Talking about Teeth – exploring the barriers to accessing oral health services for Horn of Africa community members living in inner west Melbourne.

1<sup>st</sup> July 2009 to 30<sup>th</sup> September 2010

Prepared for

Doutta Galla Community Health Services, Western Region Health Centre and Dental Health Services Victoria

Prepared by

Carmel Hobbs
Project Co-ordinator
# Table of Contents

List of Figures .......................................................... v
List of Tables .......................................................... v
List of Abbreviations ......................................................... vi
Definitions ........................................................................................................................................ vii
Acknowledgements ......................................................... viii
Abstract ........................................................................................................................................... x

Executive Summary .......................................................... 1
  What did we do? ................................................................. 1
  What did we find? ................................................................. 2
  Important messages to take forward ........................................ 3
  Further information ............................................................... 6

Introduction ................................................................................................................................. 7
  Background to the Research ....................................................... 7
    Demographics of the Horn of Africa community in Australia ................... 8
  Aim of the Research ................................................................. 10

Literature Review ............................................................... 11
  Utilisation of Health Services ...................................................... 11
  Communication and Language Barriers ........................................ 11
    Language .................................................................................. 11
    Working with interpreters .......................................................... 12
  Pain versus Preventive Care ....................................................... 14
  Cost ........................................................................................... 14
  Limited or No Experience with Oral Health Services Overseas ................ 14
  Waiting List .............................................................................. 15
  Addressing Barriers ................................................................. 15
    Education and health promotion ................................................ 15
    Cultural competency ................................................................. 16
  Conclusion ................................................................................. 17
  Research Questions ................................................................. 17

Theoretical Framework ......................................................... 19

Methodology ................................................................. 21
  Research Design ................................................................. 21
  Research Process ................................................................. 22
  Consultation phase ................................................................. 22
Talking about Teeth

Focus Groups............................................................................................................................. 22
In-depth interviews ................................................................................................................... 23
Participants ........................................................................................................................................ 25
Community members................................................................................................................ 25
Oral health professionals .......................................................................................................... 25
Recruitment ........................................................................................................................................ 26
Community members................................................................................................................ 26
Oral health professionals .......................................................................................................... 26
Data Analysis – Focus Groups and Worker Interviews ............................................................. 26
Data analysis – Questionnaires and Client Usage Data ............................................................ 28
Rigour and Trustworthiness.......................................................................................................... 28
Ethical Issues ....................................................................................................................................... 29
Record keeping................................................................................................................................. 29
Consequences of participation ........................................................................................................ 29
Confirmation of approval ............................................................................................................... 29
Methodological Limitations .............................................................................................................. 30
Data collection in a language other than English ................................................................. 30
Community member participant recruitment ............................................................................. 30
Bias and confounding ...................................................................................................................... 30
Conclusion .......................................................................................................................................... 31
Project findings .................................................................................................................................. 33
Structural barriers .............................................................................................................................. 34
The waiting list: the biggest barrier? ................................................................................................. 34
Understanding the system and services available ............................................................................. 35
Understanding appointment systems ............................................................................................ 36
Priority access .................................................................................................................................. 39
Accessing the dental hospital .......................................................................................................... 40
Service atmosphere and culture ...................................................................................................... 40
Discussion .......................................................................................................................................... 42
Recommendations ............................................................................................................................. 44
DGCHS ............................................................................................................................................. 44
Increase and improve referral pathways and partnerships .......................................................... 44
Communication ................................................................................................................................. 44
Community engagement ................................................................................................................... 44
Other .................................................................................................................................................... 45
Community health services .............................................................................................................. 45
Talking about Teeth

Obtaining the perspectives of Horn of Africa community members AND the oral health professionals working with this community. ................................................................. 68
Including interpreters as participants. .............................................................................. 69
Culturally appropriate catering ......................................................................................... 69
Community engagement.................................................................................................... 69

Appendices ....................................................................................................................... 70
Appendix A: Focus group questionnaire ................................................................................. 70
Appendix B: Worker questionnaire ......................................................................................... 74
Appendix C: Focus group questions ....................................................................................... 76
Appendix D: Worker interview questions ................................................................................. 79
Appendix E: Additional findings of interest ........................................................................... 81
In the community .................................................................................................................. 81
Clinical issues ...................................................................................................................... 86

References .......................................................................................................................... 94
List of Figures

Figure 1 - Map of the Horn of Africa ...................................................................................................................................... 8
Figure 2 - The Number of Times Horn of Africa Community Members Have Seen a Dentist in Australia .......................... 35
Figure 3 - Failure To Attend (FTA) Appointments in 2009-2010 by Language Group .................................................. 37
Figure 4 - How Often Community Member Participants Experience Pain in Their Mouth .............................................. 47
Figure 5 – Community Member Participants Preferences for Methods of Health Promotion Delivery ............................. 50
Figure 6 - Service Utilisation of Professional Interpreters by Language Group in 2009-2010 .............................................. 52
Figure 7 - Effectiveness of Word of Mouth for Recruiting Focus Group Participants ....................................................... 55
Figure 8 - Recommendations for Addressing Barriers to Access ....................................................................................... 67
Figure 9 - Preference For Appointment Alone or With Family ............................................................................................ 82
Figure 10 - What Community Members Think of Their Own Teeth ................................................................................... 82
Figure 11 - Ideal Length of Appointment .......................................................................................................................... 89

List of Tables

Table 1 - Birthplace of Residents of the Flemington PHE ............................................................................................... 9
Table 2 - Main Language Spoken at Home of Residents of the Flemington Housing Estate .............................................. 9
Table 3 - Benefits and Problems with Using Professional and Informal Interpreters ......................................................... 13
Table 4 - Characteristics of Candidacy Theory .................................................................................................................. 20
Table 5 - Stages of Data Analysis ...................................................................................................................................... 27
Table 6 - Main Language Spoken at Home of All Clients in 2009-2010 Financial Year ....................................................... 49
List of Abbreviations

CM – Community Member

CMI – Community Member Interpreter

DGCHS – Doutta Galla Community Health Service

DHSV – Dental Health Services Victoria

Flemington PHE – Flemington Public Housing Estate

FTA – Failure to Attend

WRHC – Western Region Health Centre
Definitions

Barrier - Barriers to health care are obstacles that prevent vulnerable patient populations from getting needed health care, or that cause them to get inferior health care compared to advantaged patient populations (Flores, Abreu, Oliver, & Kastner, 1998).

Community - A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them (World Health Organization, 1998, p. 5).

Horn of Africa – The Horn of African is a peninsula of East Africa bounded by the Arabian Sea, and the Gulf of Aden. The seven countries of the region are Djibouti, Eritrea, Ethiopia, Kenya, Somalia, the Sudan and Uganda (Pittaway & Muli, 2009, p. 20).

Miswak - The Miswak is a teeth cleaning twig made from the Salvadora persica tree, also known as the arak tree or the peelu tree that contains anti-microbial properties and other elements which are good for the teeth and general health (Almas, 2004).

Newly/recently arrived communities – a community with an Australian wide population of less than 15,000, of whom 30% or more have arrived in the past five years. This includes people from the countries of Eritrea, Ethiopia, Somalia and Sudan (Department of Immigration and Multicultural Affairs, 2006, p. 5).
There are many people to acknowledge. I start with Anne Lennard of Doutta Galla Community Health Service (DGCHS) who has provided ongoing supervision and support throughout the last 14 months. Without her passion for quality improvement and community engagement this project would not have emerged, nor been supported in the way that it has been. In addition, Russ Sevior of DGCHS, Nicole Bartholemeusz and Paula Bacchia have been key support people from Western Region Health Centre (WRHC). Crucial research support has been provided by Priscilla Robinson and Jen Power of La Trobe University, and John Bamberg of WRHC. Assistance in organising and running the focus groups was provided by a number of workers at DGCHS.

I need to thank Penny Jordan (Co-ordinator of the Flemington Renewal Project) and Hodan Abi (DGCHS Health Promotion Worker and community member) for their invaluable ‘on the ground’ experience and advice. In addition, Abdo Abdulkarim and Hili Hassan provided invaluable assistance with data analysis, ensuring that no cultural misinterpretations of the data occurred.

Members of the Advisory group:

- Ali Abdihakim – Community member
- Amy Lee – Department of Health
- Anne Lennard - DGCHS
- Anthony Rodriguez Jimenez – La Trobe Refugee Health Research Centre
- Catherine James – Department of Health
- Colin Riley - DHSV
- Elisha Riggs and Maryanne Tadic – Merri Community Health Centre
- Gemma Kennedy - WRHC
- Hodan Abi - DGCHS
- Mark Stracey, Zoe Hancock and Tim Fry – Department of Health
- Nasiib Mohmud – Community Member
- Penny Jordan – Flemington Renewal Project
- Peter Sullivan - DGCHS
- Sue Casey and Louise Crowe – Foundation House
Individuals and services who participated in the consultation phase:

- Ambi Kaur – Refugee Health Nurse, DGCHS
- Berhan Ahmed – Chairperson, African Think Tank
- Fadumo Mohamud – DGCHS
- Joanne Goodman and Barb Ladd – North Melbourne Language and Learning Inc
- Kelly Hardy – Wingate Ave Community Centre
- Julie Satur – School of Dental Science, University of Melbourne
- Professor Sandy Gifford – Director, Refugee Health Research Centre

Acknowledgement also needs to go to DGCHS for having the integrity to be transparent and publicly report on the challenges experienced by their workers and dental services.

Most importantly, a big thank you to all of the project participants, without whom this project would not have been possible.
Talking about Teeth

Abstract

The aim of “Talking about Teeth” is to identify barriers to accessing oral health services for the Horn of Africa residents of the Flemington Public Housing Estate (PHE) (Melbourne, Victoria). Problems with accessing oral health services contribute to poor oral health outcomes, which in turn, have an impact on the physical, psychological and emotional health and wellbeing of individuals. The research questions utilised to uncover the barriers to access include:

1. What are the patterns of usage of the Horn of Africa community that are identifiable in clinic data and questionnaires completed by community members and oral health workers?
2. What are the barriers to accessing oral health services for Horn of Africa residents of the Flemington PHE as perceived by:
   - Horn of Africa community members?
   - Public dental clinic workers (including oral health professionals and administrative staff) working with this community?

Twenty-nine community members participated in a total of four focus groups, and nine workers from Doutta Galla CHS dental service took part in semi-structured interviews. Participants also completed short questionnaires which provided data to compare with qualitative responses and clinic usage data. As a result of involving both Horn of Africa community members and oral health professionals in this project, major barriers to accessing oral health services have been identified. These include structural barriers such as the waiting list, understanding the system and services available, priority access eligibility, accessing the dental hospital, and service atmosphere and culture. Individual barriers were also identified which include awareness of the importance of preventive care, language and literacy, word of mouth, challenges for new arrivals, financial costs, lack of previous exposure to oral health services, cultural barriers, fear and trust.

Optimum oral health of the Horn of Africa community in Australia will not be achieved without a cooperative and collaborative approach between the community and oral health service providers. The findings from this project revealed that to improve access to oral health services for Horn of Africa residents of the Flemington Public Housing Estate, the community needs to be provided with education about preventive care, the services available to them, and how to utilise those services. Workers require increased confidence in working with diverse client groups and interpreters, and oral health services and the oral health sector need to build and maintain capacity to provide culturally competent services to this community group.
Executive Summary

In 2009, discussions between Doutta Galla Community Health Services and Western Region Health Centre highlighted the underutilisation of their dental programs by the local Horn of Africa community. Funding was sought from Dental Health Services Victoria (DHSV) to identify the reasons behind this and provide suggestions for how access can be improved for the Horn of Africa background community in inner west Melbourne.

The brief literature review reveals that there is little research on Horn of Africa adult community members in Australia in terms of their access to oral health services. The existing literature has demonstrated that patterns of utilisation are problematic and highlighted barriers to accessing services including communication and language, cost, limited previous experience accessing oral health services, and the waiting list. This is what we know about other populations regarding barriers to access. “Talking about Teeth” focuses on Horn of Africa adults in Australia and the barriers they perceive to exist in accessing public oral health services. By doing this, the project aims to fill the research gap and provide recommendations that oral health services can use to address the identified barriers.

What did we do?

A qualitative approach was selected for this project to explore the research questions in detail, allowing scope for the community and the workers at the local oral health service to self-define their needs. Focus groups with the community members and interviews with current employees of the dental service were the primary means of collecting data. Four focus groups with a total of 29 participants, and nine interviews with workers were held between July and September in 2010. Community member participants were recruited through word of mouth strategies, and advertising of the program through local service providers. Employees were recruited via email and a flyer posted on the staff noticeboard. Professional interpreters were employed to interpret at each focus group, and community members assisted with the data analysis process to ensure that interpretations of the data were accurate. All of the focus groups and interviews were voice recorded and then transcribed in English by the key researcher and a professional transcribing service. These transcripts were then thematically analysed using an inductive theming strategy to uncover the key findings. These identified themes were also checked by community members and advisory group members to add to the rigour of the research process.
Talking about Teeth

What did we find?

The findings represent the experiences and perceptions of oral health access for Horn of Africa residents of the Flemington housing estate to local public oral health services from the perspectives of the community members, community member interpreters and the professionals working in the dental clinic. The key findings of “Talking about Teeth” are divided into two broad categories – structural barriers, and individual barriers. Recommendations for improving access were provided by the project participants and further developed through analysis of the data collected.

The structural barriers identified by participants revealed that the waiting list, navigating the health system in Australia, awareness of priority access eligibility, accessing the dental hospital, and adjusting to appointment systems are the major barriers to accessing oral health care for the Horn of Africa community. Community members reported being deterred from accessing services for preventive care because of the long waiting list and instead access services in emergency situations and when they are in pain.

Not understanding how the system works creates a major barrier for community members. This includes awareness of eligibility criteria, how to make an appointment, and the processes involved once an appointment has been made. Under current Dental Health Services Victoria policy, refugees and asylum seekers are entitled to priority access to oral health care. This means that they are not put on a waiting list and are exempt from the co-payment when they attend. Discussions with community members revealed that many were not aware of their priority access eligibility.

Community members also discussed accessing the dental hospital and that the long wait for treatment can lead to clients returning home to take care of young children and missing out on care, and turning to expensive private services in order to receive treatment. However, the cost of private care often meant that clients did not complete their course of care.

Adhering to appointment schedules and systems can be challenging for community members who have had limited exposure to such systems in the past. Community members discussed topics including the importance of attending on time, feedback that for government and health appointments they are on time, but for social events, late attendance is acceptable and often assumed. A different culture of appointments in home countries, and also a different way of telling time contributed to community members adds difficulty in adhering to appointment systems in Australia.

In addition, a number of other findings emerged in the project that although not directly related to barriers, may serve as useful knowledge for services providing oral health care to the Horn of Africa community. These findings are presented in Appendix E.
Important messages to take forward

The findings from “Talking about Teeth” have revealed a number of ways in which service providers and policy makers can implement strategies to improve access to public oral health services for the Horn of Africa community. The recommendations to emerge from this project are listed below.

DGCHS

**Increase and improve referral pathways and partnerships**

- Increase referral pathways between dental and other programs at DGCHS.
- Coordinate worker forums and partner with external agencies to educate other services about the processes and procedures in public dental providing other workers with the knowledge needed to inform their clients of this information.

**Communication**

- Increase opportunities for clients to provide feedback in the clinic:
  - Feedback forms / questionnaires to complete following appointments.
  - Employ community liaison officers to speak with clients following appointments.
- Offer clients a copy of their treatment plan following their first appointment so that they know what to expect in subsequent appointments, and why they are required to come back for additional appointments.

**Community engagement**

- Build connections and relationships within the community to enable ongoing dialogue and program improvements.
  - Be conscious of the role that politics can play. It was revealed that some people will attend events that community leaders recommend for fear of not being seen doing what the community leaders have told them to do, additionally, some community members are wary of people in positions of power (such as community leaders) because of the role that people in power played in countries they have lived in before coming to Australia and so they don’t go to events promoted by community leaders for this reason. Being transparent about what you are doing, how you are doing it, and what the benefits will be to individuals in the community might be a more effective approach to engaging community members who are wary of community leaders.
Talking about Teeth

Addressing fear

- Take extra time and care with clients who appear to be fearful or anxious.
- Ask family members and children to leave the room if you are performing treatment that may incite fear (for example administering anaesthetic).
- Encourage family members and children who accompany clients to watch procedures that may assist them in feeling more comfortable in attending for their own personal treatment.
- Describe and show tools and noises that may be unknown to clients to address any potential anxiety that may arise.

Building trust

- Give stickers to children and free oral hygiene products to clients where appropriate.
- Learn about the culture and backgrounds of client groups and demonstrate this knowledge through respectful and professional interactions with all clients.
- Understanding the meaning of words in other languages can be a fast and effective way of building trust.
- Take time in appointments to explain treatment options and plan.
- Structure appointments in such a way that trust can be built and treatment can be undertaken efficiently.

  *First a short one and then follow with a long one if patient is really happy with it, so that he feels more confident with me, you know? (Worker 6)*

Other

- Build a new clinic that is physically more accessible to residents of the local housing estates.
- Display names and qualifications of all oral health professionals working in the clinic.
- Display a list of the different oral health professional titles and description of roles in reception area.

Community health services

Communication

- Provide reception staff with a list of commonly used words (such as days of the week) translated into languages other than English.
- Ensure that clients are actively involved in health decision making processes ensuring that professional interpreters are utilised where language barriers exist.
- Ask clients if they have a gender preference for their worker when making appointments.
Executive Summary

Health promotion activities

In partnership with the community, develop and deliver an education program that covers information regarding preventive care and navigation of the system. Deliver this program at a local venue, at regular intervals (every 6-12 months), on weekends, in local languages with an oral health professional present to perform examinations. This could be done using an existing peer education model (peer education has been used successfully in the estate across a number of health topics including child nutrition, Vitamin D and heat stress).

- What services are available in a public dental clinic
- The appointment system
- What to bring to an appointment
- The role of public dental services and the Dental Hospital in Victoria
- The importance of preventive care including:
  - How to take care of teeth – how to brush, how to clean, knowing what to do at home between visits to the dentists;
  - That ill-health can exist in the absence of pain;
  - Food and drink that is good/bad for teeth; and
  - What causes damage to teeth.

Produce a DVD in a variety of appropriate languages that includes information as listed above.

Capacity building

- Training for oral health workers in
  - Rapid rapport building
  - Dealing with distress / conflict resolution
  - Working with interpreters
  - Cultural awareness and understanding the refugee experience
  - Learning about the community, their culture and background
  - Managing ‘hard’ patients (mental health, disabled, drug/alcohol affected)
  - Reading / using body language to overcome language barriers

Other

- Provide after hours and/or weekend services for clients who work during the day. *Drop in sessions were not wanted by the Horn of African community member participants.
- Create a positive atmosphere in services.
Talking about Teeth

DHSV and Department of Health (DoH) policy

- Advocate for the provision of oral health information sessions to be included as part of compulsory English language classes for new arrivals.

Waiting list

- Implement a centralised intake system to direct clients to services with the shortest waiting lists.

Communication methods

- Reminder calls for appointments should be made on the day before, and on the day of appointments. Some community members suggested that a call a few weeks in advance for appointments made months earlier would also be very useful. This would be most effective if made in the clients language.
- Call clients in their language when they reach the top of the waiting list as well as instead of sending a written letter.

Eligibility criteria

- Advocate for a clear definition of refugee to be used in determining eligibility and parameters of care provided.

Funding

- Increase funding to allow for better utilisation of interpreters and lengthened appointment times where there are language barriers (to provide the time required to obtain medical history, create a treatment plan, obtain consent, and begin treatment).

Interpreter accountability

- Interpreter services need to be held accountable for the interpreters they are sending to health services, this needs to be reinforced through policy agreements between health services/departments and interpreter service providers.

Further information

For further information about this project, please contact Carmel Hobbs at Doutta Galla Community Health Services by emailing carmel.hobbs@dgchs.org.au.
Introduction

The main aim of “Talking about Teeth” is to identify barriers to accessing oral health services for the Horn of Africa residents of the Flemington Public Housing Estate (PHE) (Melbourne, Victoria). The impetus for this research project originated in discussions between Doutta Galla Community Health Service (DGCHS) and Western Region Health Centre (WRHC) who identified this community as a growing population and disadvantaged group that should be actively engaged to increase their utilisation of preventive oral health care. Oral disease (such as dental caries and periodontal disease) affects an individual’s “quality of life, nutrition, self-esteem and social and economic well-being”, and has an impact on other health conditions such as diabetes, cardiovascular disease, peptic ulcers, aspiration pneumonia, cerebrovascular disease, and rheumatoid arthritis (Mariño, Wright, Schofield, Minichiello, & Calache, 2005; Satur, Gussy, Morgan, Calache, & Wright, 2010, p. 258). Accessing oral health services not only provides opportunities to identify and treat oral health problems, it provides an opportunity for education about the importance of preventive care (Mariño, et al., 2005). Therefore, improving access to preventive oral health care for vulnerable groups is an essential contributor to their overall health status and well-being.

Background to the Research

DGCHS is a community health centre operating in the inner-west suburbs of Melbourne, Victoria. Geographically it is the closest service available for residents of the Flemington PHE. The oral health program is one of the biggest programs at DGCHS and provides oral health services to Health Care Card holders. In Victoria, public oral health programs are funded by Dental Health Services Victoria (DHSV). There is currently 15 employed staff at the DGCHS dental clinic in Kensington. This includes reception staff, dentists, dental therapists, dental assistants and a prosthodontist. On average, the clinic sees 180 clients per week. By involving community members and oral health professionals in the project both perspectives have been obtained to better inform services of the existing barriers to access and strategies for overcoming the identified barriers. This project has been funded by Dental Health Services Victoria (DHSV).

Under current DHSV policy, priority access (next available appointment) is provided at no cost to refugees and asylum seekers, children and young people under 18 years of age, Aboriginal and Torres Strait Islander people, pregnant women, and registered patients with a psychiatric illness or intellectual disability. Other Health Care Card holders are eligible for treatment at minimal cost and are placed on a waiting list (Dental Health Services Victoria, 2010). Many Horn of Africa community members living on the Flemington PHE arrived in Australia as refugees (Australian Bureau of Statistics, 2006), and as such,
Talking about Teeth

are eligible for priority access dental care. However, despite current policies, organisational records show that in 2009-10 less than 25% of clients at the DGCHS dental clinic sought treatment under priority access (this includes all of the groups mentioned above). With the Horn of Africa community making up 27% of the residents at the Flemington PHE, this provides evidence that there is low utilisation of DGCHS dental services by the Horn of Africa community.

Demographics of the Horn of Africa community in Australia.

As a result of changing global circumstances, the national origin of people coming to Victoria as refugees continues to change (Department of Immigration and Citizenship, 2009). Increasing diversity within the community has brought with it the need for local health services to work closely with the Horn of Africa and other emerging communities. The Horn of Africa is made up of countries including Sudan, Eritrea, Djibouti, Ethiopia, Uganda, Kenya and Somalia (Pittaway & Muli, 2009). Residents of Australia from these source countries are considered newly arrived communities who face significant challenges during the settlement period (Department of Immigration and Multicultural Affairs, 2006, p. 5; Neale, Ngeow, Skull, & Biggs, 2007).

Figure 1 - Map of the Horn of Africa

(Pittaway & Muli, 2009, p. 20)

Census data from 2006 show that over 56% of residents of the Flemington PHE were born outside of Australia (Australian Bureau of Statistics, 2006). A large number of these residents are newly arrived refugees from Vietnam and the Horn of Africa (See Table 1) with over 40% of residents speaking
an African language (including Arabic speakers who may not be Horn of Africa community members),
compared with 18% who speak English as their main language at home (See Table 2) (Australian Bureau
of Statistics, 2006).

Table 1 - Birthplace of Residents of the Flemington PHE

<table>
<thead>
<tr>
<th>Birthplace</th>
<th>Flemington PHE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>647 (43.7%)</td>
</tr>
<tr>
<td>Vietnam</td>
<td>278 (18.8%)</td>
</tr>
<tr>
<td>Somalia</td>
<td>183 (12.4%)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>125 (8.4%)</td>
</tr>
<tr>
<td>East Timor</td>
<td>88 (5.9%)</td>
</tr>
<tr>
<td>Eritrea</td>
<td>56 (3.8%)</td>
</tr>
<tr>
<td>Sudan</td>
<td>45 (3%)</td>
</tr>
<tr>
<td>China</td>
<td>39 (2.6%)</td>
</tr>
<tr>
<td>Turkey</td>
<td>20 (1.4%)</td>
</tr>
</tbody>
</table>

*Note: Australian born residents includes children with parents who were born overseas.

Table 2 - Main Language Spoken at Home of Residents of the Flemington Housing Estate

<table>
<thead>
<tr>
<th>Language spoken at home</th>
<th>Number and % of residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>350 (23.9%)</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>268 (18.3%)</td>
</tr>
<tr>
<td>English only</td>
<td>263 (18%)</td>
</tr>
<tr>
<td>Cantonese</td>
<td>238 (16.2%)</td>
</tr>
<tr>
<td>Arabic</td>
<td>228 (15.6%)</td>
</tr>
<tr>
<td>Hakka</td>
<td>60 (4.1%)</td>
</tr>
<tr>
<td>Turkish</td>
<td>28 (1.9%)</td>
</tr>
<tr>
<td>Amharic</td>
<td>16 (1%)</td>
</tr>
<tr>
<td>Spanish</td>
<td>14 (0.9%)</td>
</tr>
</tbody>
</table>
Aim of the Research

The aim of this research is to identify barriers to accessing oral health services for Horn of Africa community members living in the Flemington PHE. The employees of the DGCHS dental program seek not to do things for the community, but to work collaboratively with the Horn of Africa community to improve access to oral health services.

By exploring the barriers to access, services are better equipped to understand the challenges facing clients in attending oral health services. This will enable oral health services to work towards providing culturally appropriate services to the community, and support its staff to feel confident about working with a diverse group of clients.
This literature review highlights what is known about barriers to accessing health care services for minority groups including Horn of Africa community members, providing background knowledge to inform the project and identify gaps in the literature which the project aims to fill. This review begins with a brief discussion about utilisation of health services more generally, goes on to explore major barriers to accessing services and concludes with an overview of strategies identified in the literature to address barriers. The barriers discussed include communication and language, awareness of preventive care, cost, previous experience with oral health services, and the waiting list.

**Utilisation of Health Services**

In many countries, public dental services are provided to population groups deemed to be in most need of assistance (World Health Organization, 2002). Although eligibility for public oral health services differ across states and nations, research reveals that migrant populations commonly underutilise oral health services (World Health Organization, 2002). Underutilisation of health services contributes to poorer oral health status, impacting on the overall health and wellbeing of individuals (World Health Organization, 2002). Marino et al (2005) administered face to face questionnaires with 374 Greek and 360 Italian adults in Melbourne to explore barriers to accessing oral health services. They found that although 95% of participants were eligible for oral health services through the public dental system, 57% reported not visiting a dentist in the last 12 months with approximately half of this group having not accessed a dentist in five years or more (Mariño, et al., 2005, p. 34).

International research reveals further evidence of underutilisation of oral health services by migrant and minority groups in England and the United States, and of Africans living in Burkina Faso (Africa). These studies cite barriers such as cost, lack of knowledge of service availability, and communication as reasons for underutilisation (Kelly, Binkley, Neace, & Gale, 2005; Varenne, Msellati, Zoungrana, Fournet, & Salem, 2005; Williams, Godson, & Ahmed, 1995). The remainder of this literature review explores some of the major barriers that contribute to underutilisation of oral health services for migrant and minority groups.

**Communication and Language Barriers**

**Language**

In Australia, language is commonly identified as a barrier to accessing information and communicating with health professionals for refugees and Horn of Africa community members (Australian Human Rights Commission, 2010; Finney Lamb & Smith, 2002; Neale, et al., 2007). Language
Talking about Teeth

barriers can contribute to “miscommunication, misdiagnosis, and lack of appropriate follow up” (Finney Lamb & Smith, 2002, p. 161). Goldsmith et al (2005) found that from the perspectives of dentists, language was seen to be a bigger barrier than being born overseas in terms of accessing service for preventive care. Marino et al (2002) found that for older Italians in Australia, language was the biggest barrier to accessing public dental services in Melbourne. In a study of 29 female and 25 male Somali refugees in New Zealand language was identified as the biggest barrier to accessing general health services, followed by transportation and medical costs (Guerin, Abdi, & Guerin, 2003). These same barriers were identified in Dasanayake et al’s (2002) research which compared dental service utilisation rates of White Americans to minority groups in the United States.

One Western Australian study has explored language barriers and interpreter usage in public dental services. All registered dentists in the state were sent a written questionnaire featuring Likert-style questions which were analysed using quantitative methods. A small number of questions allowed space for comments, and a qualitative thematic analysis approach revealed key themes. One hundred and twenty questionnaires were returned (a low response rate of 13%). Data revealed that the level of training provided to dentists to treat patients with limited English was rated as poor or very poor by 78% of respondents (Goldsmith 2005). Participants reported that difficulty communicating complex dental information such as endodontics and periodontics to clients often led to simplified treatment plans thus reducing the quality of care delivered and that non-English speaking clients would probably ask more questions if they could speak English (Goldsmith, et al., 2005).

Working with interpreters

The literature on working with interpreters is somewhat contradictory with some research reporting a lack of available interpreters, and other research reporting a lack of desire to use interpreters. A lack of available, qualified interpreters is noted in a number of studies as contributing to barriers to access to health services for refugee communities and despite a free telephone interpreter service being available to medical practitioners in NSW, many were reluctant to use it (Australian Human Rights Commission, 2010; N Davidson et al., 2004; Finney Lamb & Smith, 2002; Neale, et al., 2007).

For a number of reasons, many clinicians used informal interpreters when language barriers were present. This is problematic as untrained interpreters may be biased, the lack of a professional interpreter jeopardises patients’ privacy and, most importantly, their ability to provide informed consent (Goldsmith, et al., 2005). Use of untrained interpreters (family members and bilingual workers) can contribute to frequent interpreting errors and deficient translation can lead to misunderstandings, incorrect diagnoses and referrals and low compliance (Bischoff et al., 2003).
Goldsmith et al’s (2005) study revealed that almost 60% of dentists reported not using professional interpreter services and preferred to use informal interpreters such as family members or colleagues. Reasons for this are presented in Table 3. Phone interpreters were used rarely, possibly because of a lack of knowledge of how to access them, and the increased challenges of having to explain dental procedures over the phone. At the time of the study, Western Australian dentists were not provided with funding to utilise professional interpreter services.

Respondents in this project reported informal interpreters as the most satisfactory method of communication with a non-English speaking client (high or very high satisfaction 64%), compared to in-person professional interpreters (high or very high satisfaction 34%), this was followed by dental staff interpreters (high or very high satisfaction 31%). Neale et al (2007) recommended increasing interpreters and health service staff who speak community languages as a means of improving satisfaction with health services.

Time and cost were the main reasons for not using professional interpreters and 29% of respondents felt that informed consent was compromised as a result of not using professional interpreters. Obtaining consent is both an ethical obligation and a legal requirement in dental services. Recognition of the legal ramifications of not using a professional interpreter was only acknowledged by a minority of respondents (Goldsmith, et al., 2005).

Table 3 - Benefits and Problems with Using Professional and Informal Interpreters

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Professional interpreters</th>
<th>Informal interpreters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speed</td>
<td></td>
<td>Convenience</td>
</tr>
<tr>
<td>Accuracy</td>
<td></td>
<td>Speed</td>
</tr>
<tr>
<td>Better informed consent</td>
<td></td>
<td>Lack of expense</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Easier to build trust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td></td>
<td>Time</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td>Cost</td>
</tr>
<tr>
<td>Practicality</td>
<td></td>
<td>Practicality</td>
</tr>
<tr>
<td>Lack of trust in conveying dental terminology effectively.</td>
<td></td>
<td>Lack of trust in conveying dental terminology effectively.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients not disclosing all information for privacy reasons.</td>
</tr>
</tbody>
</table>
**Talking about Teeth**

**Pain versus Preventive Care**

The pattern of accessing oral health services in a crisis, such as toothache or emergency services, rather than for preventive care is a common finding amongst the research (Mary Dixon-Woods et al., 2006). Two studies from the United States revealed that African Americans were more likely to access services for emergency reasons rather than preventive care when compared to non-Hispanic whites and other minority groups (Gilbert et al., 2002; Okunseri et al., 2008). Availability and access to oral health services in Sub-Saharan Africa is seriously constrained. Utilisation of these services is low and in most cases symptomatic reasons (such as pain) are the reason people visit. This can affect the pattern with which Horn of Africa refugees access dental services in Western countries (Varenne et al., 2006).

There is a paucity of research on access for pain versus preventive care in the Australian literature. Goldsmith et al’s (2005) research supported the international findings, reporting that overseas born persons who speak a language other than English are more likely to access dental services for a specific event rather than preventive care. Although Goldsmith’s research was not focused on a particular overseas born group in Australia, the findings of “Talking about Teeth” will contribute to this limited Australian research and reveal whether access for pain rather than preventive care is common health behaviour within the Horn of Africa community.

**Cost**

Cost was identified as another major barrier to accessing health services for refugees in Australia and New Zealand (Finney Lamb & Smith, 2002; Guerin, et al., 2003). Additionally, Marino et al (2002) found in their study of older Greek and Italian residents of Melbourne that the cost of oral health care was the biggest barrier for older Italians, and that access to oral health services decreased after retirement because of the cost.

**Limited or No Experience with Oral Health Services Overseas**

Exploring barriers to access for newly arrived refugees in Australia, Sheikh-Mohammed et al (2006) administered questionnaires in person to parents of children attending a children’s health clinic for refugees. Part of the research included questions about access to health care services overseas. Participants described previous experiences with health care in overseas countries as poor, with many participants reporting on negative experiences such as corruption and bribery, the financial cost, and a lack of care and quality treatment. These experiences led to apprehension about accessing services in Australia (Sheikh-Mohammed, et al., 2006). Finney Lamb and Smith (2002) explain that different health care systems in countries of origin makes navigating the Australian system difficult. Additionally, a lack
of trust in health service providers can stem from past experiences in their country of origin and this presents as a major barrier to accessing health services in Australia (Finney Lamb & Smith, 2002).

Waiting List

Australian literature identifies the waiting list as another major barrier. The waiting list was identified as one of the biggest barriers to accessing oral health services for refugee children (N Davidson, et al., 2004). Furthermore, the waiting list and waiting in the clinic were the biggest barriers for Greek participants, and cost, length of waiting list and language barriers were the biggest barriers identified by Italian participants (Mariño, et al., 2005). Long waiting lists have a number of impacts on clients, they contribute to a lack of trust in programs aimed at improving oral health, push people to seek care in the private sector and don’t assist in maintaining positive oral health behaviours (Mariño, et al., 2002).

Addressing Barriers

Education and health promotion

The research suggests that the provision of oral health information designed for specific cultural contexts might help deliver messages about the need for preventive care. Marino et al (2005, p. 34) suggested that barriers to access can be reduced by providing oral health specific information to communities to increase knowledge of oral diseases, including asymptomatic diseases. Participants in Marino et al’s (2005) study requested information about oral health topics be provided in writing, and also via free group information sessions every 6-12 months (Mariño, et al., 2002). These participants requested a health professional to attend the sessions to help them feel more comfortable, and that information be delivered in group session in appropriate languages for the group (an idea also suggested by Neale, et al., 2007). Furthermore, Sheikh-Mohammed et al (2006) recommended making use of ethnic group organisations in the community to deliver health information and promotion.

In their study of Horn of Africa refugee access to health services, Sheikh-Mohammed et al (2006) found that most families had access to a radio and recommend that services promote the use of the radio amongst Horn of Africa clients. They suggest that utilising the radio as a means of communication could be an effective way of sharing health information with newly arrived communities.

In addition, Marino et al (2002) suggested targeting oral health promotion programs at older migrants in Australia that address structural and financial barriers to access. They believe that although education might improve oral health status of recipients, without accessible services supporting these messages, it is unlikely that individuals will change behaviours or take the notion of preventive care
Talking about Teeth

seriously. They state that the system needs to be structured in a way that allows for health promotion to lead to improved access (Mariño, et al., 2002).

Cultural competency

Brach and Fraserirector (2000) suggested that improving cultural competency within organisations and broader health systems will improve health outcomes for minority groups. They described cultural competency as going beyond cultural awareness and sensitivity to include possessing cultural knowledge and respect for other cultures, as well as using skills effectively in cross cultural interactions (2000, p. 183). They defined nine key components of cultural competency:

1. Interpreter services – to improve communication.
2. Recruitment and retention of minority staff – improves communication, creates a welcoming environment and helps services to understand needs of minority groups.
3. Training for clinicians to increase cultural awareness, knowledge and skills to enable more effective work practices when working with minority clients.
4. Coordinating with traditional healers to ensure continuity of care is upheld and that incompatible therapies are not being used simultaneously.
5. Use of community health workers – employ members of minority groups to act as community liaison officers, acting as guides to the health system and assisting clients to navigate the system, improve access and patient-client relationships and communication.
6. Cultural competent health promotion – campaigns and programs that incorporate culture specific attitudes and values.
7. Including family and/or community members – some cultures prefer for family members to be told of particular conditions and make health care decisions on the part of the patient, being aware of this is important to these groups.
8. Immersion into another culture helps professionals to be more culturally aware, conscious of their preconceived ideas, and integrate cultural beliefs into their work practices.
9. Administrative and organisational accommodations – services need to consider things such as clinic location, opening hours, physical environment and written materials in providing culturally competent services to minority groups.
Conclusion

The literature has demonstrated that patterns of utilisation are problematic, with many people attending dental services most often when they are in pain rather than for preventive care. Barriers that have been identified include communication and language, lack of importance placed on preventive care, cost, limited or no experience with oral health services overseas and the waiting list.

This literature review reveals that there have been no studies identified which specifically focus on barriers to accessing oral health services for the Horn of Africa community in Australia. The aim of this study is therefore to identify barriers to accessing oral health services for Horn of Africa community members living in Flemington PHE. The questions that arise from this literature review are listed below.

Research Questions

To address the aim of this study, the following questions arise:

1. What are the patterns of usage of the Horn of Africa community that are identifiable in clinic data and questionnaires completed by community members and oral health workers?

2. What are the barriers to accessing oral health services for Horn of Africa residents of the Flemington PHE as perceived by:

   - Horn of Africa community members?

   - Public dental clinic workers (including oral health professionals and administrative staff) working with this community?
Theoretical Framework

Access to health care is a major component of many public health approaches. It is featured as a high priority in reports and recommendations of key bodies including the World Health Organization and many government programs (Gulliford & Morgan, 2003). Understanding access is made easier when recognition of how vulnerabilities in communities and individuals arise. Candidacy theory is a relatively recent concept developed by Dixon-Woods et al (2005) that can be described as the ways in which individuals and health services work together to negotiate eligibility for health care and intervention. Candidacy theory recognises that barriers may exist at each stage of negotiation that can hinder a person’s capacity to access a particular service (Mary Dixon-Woods, et al., 2006; Goddard, 2009).

Dixon-Woods et al (2005) describe candidacy as a fluid concept that is a dynamic and contingent process, defined and redefined through interactions between individuals and professionals. In other words, people are not seen to either “have” or “not have” access to health services. Rather, access is something that is subject to change over time as the relationships between the consumer and service providers are built and is negotiated and renegotiated, or as the consumer’s circumstances change (Mary Dixon-Woods, et al., 2006). They argue that existing theories of utilisation, often measured in relation to affluent groups, tend to overlook the issues faced by vulnerable groups and that the complex processes involved in access for vulnerable groups need to be understood in order to effectively measure access to health care (D’Ambruoso, Byass, & Nurul Qumariyah, 2010; Mary Dixon-Woods, et al., 2006). The key characteristics of candidacy are presented in Table 4.

Working within the candidacy framework, the “Talking about Teeth” study seeks to identify points where people’s access to dental services may be vulnerable. These vulnerabilities are explored through qualitative data collection processes with both the individuals in the community, and the oral health professionals working in the community health centre. This exploration has enabled the identification of barriers that contribute to inequitable access to oral health services for this group in the community and these findings are presented in the following chapter.

Although there are a number of theories in health that could be applied to this project, using candidacy theory ensures that both the community members and the community health service have an opportunity to self-identify their needs, and the preferred methods through which to meet those needs.
### Table 4 - Characteristics of Candidacy Theory

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification</td>
<td>Differential recognition of symptoms as needing medical attention. Vulnerable populations are more likely to manage health as a series of crises.</td>
</tr>
<tr>
<td>Navigation</td>
<td>Awareness of the services on offer; known to be reduced for vulnerable populations. Mobilisation of practical resources, for example time off work and transportation, which are typically less readily available to vulnerable populations.</td>
</tr>
<tr>
<td>Permeability of services</td>
<td>Services are more or less accessible (permeable) depending on the qualifications of candidacy required to use them (for example a referral) and the degree to which resources need to be organised. Less permeable services “demand a higher degree of cultural alignment between themselves and their users.” (Mary Dixon-Woods, et al., 2006, p. 12)</td>
</tr>
<tr>
<td>Appearances at health services</td>
<td>Credibility once the client has presented at a health service depends on his/her competence in formulating and articulating the issue for which help is being sought.</td>
</tr>
<tr>
<td>and Adjudications</td>
<td>Judgements made by the health professionals about the cultural and health capital required to convert health provision into a health gain. This also involves some degree of judgement about ‘deservingness’.</td>
</tr>
<tr>
<td>Offers and resistance</td>
<td>Resistance by patients to referrals / treatment / medication.</td>
</tr>
<tr>
<td>Operating conditions</td>
<td>Locally-specific influences on interactions between practitioners and patients.</td>
</tr>
</tbody>
</table>

(Koehn, 2009, p. 589)
Methodology

This chapter describes the methodology and research plan for “Talking about Teeth”. It provides details about the research design and process, participants, recruitment, data analysis, rigour, ethical issues, and methodological limitations.

Research Design

A qualitative approach has been chosen to explore the lived experiences of accessing dental services for the Horn of Africa community in Flemington, and the experiences of the oral health professionals providing dental services to this community. The strength of a qualitative approach is that it allows the participants to express their opinions and experiences in their own words and raise issues that may not have been thought of by the researcher (Bryman, 2008). A quantitative approach was not selected for this project as it would not yield the in-depth information of the lived experiences of people that is required to inform how best to address barriers to access relevant oral health services for this population group.

What we believe about the nature of reality is known as ontology, and how we know what we know is known as epistemology (Lincoln & Guba, 2000). The nature of knowledge is explained by five epistemological paradigms, these are: positivism, post-positivism, critical theory, constructivism, and participatory. This project fits within a constructivist paradigm which is concerned with the ways in which human beings interrelate and interact in society, and interpret social life (2006, p. 17). Constructivism suggests that social phenomena and their meanings are produced through social interaction, and that they are constantly being revised by social actors (Bryman, 2008). In this project, the knowledge obtained is subjective and will be explored within a constructivist paradigm, taking a phenomenological approach to frame the research process.

The methodological perspective of this research fits within the interpretative phenomenological analysis framework developed by Smith, Jarman and Osborne (Schweitzer & Steel, 2008, p. 91). The focus of this framework is an emphasis on openness to human experience and the recognition that these experiences are likely to be outside of the researchers own experiences (Schweitzer & Steel, 2008). As the focus of “Talking about Teeth” is on the barriers to accessing oral health services for Horn of Africa community members as they have experienced them, and this is something that is outside of my own experience, it makes phenomenology an appropriate approach to use in this project.

Other theoretical frameworks commonly used in qualitative research include symbolic interactionism, ethnography, hermeneutics, feminism, and postmodernism. I have chosen to frame this
Talking about Teeth

research within a phenomenological framework because of its focus on the individuals’ creation of meaning to understand their world.

Research Process

In this project multiple methods were used for data collection. Using a phenomenological methodological approach led to the selection of semi-structured interviews with oral health workers and focus groups with Horn of Africa community members as the key methods of data collection.

Short questionnaires were provided to all focus group participants to collect demographic data including age, gender and language spoken at home (Appendix A). Different questionnaires were provided to the workers that collected data including years worked in oral health, perceptions of interpreter use and Horn of Africa utilisation of the service, and the barriers and challenges to working with this community (Appendix B). De-identified 2009-2010 financial year data (for example: client age, language, gender, interpreter needs, attendance) collected from appointments made with DGCHS dental service were provided by DGCHS and included to provide context and support to the lived experiences of participants. These multiple data sources provided an opportunity for triangulation to occur, adding to the rigour of this study. These methods allowed me to obtain both rich descriptions from the oral health workers, and a consensus view of the barriers to accessing oral health services from the perspective of the Horn of Africa community members.

Consultation phase

Widespread consultation with providers of services known to be working with the local African community was undertaken in the early stages of the project. These people provided valuable advice about engaging with the community, and assisted in promoting the project to the community.

Focus Groups

Why?

Focus groups are a form of interviewing that is conducted with a group of people who express their views about the issues through interaction with other group members. The data collected should represent a range of opinions and insights and consensus experiences of participants that emerge through the groups interactions with each other (P. Davidson, Halcomb, & Gholizadeh, 2010; Travers, 2006). The reasons I chose focus groups as a data collection method were to:

- Generate a collective perspective by providing an opportunity for participants to stimulate each other to comment and question, and to reveal differences in opinions;
Methodology

- Elicit data, through the group dynamic, that may be missed in individual interviews;
- Enable potential participants, who may not feel comfortable with individual interviews (for example – people with limited literacy or English language skills), to have their voices heard; and
- Access a larger number of participants whilst using similar resources as individual interviews. (P. Davidson, et al., 2010, p. 65)

How?

Three focus groups with women, and one focus group with men, with a total of 29 participants were held between July 22nd and August 5th 2010 at the Vietnamese Welfare Resource Centre, 58 Holland Ct, Flemington. This venue was selected as it was the only available venue we could access on the estate in the times that we needed. Consent to participate in the focus groups was sought prior to data collection taking place. At the beginning of the focus groups, I made a clear statement about the privacy and confidentiality practices to be observed by all group members. The study was explained in full, including the type of information being sought, privacy and confidentiality processes, and what was going to be done with the information provided. This was available in writing (in English, Arabic, Amharic, Afaan Oromo and Somali), explained in English and interpreted by professional interpreters. Time was allowed for questions, and interpreters attended each focus group to assist in overcoming language barriers. The questions asked of participants can be found in Appendix C. The focus groups were audio-recorded and the placement of the participants in the room was mapped on diagrams to allow for detailed data analysis to occur.

Focus group participants were provided with African food following the focus groups, bags containing oral health information, a toothbrush and toothpaste, Miswak (a traditional teeth cleaning twig), and the opportunity to make an appointment (within 3 weeks) with DGCHS dental service.

In-depth interviews

Why?

In-depth interviewing is one of the most common data collection methods utilised by qualitative researchers and is used to “answer social questions through the subjective meanings and understandings people bring to their interpretation of the social world” (Travers, 2006, p. 86). The reasons I chose semi-structured interviews as a data collection method included:
Talking about Teeth

- To address meaning in greater depth, and with more attention to complexity than structured interviews;
- To enable a wider range of topics to be covered;
- They require less time, are less intrusive and impose less demands on participants in contrast to other data collection methods, (for example, conducting ethnographic fieldwork); and
- They can be a remarkably effective means of collecting information about a wide range of topics quickly and cheaply.

(Travers, 2006, p. 104)

Whilst planning this project and spending time working in the back of the dental clinic, I developed an understanding of the relationships between staff members and felt that in a focus group some may feel uncomfortable sharing their thoughts in front of their colleagues which would not produce a rich source of data. In addition, individual interviews are less disruptive to the appointment schedule of the dental service. Therefore, a semi-structured interview method was selected to allow each participating staff member to have their own private discussion about the topic.

How?

Nine workers from the clinic participated in a one-hour semi-structured interview in a private room at DGCHS in Kensington. Information and consent forms were given to staff prior to the interview and an opportunity was provided at the beginning of the interview to address anything requiring clarification for the participant. The interview questions can be found at Appendix D. The interviews were audio-recorded and notes were taken during the interviews, which were elaborated on immediately afterwards. Lists of names and codes were stored separately from the data. Upon completion of the interview, participants were presented with a $20 Coles-Myer card to show appreciation for their participation.
Methodology

Participants

In this project, it was not appropriate to obtain a representative sample using random sampling techniques as the project aims are targeted at the chosen population and not intended to be generalised more broadly than the Horn of Africa community living in public housing facilities in inner-west Melbourne. Therefore, purposive, volunteer, and homogeneous sampling techniques were employed.

- **Purposive sampling** – cases that can provide in-depth information are sought out (Liamputtong, 2010, p. 19).

- **Volunteer sampling** – participants may be difficult to contact directly and are drawn to participate through a range of advertising methods (Kuzel, 1992).

- **Homogeneous sampling** – focus group participants are selected to minimise variation and allow for in-depth, detailed discussion about their experiences accessing the dental service (Kuzel, 1992).

Other possible sampling methods such as typical case, convenience, maximum variation and snowballing were not chosen as they would not best recruit the participants required to elicit the in-depth data needed for this project.

**Community members**

*Inclusion criteria*

- Aged over 18

- Horn of Africa background (self-identified) (not necessarily refugee background)

- Current residents of the Flemington PHE

**Oral health professionals**

*Inclusion criteria*

- Aged over 18

- Currently employed by DGCHS and working in the Kensington dental clinic
Recruitment

Community members

Recruitment for the focus groups was conducted by distribution of invitation flyers and posters (translated into relevant community languages) placed around the Flemington PHE. These flyers were also distributed electronically through community leaders, and colleagues and organisations known to be working with the community. Workers from these organisations and community leaders also promoted the project via word of mouth, and the focus groups were promoted on the Somali community radio station in the weeks prior to the groups being held.

Names and contact details of the focus group participants were not collected until the day of the focus groups. Consultation with agencies working with the community revealed that advertising the focus groups through flyers and word of mouth strategies is a more effective method of recruitment than more cumbersome registration processes.

Oral health professionals

Initial contact was made with staff of the local public dental service via email, accompanied by a notice on the staff noticeboard. The information sheet and consent form accompanied the advertisement giving potential participants time to read it and contact the researcher should they require any further clarification. Participation was voluntary and had no impact on the employment status of participants.

Data Analysis – Focus Groups and Worker Interviews

In order to develop an in-depth understanding of the barriers to accessing oral health care, thematic analysis was used in this project. This type of analysis is commonly used in qualitative research as it involves the drawing of descriptions, comparisons and explanations of the data (Liamputtong & Serry, 2010). In comparison, content analysis (which can also be used in qualitative research) involves identifying codes prior to data collection and counting how many times they appear in the data. I chose not to use content analysis because it can be difficult to obtain responses for why a particular phenomenon occurs using this method (Bryman, 2008), and because of the diverse backgrounds and language proficiency of participants, a content analysis may have missed important data that was able to be identified through thematic analysis. Recordings of focus groups and interviews were transcribed, de-identified and coded. To assist with limited timeframes, professional transcribing services were employed to transcribe seven worker interviews. Data analysis was completed using a Six Stage process. These stages included acquiring a sense of the transcripts, extracting significant statements, formulation of meaning from the statements, organising meanings into themes, exhaustively describing the
investigated phenomena, and describing the fundamental structure of the phenomenon. These steps are presented in more detail in Table 5 below.

Table 5 - Stages of Data Analysis

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1  Acquiring a sense of each transcript</td>
<td>Read the transcripts and listen to the original recordings to get a sense of the data as a whole without making notes or attempting to interpret the data.</td>
</tr>
<tr>
<td>open coding</td>
<td>After reading the transcripts, record reflections of particularly interesting or significant issues.</td>
</tr>
<tr>
<td>Stage 2  Extracting significant statements</td>
<td>Read through the transcripts repeatedly and made basic notes in the margins.</td>
</tr>
<tr>
<td>focused coding</td>
<td>Label the notes with the participants’ code, page and line number, and then group together.</td>
</tr>
<tr>
<td>Stage 3  Formulation of meanings</td>
<td>Explore connections between the codes and the literature to ascertain if there is evidence that one thing might be associated with another.</td>
</tr>
<tr>
<td>focused coding</td>
<td>Print each transcript on coloured paper (a different colour for each transcript) and cut each one into sections based on their themes.</td>
</tr>
<tr>
<td></td>
<td>Collate the pieces of transcripts according to themes.</td>
</tr>
<tr>
<td></td>
<td>Interpret meanings from the commonly made statements in the transcripts.</td>
</tr>
<tr>
<td></td>
<td>Record reflections of assumptions, reactions to participants’ narratives, and connections with the literature.</td>
</tr>
</tbody>
</table>
**Stage 4**

Organising formulated meanings into clusters of themes – axial coding

- Group together statements with commonalities.
- Draw the data back together after sorting it in focused coding, and break into smaller categories.
- Member checking of data interpretation.

**Stage 5**

Exhaustively describing the investigated phenomenon

- Describe in detail the main themes that emerged.
- Define themes so that they make sense to the reader.
- Submit analysis to research supervisor for review.

**Stage 6**

Describing the fundamental structure of the phenomenon – selective coding

- Reduce theme descriptions to their fundamental or essential structure.
- Clearly define core themes drawn from previous stages.
- Begin to write preliminary conclusions highlighting links to the literature.

---

The above data analysis framework was adapted from those suggested by Carpenter (2010), Liamputtong and Serry (2010), and Willis (2007).

**Data analysis – Questionnaires and Client Usage Data**

The data were entered into statistical analysis program EpiData v.3.1 and EpiData Analysis software (Lauritsen, 2000-2008) was then utilised to generate descriptive statistics including frequency counts. Data from the community member and worker questionnaires have been represented using pie charts and column graphs.

**Rigour and Trustworthiness**

A number of steps were taken to ensure rigour in the research process. These included:

- My classmates in Action Learning Project (a Master of Public Health unit at La Trobe University) reviewed and completed the questionnaires and provided suggestions for improvement;
Methodology

- Members of the advisory group provided feedback around the focus group and interview questions;
- The project advisory group reviewed the de-identified data and checked my interpretations against the meaning they saw in the data;
- Workers were sent a copy of their transcript to review for accuracy;
- Two Horn of Africa community members read the transcripts that included the researchers interpretations and provided feedback regarding any cultural meanings which may have been misinterpreted; and
- The recording of the one focus group which was mostly spoken in Arabic was listened to by a third party Arabic interpreter to ensure that the recorded interpretation was accurate.

Ethical Issues

Record keeping.
The raw data collected and consent forms have been stored in accordance with La Trobe University Faculty of Health Science Human Ethics Committee regulations.

Consequences of participation
There were no foreseen adverse consequences for participation in these focus groups or interviews. However, participants were reassured that should they experience any discomfort, they were free to take a break or leave the focus group or interview if they wished. Participants were offered free counselling services through DGCHS and this offer was included on the Participant Information Sheet and Consent Form. Participants were informed that they were welcome to call, or approach me (or my supervisor) following the focus group or interview if there was anything they would like to discuss in further detail.

Confirmation of approval
The La Trobe University Faculty of Health Science Human Ethics Committee granted approval for the commencement of this project on May 7th, 2010 (approval number FHEC10/59). This approval was endorsed by the Executive Sponsor, Human Research Ethics Committee, Dental Health Services Victoria on July 28, 2010 (approval number 227).
Methodological Limitations

Data collection in a language other than English

Undertaking cross-cultural qualitative research with participants speaking a language other than that of the researcher presents potential limitations (Hennink, 2008). In this project interpreters were used to translate the dialogue of participants in the focus groups. The subjectivity of the interpreters is important to acknowledge, because like researchers, they bring with them their own perspectives and background which can influence the way in which they interpret dialogue (Hennink, 2008). One of the problems with this is that although the interpreters were instructed to interpret word for word, without paraphrasing or adding their own perspective into their translation there are some words which do not have direct translations (Hennink, 2008). This means that interpreters are required to choose what they deem to be the most appropriate translation and this can have an impact on the meaning that the researcher draws from the data (Hennink, 2008). The voice recordings were transcribed in English which can lead to loss of potential meanings in the data. It was outside the scope of this honours project to have the recordings transcribed in the primary language of participants. By employing two research assistants of Horn of Africa background to read the transcripts and assess the meanings interpreted from them, it is hoped that the trustworthiness of the data analysis was enhanced.

Community member participant recruitment

The low number of male participants means that most of the results present a female perspective. Refugee status was not a criterion for involvement in this project and whilst it is unknown how many participants were refugee background (some certainly were), the participants are likely to know refugees even if they are not themselves. The findings therefore cannot be specifically applied to refugee groups, but will be a useful start for services working with both refugee and Horn of Africa communities.

Bias and confounding

As the sample was self-selected, it is likely to be a biased sample. Possibly the people with the biggest problems with the dental service wanted to attend so that they could have their say, but I don’t believe this is the case as many had positive things to say about the service. The clinic usage data is not biased (as it includes details of all appointments made in the 09-10 financial year) and provides data to compare with that collected from community members and workers, reducing the impact of bias on the results of this project.
Conclusion

This chapter has provided a description of the methods used in this project, the participants and how they were recruited, the methods of data analysis, how rigour was achieved, an overview of the ethical issues, and the recognised limitations of this methodology. The findings elicited through these processes are presented in the following chapter, along with recommendations for addressing the barriers identified.
Talking about Teeth
Project findings

The findings of the project are presented in the following two chapters and include the themes derived from the data collection. The first chapter covers the structural barriers, and the second covers individual barriers. Individual barriers are those that vary between individuals, where structural barriers are those which affect almost all community members and are more likely to require service or government level assistance to overcome. Each chapter concludes with a discussion and recommendations. Direct quotes have been used as much as possible to highlight the key points made by participants in the study. These are presented in italics and ellipses have been used to demonstrate where text has been excluded to provide additional clarity. A number of findings were uncovered that don’t fit specifically into barriers to access, these can be found in Appendix E.

The major themes identified in the findings include:

1. Structural barriers
   i. The waiting list: The biggest barrier?
   ii. Navigating the system
   iii. Priority access
   iv. Accessing the dental hospital
   v. Adjusting to appointment systems

2. Individual barriers
   i. Preventive care? We only come when we are in pain
   ii. Language and literacy
   iii. Word of mouth
   iv. Challenges for new arrivals
   v. Financial costs
   vi. Lack of previous exposure to oral health care
   vii. Cultural barriers
   viii. Safety and hygiene in the clinic
   ix. Fear
   x. Trust

   b. Discussion and recommendations
Talking about Teeth

Structural barriers

System or service level barriers are described here as structural barriers. They include the waiting list, understanding the system and service available, priority access eligibility, accessing the dental hospital, and service atmosphere and culture.

The waiting list: the biggest barrier?

The waiting list was identified as a major barrier by all community members. Many of the participants reported positive experiences when attending local oral health services however these comments were often followed with a comment about the waiting list:

I found very good service but the problem is...you wait a long time. (CM16)

The service is good, but only the waiting list because they wait until your teeth are already really damaged and then they call you so at that time you have to take it out. And you live with the pain all this time cos everytime you call they say you know if your face is not swollen or you’re not having any severe pain they don’t call you. You wait. You can’t call. (CM3)

One community member who has been in Australia for three years said that they hadn’t made an appointment because they knew the waiting list was long. Another said that it is easier to just wait until you have pain.

People don’t make the appointment because you know you are not going to go straight away, you are going to be on the waiting list, so you say ok I will just wait until I have pain and then I will go. (CM1)

For some participants, they felt like the long waiting list and also the length of time it takes to complete a course of care are because it is a public system and assumed that because the workers/service are not getting paid like in private care they aren’t concerned about how long it takes to complete treatment for clients. Knowledge of long waiting lists deters people from making appointments, one community member who has been in Australia for three years said that they hadn’t bothered to make an appointment because they knew the waiting list was long.

There was also discussion about why it is recommended that they have six monthly check-ups when the waiting list is so long that this kind of preventive treatment is impossible to access in the public system.
We don’t have a lot of preventive treatment, we wait until the last minute when we have the tooth decay or anything like that, they should reinforce preventative treatment, how to clean the teeth how to eat... (CM12)

Some community members reported being told that they were being put on a waiting list when they called to say that they were experiencing pain. One community member reported being in pain, but that she is on the waiting list because the pain isn’t causing facial swelling. Community members were aware of the increased risk of more dental problems while being on the waiting list. They said that while they are waiting their teeth get worse and then they are told the only option is extraction. They said that if they were able to get an appointment sooner, the problems could be fixed before they get worse.

They do everything, but the problem is until you get there, what is going to happen? (CM4)

Understanding the system and services available

Community member consensus view revealed that a lack of knowledge of how the system works (including knowledge of eligibility criteria, how to make an appointment, and the processes involved once you have an appointment) creates a major barrier for community members as they are hesitant to attempt access for fear that the service won’t understand them and they would not be able to get an appointment. In the community member questionnaires, participants were asked how many times they had seen a dentist in Australia. The responses to this question are presented in Figure 2. This question was asked to provide a context for the verbal responses provided by community members.

**Figure 2 - The Number of Times Horn of Africa Community Members Have Seen a Dentist in Australia**

![Bar chart showing the number of times community members have seen a dentist in Australia.](chart)

1 *Note – the word ‘dentist’ was used as opposed to other more accurate oral health terms as a means to overcome language barriers. Most people have a broad understanding of the word dentist, but may not understand other terms such as hygienist or therapist.*
Talking about Teeth

Roughly half of the community members discussed being unsure of the qualifications of workers and assume that they are students or not fully qualified because they work in public health services. They said that this deters them from making appointments as they don’t feel confident in the skills of the workers. Most of the workers reported that they are often asked if they are qualified by clients, not just of Horn of Africa clients, but clients in general. It was revealed that assumptions that workers are unqualified can cause some community members to not seek oral health care.

Another barrier to access arises when prospective clients are on the waiting list and they move house before they are offered an appointment. Appointment offers are made via written letters and if clients don’t update their address when they move, they will miss this information and a lack of response will lead to them being removed from the waiting list.

Some workers described the expectations clients have that are beyond what the service can deliver. Some had experienced appointments with clients who wanted braces and other types of specialist services such as implants that are not provided in public dental clinics. Being refused these services can create feelings of frustration for clients and when language barriers exist, this can be challenging for workers and clients to overcome.

Understanding appointment systems

Late attendance to and failure to attend (FTA) appointments are indicators that barriers exist at different stages of accessing services. Clinic usage data is used to present the FTA rate of clients in 2009-2010 by language group in Figure 3 and shows that along with English speaking clients, African language groups are more likely to FTA than European, Asian (excl Chinese), Chinese and Middle Eastern language speakers. If you add Arabic speakers to the African language, their likelihood to FTA is proportionately higher than English speakers. (Presenting languages in groups rather provides a figure that is more useful for interpretation than if it was to be presented using individual languages). The total cost of FTA’s to the service in 2009-2010 was more than $225,000 ($115 per appointment - Note that some of this is recuperated by ‘Sit and Wait’s’ – clients who attend on the day and wait for an appointment to open up). This is an additional issue where interpreters are booked, and in the last financial year 1,639 interpreters were booked for appointments where clients did not turn up or cancel their appointment.
Community members in all focus groups discussed late attendance and said that being late is socially accepted and even expected in African culture, so adjusting to Australian social norms of being on time to things can be difficult for some people. Participants in one focus group talked about having “no culture of appointments back home” as being a reason for people being late to appointments. They also said that for official appointments they are always on time, but for social events it is acceptable to be hours late. Discussion about time led to some very useful information for Australian services working with the Horn of Africa community. In some Horn of Africa countries, time is told in a different way to Western ways of telling time. Instead of operating on a 24 clock, the clock instead has two 12-hour sections, with the day beginning at sunrise which is 1:00, going through to 12:00, then starting at 1 again at sunset. Therefore 11am Australian time is known to many Horn of Africa community members as 5:00pm. Knowing this, it might be helpful for services to clearly stipulate either “Australian time” or when saying eleven o’clock, to add “in the morning”. For many Horn of Africa community members living in Australia, there is a very conscious thought process involved in understanding the time and getting it “right”.

…in our country (Australia) now it’s ten to 11, but if you ask someone come here what’s the time, they’ll tell you ten to five. (CMI 10)
Talking about Teeth

Community member interpreters and the oral health workers were eager for messages of the importance of attending appointments on time and calling to cancel appointments be given to the community. Workers were aware that attending appointments on time can be challenging for Horn of Africa clients, but felt frustration at their inability to provide planned treatment when clients are late.

*I think in a way you have to accept for the newly arrived that they will be late and that they will fail (to attend) because they haven’t learnt the systems yet. So there is either two things to think about; either we don’t offer them that care before they have got that social integration that has happened already or if we do offer them the care, we have to expect that they are not going to conform to our ways. And I think that makes life easier if you can just accept that.* (Worker 2)

The interpreters and some community members emphasised the importance of reinforcing the need to attend appointments on time. Community members said that services/events should start on time and the people who are late will just have to miss out. Because currently, people aren’t missing out on anything by being late, they aren’t learning anything. Community member interpreters were insistent about the need to enforce ‘on time attendance’ with the community.

*But they (the service) say ok you come today late, they still see you, the next time they (the client) come after an hour, they know that someone will see them so it’s really good to be serious about this.* (CMI3)

One community member interpreter gave an example of how they learned the importance of attending appointments on time.

*I remember when I arrived here a long time ago, I had a dental appointment, it was a private one I saw them first and I went there. I was about ten minutes late and when I went for that treatment, and the doctor told me ‘sorry you are late so we can’t see you today’. From that day, I make sure that I am always on time. I learnt from one lesson.*

In the first focus group, the community member interpreters suggested that the importance of attending appointments on time be enforced with the community. They also discussed how some organisations make people pay a fee when they are late and that enforcing attending on time will help clients to avoid these kinds of consequences with other services. One of the workers had had some success in being firm about attending on time.
There’s a couple of families I’ve had to seriously put my foot down, refused to see the patients because I’ve tried everything else to get them on time and it’s just that last effort, “If you don’t turn up on time next time, I’m not going to see you whether there’s an appointment time or not,” which then cuts into my day because I’m losing productivity, but it seemed to work.

Educating the community members that this is a free service that is funded by the government loses money when people don’t attend may give community members a greater appreciation of the need to attend on time.

**Priority access**

Currently, all refugees and asylum seekers have priority access to public dental services. This means that they are not put on the waiting list and are given the next available appointment and that when they attend for their appointment they are not required to pay a co-payment. For many community members, it seemed that they were unaware of their priority access eligibility:

“Why do children and the elderly get special access, but we don’t?” (CM 24)

In order for clients to be given priority access, workers need to know if they are a refugee or an asylum seeker. Other than directly asking a client, there are a few ways that workers can identify whether a client is a refugee or not. Referrals that come from AMES, Foundation House or the refugee health nurse is the first indication. One worker also mentioned that the clients address can also be an indicator of their refugee status, although this is an assumption and may not always be correct. Finally, the only other way to know is if the client tells the worker. Workers didn’t always feel comfortable asking the question directly and said that sometimes you would get an indication based on other discussions around how long a client has lived in Australia and where they lived prior to coming here.

(I knew she was a refugee because) her husband said, we have the war. There’s a war there. That’s why they came here to Australia. That’s why we don’t have any experience with the dentist because we left our country...(Worker 5)
Talking about Teeth

Accessing the dental hospital

Many of the community members reported on their experiences with the dental hospital. Waiting to be seen at the hospital was a particular concern of community members. Some participants reported waiting all day and then having to go home with no treatment. They discussed the challenges of waiting when you have small children as sometimes you wait to be seen but have to leave to attend to children’s needs.

...if you go to the emergency you will stay there for at least four hours before you give up and then you go back home. And if you have kids and you have life at home, you can't leave your kids that long. I did it a few times actually, waited so long and then just go home. (CM3)

There was also discussion around access for emergency care and questioning around why general hospitals are available 24hrs, but the dental hospital is not. For some people, waiting in the hospital caused them to turn to expensive private care in order to get the treatment for pain that they needed. One community member who accessed private dental care said that they started but didn’t finish treatment because it was too expensive.

At times workers found referring clients to the hospital for pain challenging. They reported that clients don’t like being referred, particularly if they’ve been to the hospital before, the waiting time and the distance to travel is frustrating for clients. Additionally, the criteria set by the hospital for orthodontic needs are incredibly strict and many clients who the workers would like to refer for more specialist treatment that can’t be provided by the clinic are ineligible. This means that the clients have to seek private care, which for many is simply unaffordable and as a result they may suffer oral health problems in the future.

Typically if you don’t allow those treatments to happen when they are younger, they can have much more difficulty in eating, speaking, later on or in the future. (Worker 4)

Service atmosphere and culture

The culture of the service was of particular importance to most community members. When asked how important cultural understanding was to the community members, community members in all focus groups emphasised that what matters to them is being treated equally and with respect. Community members in two of the focus groups described the “perfect clinic” as clean and organised, and a warm, positive environment with smiling workers. This makes a big difference to how clients feel
when they are at the clinic, especially for those who have not had a lot of experience with dental services before. In one focus group, all of the community members agreed that seeing all the tools and hearing the drill can be overwhelming so a positive environment can help to overcome that.

Consensus view of community members showed their eagerness for workers in health organisations to understand their culture, and would like for them to be more understanding of their needs.

If I went to public I would expect to be treated well and to be treated with respect. I don’t want them to have preconceived ideas. I want to be treated like a human being. (CM17)

The community members talked about the qualities of workers that improve the experience of accessing oral health care. One community member summed up very clearly what many of the focus group discussions covered.

My expectation is able to have understanding and, you know, in terms of my culture, my background, to make it easier and I’m talking about somebody who’s treating my teeth, at least have some sympathy because I’m going through pain. So, somebody who, I guess, I can rely on because you’re actually trusting them to take care of your tooth...A smile wouldn’t hurt, like, to welcome you ...(CM17)
Talking about Teeth

Discussion

The structural barriers identified in this chapter present a number of issues that services can address to improve access for the Horn of Africa community. The waiting list was one of the most discussed topics in focus groups, and commonly referred to as the biggest barrier by community members. Much of the existing literature about waiting times is Australian. Davidson et al. (2007) undertook research focused on refugees in Australia and found that waiting lists for public dental services were unacceptably long. Additionally, in the two studies of Italian and Greek older migrants in Australia, the waiting list was identified as the biggest barrier to accessing oral health services (Mariño, et al., 2002; Mariño, et al., 2005). Waiting lists not only mean that people have to delay accessing oral health services, but it has been found that they discourage people from implementing positive oral health behaviours (Mariño, et al., 2002). The findings in this project support this Australian research and have successfully added the Horn of Africa community to the literature as a group that identifies the waiting list as a major barrier to accessing oral health care.

Workers concern with the Horn of Africa community’s late arrival and failure to attend appointments is supported to a degree by the service data. This is also a new finding that contributes to the literature and requires further exploration. Lateness and failure to attend appointments disadvantages other clients who are waiting for treatment, and comes at a significant financial cost to public dental services (up to $150 per missed appointment). Lateness was also an issue discussed particularly by community member interpreters who disclosed that this is not just an issue with oral health services, but the community accessing services and attending appointments more broadly. Findings regarding an alternative way of telling time in some Horn of Africa countries helps to explain why some clients may not attend appointments on time and offers space for services to adjust procedures in advising clients of their appointment times.

Enforcing the importance of attending appointments on time was a common theme to emerge from the participants. Some community member interpreters suggested denying service to clients who are late because if they are still seen by a worker, they aren’t missing out on anything by being late, so they don’t learn the importance of attending appointments on time. Community member interpreters also acknowledged that if people are only a little bit late, they should still receive some services so that they haven’t wasted effort in trying to get there.

The apparent lack of awareness of priority access eligibility amongst the community members indicates that additional effort needs to be made by service providing oral health care to this community. However, services must be cautious that they have the capacity to increase the number of priority access clients before doing this. Another reason that community members may be unaware of
their priority access eligibility is that they were only included in this group by DHSV in 2009 (Victorian Government Department of Health, 2009). DGCHS is funded by Foundation House to provide 10 hours of clinical service per month to refugee clients referred through AMES.

The issues raised regarding accessing the hospital are not unlike those issues experienced by people accessing emergency services in general hospitals in Victoria. What this piece of work has added, is that this is a problem in the dental hospital and it needs to be addressed because people are not receiving the treatment they require which potentially leads to much worse oral and general health outcomes. Finally, public oral health services need to be attending to the ‘feel’ of their clinic. This project has demonstrated that there are many positive effects of a clinic that is warm, positive and clean, with workers who are attentive to clients needs and treat all clients equally and with respect.
Recommendations

DGCHS

Increase and improve referral pathways and partnerships

- Increase referral pathways between dental and other programs at DGCHS.
- Coordinate worker forums and partner with external agencies to educate other services about the processes and procedures in public dental providing other workers with the knowledge needed to inform their clients of this information.

Communication

- Increase opportunities for clients to provide feedback in the clinic:
  - Feedback forms / questionnaires to complete following appointments.
  - Employ community liaison officers to speak with clients following appointments.
- Offer clients a copy of their treatment plan following their first appointment so that they know what to expect in subsequent appointments, and why they are required to come back for additional appointments.

Community engagement

- Build connections and relationships within the community to enable ongoing dialogue and program improvements.
  - Be conscious of the role that politics can play. It was revealed that some people will attend events that community leaders recommend for fear of not being seen doing what the community leaders have told them to do, additionally, some community members are wary of people in positions of power (such as community leaders) because of the role that people in power played in countries they have lived in before coming to Australia and so they don’t go to events promoted by community leaders for this reason. Being transparent about what you are doing, how you are doing it, and what the benefits will be to individuals in the community might be a more effective approach to engaging community members who are wary of community leaders.
Other

- Build a new clinic that is physically more accessible to residents of the local housing estates.
- Display names and qualifications of all oral health professionals working in the clinic
- Display a list of the different oral health professional titles and description of roles in reception area.

Community health services

Communication

- Provide reception staff with a list of commonly used words (such as days of the week) translated into languages other than English.
- Ensure that clients are actively involved in health decision making processes ensuring that professional interpreters are utilised where language barriers exist.
- Ask clients if they have a gender preference for their worker when making appointments

Health promotion activities

In partnership with the community, develop and deliver an education program that covers information regarding preventive care and navigation of the system. Deliver this program at a local venue, at regular intervals (every 6-12 months), on weekends, in local languages with an oral health professional present to perform examinations. This could be done using an existing peer education model (peer education has been used successfully in the estate across a number of health topics including child nutrition, Vitamin D and heat stress).

- What services are available in a public dental clinic
- The appointment system
- What to bring to an appointment
- The role of public dental services and the Dental Hospital in Victoria

Produce a DVD in a variety of appropriate languages that includes information as listed above.

Capacity building

- Training for oral health workers in
  - Rapid rapport building
  - Dealing with distress / conflict resolution
  - Working with interpreters
  - Cultural awareness and understanding the refugee experience
  - Learning about the community, their culture and background
Talking about Teeth

- Managing ‘hard’ patients (mental health, disabled, drug/alcohol affected)
- Reading / using body language to overcome language barriers

Other

- Provide after hours and/or weekend services for clients who work during the day. *Drop in sessions were not wanted by the Horn of African community member participants.
- Create a positive atmosphere in services.

DHSV and Department of Health (DoH) policy

Waiting list

- Implement a centralised intake system to direct clients to services with the shortest waiting lists.

Communication methods

- Reminder calls for appointments should be made on the day before, and on the day of appointments. Some community members suggested that a call a few weeks in advance for appointments made months earlier would also be very useful. This would be most effective if made in the clients language.
- Call clients in their language when they reach the top of the waiting list as well as / instead of sending a written letter.

Eligibility criteria

- Advocate for a clear definition of refugee to be used in determining eligibility and parameters of care provided.

Funding

- Increase funding to allow for better utilisation of interpreters and lengthened appointment times where there are language barriers (to provide the time required to obtain medical history, create a treatment plan, obtain consent, and begin treatment).

Interpreter accountability

- Interpreter services need to be held accountable for the interpreters they are sending to health services, this needs to be reinforced through policy agreements between health services/departments and interpreter service providers.
Individual Barriers

Individual barriers

Individual barriers are related to those barriers which could be addressed at an individual, rather than system wide level. These include importance placed on preventive care, language and literacy, word of mouth, challenges for new arrivals, financial costs, lack of previous exposure to oral healthcare, cultural barriers, fear, and trust.

Preventive care? We only come when we are in pain

A lack of knowledge of the importance of preventive care stops people from accessing services in the absence of pain. Almost all community members and approximately half of the workers discussed patterns of health seeking behaviour and all of these participants agreed that dental treatment is sought most often when a Horn of Africa community member is in pain rather than for preventive care.

*We don't have a lot of preventive treatment, we wait until the last minute when we have the tooth decay or anything like that... (CM23)*

To obtain an indication of the regularity of the experience of pain of community member participants, a question was included on the *community member questionnaire* asking participants how often they experience pain in their mouths. Responses to this question are presented in Figure 4.

**Figure 4 - How Often Community Member Participants Experience Pain in Their Mouth**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
</tr>
<tr>
<td>A couple of times a month</td>
<td>7</td>
</tr>
<tr>
<td>Once a week</td>
<td>4</td>
</tr>
<tr>
<td>More than two times per week</td>
<td>1</td>
</tr>
<tr>
<td>Every day</td>
<td>1</td>
</tr>
</tbody>
</table>
Talking about Teeth

Financial costs and the waiting list were reasons given for accessing services in emergency rather than preventive care situations. In two of the focus groups, community members said that they didn’t bother making an appointment for preventive treatment because they were deterred by the long waiting list. Community members in three of the focus groups reported that accessing health services for pain rather than preventive care is common in their home countries. This response was supported by a participant who had worked in an African dental clinic.

... I been working in (country) as a dental assistant and have experience there. We try to remind them about their appointment, they say “oh I don’t like to come here, the pain is gone”. We try to remind them, but they say “I don’t care”. (CMI 1)

Community members said that for some people, the concept of preventing ill-health is abstract and is difficult to understand. One community member reported that they went to the dentist for a check-up and their friends couldn’t understand why they would do that if they weren’t in pain. Community member interpreters in the first focus group discussed the pattern of disengagement with treatment or health services when pain is no longer present. This was compared with general health conditions as community members discussed things such as taking antibiotics prescribed by a GP.

People think they should seek medical assistance when they are really in pain and once the pain is gone that’s it, then they don’t have to see the doctor again. But even if they go to the doctor with a cough or something like that, even with antibiotic you have to finish that course of antibiotic, but if that cough is gone within one or two days, they stop taking the antibiotic. So it’s a lack of knowledge and education about continuing with treatments that are needed to fix health problems. (CMI2)

Four of the workers revealed that many community members don’t understand that there can be problems with their teeth when they are not in pain. One worker reported that three clients in the two weeks prior to the interview had asked for a clean only and no examination.

...one day I had three who said, ‘I just want a clean I don’t want you to check’,... ‘I have been on Christmas Island for so long I didn’t clean my teeth for so long so I need a clean desperately’... I explained I had to do the check up and I need to see if they have got holes... (Worker 9)
Language and literacy

Language is identified as one of the biggest barriers by workers and community members. It is a barrier for many community groups, not just the Horn of Africa community. Language barriers make all stages of access challenging for both community members and workers.

_"I guess any language barriers, not so much with the African background but any background..."_ (Worker 4)

The main language spoken and the percentage of clients in each language group who made an appointment with the dental clinic in 2009-10 are presented in Table 6. This table shows the high proportion of clients who are Horn of Africa background, and their similarly high needs for interpreters when compared with other language groups who access the service.

**Table 6 - Main Language Spoken at Home of All Clients in 2009-2010 Financial Year**

<table>
<thead>
<tr>
<th>Language</th>
<th>No of clients</th>
<th>% of all clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>5794</td>
<td>50.60%</td>
</tr>
<tr>
<td>Arabic</td>
<td>852</td>
<td>7.44%</td>
</tr>
<tr>
<td>Somali</td>
<td>659</td>
<td>5.76%</td>
</tr>
<tr>
<td>Italian</td>
<td>433</td>
<td>3.78%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>409</td>
<td>3.57%</td>
</tr>
<tr>
<td>Spanish</td>
<td>358</td>
<td>3.13%</td>
</tr>
<tr>
<td>Cantonese</td>
<td>356</td>
<td>3.11%</td>
</tr>
<tr>
<td>Tigre/Tigrigna</td>
<td>240</td>
<td>2.10%</td>
</tr>
<tr>
<td>Oromo</td>
<td>219</td>
<td>1.91%</td>
</tr>
<tr>
<td>Greek</td>
<td>218</td>
<td>1.90%</td>
</tr>
<tr>
<td>Chaldean</td>
<td>194</td>
<td>1.69%</td>
</tr>
<tr>
<td>Persian/Farsi</td>
<td>173</td>
<td>1.51%</td>
</tr>
<tr>
<td>Amharic</td>
<td>146</td>
<td>1.28%</td>
</tr>
<tr>
<td>Assyrian</td>
<td>135</td>
<td>1.18%</td>
</tr>
<tr>
<td>Not known/blank</td>
<td>117</td>
<td>1.02%</td>
</tr>
<tr>
<td>Mandarin</td>
<td>116</td>
<td>1.01%</td>
</tr>
<tr>
<td>All other languages</td>
<td>1031</td>
<td>9.90%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11450</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

*Note – languages with less than 1% representation have been grouped under “All other languages”.*
Talking about Teeth

Almost all of the community members talked about low literacy levels in their community and that common methods of information delivery such as written information are not always appropriate. The preferred methods of receiving information about oral health were uncovered in the community member questionnaires and are presented in Figure 5 demonstrating that group information sessions are preferred to written communication or radio.

Figure 5 – Community Member Participants Preferences for Methods of Health Promotion Delivery

*Note: participants were able to select more than one response for this question.

Community members reported that language barriers impact on all stages of accessing the service, such as knowing that it exists, making an appointment, attending an appointment, explaining a problem, understanding treatment options, what the subsequent stages of treatment will be and booking future appointments. Attending health services in Australia when English is not your first language can be frightening for clients. They said that they worry that the workers won’t know what they are saying, and that they sometimes feel judged by workers.
Sometimes if English is not your first language it’s hard and some people straight away judge you what by you look like, what you’re wearing...Initially you want to be treated the same as everybody else and you want to be feeling that, okay, I know I’m going to this, this is a hard thing for anyone to go to a dentist but I made it this far to come. You don’t want that experience of being judged before you get the chair. (CM17)

Community members in the fourth focus group talked about experiences they had had where the body language of the worker was negative and it seemed to stem from the fact that the client had poor English skills. Workers need to be polite, more explanatory and understand the cultural background of people, especially when they don’t speak English.

There are many elements of communication that were discussed by the community members and workers. Clear explanations of problems and treatment plans are essential for clients to understand what is happening in their appointment. For one community member, a sense of mistrust arose from a situation where they were told they needed a tooth extracted.

She said that they say it’s damaged from the inside but when they take it out only like a little hole on the top, but from the root, it’s very good. Yeah and like when I went, I went a few times and they did want to take it out and I refuse and I say no, I don’t wanna take it out. ...said it’s very damaged and I said I can feel it’s not damaged from the inside, I can feel the pain from the top and I don’t wanna lose my teeth every time I come. I will be like a baby!(CM3)

Also, taking the time to explain why people can’t have an appointment (for example if they turned up too late), or why they can’t receive a particular treatment has a much more positive outcome than just saying ‘no’. Workers need to take time to explain information in language that clients and interpreters understand.

It’s just explaining, not just going, “I’m not going to do this,” and that’s it. You need to tell people, and once they know they’re fine.(Worker 2)

Three of the workers also suggested that there may be difficulties for community members communicating with workers who are from overseas and have strong accents.
Talking about Teeth

Some of them...their accent is really hard for some patients to understand and...they’re looking at you and they say, what did she say? And you have to re-explain to them what they said. (Worker 5)

Interpreters – the critical link

Clinic usage data show that approximately 20% of clients who accessed DGCHS dental service in the 2009-2010 financial year spoke an African language (including Arabic) as their main language at home, and that 18% of all clients required a professional interpreter. Thirty-eight per cent of these interpreters were booked for African languages (including Arabic). Figure 6 presents the language groups of the interpreters who were booked for these appointments. The Horn of Africa languages include Arabic, Tigre/Tigrignia, Oromo, Somali, Amharic and Harari.

Figure 6 - Service Utilisation of Professional Interpreters by Language Group in 2009-2010

Language groups of interpreters

*Languages with less than 1% representation not shown here

Health service personnel expect that the use of interpreters will improve access. However, all workers discussed challenges in working with interpreters. These challenges influence communication

*Note that Arabic is spoken by a number of community groups other than those in this study and it was not possible to determine how many of these interpreters were booked for Horn of Africa clients.
and can deter clients from accessing the service if communication barriers are not overcome. Challenges working with interpreters identified by workers include:

- Lack of appropriate qualifications / not being NAATI Level 3 qualified (National Accreditation Authority for Translators and Interpreters Inc);
- Limited numbers of interpreters especially for smaller / newer language groups;
- Difficulty of using phone interpreter services (that may provide more flexibility and lower costs); and
- Accessing interpreters at short notice.

The lack of qualified interpreters poses challenges for workers who at times felt that the interpreters were unable to convey information to the client sufficiently. For some workers, this required them to rebook appointments with clients in order to get a more experienced interpreter in whom they could trust. Although two workers acknowledged that using informal interpreters is against current policy, all of the workers said that in some circumstances it was acceptable and/or necessary. For example:

- Children interpreting for their elderly parents or family members who live together and know what kinds of medication are being taken and the medical history of the person;
- For practical information such as how to get to the toilet or reception, making appointments, and explaining the waiting list or triage/emergency processes;
- When the child doesn’t speak English but the parent or guardian does;
- When professional interpreters aren’t available at short notice for treatment that needs to be done immediately (emergencies).

All the workers that were interviewed preferred on site interpreters to phone interpreters because of the value placed on being able to show interpreters things visually.

... you always prefer to have a face-to-face interpreter. Because they can see, you can say to them, “Come and have a look. This is what I’m trying to tell you.” (Worker 4)
Waiting for phone interpreters can also require appointments to be rebooked because the time for clinical dental work is taken up if the entire appointment is spent waiting for a phone interpreter. Using phone interpreters can increase anxiety in clients who are struggling to communicate with the workers, and are often lying in a chair for up to 30 minutes waiting for a phone interpreter to be available.

For emergency appointments, it can be very difficult to access an interpreter at short notice. This is frustrating for the client and the workers. The workers can tell that the client is in pain but can't do anything until they are able to communicate with them, ask about their medical history, find out what the problem is, and obtain consent to commence with treatment.

Word of mouth

Word of mouth plays an important role in the Horn of Africa community and this can act as both a barrier and an enabler to access. Community members in the first three focus groups (all female) talked about the way that information is spread through the community, and how this can act as a barrier when the information is inaccurate.

... they ask people's opinion, like say for example the dentist says they need to fill up my tooth, I'm going asking my friends "Can I do this, he ask me to do that", she tell me "No don't do that, it's not good!" You know instead of relying with the dental or with the doctor they is talking with people and they don't know what to do, they're confused. One person they ask them, "If you do this surgery you're gonna be paralysed after that." You know, we need to have the information so they're not confused. (CM15)

Word of mouth also influences people to access the service. One of the workers who historically has had to go out to schools and promote the service every couple of months has only had to do this once in the last three years.

I could say pretty much the whole of my practice has been built up on word of mouth. The people go back and say you can get your treatment done here...They tell each other and you get more and more clientele that way, and that’s nice because you presume they’re saying we’re okay. (Worker 2)

The effectiveness of word of mouth was demonstrated through responses to the questionnaire which asked how participants found out about the focus groups. The answers to this question are presented in Figure 7.
Challenges for new arrivals

New arrivals face significant barriers in accessing services. These were identified by community members in all four focus groups who all agreed that barriers faced by the whole community are amplified for new arrivals.

...if they’ve been in the country like two or three months, probably they don’t know how to get to the dentist. Or they don’t know how to use the phone even... some of them, because they’re scared. Oh, “I can’t understand what the dentist is going to say to me. It’s better that I not go”. Or “maybe they don’t have an interpreter for us and they make it difficult”. Or they’re scared of the dentists. (CMI 2)

Six of the workers discussed the barriers that new arrivals face, acknowledging that for many people, oral health care can’t be a priority at different times in life.

I’ve noticed with new arrivals, they just have so much on their plate to try and find somewhere to live, a job, settle the kids in at school, get that all sorted out. We become a low priority unless they’ve got a toothache. That’s fine. That’s got to be accepted. (Worker 2)
Talking about Teeth

Financial costs

The cost of oral health care is another barrier to accessing services and an undebated topic amongst community members who talked about many of the challenges of affording oral health services and the need to distribute limited finances to other priorities.

*My friend, she has five children, her husband’s working, and they have many bills. She’s really in a lot of pain and she can’t go to the dentist, it’s very expensive. There is not enough to cover the rent or school fees and other important bills.* (CM2)

Casual workers find making appointments difficult because of their need to be flexible for their employers. Two community members identified working as a barrier, saying that it can make you ineligible for a health care card, but you might not be earning enough money to afford private health care.

*I think that the system is not fair. When you work they cut off everything.* (CM1)

Lack of previous exposure to oral health care

Community members in all of the focus groups talked about a lack of access to oral health services in their home countries. In some countries, access to health services is only available if you are working in a particular industry, or if you have a lot of money. Community members suggested that a reason people might not be accessing services in Australia is because they assume that the system works in a similar way to their home countries and they don’t have access to it.

*I’ve never seen any dental in my country, so never, no treatment. So when I come here in the first two years, I have to talk to the dental, the check-up I say ahah, ok…but we’re not used to this...* (CM15)

Cultural barriers

Although not discussed in all focus groups, cultural barriers were discussed by most participants in the first two groups. This was mostly related to family structure and expectations of women to take responsibility for children and for the health of the family.

*...in the * community there’s one big problem that I know about which is mostly the * mothers have big families - about 4 or 5 kids, most of them are very close*
Individual Barriers

ages like maybe 10, 8, 6, 7 and this responsibility is mainly with the mothers. Mainly the men think that the women are responsible for those children and the mothers take the children to whatever appointment that they’re going to. If it’s school, if it’s the hospital, if it’s anywhere else, the father believes that if he provides the money or the financial support that’s his job done. I’m not saying everyone, but this is a culture which exists back home, and many people from this culture here...Yeah so the mothers have the problem of dealing with having about 4 or 5 kids, taking them to school, bringing them to appointments, and so this is like um, and then maybe she’ll have 2 or 3 children at home and she can’t leave them at home...So she’ll end up missing appointments... (CMI2)

Fear: Of extractions and contracting disease

Community members in all focus groups said that fear of extractions was a major reason that they avoided accessing oral health services.

We have reason for why we are not coming to dental - we are always scared from extracting, extracting teeth is very big for us. Instead of extracting our teeth it’s better to wait until it goes itself. (CM7)

Community members in the second and fourth focus group talked about fear of losing teeth, some said that it was a sign of ageing, and some said that removing a part of your body means that you are not whole anymore and this creates an uneasy feeling. They commented that it changes a person’s appearance and that no compensation is available for this.

We avoid going to the dentist so we don’t have to have our teeth extracted...I don’t wanna lose my teeth every time I come. I will be like a baby! (CM8)

Extractions were a big concern for many people who were worried about things like not being able to chew food as they get older. When asked about their expectations around losing teeth in old age, community members expected to lose some teeth as they get older, but not all of them.

For me, I feel like I’m gonna lose all my teeth in this age, I’m not gonna have my own teeth, and then I think when I grow up, when I be old woman, what I’m gonna do? If you lose your tooth, it’s not gonna be easy when you’re old and you chew. I saw people and they complain or they have to choose what they eat because they can’t chew it properly. So it will never be the same. (CM3)
Talking about Teeth

Alternatively, there was one report from a worker about an African client who had the opposite attitude to extractions.

*He wanted to pull out the tooth. And I told him, look, we have to save this tooth because if you lose it, that’s it. We can’t put it back. Another one is not going to grow and there’s a space here. You’re still really young to lose one tooth if you can save it with root canal treatment. And they started to explain to him what was the meaning of root canal treatment, step by step, and yeah, he did.* (Worker 9)

For community members in all of the focus groups, there was a perception that extractions are a common method of treatment in public dental services as this is the easy, fast and cheap way to deal with tooth problems. Previous experiences with dental services overseas reinforced this perception. Community members in the second focus group discussed this in great detail, agreeing with each other that extractions wouldn’t be necessary if the waiting list wasn’t so long and problems with teeth could be dealt with before they are so bad that they need extractions.

Community members in all of the focus groups agreed that a lack of experience with oral health services can make people fearful of approaching such services. About one-third of the community members who were unfamiliar with oral health services in Australia were concerned about the risk of contracting disease in the clinic.

*Maybe the disease transmitted through the tools of the dentist. Yeah, this is the main issue especially with the HIV and other things, disease is our main worries...here I don’t have any experience with the dentist. He has tools waving in my mouth and do things and there is blood...* (CM1)

One of the workers said that when Horn of Africa clients are in pain, they will accept any treatment that you suggest, but when they are not in pain, they try to avoid extractions.

*I notice some African patients when they are in pain, then any treatment they will accept, otherwise they just want to keep the tooth as long as possible no matter how bad the situation is... especially for wisdom tooth we can’t keep that and they will certainly cause trouble and pain in the future and they don’t want to remove it as well... even though the tooth is broken down quite a lot, no way to restore it, they still want to keep it as long as no pain there.* (Worker 9)
Trust

A lack of trust poses a barrier to accessing oral health services. Community member interpreters, community members and workers all discussed the importance of trust, and highlighted that trust needs to exist between the workers, the clients, and the interpreters.

Trust in interpreters is important for the community and for workers. For the community, there is fear that information will not be kept confidential and that people in their community might find out personal things about them if the interpreter is also from their community. This is a much bigger concern in areas such as social work and family support than it is for dental. For workers, trust in interpreters is essential for language barriers to be overcome, true informed consent to be obtained, and for quality care to be provided.

Workers talked about the value of building trust with the clients which contributes to positive outcomes and returned visits.

... if we have a long appointment...that builds the confidence because when he comes in first and he doesn’t receive a treatment, he thinks ‘what’s going to happen?’ You know? ‘Why I came all the way and nothing is done?’ So that brings a negative attitude and then, so it’s better to do something on them, maybe a small, you know? May not be a big one, maybe I just clean one quarter or something like that, so it pleases them and gives them confidence that “yes, this person is trying to do something for me. He’s going to help me.”(Worker 7)
Discussion

There are a range of barriers to access that exist on an individual level. As presented above, these include knowledge of preventive care, language and literacy, word of mouth in the community, challenges for new arrivals, financial cost, previous exposure to oral health services, fear and trust.

The findings show that Horn of Africa community members are more likely to access oral health services when they experience pain, and at times will delay seeking care until they are in pain as a means of avoiding the waiting list or for financial reasons. Disengagement with treatment and health services following alleviation of pain is problematic as underlying causes of pain may not be addressed.

The findings revealed that a major reason the Horn of Africa community are not accessing oral health services is because of their fear of extractions. This is not something that has been uncovered in existing literature and highlights a need for future research that uncovers more in-depth reasons for this fear. The community’s perception that extractions are the “easy way out” for services further indicates a need for more exploration of this topic with other community groups that would add strength to these findings and contribute to a new area in which services could look to improve access. The existing literature reports fear as being a barrier to oral health services, and the research project report “In our own words - African Australians: A review of human rights and social inclusion issues” revealed that a lack of previous experience with oral health services contributes to fear being a major barrier for Horn of Africa community members in Australia wanting to access oral health services (Australian Human Rights Commission, 2010; Hilton et al., 2007; Patton, Strauss, Mckaig, Porter, & Eron, 2003).

Lack of knowledge about the importance of preventive care contributes to decreased utilisation of oral health services for non-emergency care. The findings in this project are consistent with existing research from the United States and Africa that found oral health care is sought out most often for emergency services and treatment of pain (Cohen et al., 2007; Okunseri, et al., 2008; Riley et al., 2005; Varenne, et al., 2005). The findings in this project have also found that long waiting lists are a reason that people don’t attempt to access preventive care. What it has added to the literature is that many members of the Horn of Africa community stop care after pain is gone and that community members may not understand that they may have oral health problems in the absence of pain.

Research reveals that pain is a major reason that people of Horn of Africa background/ethnicity are likely to utilise emergency services (Okunseri, et al., 2008), this was supported by the project findings and highlights a need to educate the community about the importance of oral health prevention.
Community members talked about the fear of extractions, this led to discussions about expectations of oral health status in later life. Participants revealed that they did want to have their teeth at an older
Individual Barriers

age. If people weren’t expecting to have all of their teeth in old age, then you could expect their motivation for preventive care would be low, however, they do want to have all of their teeth, yet still aren’t accessing services for preventive care. Community members wanted more education about how to look after their teeth at home so that they can still look after their teeth as best they can even if they can’t get to the dentist as often as they’d like to. Community members also said that there needs to be more focus on engaging adults in oral health care, for children this is easier as it is done in schools but when young people leave school there is no more reinforcement for oral health care.

Language barriers create issues for access at all levels...from knowing that a service exists, how to access the service, what to do when you get there, and what is happening during an appointment. If community members have low literacy levels this further exacerbates language barriers and strategies need to be put into place by health services that take language and literacy levels into account when promoting their services. It is important to remember that word of mouth in the Horn of Africa community plays an important role and ensuring that the community has accurate information will mean that health promotion messages and information about access to services is spread in a productive manner. Suggestions for ways in which education for the community might be conducted follow.

New arrivals face barriers to accessing care at a more extreme level than other community members. Navigating the system, language, transport, financial cost and priorities that come before oral health services all contribute to decreased motivation to seek preventive oral health care.
Talking about Teeth

Recommendations

DGCHS

Addressing fear

- Take extra time and care with clients who appear to be fearful or anxious.
- Ask family members and children to leave the room if you are performing treatment that may incite fear (for example administering anaesthetic).
- Encourage family members and children who accompany clients to watch procedures that may assist them in feeling more comfortable in attending for their own personal treatment.
- Describe and show tools and noises that may be unknown to clients to address any potential anxiety that may arise.

Building trust

- Give stickers to children and free oral hygiene products to clients where appropriate.
- Learn about the culture and backgrounds of client groups and demonstrate this knowledge through respectful and professional interactions with all clients.
- Understanding the meaning of words in other languages can be a fast and effective way of building trust.
- Take time in appointments to explain treatment options and plan.
- Structure appointments in such a way that trust can be built and treatment can be undertaken efficiently.

  First a short one and then follow with a long one if patient is really happy with it, so that he feels more confident with me, you know? (Worker 6)

Community Health Services

Health promotion

In partnership with the community, develop and deliver an education program that covers information as listed below. Deliver this program at a local venue, at regular intervals (every 6-12 months), on weekends, in local languages with an oral health professional present to perform examinations. This could be done using an existing peer education model (peer education has been used successfully in the estate across a number of health topics including child nutrition, Vitamin D and heat stress).
Information sessions should cover the following topics:

- The importance of preventive care including:
  - How to take care of teeth – how to brush, how to clean, knowing what to do at home between visits to the dentists;
  - That ill-health can exist in the absence of pain;
  - Food and drink that is good/bad for teeth; and
  - What causes damage to teeth.

- Produce a DVD for distribution in a variety of appropriate languages that includes information as listed above.

**DHSV and Department of Health policy**

- Advocate for the provision of oral health information sessions to be included as part of compulsory English language classes for new arrivals.
Conclusion

The aim of this research was to identify barriers to accessing oral health services for Horn of Africa community members of the Flemington PHE. The findings represent the experiences and perceptions of barriers to oral health access for Horn of Africa residents of the Flemington PHE from the perspectives of the community members and oral health professionals working in the dental clinic.

Major findings that support existing literature:

- Lack of awareness of service eligibility, preventive care and how to navigate the system;
- Working with interpreters;
- Cost;
- Barriers for new arrivals are amplified;
- Language; and
- The waiting list.

Major findings that add to the literature:

- Disengagement with treatment and health services following pain alleviation;
- Community members associate absence of pain with good health;
- The importance of word of mouth in the community;
- Community member concerns with qualifications of workers;
- The importance of organisational culture;
- Reasons behind fear of going to the dentist;
- How worker accents can act as a language barrier; and
- Client lateness and FTA.

The nature of Australia’s ever-changing diverse population means that services need to be aware of the needs of the communities they work with and be willing to increase cultural competency within the service and implement strategies that enable access to service for these communities. In order to improve access to oral health services for Horn of Africa residents of the Flemington PHE, the
community needs to be provided with education about preventive care, the services available to them, and how to utilise those services.

Optimum oral health of the Horn of Africa community in Australia will not be achieved without a cooperative and collaborative approach between the community and oral health service providers. The findings from this project revealed that to improve access to oral health services for Horn of Africa residents of the Flemington Public Housing Estate, the community needs to be provided with education about preventive care, the services available to them, and how to utilise those services. Workers require increased confidence in working with diverse client groups and interpreters, and oral health services and the oral health sector need to build and maintain capacity to provide culturally competent services to this community group.

Figure 8 provides a visual representation of recommended actions for addressing barriers to accessing oral health services for the Horn of Africa community. The cogs represent the importance of ongoing negotiation and re-negotiation of candidacy between oral health professionals and services and the Horn of Africa community in order for improved access to become a reality that is sustainable and has space for ongoing change as new needs are identified. In doing this, the overall oral health status of the Horn of Africa community can be improved, and contribute to improving the general health and wellbeing of this valuable community group in Victoria.
Recommendations for Future Research

This project focused on the Horn of Africa community and the DGCHS public dental service in inner-west Melbourne. Although many of the findings may be useful for oral health services working with this community, it was not intended that the findings be generalised to health services in general, or to other community groups. Future research of this kind could be used to explore the barriers to accessing oral health services for other community groups and other types of health services.

The reported importance of word of mouth in the Horn of Africa community provides an opportunity for services working with the community to improve their methods of information delivery. This body of knowledge would benefit from future research that explores this concept in more depth than was possible in this project.
Talking about Teeth

Finally, additional research into accents of health professionals, and interpreter use in oral and other health services would add to the challenges uncovered in this research and provide an opportunity to uncover improved methods for overcoming language barriers.

Limitations

Data collection in a language other than English.

Whilst employing interpreters was intended to assist in overcoming language barriers, in some languages there are words which do not have direct translations (Hennink, 2008). This means that interpreters are required to choose what they deem to be the most appropriate translation and this can have an impact on the meaning that the researcher draws from the data (Hennink, 2008). To reduce the impact of this limitation, two Horn of Africa community members read the transcripts that included the researchers interpretations and provided feedback regarding any cultural meanings which may have been misinterpreted.

Community member recruitment.

The low number of male participants means that most of the results present a female perspective. Refugee status was not a criterion for involvement in this project and it is unknown how many participants were refugee background (some certainly were). The findings therefore cannot be specifically applied to refugee groups, but will be a useful start for services working with both refugee and Horn of Africa communities.

Bias and confounding.

As the sample was self-selected, it is likely to be a biased sample. The clinic usage data is not biased (as it includes details of all appointments made in the 09-10 financial year) and provides data to compare with that collected from community members and workers, reducing the impact of bias on the results of this project.

Strengths

Obtaining the perspectives of Horn of Africa community members AND the oral health professionals working with this community.

Obtaining the views from community members and health professionals provides a broad picture of what perceived barriers to access are from both perspectives, enabling the likelihood of implemented strategies to address barriers to be successful. Workers who assisted in organising the
focus groups gained greater appreciation for the challenges that the Horn of Africa community face and were able to reflect on their own work practices as a result.

Including interpreters as participants.

Including interpreters as participants (when no community members attended who required their services) added depth to the findings as it provided a “middle man” perspective. The interpreters work with the community, and are also part of the community so their input was valuable in identifying barriers and suggesting strategies to overcome them.

Culturally appropriate catering

Providing traditional cuisine from countries in the Horn of Africa (prepared by The Sorghum Sisters catering service) was very well received and is something that should be considered in future projects with the community. Participants appreciated the effort that went into sourcing the catering service and in two of the groups it gave an indication that some of the participants may have needed this more than was expected, as many of them were packing food into their laps to take home with them.

Community engagement

Community members assisted in many stages of the project, including the planning, recruitment, data collection and analysis. On a family day out to Geelong where over 200 Horn of Africa community members attended, they selected the project logo from three that were shortlisted by the advisory group. In addition, the logos were given to Horn of Africa clients attending the clinic who also gave feedback. As a result, a fun looking, easily identifiable logo was chosen that will continue to be used in promotion of the service and relevant documentation the community will have access to.

A project volunteer was recruited to assist with a range of tasks including recruitment of participants, administrative tasks and preparation of oral health information that is culturally sensitive. Two community members provided assistance in the data analysis process. In addition, two members of the advisory group were from the community and provided advice and direction for the project as it was carried out. The advisory group met monthly and discussed a wide range of topics including research questions, methods of community engagement and policy and practice implications.

Community leaders played a critical role in recruitment for the focus groups. They were provided with information about the project via phone and email, and they then distributed this information through their communities. One Somali community leader also promoted the project on the Somali radio show twice a week in the lead up to the focus groups.
### Appendix A: Focus group questionnaire

Hello,

The information collected on this questionnaire will help us understand what we can do to make going to the dentist easier for you. The information you provide is anonymous so your responses will not be linked back to you. We thank you kindly for taking the time to help us with this.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your age?</td>
<td>____________________________</td>
</tr>
<tr>
<td>2. Male / Female (please circle)</td>
<td></td>
</tr>
<tr>
<td>3. Main language spoken at home</td>
<td>____________________________________</td>
</tr>
<tr>
<td>4. How many years have you lived in Australia?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less than 1</td>
</tr>
<tr>
<td></td>
<td>1-3</td>
</tr>
<tr>
<td></td>
<td>4-5</td>
</tr>
<tr>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td></td>
<td>More than 10</td>
</tr>
<tr>
<td></td>
<td>I don’t know</td>
</tr>
<tr>
<td>5. Have you been to the dentist at Doutta Galla?</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Do you smoke?</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Do you chew khat?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
8. **Do you think your teeth are:**

<table>
<thead>
<tr>
<th>Very bad</th>
<th>Bad</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
</table>

9. **How often do you have pain in your mouth?**

<table>
<thead>
<tr>
<th>Never</th>
<th>A couple of times a month</th>
<th>Once a week</th>
<th>More than two times per week</th>
<th>Every day</th>
</tr>
</thead>
</table>

10. **How many times have you been to a dentist in Australia?**

<table>
<thead>
<tr>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 or more</th>
</tr>
</thead>
</table>
11. How would you describe the way you were treated at the dentist?

<table>
<thead>
<tr>
<th>Very bad</th>
<th>Bad</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
</table>

12. Would you like to have an interpreter at your dental appointments?

Yes                          No

13. Would you prefer to visit the dentist by yourself or have your whole family see the dentist on the same day?

Alone                             With family

14. How did you find out about this session?

<table>
<thead>
<tr>
<th>Saw a poster</th>
<th>Was told by a friend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was told about it by a worker</td>
<td>Other – please list:</td>
</tr>
</tbody>
</table>


15. **How do you want to learn about looking after your teeth?**  
*(You can tick more than one box)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Written information.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Group information sessions at the dentist</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Information sessions in a local venue</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Talking to your dentist at your appointment</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>A DVD you can watch at home</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Radio</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Community newspaper</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Other (please list)</strong></td>
</tr>
</tbody>
</table>

_______ | **I don’t want to be given any information about looking after my teeth**

Thankyou for completing this survey. If you have any questions or would like to talk to us about anything in this questionnaire, please don’t hesitate to contact us either by phone or email.

Phone: 8378 1685

Email: carmel.hobbs@dgchs.org.au
Appendix B: Worker questionnaire

Hello,
The information collected on this questionnaire will help us to better understand you and your experiences working with the African community. The information you provide is anonymous so your responses will not be linked back to you. We thank you kindly for taking the time to help us with this.

1. How many years have you worked in oral health? ______________________

2. How many days per week do you work at this clinic?

[ ] 1  [ ] 2  [ ] 3  [ ] 4  [ ] 5

3. Have you heard of Miswak/Sewak? Yes  No

4. Have you heard of Khat? Yes  No

5. What is your professional title?

- Receptionist
- Oral Health Therapist
- Dentist
- Dental Assistant
- Dental Therapist
- Prosthetist
- Dental Hygienist
- Dental and Oral Health Therapy Student
- Other (please list)

6. Approximately how many times per week do you use a professional interpreter?

[ ] 1-3  [ ] 4-6
[ ] 6-10  [ ] More than 10

7. Approximately what percentage of the clients that come to the clinic are of an African background?

[ ] Less than 20%  [ ] 21-40%
[ ] 41-60%  [ ] More than 60%
9. If the length of appointments was funded to allow you to spend more time with clients, what would be the ideal length of time for working with clients of African background?

☐ 60 minutes  
☐ 90 minutes  
☐ I am happy with the current 45 minute appointment time

10. List the three biggest challenges you face when working with clients with an African background:

1. ___________________________________________

2. ___________________________________________

3. ___________________________________________

11. List three things that you find rewarding about working with clients with an African background:

1. ___________________________________________

2. ___________________________________________

3. ___________________________________________

Thankyou for completing this questionnaire. If you have any questions or would like to talk to me about anything in this questionnaire, please don’t hesitate to contact me either by phone or email.

Phone: 8378 1685  
Email: carmel.hobbs@dgchs.org.au
Appendix C: Focus group questions

YOUR EXPERIENCES WITH DENTAL SERVICES IN AUSTRALIA

1. Can you tell me, if you have been to the dentist in Australia, what was it like for you?
   a. Can you please tell me what you think about the dentist services in Australia?
      i. What have your experiences been?
      ii. What is it like compared to other places you have been?
      iii. Why did you go? Pain? Another reason?
      iv. What did you like about it?
      v. What did you not like about it?
      vi. Were you happy with what happened?
      vii. How were you treated by the staff?
      viii. Where did you go to the dentist? Was it private or public?
      ix. Do you know about the differences between private and public dental services?

2. What worries you about going to the dentist?

3. What (else) makes it difficult for you to go to the dentist here?
   a. Have you noticed any differences between accessing the service for children and accessing the service for adults?

4. What is important for you when you go to the dentist?

5. If you have a problem with your teeth what do you do?

6. When you think about going to the dentist, what are the greatest needs faced by people in your community?

7. In previous focus groups, participants have said that they are worried about having their teeth extracted, why do you think they might have said this?
   a. Do you worry about having your teeth extracted? Why?

8. What things about your culture do you think health workers in Australia should understand better?

COMPARISON TO OTHER COUNTRIES

9. In other countries you have been, what did you do if you had problems with your teeth?

10. Can you tell me about dental services in other countries where you have lived?
11. When you think about your teeth and your mouth, what things are different in Australia compared to other countries you have lived in?
   a. Eg hygiene practices, food/drink.
   b. If you needed to go to a dentist in other countries where you have lived, what would you do?

TIME

12. Tell me about time in Africa and how it is different to time in Australia.
13. Appointments are the most common way for people to see a health professional in Australia. It is important to go to appointments on time, it seems that in the African community, people are often late to appointments. Can you tell me why?
   a. Is there a better way to run health services for the African community?

IDEAS FOR IMPROVING SERVICE

14. Imagine you own your own dental clinic. Tell me what it would be like?
   a. Who would work there?
   b. How would people make appointments?
   c. What would the waiting room be like?
   d. What times of the day and days of the week would it be open?
   e. Anything else?
15. What do you think about African people working at the dentist? What are the good and not so good things about that?
16. The current opening hours are Monday to Friday 8:30-4:30, do you think it would be useful to be open at other times?
   a. What other times?
   b. Why?

KNOWLEDGE

17. Can you tell me about miswak / sewak?
18. Can you tell me about khat?
19. What information would you like to learn about looking after your teeth?
20. What is the best way for us to give you information about looking after your teeth?

Other possible questions:
21. Is there anyone you know who feels differently about going to the dentist than you do? What do they think?

22. Is there any advice you would like to give to other people in your community about visiting the dentist?

23. Tell us what you think about teeth in your community.
   c. What are the good things and the bad things? (eg pain / appearance / knowledge / diet / behaviours)

24. Expectations – how do you expect your teeth to be when you are old?

---

**Closing**

1. As you know, we are going to be reporting back to the dental services in Victoria and passing on the information you have given us today. Think back on your experiences and our discussions today and tell us what we can do to improve the care people receive.

2. Is there anything we have not discussed that you would like to tell me more about?
Appendix D: Worker interview questions

Talking about Teeth – interview questions for dental clinic staff

Focus area 1: Barriers

**Knowledge / awareness**

1. Can you please tell me about your thoughts about the African clients that visit the clinic?
2. As a professional working in a dental clinic, could you tell me about your experience working with the African community?
3. What makes them different from other communities that access the service?
   a. How do the needs of African clients differ from other clients?
4. How can you tell if a client is a refugee or asylum seeker?
5. What do you think might make it difficult for African community members to attend this clinic?

Focus area 2: Strategies

**Experiences**

6. On the questionnaire you put … As challenges, can you tell me more about that?
7. On the questionnaire you put … As things you find rewarding about working with the African community, can you tell me more about that?
8. What kinds of things do you think DG could do that would make it more accessible for the community?
9. The use of interpreters seems to be important for this community, what do you think can get in the way of using a professional interpreter?
   a. What’s difficult about accessing professional interpreters?
10. Under what circumstances would you use a family member for interpreting?

Focus area 3: Implications

11. If the number of African clients attending the clinic increased, what impact do you think that would have?
   a. The clinic
   b. Workers
c. Anything else?

12. Have you had any training, or information provided to you that has made you feel more confident about working with African clients?

13. What kind of training or information would you like to receive to make the work you do with African clients better?

14. Is there any advice you would like to give to other dental professionals about working with the African community?

15. Is there anything else that you would like to say that we haven’t covered?

Other possible questions...

16. What do you know about the African community in this area?
   a. Prompts – where are they from, what experiences have they had, where do they live, what is family structure like, age demographics, language, religion.

17. What do you know about the traditional practices the African community have in terms of caring for their teeth, and behaviours that might not be so good for their teeth.
Appendix E: Additional findings of interest

In the community

Dental in home countries

Participants in three of the four focus groups talked about dental care overseas. Overall, they preferred the dental health system in Africa to the system in Australia. They said that there is no waiting list, you can almost always get an appointment on the same day that you call, and if not you wouldn’t have to wait for more than one week, and all of your treatment is finished within a couple of weeks. Dental clinics in the home countries of the community members are also open late at night, many until 10-11pm. It is not free, but it is cheap (about $40 for an appointment), yet still more expensive than the cost of GP services (in Egypt dental care is four times more expensive than seeing a GP). Community members talked about people they know who have gone overseas for dental treatment, and that in most cases they go to Egypt, Syria or Kenya. Although this seemed to be a preferred method, participants did talk about the risk of contracting HIV through an overseas clinic and while some weren’t worried about it, others said that they wouldn’t risk it. In relation to the quality of care and financial cost participants in one focus group “swear by it, it’s cheap and very good treatment, maybe even the best”. Whether people are specifically going overseas to receive treatment, or if it is something that they do when they are overseas for other reasons was not explored.

Family groups

Workers reported that it is common for Horn of Africa clients to attend the clinic with up to six others accompanying them (usually children). This poses a challenge in the clinic in terms of the physical space in a clinic room and managing children while a parent is in the chair. Some workers love this opportunity to get away from the daily grind of regular work and interact with the children, playing games, colouring and that sort of thing. Reception staff said that in these cases, they try to book subsequent appointments at times where the parent may be able to come in alone. Workers also said that as family groups they are very caring of each other, which is something that you don’t see as much in other community groups.

...as family groups they are very caring of each other. The 24 year old brother that brings the 13 year old into the appointment, if that was an Aussie family they’d be worried about being called geeks, but the kids are different. They are very caring of each other. (Worker 8)
Community members answered a question on the questionnaire about their preference for attending oral health services alone or with family members. The responses indicated that they prefer to come to the dentist by themselves, rather than having an appointment with other family members (See Figure 9).

**Figure 9 - Preference For Appointment Alone or With Family**

![Chart showing preference for appointment alone or with family]

---

**Self-reported oral health status**

In the questionnaire given to community members, they were asked “Do you think your teeth are very good, good, very bad, or bad?” The responses to this question showed that no participants viewed their teeth as being very good, and that most either thought their teeth were very bad or bad. These results are presented in Figure 10.

**Figure 10 - What Community Members Think of Their Own Teeth**

![Bar chart showing self-reported oral health status]
Religion

For some clients, a female worker is preferred. DGCHS provides this where possible, and if not an option, appointments can be rescheduled to meet client requests. It was also noticed that this isn’t always an issue of gender, and that some clients from all community groups prefer to be seen by certain workers simply because of the workers personality.

Culturally sensitive? I just want to be treated like a human being

When asked how important cultural understanding was to the community members, many emphasised that what matters to them is being “treated like a human being” and just generally to be treated with respect. Some community members were eager for workers in health organisations to understand their culture, and a desire for them to understand their needs such as female clients having female workers, although this was not a need for all Horn of Africa women.

Sometimes if English is not your first language it’s hard and some people straight away judge you what by you look like, what you’re wearing, even though you just came here for one problem that needs fixing. Initially you want to be treated the same as everybody else and you want to be feeling that, okay, I know I’m going to this, this is a hard thing for anyone to go to a dentist but I made it this far to come, you don’t want that experience of being judged before you get the chair. (CM9)

Workers talked about some of the cultural practices that they have learnt about through their work in the clinic.

...cultures that think when they are six years old, they pull out all the lower interior teeth from four to four...Why did they pull them out? Later on I found out it’s a kind of culture to pull out. It’s a beauty thing. I don’t know what the beauty of that is. To remove six to six. I don’t know... Because he grows up or she grows up with this idea. You can’t change it sometimes. (Worker 7)

Oral health behaviours

Miswak

The Miswak is a teeth cleaning twig made from the Salvadora persica tree, also known as the arak or peelu tree. Although there has been little research done on the miswak, the existing literature reports that it contains anti-microbial properties and other elements that are good for the teeth and general health. Users of the miswak will chew it up to five times a day as part of a cleansing practice.
before prayer, and others may use it in the morning and night. Community members said that most people in the community use it and that it is very popular at home where people only use this and no other oral health products.

**Behaviour change**

Many of the workers found Horn of Africa clients to be very responsive to information and instructions given for taking care of teeth. One worker talked about children being proud of looking after their teeth and returning to the clinic to show the workers their teeth following initial appointments.

*They’ll usually just take the message on board; there isn’t much questioning...they seem to be accepting; body language shows they’re accepting, and the fact that they do change behaviours, reinforces that as well...Also oral hygiene too, that the parents need to help with the brushing. Usually by second or third visit you can see an improvement, and they’ll actually report back either the children have made the changes themselves and said, “We’re going to change this. We’re not having lollies anymore,” or the parents are reporting that they’ve cut down. So it’s actually really rewarding for me.* (Worker 2)

Workers have noticed a small number of clients reading brochures in the waiting room, and the impact this has had.

*Some would read it, every time they come here they read it and then they ask something, they know something more about the teeth. They are two young refugees. When they are waiting in the waiting room they read and they come and ask the same question. I think they learn more. Before they didn’t know anything.* (Worker 9)

**Khat – the legal drug causing harm to the community**

Khat is a leaf that is chewed, not swallowed, and contains an amphetamine like stimulant. It is known amongst the community and used by many Horn of Africa and Middle Eastern background community members and is used most commonly in social situations with others, rather than alone and in private. Currently, it is legal in Australia with a small number of community members carrying a licence to import and sell it. It is illegal in the United States and Canada.

In the focus groups, the female participants were particularly passionate about Khat, emphasising the many negative effects that it has. In terms of oral health, it causes staining of the teeth
and ulcerations in the mouth. Socially, it has wide implications with many of the women saying that it is a major cause of relationship and family difficulties and can contribute to divorce. They said that it is commonly used in the community, with no specific demographic group using it more than another, but that its use is slightly more common amongst men than women.

That's what I'm talking about. You know there was a meeting last time, in Flemington somewhere, about 90 per cent of Somalis were complaining because all the divorce come because of the khat. The eating Khat. You know, they are lazy, you know a lot of arguments from eating chat. (CMI4)

They don't like their children, their family, they don't like anything. So it's really really really really bad. A lot of problems with the community. Problems for the people who eat it and for others around.(CM8)

Although the men’s focus group said that it’s not as addictive as cigarettes, some women compared it to heroin in terms of its addictive properties and the effect it has when used.

I know of one guy he used to eat all his life chat, now it's become, it's become the hole here (points to the cheek), but still he cover it and he eats it. He can't stop it, it's that addictive.(CM5)

They said that users get a high, become unreliable, unstable and the next day can’t remember what they did when they were high. They also said that is it particularly bad for people with depression as it exacerbates the symptoms. One of the men talked about sharing a house in his home country with a student who used it and stayed awake for two days, he said “so it’s a pretty serious drug and can’t be good for you”. Others said that many students use it to stay awake when they are trying to study.

I used to have a friend he used to eat chat all the time, when they eat that oh, they are over the moon, they good, they happy...(CM5)

They say I am king! I am king until tomorrow, then tomorrow they don’t know where they are...and they feel good and everything, then the next day, headache, some of them they can’t walk, lazy, headache, whatever. So they have to eat it all the time, if they don’t, like they don’t want to talk to you, they absent.(CM16)
Some community members believed that it is grown in Perth and Melbourne but most said that it has to be imported from overseas. In some Horn of Africa countries it is not used, however some participants mentioned that people from these countries often begin using it when they get to Australia.

Yeah, my country doesn’t have that habit. I think it’s Ethiopia and Somalia and other countries like Yemen, that area but in Nigeria it’s forbidden but some of our community started here in Australia because it’s available. (CM2)

It’s available, affordable and easy to get it and even sometimes somebody can invite you to use it, like the taxi drivers. (CMI1)

The community members were eager for the Australian government to do something to put a stop to Khat use in the community.

The Australian government have to avoid our people from Africa for Khat, they don’t want to go to school, they don’t want to go to work, they just take from Centrelink and right back at the beginning again. (CMI8)

Clinical issues

Employ oral health professionals and volunteer workers from the community

The community members valued seeing other community members working in clinics as it helped them to feel more comfortable, but mostly the benefit for them was seeing someone from their community working in a professional role in a mainstream service. They discussed issues related to being from a small community and that workers in positions that involve personal and social issues raises concerns around confidentiality. However, for medical services (such as dental) this was not as much of a concern. Community members valued professionalism, quality of service and interpersonal skills more highly than cultural background. However, having a worker who speaks their language was something that can make clients feel more comfortable.

If I don’t know the language and I come from my country I think like ohh I found someone here who can understand me, that is the difference. (CM3)

When asked about having community members working in the clinic, workers said that there were benefits for the community in seeing someone from their community working there as it helps them to feel more comfortable and a sense of reassurance. They also reported that having community members working in the clinic is particularly helpful if they speak another language and are able to communicate with clients who speak the same language, however workers are not able to interpret for
clients at a professional level that is higher than their own (for example a dental assistant is not allowed
to interpret what a dentist is saying – professional interpreters are required for this).

On the whole, workers also valued the personality of their colleagues over their cultural
background. Workers identified maturity, life experiences, passion for the work, professional, reliable,
and a desire to learn as key factors in ‘what makes a good worker’. They also reported that having
community members working in the clinic contributed to changed attitudes of the existing workforce as
it gave them an opportunity to learn more about the community and the challenges that they face.

One worker asked an interesting question that raised a notable point about being treated by
someone of the same background as a client:

Well if you were in Germany and you had just arrived and you had toothache
and they said “I’ve got a dentist who speaks German or we do have a young
Aussie here that is here as a backpacker”. Which one would you go and see?
You’d go the Aussie. Of course we would because they wouldn’t have to bother
with all of this not understanding. (Worker 8)

**Funding**

When asked what was needed to enable workers to provide a better service to the community,
many of the responses included issues of funding. Additional funding would enable better use of
interpreters and more time with patients that allows for more treatment to be done, as well as
providing important oral health information in an appointment. Pressure to meet targets means that
sometimes the extra time that workers would like to spend with clients is not a possibility.

Well to provide us with interpreters, more money for the interpreters.
Obviously more time to sit down with the patients and really help them with
their oral health. And do the treatment that we can do. (Worker 4)

**Decision making – actively involve clients**

Participants want to be involved in the decision making process regarding their oral health care.
By not explaining the options and possible outcomes of treatment clients can be left feeling
disappointed and frustrated with the service. Community members provided examples of being told
they needed a tooth extracted but if they didn’t want this they would have to seek private care. After
looking into private care and discovering the cost, the community member had to go back to the public
clinic for the extraction and was upset about that, they said that if they’d known the cost from the
beginning they wouldn’t have bothered trying. This was a major topic of discussion in most focus groups
with the community reporting that not being involved in decision making creates significant anxiety for them. Many of the workers also expressed concern about this and that more effort needs to be made to fully explain treatment options to clients.

...root canal therapy. What’s root canal therapy? If the patients don’t know they need to explain, I think the dentists need to explain to the patients more what each stage is and what’s involved and not just say we can do it now but if you don’t want it you’ll have to go to private. Then the patients walk out the front door feeling like they haven’t been treated properly and I can see that and I feel sorry for them. I think, yeah, I just think each stage should be explained more. (Worker 6)

I want to be involved in the decision in terms of the steps they’re going to take, the recommendations... (CM22)

Community members said that the workers need to explain everything thoroughly, clients need to be given options and be involved in decision making around their treatment plan.

I would probably agree with the dentist no matter what they said anyway but I would still want to know. Like, if they say this is the problem, we can do this or we can do this or we can do this, I think we should do this and then they’d probably say okay we’ll do that but at least I would know. (CM15)

Offer clients a copy of their treatment plan

Community members asked if there was a possibility of being given a print out of their treatment plan following their initial appointment. A treatment plan includes information about identified oral health problems, and what the worker plans to do in each subsequent appointment to fix them. This would help clients know what to expect at future appointments, and justify the need for more than one appointment. Workers pointed out that a clear treatment plan can really improve the dental experience for clients. Focus groups participants suggested that providing clients with a written treatment plan to take home would contribute to the clients feeling like they were more involved in their treatment and to more easily trust the workers by being more involved in the decision making around their health care.

Just a little information so there’s a link between the dentist and the patient as well and the patient is playing an active role in her or his treatment. (CM17)
Extended appointment times

Workers were keen for extended appointment times when working with clients who needed an interpreter, particularly for the first appointment when medical history is discussed and often takes significant time.

Yeah so I'm thinking maybe we should be looking at longer appointment times as well... organise it and make sure there is an interpreter present. Complete a full medical history, maybe do some more work rather than just do an examination cos by the time you get through your medical history and all your other communication barriers there's no time left to do actual treatment.

(Worker 3)

Workers explained that a half hour appointment can be easily taken up by a quick examination and preparing a treatment plan. Most workers preferred a 45-minute appointment block as can be seen in the figure below.

Figure 11 - Ideal Length of Appointment

Priority access: A second waiting list?

One worker suggested creating a second waiting list for priority access clients. They suggested that a set number of priority access appointments be allocated to prevent the existing waiting list from blowing out as a result of increased numbers of clients accessing the service under priority access eligibility. This has been done before but stopped, the worker said that the main problem with this was clients who thought they were on the waiting list but they actually weren’t. The worker suggested that
this could have been a result of human error and poor communication between relevant parties (such as the service, client and referral agency).

**Impact of lateness and FTA**

The impact on the workers when clients are late for appointments was described by one of the workers.

*It just puts extra pressure on if they’re not on time, and then they expect a service which you can’t deliver so it’s like a vicious cycle, they get upset, we get frustrated.* (Worker 3)

Another worker acknowledged the impact, but also a possible gap in understanding that if addressed could reduce the FTA rates.

*I am not even sure that they understand what happens when they fail to attend, that we are sitting around doing nothing, that it is costly for us. It is a big deal for us, but I am not sure that they see it as a big deal.* (Worker 8)

This was followed by recognition of the challenges for some clients to attend appointments.

*...Something has come up. Now I need to go to the hospital or I need to do this or I need to do that so it is only the dentist. I think there is a bit of that. And I think if you have to walk or ride or push a whole bunch of kids around the place and it is cold or it’s wet or it’s hot are you going to? Are you going to ring up when you don’t know whether they will understand what you say?* (Worker 2)

**Impact of increased numbers**

Workers were asked what the impact of increasing the numbers of Horn of Africa clients might have on the clinic and on the workers. Workers anticipated increased late attendance and broken appointments, and increased pressure on staff. For some workers it was noted that an increase in refugees who are eligible for priority access would impact poorly on the waiting list and make it longer. This was not specific to Horn of Africa background clients, but refugees in general. Workers were also conscious that if they were experiencing increased stress and pressure that the clients would feel this too.

*I think the biggest issue will be burnout if we continue to increase...So we have to look after the workers.* (Worker 8)
An increase in costs for the clinic would be a significant impact of increasing numbers of Horn of Africa clients. This would be because of the cost of interpreters, that refugee background clients are exempt from paying a co-payment, and if FTA rates are high, this costs the service approximately $150 per appointment. All workers proposed that increased funding would be the only way to address the increased financial costs.

Consent: Is it really being given?

Consent is of critical importance in the clinic. Treatment cannot proceed without the full consent of the client, and when language barriers are present, obtaining consent can be particularly challenging. Interpreters play an integral role in this process, and when a professional interpreter is not available, and a family member is interpreting, or when the worker doesn’t have confidence in the professional interpreter, the appointment needs to be rescheduled. Workers were very clear that they can’t proceed with any treatment until they feel confident that the client understands what they are consenting to.

Workers reported times where clients have returned for a second appointment and not fully understood what they consented to in the first appointment. This misunderstanding could have been because of interpreter issues, or dentists using dental terms as opposed to lay language.

We’ve had instances and we have had to redo the consent for treatment at the next appointment. We had one case over the phone when we tried to explain to them and he did not understand a word of what we were saying. That was frustrating so we had to reappoint the patient with an interpreter, face-to-face interpreter. (Worker 3)

...we double check with them before we go ahead with the procedure but what happens is they misunderstand what we are saying so we don’t know if the interpreter could had stuffed it up, or we don’t know if the dentist hasn’t explained it properly, because a lot of the problems that I’ve had working as an assistant and working with the dentists is that sometimes they don’t properly explain the procedures. So even if I was the person sitting there trying to listen to what they are saying, I wouldn’t know what they were on about. I think sometimes dentists get to caught up in their own lingo. They don’t seem to snap back and go, “Okay well…” they just say, “Root canal treatment.” What the hell is root canal treatment? (Worker 4)
The time taken to obtain consent can also be an issue for new arrivals who are under 15 without a legal guardian attending the clinic.

*It usually needs a second appointment because you have that initial contact, try and figure out who’s what, where and when, or it’s paperwork and needs to be sent say to a government department or some type of care service, just to get signed off. So that’s actually extra time that we’re spending on that in our own time or work time. It’s not an issue. It’s just something extra.* (Worker 2)

Consent is a really important issue across all health services. It was highlighted that the current policy needs to be made clear to all employees, in conjunction with other related policies.

*We need to roll out what we were going to roll out; this consent policy and this consenting to care and when do you require consent? So for what things that you do you require consent. So for instance, if I am doing a treatment plan and working with someone then I need consent and therefore, I need an interpreter. But if I am then following that treatment plan and doing some fissure seals and doing some things that I have said the first time that I’ll do and they have got their friend with them, then it doesn’t matter. But I am not sure conceptually we have got that idea across...that you need an interpreter for informed consent or when you’re doing an irreversible thing... it is important as an organisation that we send the same message.* (Worker 8)
References


Talking about Teeth


