much else (.) to deal with, so if they're not in pain it's probably not a big priority for them … But if they are in pain then it's a big priority. ([redacted] practitioner, lines 196-199).

3.2.3.2 Seeking help for preventive care is important, but prevented by other barriers

Some participants reported that barriers (considered 'enabling resources' by Andersen's Model) prevented their aspirations to utilise regular, preventive dental services, suggesting that their true or intended needs were often not actualised, as [redacted] (Iran, BV) explained, "I like to yeah for check-up if there is any issue something but um (.) the problem sometimes time and wel- well the time is excused to be honest but the expenses" (lines 80-81).

Furthermore, some participants felt that only severe pain justified seeking help:

> If you don't have any problem and you want to go there to make the appointment, they don't give you the appointment … if you do have a problem to go and you need to have an appointment with the dentist then you go there then they ask you a lot of questions, what type of pain is that, is it severe pain, does it have bleeding … even to get the emergency appointment is also really difficult". ([redacted] Afghanistan PR, lines 229-237)

3.3 Themes Not Reflected by Andersen's Model

While many identified themes converge with Andersen's Model's predisposing, enabling and need domains, other themes pertained to broader system factors (not reflected by the Model's three population-oriented domains) and the impacts of participants' dental service experiences. These themes are presented below, with implications for Andersen's Model's utility in understanding oral health help-seeking among this population discussed in the final Chapter.

3.3.1 Government resettlement policies interact with the healthcare system to impact help-seeking

External factors related to the healthcare system in conjunction with resettlement policies contributed to participants' oral health help-seeking. Systemic health service issues were compounded by varying visa restrictions and service eligibility, resulting in unequal dental accessibility. These are system-level factors – external to population-level enabling resources – as they relate to policies, systems and service availabilities independent of individuals' understanding or influence.

Resettlement schemes for certain new arrivals (i.e. those accepted directly under the Humanitarian Resettlement Scheme) were a key facilitator for many participants' help-

seeking and dental service use, particularly if schemes included financial subsidy for appointments:

> One of them [a filling of my Mother's] came off like quite a long time ago and the other one is really painful these days and luckily she got this letter from the government it's it's called SA Dental service and they got a she got a voucher for free dental check-up. ([redacted] Afghanistan, PR, lines 66-68)

However, some practitioners suggested that government schemes hinder help-seeking by perpetuating refugees' and asylum seekers' reliance on them for dental access without alternative resources:

> As soon as there is that [government subsidy] is almost a barrier because it makes people dependent, you know like 'oh I can't do it because I don't get enough money from the government'. Now that's obviously not what it's designed to do but it's actually creating barriers and, you know you, you can't get enough subsidy to live but you're not allowed to work. I mean how crazy is that? ([redacted] practitioner, lines 310-314)

Additionally, and importantly, the provision of government-facilitated dental entitlements was reported among both participant groups to vary over time depending on individuals' visa category:

> He's [my brother] been to to the dentist… dentist a few times … but he was sort of able to get everything you know easily for his health and all that so… and also the den- you know, dental treatment so that's why he was able to get that. But now, now he's on a different

> visa so he doesn't go, he doesn't go because it's costly. ([redacted] Iran, SHEV, lines 44-56)

Particular differences were also noted between dental service provision based on participants' country of origin; most notably between patients from Syria compared to other countries:

> I've actually seen down at [removed] when we've been doing a screening (.) the difference that it makes when it- we've seen Syrians and we've done a screening and said 'yep you can go into the hospital and have that done' and their attitude is a positive attitude. The people that don't aren't accepted like that, that come in by other means and are on Bridging Visas. In South Australia they can't go to the hospital. ([redacted] practitioner, lines 265-269)

For participants without government-facilitated assistance, health system complexities further hindered their help-seeking. Referrals were considered by both participant groups to impact dental service accessibility, especially for new arrivals reliant on migration services:

> We need to have a referral for seeing a dentist and GP didn't give me any referral to see a dentist so I can't go just by myself to see a dentist. ([redacted] Afghanistan, PR, 152-154)

> We don't really even have people sort of ringing up it's all by referral … so you know, so yeah if it that (.) if that migrant service wasn't there, that would be a major major problem I would think. ([redacted] practitioner, lines 344-348)

Additionally, many participants reported extensive appointment waiting times as a major dental service barrier:

> When I had the problem with my teeth, with my tooth, I went to a few different places and they all told me that um you have to, you have to wait until your name come up on top of the waiting list. And I was really really in pain, and I cried a few times. ([redacted] Afghanistan, PR, lines 129-131)

3.3.2 Experiences with oral health services influence future help-seeking

Many participants described how direct experiences with dental services in Australia impacted their future help-seeking. Dental experiences differ to Andersen's predisposing, enabling and need domain variables as, rather than existing prior to help-seeking, they are formed by service contact and influence individuals' future predisposition, resources and perceived need for professional dental care.

Many participants reported positive dental experiences in Australia impacting their service-use attitudes, and identified trust and rapport as key, as [redacted] (Iran, SHEV), conveyed, "I think mostly it's how much you trust the person that you go through" (line 117), as well as Hafiza:

> When you come you don't feel like a doctor she very fashion she put music, like music, and she like very active and in, uh her clinic and street like the window you feel … You feel like yeah you enjoy and she talks lots of things. ([redacted] Syria, PR, lines 516-519)

However, dissatisfaction was greatly impactful, as reported by some participants following dental procedures conducted by student dentists whom they regarded as inexperienced and technically untrustworthy:

> A lot of dentists were students practicing so I have had friends and (.) they're complain a bit that they're not good enough yet to <laughs>

> (.) that… scared and hesitant to go to public services because of that reason. ([redacted] Afghanistan, Australian citizen, lines 333-335)

Furthermore, some participants who saw dentists in Australia expressed concerns that seeking dental assistance will result in the removal of their teeth, rather than restoration:

> I was crying I say 'I'm only 28 and you gonna take all the tooth' and I was crying and they say 'OK, we gonna fix it'. Oh my god, if I don't cry they gonna take them all out … I don't like thing when they say that every like the very fastest solution is to take it out". ([redacted] Syria, PR, lines 673-680)

Some practitioners corroborated the belief that teeth may be extracted, attributing this to restrictions of the Australian healthcare system to provide affordable care:

> [There are] a number [of dentists] who won't take them on they might do an emergency treatment they might do an extraction but they won't do any more. ([redacted] practitioner, lines 386-391)

Conversely, other practitioners attributed such beliefs and subsequent treatment expectations to peoples' experiences of dental treatment in the Middle East:

> I don't think it's more common to have them extracted here … that might be their perception … what they're used to is their dentist would not put any demands on them. Their dentist would just say 'OK I'll do it, it'll cost you this much'. ([redacted] practitioner, lines 156-164)

> Depends where they've come from as to what sort of what past treatment they've had so like we could see someone from Afghanistan that has actually never had dental and then you might see someone

> from Iran who's had a myriad of dental treatment even implants and stuff like that so you might think that they're really close but the there's a big difference ... in services (.) dental services and stuff (.) so and then what their expectations are. ([redacted] practitioner, lines 73-78).

Some participants validated this notion, where their experiences in their home countries constructed their dental service expectancies in Australia:

> I'm sorry, but I have to tell the truth (.) in comparison to the services that we that we had in Syria (.) the doctors there seem to be much more confident … I'm so surprised, [Australia] is much more advanced than than Syria but I don't know why the doctors in Syria are more skilled so (.) what can the government do I I I'm not sure what they can do in this relation to make them more skilled … What we found here is that mostly they just prescribe Panadol (.) and but but there are things that we believe needs more than Panadol. ([redacted] Syria, PR, lines 356-368).

Although [redacted] in the quote above, compares Australian services unfavourably to those in Syria, other participants felt the opposite; that Australia offered better quality services.

This theme highlights how participants' direct experiences with (and appraisals of) dental services in Australia influence their *subsequen*t help-seeking, as well as connections between their dental experiences prior to resettlement in determining service norms, expectations and appraisals post-resettlement. This suggests a reciprocal relationship between service experiences and Andersen's Model's predisposing characteristics.

CHAPTER FOUR: DISCUSSION

4.1 Theme Overview and Application to Andersen's Model

In general, identified themes provide support for Andersen's Model in understanding Middle Eastern refugees' and asylum seekers' oral health help-seeking, although identification of independent themes suggests Model revisions are required.

4.1.1 Predisposing characteristics

Some predisposing variables as described by Andersen's Model were important for explaining participants' predisposition to seek help, while others appeared less so. These variables were observed to interconnect in complex ways, warranting further consideration.

The theme 'age and education compound to predispose oral health help-seeking' concurs with studies attributing refugee families' positive oral health practices, outcomes and service use patterns to their higher education and younger age (Nicol et al., 2014; Reza et al., 2016). Oral health help-seeking may be best conceptualised by their combination rather than traditional separation by demographic and social structure components. Interestingly, no noticeable differences by gender were reported; similarly the case in a Norwegian mixed-methods study of Middle Eastern and African refugees' oral health (Høyvik et al., 2018). Social networks were identified to predispose and *facilitate* participants' help-seeking. This warrants further research as past studies have primarily recognised poor social support as a barrier to dental care for migrants in Germany and child refugees globally (Brzoska et al., 2017, Riggs et al., 2017).

The theme 'cultural and religious norms inform oral health beliefs, as well as distinct behaviours' converges with Andersen's (1968; 1995) contention that health beliefs and culture are impactful to health service use. Islamic religious connections were a newly identified consideration; possibly unique to the Middle Eastern populations considered in this research. The identified complexities of health beliefs concur with Andersen's (1968) and

Baker's (2009) contention that they can predict, and be predicted by, enabling or need factors. Also reflective of participants' cultural backgrounds, oral health *behaviours* were distinct from beliefs and at times contradictory; supporting Australian research exploring Middle Eastern parents' perceptions of causes and prevention of children's dental caries (Riggs et al., 2015). Dental service norms and contact in participants' original countries also accounted for subsequent behaviours, as reported in a study regarding dental outcomes among refugee families in Australia (Nicol et al., 2014). Pre-migration dental norms were particularly pertinent in explaining Afghani refugees' help-seeking behaviours post-resettlement, as purported by other Australian studies (Cheng et al., 2015; Lamb et al., 2009).

Resettlement and acculturation, following exposure to Australian social norms, also impacted participants' oral health beliefs and behaviours, representing a novel addition to Andersen's Model not previously discussed. Highlighting acculturation's predisposing effects, and reflecting prior refugee and migrant-focused research, acculturative mechanisms promoted help-seeking through informing positive oral health beliefs and outcomes (Gao & McGrath, 2011; Mariño et al., 2001; Nicol et al., 2014; Riggs et al., 2015). However, acculturative mechanisms also encouraged higher sugar intake linked to negative outcomes including dental decay, as consistent with international refugee studies (Geltman et al., 2013; Riggs et al., 2017). Despite diverse measures of acculturation, these findings emphasised the psychological influences of acculturation, which also explained dental service use, outcomes and knowledge among Vietnamese migrants in Melbourne (Marino et al., 2001).

Another consideration from these results is that the simplistic categorisation of 'predisposing characteristics' may not explain the complexities of refugees' and asylum seekers' cultural backgrounds underpinning their oral health beliefs, behaviours, and help-seeking. As Koehn, Neysmith, Kobayashi and Khamisa (2013) argue, defining culture simply by norms into which a person is born may conceal more salient health behaviour

determinants; particularly among this population with complex pre-, during- and post-migration backgrounds. Following exposure to volatile health climates and displacement, some participants (particularly from Afghanistan) had lived in alternative countries to their origin for years prior to Australian resettlement. As suggested in section 3.2.1.3, pre-migration experiences may impact refugees' engagement with healthcare services (Cheng et al., 2015; Lamb et al., 2009; Riggs et al., 2015). Applying an intersectional lens (Crenshaw, 1989) may improve understandings of intersecting factors (country of origin, culture, migration pathways, age and education); a framework increasingly used in psychology to addresses social inequalities from social category memberships (Cole, 2009). Intersectionality may complement Andersen's Model in building more nuanced understandings of defining help-seeking attributes (traditionally 'predisposing characteristics'), and suggests the need for a tailored approach to this population.

4.1.2 Enabling resources

Factors considered 'enabling resources' (Andersen, 1968) were most frequently reported; often overshadowing predisposing and need variables to inhibit, rather than enable, help-seeking. However, interconnections with predisposing characteristics variables of social networks were also revealed to mitigate resource barriers. Firstly, limited financial (personal) and logistical (community) resources hindered service use despite participants' intentions. Similar barriers were identified among Syrian refugees in Jordan (Ay et al., 2016), and refugees in Australia (Davidson et al., 2007; Lamb & Smith, 2002). This supports Andersen's principle that enabling resources are essential for service use regardless of individuals' predisposition to seek care (Andersen, 1968; 1995, see also Baker, 2009; Drummond et al., 2011).

The second theme ('participants' knowledge of navigating the health system and government initiatives is essential for help-seeking') revealed the importance of knowledge

in enabling independent help-seeking among new arrivals from the Middle East. Although not part of Andersen's original Model, this theme pertains to enabling resources as insufficient knowledge prompted participants' informal or failed help-seeking, corroborated by Nicol et al. (2014) among refugee families in Australia. Also in Australia, oral (Riggs et al., 2015) and primary (Cheng et al., 2015) health information was poorly received by Middle Eastern refugees and migrants, reiterating the need for improved information dissemination. Although charity services may assist refugees' and asylum seekers' dental service access, deeper issues facilitating transitions between public and private sectors remain problematic. Participants' confusion and frustrations regarding eligibility, inflexibility, and diminished autonomy also positioned government initiatives (which are often relied upon) as barriers. Similarly, scant consideration of other refugees' resettlement priorities (e.g. organising housing) in Australia reduced dental service use (Nicol et al., 2014). Previous applications of Andersen's Model among different populations also reported autonomy to determine oral and other health practices and service use (Bradley et al., 2002; Adair et al., 2004; Andersen, 1995). Participants' disempowerment highlighted how essential system knowledge is for enabling oral health help-seeking among Middle Eastern refugees and asylum seekers; positioning it as an enabling resource.

4.1.3 Need factors

Andersen's 'perceived' rather than 'evaluated' need was reflective of participants' help-seeking, although less explanatory than predisposing and enabling variables. This validates Andersen's (1968) argument that need is less essential for dental utilisation. Pain was the greatest predictor of participants' oral health help-seeking, consistent with findings among other ethnically diverse groups (Davidson & Andersen, 1997; Xu et al., 2018). Tendencies to solely consider pain to warrant help-seeking may be attributable to cultural norms (a predisposing characteristic). Afghani Hazara refugees in Australia were reported to

seek dental treatment only for severe oral symptoms (Lamb et al., 2009), as well as Middle Eastern and African refugees in Norway (Høyvik et al., 2018). However, the theme 'seeking help for preventive care is important, but prevented by other barriers' revealed participants' difficulties obtaining regular appointments in the overloaded healthcare system despite intentions to do so; rarely discussed in the literature. However, studies in other resettlement countries have also reported Middle Eastern refugees' service use patterns do not reflect their actual needs (Høyvik et al., 2018; Davidson et al., 2007; Ay et al., 2016). Riggs et al. (2015) accredited low preventive dental use among Middle Eastern refugees and migrants to poor awareness of the imperative of oral health. However, all participants in this study regarded oral health as important. Practitioner participants also assumed that Middle Eastern people did not consider oral health important, representing a divergence between the two participant groups. Warren et al. (2009) determined that similar professional opinions discouraged service use among African women in the US, emphasising the importance of understanding true-help seeking intentions (and need) among this population to ensure positive outcomes.

4.1.4 Help-Seeking Determinants Not Reflected by Andersen's Model

While the aforementioned themes validated components of Andersen's Model for application to Middle Eastern refugees and asylum seekers' oral health – particularly regarding predisposing and enabling factors – other identified themes did not fit Andersen's original Model. Their inclusion may strengthen the Model's future utility.

The theme, 'government resettlement policies interact with the healthcare system to impact help-seeking' revealed visa categorisation and dental service eligibility impacted participant's perceived ability to access dental services in combination with overarching system complexities. Other Australian research has cited visa categories and eligibility criteria for health provisions as disadvantaging refugees (Lamb & Smith, 2002; Davidson et al., 2007), concurring with this study that participants were disadvantaged regardless of their

predisposition or resources to seek dental help. Long waiting times are known to impede refugees' oral health services use (Ay et al., 2016; Davidson et al., 2007; Nicol et al., 2014), and further research is required regarding other systemic barriers to dental help-seeking which impacted participants' personal resources to reach services; as suggested by studies of migrants in Germany (Brzoska, Erdsiek, & Waury, 2017) and Afghani refugees in Australia (Cheng et al., 2015).

The second theme, 'experiences with oral health services influence future help-seeking', explains disparities in participants' help-seeking where dental service appraisal influenced their future help-seeking attitudes. Positive encounters with clinic staff, clear and consistent appointment times, and paperwork and interpreter assistance are known to improve refugees' dental satisfaction in Australia (Nicol et al., 2014). This study highlighted the positive impacts on participants' future help-seeking from patient-practitioner rapport, as well as negative impacts following tooth extraction and treatment by student dentists. Few studies have investigated this situation, although Lamb and colleagues (2009) contended stress (and trauma) impacts refugees' dental service use. Extraction stresses may result in dissatisfaction, service mistrust and help-seeking aversion. Moreover, participants from Syria and Iran (compared to Afghanistan) held higher service expectations which determined their satisfaction with Australian services, suggesting that predisposing characteristics (culture and country of origin) may account for some disparities. Likewise, Høyvik and colleagues (2018) found that oral health satisfaction differed between refugees from the Middle East and Africa. This may account for some practitioners' perceptions of greater service expectations among Middle Eastern patients. Treatment demands are challenging for practitioners working in an overloaded dental system, which Lamb and Smith (2002) suggested may act as a disincentive to practitioners to provide specialised care to refugees without adequate reimbursement, which in turn impacts help-seeking experiences and subsequent behaviour.

4.2 A Revised Andersen's Model

The aforementioned themes suggest revisions to Andersen's Model for understanding oral health help-seeking among Middle Eastern refugees and asylum seekers and to facilitate best-practice dental care and access. Based on these results, figure 4 presents a revised version of Andersen's Model for application to this specific population.

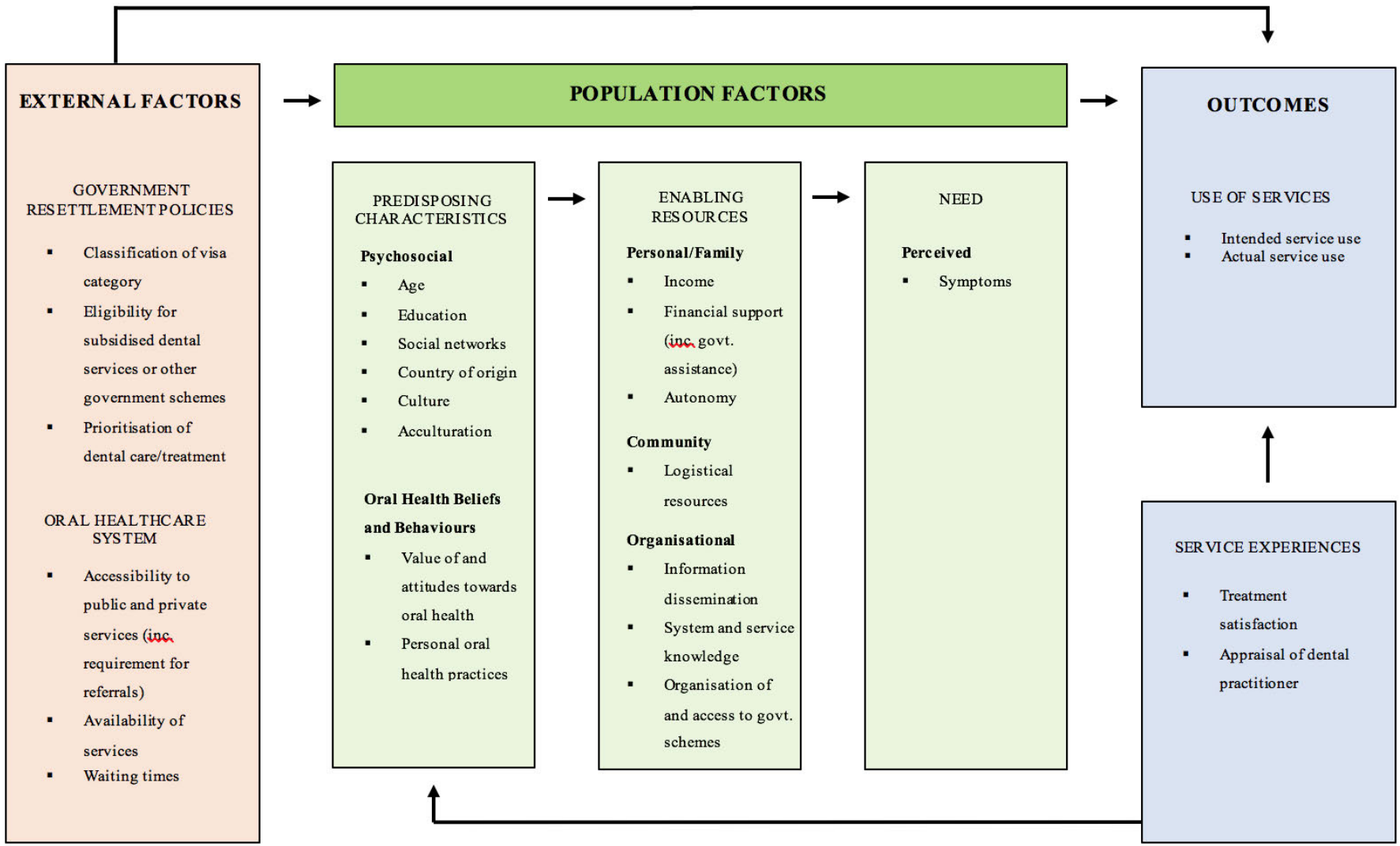

Figure 4: A revised version of Andersen's Model for understanding oral health help-seeking

Consistent with suggestions by Andersen (1995), Andersen and Davidson (1997) and Valente and Vettore (2017), predisposing, enabling and need components are represented under a 'population' domain. Determinants attributed to external policies and systemic factors (discussed as themes new to Andersen's Model) are placed in a prior domain as 'external factors'. The outcome domain is expanded to include dental service use and experiences (as discussed as a theme new to the Model). Feedback loops, suggested by Andersen (1995) and Phillips et al. (1998), explain complex interactions between Model components. The following sections discuss these revisions to Andersen's Model and set precedence for its future application to this research area.

4.2.1 External Factors

Andersen (1995) and Davidson and Andersen (1997) previously suggested including environmental factors for utility among different populations by considering external environmental impacts on individuals' predisposition to seek care, the resources available to them and their resulting need. In this study, the oral healthcare system and government resettlement policies were salient determinants of oral health help-seeking, with potential impacts on subsequent population components, or directly on service use outcomes.

Previous recommendations for Andersen's Model suggested system factors may include healthcare policies, resources, organisation and finance (Andersen, 1995; Davidson & Andersen, 1997; Phillips et al., 1998; Valente & Vettore, 2017). In this study, anticipation of system-related difficulties (including dental appointment organisation and availability, reliance on referrals and waiting times) prevented participants' help-seeking.

Visa status categorisation and eligibility for subsidised dental services determined by government resettlement policies also determined participants' dental service access and explained marked differences in help-seeking behaviours. Limited literature has explored

these impacts on refugee' and asylum seekers' oral health outcomes; highlighting a need for further exploration.

4.2.2 Population factors: predisposing characteristics

In this study, the significance of predisposing characteristics concurred with Andersen's original Models (1968; 1995), where age, education, social networks, ethnicity, culture and health beliefs determined participants' predisposition to seek dental care. Demographic and social structure variables are recommended to be grouped as a combined psychosocial sub-component to better explain their interactive influences on help-seeking. Additions of acculturation as a psychosocial variable, and health behaviours alongside beliefs are also recommended. Health behaviours were previously recommended for consideration in Andersen's Model as a separate component incorporating service use (Andersen, 1995; Andersen & Davidson, 1997; Baker, 2009; Valente & Vettore), 2017. Here, behaviours are included with beliefs as they were often intertwined and difficult to separate due to complex interactions between country of origin, culture, and religion.

4.2.3 Population factors: enabling resources

Enabling resources especially influenced participants' oral health help-seeking behaviours, and more so as barriers rather than facilitators. Factors considered personal or family (finance) and community resources (logistics) were particularly impactful, affirming their use in this Model domain. Additions of autonomy and organisational factors are included in this revised Andersen's Model, as previously recommended by Andersen (1995) and Bradley et al. (2002). The results of this study position autonomy as a personal enabling resource (by impacting participants' perceived resources to seek help) and system and service knowledge, information dissemination and access to government schemes as organisational enabling resources.

4.2.4 Population factors: need factors

Perceived need was of greater importance than evaluated need (requiring clinician assessment of oral issues which was often not applicable to participants) in explaining Middle Eastern participants' true help-seeking intentions and behaviours (although often disputed by practitioners' assumptions). This is consistent with Baker's (2009) findings regarding general health in the UK. As such, perceived need remains the sole need variable.

4.2.5 Outcomes

This expansion of Andersen's Model includes two outcome components within its domain: dental service use (intended and actual), as well as a separate but related 'service experiences' component.

Separation of dental service use by intended and actual contact reflects participants' regular dental contact intentions, and prevention by systemic barriers. This separation corroborates with Bradley et al. (2002), who also separated the two.

Service experiences include treatment satisfaction and appraisal of dental practitioners as outcomes influencing future help-seeking behaviours, particularly following patient dissatisfaction. Other researchers advocated the importance of service experiences for predisposing future service use and explaining help-seeking variance (Andersen, 1995; Andersen & Davidson, 1997; Valente & Vettore, 2017; Phillips et al., 1998). In this revised Model, service experiences can be conceptualised as an independent outcome variable, or interconnected with service use, as service experiences may be informed by service use (and vice versa). A feedback loop also represents the potential for service experiences to predispose future health beliefs and behaviours, and in turn, help-seeking.

4.2.6 Summary

This version of Andersen's Model for understanding oral health help-seeking among Middle Eastern refugees and asylum seekers mostly mirrors the structure of Andersen's

(1995) emerging model, validating more recent research concerning the Model while also suggesting additional complexities. To further test this more complex model for understanding oral health help-seeking among refugees and asylum seekers (and diverse sub-populations), large, quantitative studies are required (Andersen, 1995; Bradley et al., 2002). This study lays the foundations for such research and holds a number of strengths.

4.3 Strengths and Limitations

Employing qualitative research methods provided the opportunity to research deeper understandings of help-seeking and the lived experiences of refugees and asylum seekers from the Middle East. Use of interpreters encouraged participants' inclusion from diverse backgrounds and English proficiencies; providing people with a voice who otherwise may not be included in research, although admittedly, their use may also bias results without achievable means of measuring translation accuracy given resource constraints. Additionally, triangulation through the inclusion of health practitioners' perspectives (although recruited from only two organisations) alongside refugees and asylum seekers increased the credibility of the results by understanding help-seeking realities from contrasting perspectives. These insights may help to strengthen future cross-cultural and patient-provider understandings.

Moreover, qualitative methods enabled exploration of Andersen's Model to determine *which* variables were of importance for oral health help-seeking, which variables overcome such challenges, and which are of greatest relevance for future studies among this particular population; both validating Andersen's original Model and providing new insights into this under-researched area.

A key limitation, however, related to potential bias in the sample (e.g., while interpreters may have assisted some vulnerable community members to participate, the most vulnerable may not have access to the services through which participants were recruited). As such, the sample may represent people with particular oral health interests and resources.

Ethical constraints also prevented exploration of possible trauma experiences impacting participants' oral health help-seeking, as alluded to in the literature, and may be an important consideration in future applications of Andersen's Model among this population.

Finally, focus on both refugees and asylum seekers from different Middle Eastern countries allowed consideration of intersecting notions of country of origin, culture, religion, and immigration and visa status not reported elsewhere. However, given the specificity of some issues noted (e.g., norms related to food and religion, and differing pre- and post-migration and resettlement experiences) the proposed Model may need tailored modification for participants or populations from other areas of the world.

4.4 Implications

This study addresses the literature gap regarding oral health help-seeking among Middle Eastern refugees and asylum seekers and provides understandings of their oral health beliefs, service use norms, and barriers and facilitators to their help-seeking. It also highlights the need for continual revision of Andersen's Model to explain oral health help-seeking within this diverse and changing population. These findings lay the foundations for future quantitative studies (longitudinally designed to explore interrelations between variables and acculturative changes over time), and may assist to inform policy and program-planning impacting Middle Eastern communities, the Australian oral healthcare system and dental service providers.

4.5 Conclusions

While previous studies have identified refugees as disadvantaged regarding oral health outcomes and service access, this study contributes to a significant literature gap in understanding oral health help-seeking among Middle Eastern refugees and asylum seekers in Australia, both from their perspectives and those of dental practitioners. Application of Andersen's Model provided a robust, theoretical framework to conceptualise help-seeking

determinants otherwise potentially overlooked through other analytical methods. Thematic analysis importantly highlighted that while most participants desired to use dental services, various barriers at individual- and systemic-levels prevented their help-seeking. Andersen's Model was helpful in understanding the importance of enabling resources in particular for determining help-seeking. However, additional considerations of health and resettlement policy, service experiences, and cultural and migration impacts on help-seeking are recommended. A tailored approach to understanding refugees' and asylum seekers' oral health help-seeking (including among specific sub-populations and individuals) is ultimately required, which necessitates further exploration through quantitative studies. This study contributes to identifying which help-seeking determinants are important for future analysis, from the perspectives of refugees and asylum seekers themselves.

References

Adair, P. M., Pine, C. M., Burnside, G., Nicoll, A. D., Gillett, A., Anwar, S., ... & Ferro, R. (2004). Familial and cultural perceptions and beliefs of oral hygiene and dietary practices among ethnically and socio-economically diverse groups. *Community dental health*, *21*(1 Suppl), 102-111.

Al-Harthi, L. S., Cullinan, M. P., Leichter, J. W., & Thomson, W. M. (2013). The impact of periodontitis on oral health-related quality of life: a review of the evidence from observational studies. *Australian dental journal*, *58*(3), 274-277. doi: 10.1111/adj.12076

Andersen, R. (1968). A behavioral model of families' use of health services. *A behavioral model of families' use of health services.* Chicago: Center for Health and Administration Studies.

Andersen, R. M., & Davidson, P. L. (1997). Ethnicity, aging, and oral health outcomes: a conceptual framework. *Advances in Dental Research*, *11*(2), 203-209. doi: 10.1177/08959374970110020201

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society*, 95-124. doi: 10.2307/3349613

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter?. *Journal of health and social behavior*, 1-10. doi: 10.2307/2137284

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative research*, *1*(3), 385-405. doi: 10.1177/146879410100100307

Australian Bureau of Statistics, (2017). *2071.0 – Census of Population and Housing: Reflecting Australia – Stories from the Census*, 2016, Canberra, Australia.

Ay, M., Arcos González, P., & Castro Delgado, R. (2016). The perceived barriers of access to health care among a group of non-camp Syrian refugees in Jordan. *International Journal of Health Services*, *46*(3), 566-589. doi: 10.1177/0020731416636831

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine*, *9*. doi: 10.3205/psm000089

Baker, S. R. (2009). Applying Andersen's behavioural model to oral health: what are the contextual factors shaping perceived oral health outcomes?. *Community Dentistry and Oral Epidemiology*, *37*(6), 485-494. doi: 10.1111/j.1600-0528.2009.00495

Bennadi, D., & Reddy, C. V. K. (2013). Oral health related quality of life. *Journal of International Society of Preventive & Community Dentistry*, *3*(1), 1. doi: 10.4103/2231-0762.115700

Berry, J. W. (1992). Acculturation and adaptation in a new society. *International migration*, 30, 69-85. doi: 10.1111/j.1468-2435.1992.tb00776

Bradley, E. H., McGraw, S. A., Curry, L., Buckser, A., King, K. L., Kasl, S. V., & Andersen, R. (2002). Expanding the Andersen model: the role of psychosocial factors in long-term care use. *Health services research*, *37*(5), 1221-1242. doi: 10.1111/1475-6773.01053

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Bronfenbrenner, U. 1986. "Ecology of the Family as a Context for Human Development: Research Perspectives." Developmental Psychology 22 (6): 723–742. doi:10.1037/0012-1649.22.6.723.

Brzoska, P., Erdsiek, F., & Waury, D. (2017). Enabling and predisposing factors for the utilization of preventive dental health care in migrants and non-migrants in Germany. *Frontiers in public health*, 5, 201. doi: 10.3389/fpubh.2017.00201

Buset, S. L., Walter, C., Friedmann, A., Weiger, R., Borgnakke, W. S., & Zitzmann, N. U. (2016). Are periodontal diseases really silent? A systematic review of their effect on quality of life. *Journal of clinical periodontology*, *43*(4), 333-344. doi: 10.1111/jcpe.12517

Cheng, I. H., Wahidi, S., Vasi, S., & Samuel, S. (2015). Importance of community engagement in primary health care: the case of Afghan refugees. *Australian journal of primary health*, *21*(3), 262-267. doi: 10.1071/PY13137

Council of Australian Governments (COAG) Health Council. (2015). *Healthy mouths healthy lives: Australia's national oral health plan 2015-2024.* Retrieved from http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/81/Australias-National-Oral-Health-Plan-2015-2024

Cole, E. R. (2009). Intersectionality and research in psychology. *American psychologist*, *64*(3), 170. doi: 10.1037/a0014564

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U. Chi. Legal F.*, 139.

Davidson, P. L., & Andersen, R. M. (1997). Determinants of dental care utilization for diverse ethnic and age groups. *Advances in Dental Research*, *11*(2), 254-262. doi: 10.1177/08959374970110020801

Davidson, N., Skull, S., Chaney, G., Frydenberg, A., Isaacs, D., Kelly, P., ... & Smith, M. (2004). Comprehensive health assessment for newly arrived refugee children in Australia. *Journal of paediatrics and child health*, *40*(9-10), 562-568. doi: 10.1111/j.1440-1754.2004.00465

Davidson, N., Skull, S., Calache, H., Murray, S., & Chalmers, J. (2006). Holes a plenty: oral health status a major issue for newly arrived refugees in Australia. *Australian dental journal*, *51*(4), 306-311. doi: 10.1111/j.1834-7819.2006.tb00448

Davidson, N., Skull, S., Calache, H., Chesters, D., & Chalmers, J. (2007). Equitable access to dental care for an at‐risk group: a review of services for Australian refugees. Australian and New Zealand journal of public health, 31(1), 73-80. doi: 10.1111/j.1753-6405.2007.00014

De Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation. *Australian Psychologist*, *45*(1), 29-37. doi: 10.1080/00050060903262387

Department of Health, Australian Government. (2012). *Appendix D – Adult Dental Services Provided by the States and Territories.* Retrieved from http://www.health.gov.au/internet/publications/publishing.nsf/Content/report_nacdh~report_nacdh_app~report_nacdh_appd

Department of Health, Australian Government. (2014). *Health assessment for refugees and other humanitarian entrants to Australia.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees_qanda

Department of Home Affairs, Australian Government. (2016). *Fact sheet – Australia's*

refugee and humanitarian program. Retrieved from https://www.homeaffairs.gov.au/about/corporate/information/fact-sheets/60refugee#e

Department of Home Affairs, Australian Government. (2018). *Health examinations.* Retrieved from https://www.homeaffairs.gov.au/Trav/Visa/Heal/meeting-the-health-requirement/health-examinations

Department of Social Services, Australian Government. (2018). *Syrian/Iraqi Humanitarian Crisis,* Department of Social Services. Retrieved https://www.dss.gov.au/settlement-and-multicultural-affairs-programs-policy/syrian-iraqi-humanitarian-crisis#whatisaustralidoing

Desmet, K., Ortuño-Ortín, I., & Wacziarg, R. (2017). Culture, ethnicity, and diversity. *American Economic Review*, *107*(9), 2479-2513. doi: 10.1257/aer.20150243

Drummond, P. D., Mizan, A., Brocx, K., & Wright, B. (2011). Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care for Women International*, *32*(3), 206-224. doi: 10.1080/07399332.2010.529216

Gao, X. L., & McGrath, C. (2011). A review on the oral health impacts of acculturation. *Journal of immigrant and minority health*, *13*(2), 202-213. doi: 10.1007/s10903-010-9414-9

Geltman, P. L., Adams, J. H., Cochran, J., Doros, G., Rybin, D., Henshaw, M., ... & Paasche-

Orlow, M. (2013). The impact of functional health literacy and acculturation on the oral health status of Somali refugees living in Massachusetts. *American journal of public health*, *103*(8), 1516-1523. doi: 10.2105/AJPH.2012.300885

Gerritsen, A. E., Allen, P. F., Witter, D. J., Bronkhorst, E. M., & Creugers, N. H. (2010). Tooth loss and oral health-related quality of life: a systematic review and meta-analysis. *Health and quality of life outcomes*, *8*(1), 126. doi: 10.1186/1477-7525-8-126

Ghiabi, E., Matthews, D. C., & Brillant, M. S. (2014). The oral health status of recent immigrants and refugees in Nova Scotia, Canada. *Journal of immigrant and minority health*, *16*(1), 95-101. doi: 10.1007/s10903-013-9785-9

Gibbs, L., Waters, E., De Silva, A., Riggs, E., Moore, L., Armit, C., ... & Young, D. (2014). An exploratory trial implementing a community-based child oral health promotion intervention for Australian families from refugee and migrant backgrounds: a protocol paper for Teeth Tales. *BMJ open*, *4*(3), e004260. doi: 10.1136/bmjopen-2013-004260

Gibbs, L., Waters, E., Christian, B., Gold, L., Young, D., de Silva, A., ... & Tadic, M. (2015). Teeth Tales: a community-based child oral health promotion trial with migrant families in Australia. *BMJ open*, *5*(6), e007321. doi: 10.1136/bmjopen-2014-007321

Gourash, N. (1978). Help-seeking: A review of the literature. *American journal of community psychology*, *6*(5), 413-423. doi: 10.1007/BF00941418

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, *10*(1), 113. doi: 10.1186/1471-244X-10-113

Hoover, J., Vatanparast, H., & Uswak, G. (2017). Risk Determinants of Dental Caries and Oral Hygiene Status in 3–15 Year-Old Recent Immigrant and Refugee Children in Saskatchewan, Canada: A Pilot Study. *Journal of immigrant and minority health*, *19*(6), 1315-1321. doi: 10.1007/s10903-016-0452-9

Høyvik, A. C., Lie, B., Grjibovski, A. M., & Willumsen, T. (2018). Oral Health Challenges in Refugees from the Middle East and Africa: A Comparative Study. *Journal of immigrant and minority health*, 1-8. doi: 10.1007/s10903-018-0781-y

Kiang, K., & Paxton, G. (2017). *Syrian Refugees – key issues.* Retrieved from Immigrant Health Service, The Royal Children's Hospital Melbourne website: https://www.rch.org.au/immigranthealth/clinical/syrian-refugees/

Joshi, C., Russell, G., Cheng, I. H., Kay, M., Pottie, K., Alston, M., ... & Wahidi, S. S. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *International journal for equity in health*, *12*(1), 88. doi: 10.1186/1475-9276-12-88

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of

knowledge using an intersectionality lens: results of a scoping review on the health and health care of ethnocultural minority older adults. *Ageing & Society*, *33*(3), 437-464. doi: 10.1017/S0144686X12000013

Lamb, C. F., & Smith, M. (2002). Problems refugees face when accessing health services. *New South Wales public health bulletin*, *13*(7), 161-163. doi: 10.1071/NB02065

Lamb, C. E. F., Michaels, C., & Whelan, A. K. (2009). Refugees and oral health: lessons learned from stories of Hazara refugees. *Australian Health Review*, *33*(4), 618-627. doi: 10.1071/AH090618

Mariño, R., Stuart, G. W., Wright, F. A., Minas, I. H., & Klimidis, S. (2001). Acculturation and dental health among Vietnamese living in Melbourne, Australia. *Community dentistry and oral epidemiology*, *29*(2), 107-119. doi: 10.1111/j.1600-0528.2001.290205.x

Mariño, R., Schofield, M., Wright, C., Calache, H., & Minichiello, V. (2008). Self-reported and clinically determined oral health status predictors for quality of life in dentate older migrant adults. *Community dentistry and oral epidemiology*, *36*(1), 85-94. doi: 10.1111/j.1600-0528.2001.290205.x

Nicol, P., Al-Hanbali, A., King, N., Slack-Smith, L., & Cherian, S. (2014). Informing a culturally appropriate approach to oral health and dental care for pre-school refugee children: a community participatory study. *BMC Oral Health*, *14*(1), 69. doi: 10.1186/1472-6831-14-69

Nicol, P., Anthonappa, R., King, N., Slack-Smith, L., Cirillo, G., & Cherian, S. (2015). Caries burden and efficacy of a referral pathway in a cohort of preschool refugee children. *Australian dental journal*, *60*(1), 73-79. doi: 10.1111/adj.12269

Pani, S. C., Al-Sibai, S. A., Rao, A. S., Kazimoglu, S. N., & Mosadomi, H. A. (2017). Parental perception of oral health-related quality of life of Syrian refugee children. *Journal of International Society of Preventive & Community Dentistry*, *7*(4), 191. doi: 10.4103/jispcd.JISPCD_212_17

Phillips, K. A., Morrison, K. R., Andersen, R., & Aday, L. A. (1998). Understanding the context of healthcare utilization: assessing environmental and provider-related variables in the behavioral model of utilization. *Health services research*, *33*(3 Pt 1), 571. doi:

Primary Health Network Adelaide (2017). *Primary health care service access for refugees and new arrivals consultation and workshop summary report*. Retrieved from http://adelaidephn.com.au/assets/Refugee_and_New_Arrivals_Workshop_Summary_Report_March_2017_Final.pdf

Quach, A., Laemmle-Ruff, I. L., Polizzi, T., & Paxton, G. A. (2015). Gaps in smiles and services: a cross-sectional study of dental caries in refugee-background children. *BMC oral health*, *15*(1), 10. doi: 10.1186/1472-6831-15-10

Quandt, S. A., Hiott, A. E., Grzywacz, J. G., Davis, S. W., & Arcury, T. A. (2007). Oral health

and quality of life of migrant and seasonal farmworkers in North Carolina. *Journal of agricultural safety and health*, *13*(1), 45-55. doi: 10.13031/2013.22311

Refugee Council of Australia. (2018). *Statistics on people seeking asylum in the community.* Retrieved from https://www.refugeecouncil.org.au/getfacts/statistics/aust/asylum-community/

Renzaho, A.M.N., & Dhingra, N. (2017). *Addressing the needs of Syrian and Iraqi refugees in the Nepean Blue Mountains region: A formative assessment of health and community service needs*. Retrieved from Wentworth Healthcare Limited: https://www.nbmphn.com.au/Resources/About/169_0517-Refugee-Report_F_WEB.aspx>

Reza, M., Amin, M. S., Sgro, A., Abdelaziz, A., Ito, D., Main, P., & Azarpazhooh, A. (2016). Oral health status of immigrant and refugee children in North America: a scoping review. *J Can Dent Assoc*, *82*(g3), 1488-2159.

Riggs, E., van Gemert, C., Gussy, M., Waters, E., & Kilpatrick, N. (2012). Reflections on cultural diversity in oral health promotion and prevention. *Global health promotion*, *19*(1), 60-63. doi: 10.1177/1757975911429872

Riggs, E., Gibbs, L., Kilpatrick, N., Gussy, M., van Gemert, C., Ali, S., & Waters, E. (2015). Breaking down the barriers: a qualitative study to understand child oral health in refugee and migrant communities in Australia. *Ethnicity & health*, *20*(3), 241-257. doi: 10.1080/13557858.2014.907391

Riggs, E., Rajan, S., Casey, S., & Kilpatrick, N. (2017). Refugee child oral health. *Oral diseases*, *23*(3), 292-299. doi: 10.1111/odi.12530

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative inquiry*, *16*(10), 837-851. doi: 10.1177/1077800410383121

UNHCR. (2018). *Figures at a glance: statistical yearbooks.* Retrieved from http://www.unhcr.org/en-au/figures-at-a-glance.html

Valente, M. I., & Vettore, M. V. (2018). Contextual and individual determinants of periodontal disease: Multilevel analysis based on Andersen's model. *Community dentistry and oral epidemiology*, *46*(2), 161-168. doi: 10.1111/cdoe.12349

Warren, J. R., Kvasny, L., Hecht, M. L., Burgess, D., Ahluwalia, J. S., & Okuyemi, K. S. (2009). Barriers, control and identity in health information seeking among African American women. *Journal of Health Disparities Research and Practice*, *3*(3), 5.

Xu, M., Yuan, C., Sun, X., Cheng, M., Xie, Y., & Si, Y. (2018). Oral health service utilization patterns among preschool children in Beijing, China. *BMC oral health*, *18*(1), 31. doi: 10.1186/s12903-018-0494-6

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health psychology review*, *9*(2), 264-276. doi: 10.1080/17437199.2013.840954

THE UNIVERSITY of ADELAIDE

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Exploring oral health, healthcare experiences and access to health services in Australia for refugees and asylum seekers
HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-[redacted]
PRINCIPAL INVESTIGATOR: Dr Clemence Due
STUDENT RESEARCHERS: Briellen Beard and Isadora Aldam
STUDENT'S DEGREE: Honours Psychology

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?
This project aims to consider your experiences of healthcare in Australia, particularly oral health or the health of your teeth. We are also interested in what sorts of experiences you have had in seeking healthcare in Australia.

The project involves an interview which will take around 60 minutes. We will ask you about your teeth, what sorts of experiences you have had in healthcare in Australia (for example, with dentists or doctors), and why you went to see someone about your health.

Who is undertaking the project?
This project is being conducted by Clemence Due, Briellen Beard, and Isadora Aldam at The University of Adelaide.

This research will form the basis for the degree of a Psychology Honours degree for Briellen and Isadora at the University of Adelaide under the supervision of Dr Clemence Due.

Who is being invited to participate?
You are being invited to participate if you:

- Came to Australia as a refugee or an asylum seeker
- Are over 18
- Arrived in Australia less than 10 years ago.
- Are from Afghanistan, Iran, Iraq or Syria
- Can speak English well enough to participate in an interview

What will I be asked to do?
You will be asked to take part in an interview in which will ask you some questions about your health, including your teeth, and physical and mental health. We will also ask what sorts of healthcare professionals you have seen in Australia, and why you chose to go and see them. If you have children, you will also be asked a small number of questions about your children's health. This will take about 45

Appendix B: Participant Consent Form

CONSENT FORM

1. I have read the Information Sheet and agree to take part in the following research project:

Title:	Exploring oral health, healthcare experiences and access to health services in Australia for refugees and asylum seekers
Ethics Approval Number:	[redacted]

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the researcher. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.

3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

4. Although I understand the purpose of the research project, it has also been explained that involvement may not be of any benefit to me.

5. I agree to participate in the activities as outlined in the participant information sheet.

6. I agree to be audio recorded.
   ☐ Yes ☐ No

7. I understand that I am free to withdraw from the project at any time until data analysis.

8. I have been informed that the information gained in the project may be published in a journal article, Honours theses and a short report.

9. I have been informed that in the published materials I will not be identified and my personal results will not be divulged.

10. I am aware that my information will only be used for the purpose of this research and it will only be disclosed according to the consent provided, except where disclosure is required by law.

11. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date: _____

Researcher/Witness to complete:

Appendix C: Interview Schedules

Questions for Participants of Refugee and Asylum Seeking Backgrounds

Demographic questions:

Age
Gender
Children
Marital status
Country of origin
Length of time in Australia
Visa status
Private healthcare
Cultural and ethnic background
Level of education

Oral health status and practices:

1. Can you tell me about what you do to care for your teeth?
   - What do people in your broader community do to care for their teeth?
2. Are you satisfied with your dental health? (Why/why not?)
   - Are you experiencing any dental issues?
3. Prompt for children if applicable

Oral health beliefs, QoL and wellbeing

1. How do you think that your dental health impacts your wellbeing?
   - In what ways?

Previous use of dental services

1. Have you accessed dental services in Australia?

   IF YES:
   - How often (e.g. per year) do you (and your family) access dental health services?
   - How does this compare to your use of other services?
   - Who within your family or close social circle used dental services? Is it everyone or only some members, and why?
   - For what reasons have you (and your family) used dental services? (i.e. regular check-ups, critical situations)

   IF NO: For what reasons have you not accessed dental services?

   Prompts for psychological factors:
   - How do you feel about seeing a dentist?
   - In your home country, is it common for people to use dentists?
   - Do you think it is different seeing a dentist here compared to other countries?

   Prompts for practical factors:
   - Do you know about dental services that are available to you?
   - Do you feel that you are able to get to dental appointments?
   - Do you think that dental services are affordable?
2. Had you accessed dental services before coming to Australia?

   IF YES:
   - How often did you (and your family) access dental services?
   - How did this compare to your use of other services?
   - Who within your family or close social circle used dental services? Was it everyone or only some members, and why?
   - For what reason did you use dental services

     (i.e. regular check-ups, critical situations)?

IF NO: For what reasons did you not use dental services?

Prompts for psychological factors:

- How did you feel about dental services in your home country?
- Did any experiences or heard stories make you not want to see a dentist?

Prompts for practical factors:

- How easy was it to access dentists?
- Did you know about dental services that available to you?
- Were dental services affordable?

Help-seeking

1. How important do you think it is to go to the dentist?
   - How important do you think it is compared to other healthcare services?
2. How easy or hard do you find it is to go to the dentist? (Why do you think that is?)
   - How about compared to other healthcare services?
3. What are the barriers that you find prevent you from accessing a dentist in Australia?

   Prompt for psychological factors:
   - How do you feel about going to see a dentist?
   - Do you have any worries about seeing a dentist?

   Prompt for practical factors:
   - What do you know about available dental services?
   - What do you think a dental appointment might be like?
   - Do you feel that dental services are culturally appropriate?
   - In what ways might language effect your use of dental services?

   Potential further prompts: cost/childcare/transport
4. What would help you to access dental services more easily in Australia?

   Prompt for psychological factors:
   - Is there anything that would make you feel more comfortable about seeing a dentist?

   Prompt for practical factors:
   - Do you feel that you have enough information about dental services?
   - Is there anything that might make appointments more culturally appropriate?

   Potential further prompts: cost/childcare/transport

Experiences with dentists and dental services

1. Can you tell me about your experiences with health care services in Australia?
2. Can you tell me about your experiences with dental services in Australia?
   - Did you see a dentist on arrival to Australia? If yes, how did you find that experience?
   - Have you felt satisfied with these experiences in Australia?
   - How did the oral health practitioner (dentist or other) make you feel? (Comfortable? Welcome? Cared for? Happy?)
   - How do dentists make you feel like you can trust them?
   - What other things made your experience more positive or negative? (Availability of interpreters? Affordability?)
3. How did you find out about the dental healthcare providers that you have seen?

4. What would make you want to go back to see that dentist?
    - What does appropriate care mean to you?
5. What impact(s) have these experiences had on your wellbeing?
6. How have your experiences with dental services compared with previous healthcare experiences in Australia or other countries?

Recommendations

1. What would you recommend for dentists to provide better care for you and others in your community? What about on behalf of the government or other groups?

Questions for Oral Health Practitioner Participants

Prior experience and expertise

1. Can you tell me a bit about your career and work so far in general?
2. Can you tell me about your experiences with clients from refugee and asylum seeking backgrounds?
    - Prompt for: years worked, type of work, client demographics
    - Do you necessarily know if clients have a refugee background?

Oral health and health status among refugees and asylum seekers

1. To what extent do you think that oral health impacts quality of life or wellbeing for these clients?
    - *How* do you think oral health impacts this?
    - Do you think that oral health issues are different for these clients compared to those without refugee or asylum seeking backgrounds?
    - Are there any particular cultural considerations?
3. Do you think that people's experiences with oral services impact their wellbeing?
    - How is that so? What is or isn't important?

Help seeking

1. At what stage of care do you typically see these clients? (E.g. preventive, acute symptoms)
    - Does this differ to other types of clients?
2. What do you believe are barriers for people of refugee and asylum seeking backgrounds in accessing dental services? (Prompt for for individual (e.g. demographic) and system level factors (e.g. cost)
3. What do you believe helps these clients to access dental services? (Prompt for individual (e.g. demographic) and system level factors, e.g. cost)

Experiences working with refugees and asylum seekers

1. What are some of the challenges that oral health practitioners in general face when working with clients of refugee or asylum seeking backgrounds?
    - Prompt for language barriers, cultural differences, cultural/trauma training
2. What are some of the challenges that you specifically have faced working with this group?
3. What sorts of initiatives/processes are in place for retention of refugee clients where you work?
    - How do you make sure clients feel comfortable enough to return?
4. What do you think support is like for refugees and asylum seekers to access dental services in Australia?
    - Do you think there is sufficient support? Why or why not?

Future recommendations

1. How do you think we can improve access and experiences with services for these clients?

Appendix D: Participant Support Information

Support Organisations

These may be able to assist you if you experience distress during the "*Exploring oral health, healthcare experiences and access to health services in Australia for refugees and asylum seekers*" project

1. Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS)
   STTARS can help with mental health needs in person.
   Phone: 8206 8900
   Address: 81 Angas Street Adelaide

2. Migrant Health Service
   The Migrant Health Service can help with mental health needs in person.
   Phone: 8237 3900
   Address: 21 Market Street Adelaide

3. Lifeline
   Lifeline is a telephone support service, so you can talk with someone on the telephone if you are feeling distressed or upset.
   Phone: 13 11 14
   Website: https://www.lifeline.org.au/
   If you feel more comfortable speaking in another language, please call the Translating and Interpreting Service on 13 14 50 and ask them to call Lifeline for you on 13 11 14.

4. Assistance and Crisis Intervention Service
   The assessment and crisis intervention service can help in a mental health emergency.
   Phone: 13 14 65

Dental Clinics

These may be able to assist you if you require oral healthcare during the "*Exploring oral health, healthcare experiences and access to health services in Australia for refugees and asylum seekers*" project

1. Community Dental Clinics:
   The SA Health website provides a list of public dental clinics for both adults and children in South Australia.
   The list of clinics can be found at:
   https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/dental+services/dental+clinics+by+service

   The website also provides information on eligibility, waiting times, cost, interpreters and emergency services.:
   http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/dental+services/dental+services+for+adults

   If you feel more comfortable speaking in another language, you can directly contact the clinic beforehand to arrange an interpreter.

2. Emergency dental care
   The SA Health website below has advice for seeking emergency dental care, including what to do with certain dental problems and who to contact for help:

   http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/dental+care/dental+emergencies+what+you+need+to+know+and+do

   If your local dental or health clinic is not available, Healthdirect Australia is available for after hours telephone advice on dental care options. Their phone number is: 1800 022 222