“I lost my first tooth here”: Syrian former refugees’ experiences of oral healthcare in Dunedin, New Zealand

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ABSTRACT

AIM: Oral health conditions are highly prevalent among former refugees; however, little is known about their experiences of accessing dental care. We aimed to explore Syrian former refugees’ experiences of oral healthcare in New Zealand.

METHOD: Thirty-nine Syrian former refugees resettled in Dunedin, New Zealand participated in nine focus group discussions. The interviews were audio-recorded, transcribed verbatim and thematically analysed.

RESULTS: Almost all participants reported motivation to care for their teeth but multiple factors facilitated or hindered their ability to address their oral health needs, including financial factors, communication issues and dental care provider cultural safety. Most participants arrived with high expectations of New Zealand’s health system.

CONCLUSION: Oral healthcare providers and policymakers need to expect and accept their patients’ past experiences and emotions, and consider their cultures, languages and backgrounds.

The high prevalence of oral health conditions among former refugees considerably affects their quality of life. Former refugees face substantial—and unique—obstacles when accessing oral healthcare services and this can persist for years following resettlement. Moreover, traumatic events refugees experience can cause ongoing stress, further contributing to avoidance of oral healthcare. Their access to oral healthcare is also challenged by the lack of familiarity with the host’s healthcare system, and by financial instability, language and cultural barriers.

Developing oral healthcare services that are responsive to the needs of former refugees requires understanding of their knowledge, experience and expectations of oral healthcare. Prior to December 2022, former refugees were eligible for limited public funding for oral healthcare that was offered to adults on low incomes, including that available for emergency dental care. This was principally for relief of pain—predominantly, tooth extraction. They are also eligible for the government-funded insurance scheme for dental-related injuries. Former refugees also have access to specific financial support for dental treatment. However, it appears that they may not be fully utilising the support available; the reasons remain unexplored.

This study aimed to investigate the experiences of Syrian former refugees settled in Dunedin, New Zealand in accessing oral healthcare and to determine the factors that enable them to or prevent them from accessing good oral health.

Methods

This paper presents the findings from a component of a larger mixed-method study and analyses the participants’ experiences of using oral healthcare services in New Zealand. Former Syrian refugees aged 18 and over who had arrived in Dunedin, New Zealand since 2016 were recruited through organisations that provide services for former refugees, as well as through snowball sampling. Those interested were provided with an information sheet and a consent form. Recruitment for the focus groups stopped when no new themes emerged in discussions (theoretical saturation).

In total, nine focus group discussions of about 1-hour durations were held via Zoom (Zoom Video Communications Inc., San Jose, California, United States). Interviews took place during New Zealand’s COVID-19 lockdown (25 March to 13 May 2020). Participants were assembled on a family and/or friendship basis and were interviewed in their homes in the Arabic language by an Arabic-speaking dentist.

A semi-structured interview schedule was
designed, informed by a previous study, to gather information on the participants’ experiences in accessing dental care in New Zealand. Participants were given multiple opportunities to confirm they reported everything. Interviews were recorded (with permission) using the recording feature in Zoom™ and transcribed verbatim in the Arabic language, and then were translated into English by two native Arabic speakers. Each participant received oral health-care products, sufficient for the whole family for 6 months.

Data analysis

Transcripts were analysed thematically according to Braun and Clarke. First, the interview recordings were listened to several times, then the English language transcripts were read and coded on an Excel spreadsheet (Microsoft Corporation, Redmond, Washington, United States). Major themes that emerged from the data were organised in the columns; the data coded for that theme were copied into the relevant column. Two senior members of the research team reviewed data from transcripts, and all three researchers discussed the codes until a consensus was reached.

Results

There were nine focus groups, each comprised of four or five participants (N=39). Participants were aged from 18–54 years (mean 37 years) and both sexes were equally represented. Most participants (n=19) had arrived in New Zealand in 2016 and 2017 (Table 1). One third of the participants had some level of tertiary education, one third had primary school education and one third had secondary school education. The majority

<table>
<thead>
<tr>
<th>Table 1: Demographic characteristics.</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school education only</td>
<td>4 (25.0)</td>
<td>3 (15.8)</td>
</tr>
<tr>
<td>Incomplete high school education</td>
<td>5 (31.3)</td>
<td>5 (26.3)</td>
</tr>
<tr>
<td>Completed high school education</td>
<td>0</td>
<td>3 (15.8)</td>
</tr>
<tr>
<td>Incomplete tertiary education</td>
<td>6 (37.5)</td>
<td>4 (21.1)</td>
</tr>
<tr>
<td>Graduated tertiary education</td>
<td>1 (6.3)</td>
<td>4 (21.1)</td>
</tr>
<tr>
<td>Did not answer question</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed—full-time</td>
<td>6 (40.0)</td>
<td>3 (15.0)</td>
</tr>
<tr>
<td>Employed—part-time</td>
<td>2 (13.3)</td>
<td>4 (20.0)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Studying</td>
<td>6 (40.0)</td>
<td>8 (40.0)</td>
</tr>
<tr>
<td>Disabled</td>
<td>1 (6.7)</td>
<td>2 (10.0)</td>
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<tr>
<td>Did not answer question</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>22</td>
</tr>
</tbody>
</table>

* Numbers in brackets denote part-time employment
were in part-time or full-time employment (Table 1). Nearly all participants had received dental care at the University of Otago School of Dentistry. Almost all participants reported challenges in accessing the care they needed, although a few also reported some positive experiences. Participants’ experiences were founded on a range of factors, which could be categorised into two domains—structural and socio-cultural. Some factors were common to both categories and are presented according to “best fit”.

**Structural factors**

**Financial**

All participants agreed that the high cost of dental treatment in New Zealand was a major barrier to receiving oral healthcare. Many expressed frustration at their inability to afford dental care: for instance, one participant said a “refugee’s income is barely enough for food.” (A130) Consequently, participants said they would endure the pain or not seek treatment until it became necessary—for example, “I suffer a lot. I wait to the end until I go” (A134)—or would choose cheaper, rather than the ideal but typically more expensive, treatment options.

Paying for dental treatment in instalments or placing deposits were options available at the Faculty of Dentistry to some participants, which they said enabled them to complete their treatment: for example, “You can install the payments no matter how large the amount is and depending on how much you can pay. This has helped me!” (A125)

Most participants expressed gratitude for the funding available to support their dental treatment. However, when prompted, many felt that because it was only available for a limited range of services, clinicians only offered them services that matched the available funding rather than what would be consistent with best practice or that were aligned with the participants’ wishes:

“A hole can be fixed with a filling or nerve removal treatment or with a crown. Because there is no time or maybe because it is very expensive, they give you the easiest option, which is extraction for most of the people. You see most of the Syrians have extracted teeth.” (A157)

To improve support, all participants suggested increasing the amount of support available and ensuring treatment was planned appropriately.

**Language and communication**

All participants agreed language differences were a major barrier to accessing dental treatment, particularly for newly arrived refugees. Interpreters were important, even for those who could speak English, as they helped to explain complex dental jargon; for instance, a participant said that “during treatment, you face medical terminology that you do not understand.” (A155) However, some participants said interpreters were difficult to get at short notice for urgent appointments, and the consequences were often long waits for care. Further, another participant mentioned that privacy might be compromised with interpreters who might not adequately convey all the information: “The interpreter does not deliver everything ... they would cut it short.” (A159)

There were also communication issues with administrative processes. For instance, some reported missing dental appointments owing to an inability to understand the English language reminders: “You get letters and you do not understand anything. These letters give warnings, for example if you missed the first or second appointment, you’d lose the appointment.” (A125) One experienced difficulties in completing paperwork prior to receiving dental care: “Filling out papers and forms to start at dental school can be a little difficult ... I mean, they certainly will need someone to help them.” (A137) To overcome language barriers, some participants suggested providing printed information, and sending reminder texts and letters in Arabic, or assigning former refugees with Arabic-speaking practitioners, if possible: “If the letters are translated it would be better.” (A125)

**Practitioners’ cultural competency**

The attitudes of attending dental practitioners had an adverse bearing on the oral healthcare experience for many participants. They spoke of feeling undeserving—“A second-class citizen” (A144)—or being judged or stereotyped by their practitioner for having poor oral health. Many had received care from a dental practitioner who they believed did not understand the impact of war experiences on their oral health and their specific treatment needs. One participant said:

“We came after siege for 3 and 4 years we could not go to a dentist and use the toothbrush and there was no toothpaste! I wish they do not judge us in the wrong way that we are people who do not care about the cleanliness of our teeth.” (A124)
Several groups discussed how lack of continuity of practitioner had made it difficult to establish good rapport and a trusting relationship with a dentist: for example, “The most important thing is to have one dentist so they can understand the patient and the patient would understand them.” (A132) A few said their experiences—or the experiences of others they had heard about—meant they were reluctant to go to the dentist even if they had pain.

However, some participants attributed having positive experiences to being familiar with their practitioner and having a kind dentist who understood their background, culture and language. They suggested that former refugees “find a good dentist that understands the pain and the situation that we are going through” (A131) and that practitioners “treat them [refugees] just like any other person not as poor and have nothing.” (A143)

**Processes**

While many participants acknowledged that it was easy to arrange urgent dental care, they were frustrated by the difficulty of making appointments for routine or non-urgent dental treatment. Several participants commented on how these delays had resulted in disease progression, requiring urgent care or higher costs, as this participant explained:

> “When you have a small problem like a small hole, they tell you to wait until there is someone available to fix it. By the time they called us, the problem became bigger and the hole as well.” (A158)

Treatment delays had also impacted several participants’ engagement in the community:

> “I was supposed to get a lower denture and still waiting. You know that this affects the appearance, speech and eating. When one goes out, they feel embarrassed that his teeth look like this.” (A145)

Difficulties in understanding how to access care was a common discussion topic across the groups: for example, “Many people who do not know the system in the country here and how to book an appointment.” (A124) There was agreement among most groups that being better informed about the system was key: “Once you understand the system it will be easier for treatment.” (A125)

They suggested that information on accessing oral healthcare should be more readily available early on as part of the orientation “On-Arrival Programme” all New Zealand quota refugees experience.10 Some recommended that former refugees should take action themselves: “Follow up your appointment. If you have not heard anything for a few months, ask them why I didn’t get one.” (A122)

**Socio-cultural factors**

**Oral health attitudes and behaviours**

All participants highly valued their teeth and desired to keep them for as long as possible: “It is very important for me to keep my teeth ‘til the end of my life.” (A122) Many participants who were parents also described a desire for their children to have good oral health: for instance, “Our children need more awareness, so that they don’t do the mistakes we used to do when we were young.” (A140)

A majority also reported infrequent tooth brushing, not flossing, and consuming sweetened beverages, often despite knowing their harms. Many who were smokers also reported either no intention to quit or an inability to quit. Typical comments included, “I brush but honestly I do not like floss it is very difficult” and “I drink tea, fizzy drinks, and juices. They all have sugar and damage teeth, but I cannot stop it.” (A125) In addition, many participants had misconceptions about oral health such as smoking harms being alleviated by brushing—“A smoker has to smoke less or brush their teeth after smoking” (A124)—or that sugar can be safely replaced with honey: “We are trying like the honey and similar things. But the other chemical alternatives like sweeteners did not suit us.” (A123)

**Previous experiences and expectations**

More than half reported having chewing, nutrition or digestion issues that affected their quality of life: “When I eat, I chew half of the food and the other half gets swallowed.” (A145) Differences between the New Zealand and Syrian oral healthcare systems, such as cost, processes and ease of access to services, were raised in most groups. Previous experiences of oral healthcare in Syria appeared to set up assumptions and expectations among most participants about how the New Zealand oral health system worked.

Typical comments included: “The system they have differs from that in Syria. Sometimes, I do not understand them.” (A137)

Settlement in a country with seemingly well-developed systems, including healthcare systems,
also raised the expectations of most participants of the quality of care they would receive. Several participants suggested that they had expected oral healthcare services in New Zealand to be of better quality or more accessible than what they had in Syria. Their expectations may have been further heightened by the promises made to them on their arrival: for example, “On arrival, dental school will look after your teeth ... they said that Dunedin had the top dental treatment.” (A134)

**Resettlement challenges**

In addition to war and displacement trauma, participants spoke of the resettlement challenges in accessing oral healthcare, such as prioritising essential activities that facilitated their resettlement. This left little—if any—opportunity to attend to their dental problems. For instance, one participant explained, “Until today I have not been for dental treatment. First, I was busy studying the language and then I started work and I am busy. Otherwise, my teeth need urgent care.” (A158)

Thus, most participants wished their dental treatment had been completed early after their arrival before they started work.

Many participants reported missing their family and the social support they had in Syria, and they often struggled to understand New Zealand’s community values: “They [dentists] are wonderful when treating people. But we are not from New Zealand so that we would know the system, they should take this into consideration.” (A122) However, there was general agreement across all groups that local volunteers or friends were a valued key source of information and to understanding how to work through the system, as this participant recounted:

“I didn’t go to dentist, I stayed in pain for two to three days. I waited until my volunteer came and took us to the dentist.” (A126)

**Discussion**

Former refugees in New Zealand have poor oral health, poor oral health-related quality of life and poor access to care.\(^1\),\(^2\),\(^11\),\(^12\) Consistent with former refugees elsewhere,\(^3\),\(^13\)–\(^19\) structural and sociocultural factors hindered the participants’ abilities to address their oral health needs.

Communication barriers hamper former refugees’ (including our participants) abilities to access and navigate healthcare systems. Individual and systemic challenges reduce motivation and proactivity in seeking treatment.\(^14\),\(^18\)

Trust between provider and patients is critical to acceptable and accessible healthcare.\(^19\) In addition to a lack of routine care and having to accept tooth loss, study participants recounted the oral health system challenged their access and willingness to engage with services. Supporting the findings of previous studies,\(^6\),\(^17\),\(^18\) the low level of cultural competence generally displayed by the participants’ oral healthcare providers resulted in sub-optimal experiences. Participants highlighted a dental workforce that lacked the capacity or preparedness to work with former refugees. Further contributing to erosion of trust were participants’ expectations, a lack of continuity of care, the ambiguity of the New Zealand healthcare system and the lack of organisation between services,\(^20\) and a sense of helplessness and a loss of control due to language and financial barriers.

Feelings experienced while resettling in new countries are almost always neglected when talking about former refugees; rather, the focus is usually on past trauma and PTSD manifestations. Nostalgia in particular may belie the participants’ outward feelings of frustration and confusion when trying to address their oral healthcare needs. The findings of this study support recent research\(^22\) that suggests a longing for things past, especially among former refugees who lack resilience, may result in reduced optimism and inspiration. The participants in this study frequently reflected on the Syrian system or highlighted the easiness of navigating it in comparison with the system in New Zealand. In addition, former refugees (including participants in this study) often have unrealistically high expectations of their host country’s health system.\(^23\) Those supporting former refugees in their resettlement, including oral healthcare practitioners, should anticipate and be sensitive to these feelings and expectations, and take into account the multiple layers and complexity of the resettlement process.

This study is one of the first to explore the oral healthcare experiences of former Syrian refugees settled in New Zealand. The qualitative approach applied in this research enabled an in-depth exploration of the lived oral healthcare experiences of former Syrian refugees settled in New Zealand. The interviews were conducted by a native Arabic speaker allowing trust and rapport between the interviewer and participants.

Owing to COVID-19 pandemic constraints, the focus group meetings had to be conducted
online rather than the planned in-person meetings. However, the quality and quantity of data collected online appears similar to face-to-face interviews. Moreover, online focus groups may have provided a safer and a more confidential setting for participants.

Although one researcher analysed the data, the transcripts were reviewed and coded data and themes were discussed with two senior research team members until consensus was achieved. The findings may have limited transferability given they were generated from a homogeneous group of Syrian former refugees resettled in one city. Nevertheless, key factors that affected their oral healthcare are likely to be similar to those faced by former refugees living elsewhere in New Zealand and globally.

This research suggests that changes are needed to the way oral healthcare is made available and delivered to former refugees. Clinicians need to have appropriate training about cultural safety at undergraduate and graduate levels.

At a systems level, information about services and funding, along with oral health promotion material, should be provided in a range of languages. The weeks or months following arrival may be an ideal opportunity to address former refugees' oral health.

**Conclusions**

New Zealand's former refugees have diverse and specific oral healthcare needs. Oral healthcare providers and policymakers need to expect and accept their patients' past experiences, emotions, vulnerabilities, cultures, backgrounds and the complexity of the resettlement process. A culturally safe system and practitioners can facilitate former refugees' access to care.
COMPETING INTERESTS
Nil.

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REFERENCES


