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INCLUSION ORAL HEALTH – A CONTENT ANALYSIS OF AUSTRALIAN ORAL HEALTH THERAPY CURRICULA

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STATEMENT OF ORIGINALITY

This is to certify that to the best of my knowledge; the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Kelly-Jean Burden

DEDICATION

Dedicated to my younger brother, who passed away during the writing of this thesis.

Daniel Robert Tetley

May 19, 1981 – December 28, 2022

If Universities valued kindness, the way I do, my brother would have been a Rhodes Scholar.

Acknowledgments

I would like to acknowledge my husband Tim for all the support and encouragement he has given me during the writing of this thesis, along with our very patient children Samantha and Ethan.

The team of Bachelor of Oral Health academics at the University of Sydney (2016-2021), who believe in me and support my academic career.

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Abstract

A significant generalised shift in pedagogy urges undergraduate University students to reflect upon their own epistemological perspective, not only to fulfill course requirements but to initiate themselves as reflective practitioners. It is also significant for teaching academics to know who their students are, and how they relate to the world to best support their learning journey. This study examines learning outcomes of Australian universities' Oral Health Therapy curricula, and the overarching aims for graduate qualities of these programs. This research is based on a content analysis of curricula terms indicating '*Inclusion Oral Health'* as a contributor to the teaching of injustices within the delivery of Oral Health Therapy curricula (Freeman et al., 2019 p.4). This study draws on Freeman's definition of '*Inclusion Oral Health':*

> Inclusion Oral Health
>
> is based on a theoretically engaged understanding of how social exclusion is produced and experienced, and how forms of exclusion and discrimination intersect to compound Oral Health outcomes. Inclusion Oral Health focuses on developing innovative inter-sectoral solutions to tackle the inequalities of people enduring extreme Oral Health (Freeman et al., 2019, p. 4).

The publicly available learning outcomes from Australian Bachelor of Oral Health (BOH) programs were analysed to assess the presence of key themes, inclusions, and exclusions, via the application of a content analysis methodology. The preliminary results indicated that key terms such as social injustice and social exclusion were seldom included in Oral Health Therapy curricula learning outcomes in teaching institutions across the country and that cultural inclusions varied greatly across curricula. The content analysis findings indicated that, in general, the current learning outcomes of Australian Oral Health programs lack inclusiveness and fail to express a clear commitment to the implementation of inclusion oral health through their publicly available curricula.

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Chapter 1

Introduction

Researcher Positionality Statement

Given the theoretical framework for this social justice research project, it is important that I reflect on my position as a researcher. In doing so, it is necessary to state that I am a cis-gender white woman, which places me in a position of given privilege. My status as an academic and my white privilege places me in contrast to the people this study seeks to benefit. In recognising socially excluded and under-serviced groups in our community, through the lens of oral health therapy it is my personal aim to reorient oral health services toward a more equitable distribution in the New South Wales (NSW) and broader Australian communities. The means of reaching that aim is via the education of future practitioners in the field. Therefore, my experience in education adds to my position as a researcher.

My tertiary studies began in 2001 at the University of Queensland (UQ) where I completed an undergraduate degree – Bachelor of Applied Health Science (Oral Health) (B.App.H.Sc (Oral Health)). At the time of enrolling in this degree, I was a mature-aged student. The B.App.H.Sc (Oral Health) program was relatively new to UQ at the time with only three cohorts having graduated prior to my own graduation in 2004. The degree served me both personally and professionally and created a platform for growth in the emerging field of oral health. Prior to enrolment, I had travelled overseas for two and a half years visiting both global North and global South countries. The most influential

part of my travels was a three-month trip to India. As a twenty-two-year-old, this trip provided insight into a culture that was inherently different from my own and laid the foundation for my current understanding of privilege and social inequality. The fact that I had to go to India to recognise social inequality is reflective of how, in my own culture, inequality was hidden from view for most white Australians, comfortable as we were in the failure to recognise the impact of colonisation on Australia's First Nations peoples.

These formative years drove my internal motivation, and pursuit of understanding the complex issues of social inequality and how they affect diverse groups of people. Once I became a member of the oral health therapy profession, I was able to access the scholarly literature, which I pursued from the perspective of how my core values and beliefs were or were not expressed in the wider dentistry literature. This enabled me to begin constructing ideas on how the profession could be more socially and culturally responsible.

In 2016, I was employed by the University of Sydney (USYD) Bachelor of Oral Health (BOH) program as a casual Clinical Educator and found that I was able to contribute to the professional development of oral health therapy undergraduates, this empowered me and provided me the opportunity to consider research in the discipline. In 2017, I was invited by the USYD BOH academic team to join them as a junior academic, I accepted the offer on a short-term basis and together we became a productive and supportive team of educators. I was able to enrol in and complete postgraduate studies as part of my university employment. This led to the completion of my Graduate Certificate of Higher Education and the pursuit of a Master of Education (Research) which requires the completion of this thesis.

My underlying research objective was to open spaces for communities to have a voice regarding oral health, how it is delivered, when it is delivered, and how it can be modified to meet the needs of various community subgroups. Throughout my lived experience as a registered oral health therapist and an academic, I have had the opportunity to become familiar with levels of exclusion experienced

by dentally underserved communities and explore possible changes that could lead the profession to serve in a more socially just and culturally acceptable way. Traditionally, dentistry and oral health has been based on a business model, this is due to the wide commercialisation of dentistry practice. It is an aim that this thesis and the further emergence of *'inclusion oral health'* (Freeman et al., 2019 p.4) serve as an opportunity to move away from dominant, business-oriented discourses that appear to drive the profession and therefore heavily influence oral health and dentistry education.

My personal motivation for this study comes from a need to contribute to the body of evidence that calls on oral health therapists to listen to the needs of communities, a desire to become flexible in thought and action, and the pursuit of courage, enough to contribute to social change. In my undergraduate degree and later in my career, I noticed an uncomfortable truth in how oral health therapists and dentists address the dentally underserved in the community and how this is rarely discussed in professional circles, whether they be academic or clinical. In encountering '*Inclusive oral Health advancing a theoretical framework*' (Freeman et al., 2019), it was evident that the foundation for a new perspective in oral health research was emerging and that I was well-positioned to contribute to its development. The oral health therapy profession that I envisage has social justice at its core when it comes to excluded groups in the community. Such groups are excluded because of a lack of economic, geographical, and culturally safe access to appropriate levels of care. It will be through the profession's engagement with a wider critically reflective lens, by further displaying agility, and by taking action that I believe these barriers can be overcome.

Throughout this study, I have been highly influenced by key thinkers concerned with inequality and power and have set out to establish how social justice can frame new pedagogical strategies for oral health therapy education. An understanding of the complex issues of social justice, intersectionality, praxis, and power have been commonly explored within the sociology discipline. A review of relevant literature has provided a window into how social justice scholarship and self-reflective

practice could be developed as a pedagogical approach enmeshed with population oral health research.

1.1 Introduction

The 2004-2006 National Survey of adult oral health (NSAOH), reported that Indigenous adults had 2.3 times more untreated dental caries than their non-Indigenous adult counterparts and that 57% of Indigenous adults had one or more teeth affected compared with 25% of non-Indigenous adults (Williams et al., 2011). Forsyth et al. (2019), confirmed that the situation remains unchanged in more recent times, reporting that Aboriginal people in Australia continue to experience oral health outcome disparities despite numerous interventions to address the issue. Australian indigenous people aren't alone in experiencing extreme oral health outcomes in this country. This point is illustrated by the fact that some 4.4 million people with a disability, are served by only 24 practicing special needs dental specialists (Australian Dental Association [ADA], 2023). Through the process of student feedback, coupled with peer review, and changes to the Australian Dental Council (ADC) Program Accreditation Standards, determined that a new critical reflective strategy needed to be designed and implemented in the Oral Health in Society (OHS) unit of study – ORHL3101/ORHL3102, in which I taught during 2020 and 2021. The overarching goal was to highlight oral health inequality its enablers, and barriers for students, with the hope of exploring ways of creating change.

This unit of study was mapped to both the graduate qualities of the University of Sydney (USYD) and the Australian Dental Councils (ADC) oral health promotion standards for newly graduated Oral Health Therapists. After a review of the literature, it was decided to engage third-year Bachelor of Oral Health (BOH) students in deep self-reflective practice through a *'Photovoice Critical Reflective Journal'* assessment task (Appendix 1). The assessment asked students to consider four prompt words – 1) Personal and professional growth, 2) Ethical and personal identity, 3) Cultural competence, and 4) Privilege. Under the theme of each prompt students were required to engage in critical reflection using visual images (photos and/or drawings) to illustrate their personal learning journey throughout the degree. The outcome of the assessments would then be collated, then as a group, a photovoice gallery would be curated and displayed to people in positions of power internal

and external to the program. The original trajectory for this thesis was to investigate the above-mentioned assessment and provide evidence of its effectiveness in supporting students' ability to self-reflect, during situated learning experiences.

Several external factors contributed to the reorientation and subsequent pivot of the project. This reorientation led to the completion of a content analysis of Bachelor of Oral Health programs' learning outcomes at Australian universities. The key themes of social justice, social exclusion, and cultural competency, including elements of safety, processes, diversity, and sensitivity. All such factors were examined, which facilitated the project in identifying current trends in curricula. This allowed for reflection upon how Australian universities provided oral health education on inequalities, an integral component in the education it offers oral health therapists and the profession.

1.2 Background

The final year of the BOH undergraduate degree at USYD, aimed to facilitate change within students across all units of study. The curriculum and the assessments in all units were constructed in such a way as to encourage movement from an absolutist view of knowledge to relativistic conceptualisations of key concepts that were introduced in the first and second years of the degree (Perry, 1988).

The full-time team of academics employed by the university to teach the BOH program in November 2019, consisted of six academic staff members. It was comprised of two senior academics – one of which was employed as Head of Discipline, one Senior Lecturer, two Lecturers, and two Associate Lecturers. The team carried out one of its regular curriculum review meetings in November 2019. Prior to this meeting, it was requested that I present the current OHS curriculum and new evidence-based ideas that could be implemented to enhance the student experience and contemporize the units reflective assessment. At the time it was also noted that the Australian Dental Council (ADC) would be introducing a new standard in January 2021, which may have the potential to further

affect the curriculum of OHS. My actionable tasks, were to secure 2021 oral health promotion placements, complete the necessary *'Student Placement Agreements'* where required and ensure these were constructed in line with the USYD 2015 Policy (see Appendix 2), and research and develop a new evidence-based curriculum for OHS third year for implementation in 2021.

Historically, the OHS curriculum was designed to embed four notable ADC competency statements over the course of the undergraduate degree. In 2019, the ADC competency statements for oral health promotion outlined that those students who graduate from dental schools across Australia must be competent at being able to:

1. Understand the determinants of health, risk factors, and behaviours that influence health.
2. Understand the theories and principles of health promotion.
3. Understand health promotion strategies to promote oral and general health.
4. Understand the design, implementation, and evaluation of evidence-based health promotion (Australian Dental Council, 2022).

Within the Australian context, Dental and Oral Health higher education standards are governed by the ADC. The ADC is an independent accreditation authority that has been assigned by the Dental Board of Australia and the National Registration and Accreditation Scheme (NRAS), to accredit Australian programs of study for entry to practice, ensuring that graduates have the required competencies and are suitable for registration to practice in Australia. This role, among its numerous other functions, has the primary aim of ensuring the health and safety of the public (ADC, 2022). To contemporize and maintain currency, the ADC will occasionally review and adjust its competency standards to meet the changing needs of the profession and develop safe and competent dental practitioners who are equipped to meet the needs of the community. Oral Health Therapy programs in Australia, are usually reassessed for accreditation every five years, and in 2019, the academic team of the USYD program was preparing for renewing accreditation which was scheduled for 2022 (ADC, 2022).

On January 29, 2021, the ADC released its revised *'Professional competencies of the newly qualified Dental Practitioner'*. Of all the revised competencies that were handed down by the ADC, the following had the greatest potential to transform the OHS future curricula:

1. Demonstrate that the interests of the person receiving care are paramount in all decisions and actions.

2. Acknowledge colonisation and systemic racism, social, cultural, behavioural, and economic factors which impact individual and community health.

3. Acknowledge and address individual racism, your own biases, assumptions, stereotypes, and prejudices and provide care that is holistic, free of bias and racism.

4. Recognize the importance of self-determined decision-making, partnership, and collaboration in healthcare which is driven by the individual, family, and community.

5. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

6. Provide culturally safe care to diverse groups and populations, recognising barriers to accessing care, and responding to the distinct needs of those at increased risk of poor oral health.

8. Incorporate a self-reflexive approach to dental practice that recognises and supports life-long learning for all members of the dental team.

9. Practise in an ethical and professional manner consistent with the Dental Board of Australia's Code of Conduct.

11. Recognise the environmental impacts of health care provision and use resources responsibly making decisions that support environmentally sustainable healthcare (ADC, 2022).

In February, after the ADC had released its revised competencies on January 29, 2021, the USYD academic staff reconvened. The agenda items included:

1) Discussion of the most recent evidence that would support changes in the OHS curriculum; here the Freeman et al, (2019) article entitled '*Inclusion oral health: advancing a theoretical framework for policy, research and practice'*, was considered by the group.

2) Review the draft OHS curriculum; the group unanimously decided that the draft would proceed to implementation with some minor administrative amendments. This approach would require substantial change for third-year OHS students but would facilitate students in their final year of study to be fully immersed in social and cultural safety prior to graduating.

3) Revision of the ADC professional competencies and how they could be mapped with the draft curriculum; this appeared to be a straightforward process considering the team's foresight.

4) Examine the literature presented by myself regarding the most up-to-date evidence-based reflective tasks that could be implemented into OHS; the group supported the introduction of a '*Photovoice Critical Reflective Journal'* assessment task (see Appendix 1).

5) Discuss the student placement options for 2021; situated learning experiences, the first being the Aboriginal Health Hub and the second being Flintwood Disability Services. Both student placements were accepted by the team as appropriate situated learning experiences for students.

All previously mentioned members of the academic team were able to express their epistemological views, which led to discussions where multiple perspectives were expressed and considered. The primary goal, of these respectful discussions, was to improve the BOH program's curriculum and to ensure that OHS was tracking to become more inclusive of social and cultural safety.

In 2018, the International Association for Dental Research (IADR) held an international symposium titled *'International Perspectives on Socially Inclusive Dentistry: A Call to Action'*. The aim of this symposium was to initiate an international dialogue on barriers to oral health care, re-examine oral

health inequalities from a multidisciplinary perspective, and provide actions and examples of best practices in service delivery to people experiencing social exclusion. It is from this symposium that it was identified that a theoretical framework was required to push forward a socially inclusive oral health care agenda. This symposium identified that change was required in the oral health profession's approach to policy-making, research methods, and best practices. As a direct result of this symposium Freeman et al. (2019) advanced a theoretical framework for inclusion oral health. The Freeman et al. (2019) framework acknowledged the traditional approach to oral health service delivery, which clearly occurs through business, demand-led models, however it also highlighted the compounding oral health consequences of such an approach for those already experiencing social exclusion. The term social exclusion takes on various meanings throughout history, within this thesis the term refers to the following definition:

> …a complex and multidimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (University of Bristol, 2007 p. 25).

A further underlying theoretical framework draws on the idea of Intersectionality, which was first coined by Kimberley Crenshaw in 1991. Application of the idea evolved within Black feminist theory, with various contemporary definitions. For the purposes of this study intersectionality will be understood as being:

> …an understanding of human beings as shaped by the interaction of different social locations (e.g., race/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes,

> interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created. PUT SIMPLY: According to an intersectionality perspective, inequities are never the result of single, distinct factors. Rather, they are the outcome of intersections of different social locations, power relations and experiences (Hankivsky, 2014, p. 2).

Adopting an intersectional perspective allows oral health therapy researchers and educators to acknowledge, embrace and reflect on exclusion and privilege as key factors contributing to oral health disparities. This thesis draws upon several social justice-oriented thinkers, Spivak (1999) for example, whose ideas have underpinned the focus of this research that aims to open spaces from which people within socially excluded groups in need of oral health care can speak and be heard by engaging in the development of self-reflective learning amongst oral health therapy students (Spivak, 1999). Spivak's (1999) postcolonial analysis informs that the role of the intellectual is not to speak on behalf of those who have lived experience, but instead acknowledge a need for representation in solidarity with subaltern[1] groups (Young, 2020).

The development of an epistemological core for this thesis drew on multiple authors including Freeman's (2019) Inclusion Oral Health Theoretical Framework, Postcolonialism, Social Justice theory, and Black feminist theory. From these key frameworks, it is intended that this thesis provides further support for the advancement of this complex area of the oral health profession. It is also hoped that the research will contribute to initiating psychologically safe spaces for future discussions of wicked problems, such as *'extreme oral health'* (Freeman et al., 2019 p.2), on various platforms, from the perspectives *'voices'* of those who have lived experiences of social exclusion (Spivak, 1999).

[1] An adapted term, extended over time to describe any marginalized or disempowered individual or group in contemporary society, particularly with respect to gender and ethnicity.

The concept and action for social justice includes egalitarian ethical theories, addressing the issue of fair distribution of social goods, Ekmekci & Arda, (2015) drew on Rawls et al. (1987), who stated that justice can be achieved not by absolute equity but by fairness, a claim justified by two principles:

1) *Equal liberty;* each and every individual should have equal fundamental rights. Political liberties, liberty of conscience, freedom of speech and gathering, freedom of expression, self-respect, right to personal integrity, right of property, right to not being arrested arbitrarily, and freedom of thought are considered among the fundamental rights (Ekmekci & Arda, 2015 p.230).
2) *Difference principle;* the inequalities of income and welfare are considered to be fair if and only if these inequalities are for the benefit of the worst off (Ekmekci & Arda, 2015 p.230).

Lister (2013), quotes Rawls, et al. (1987), stating that the principles of justice '*define the appropriate distribution of the benefits and burdens of social cooperation.*' (p. 411).

It is evident from the above that connections have been made by Freeman et al. (2019) to key social justice theorists, providing a key to unlocking a fundamental paradigm shift toward greater oral health equality. This is demonstrated in the results of this research, which engaged in a content analysis of Australian oral health programs learning outcomes and discussion of an educational strategy that might support educators' shift focus to a social justice paradigm. The reorientation of this project included a primary motivation of raising social justice consciousness within Australian oral health programs.

1.3 Aim & Research questions

This project had two primary aims:

1. To conduct a content analysis of the learning outcomes of Australian Bachelor of Oral Health programs, aiming to reveal the extent of key terms used that align with health justice - social exclusion, intersectionality, voice and othering.

2. To explore Bachelor of Oral Health (BOH) learning outcomes, that aim to reorientate students towards a social justice focus and explore potential future curricula based on the current Australian Dental Councils guidelines.

The research questions are:

1. What is the current scope of contemporary pedagogy in relation to inclusion oral health in Australian oral health therapy and dental hygiene curricula?

2. What approaches can begin to emerge that will facilitate students in greater self-reflection and social justice learning?

This first chapter has provided insight into the context surrounding the development of this research, a brief understanding of the author's epistemological position, and the aligning theoretical framework implemented. The second chapter will highlight shortcomings in the existing research that have inspired the thesis' core research questions. Chapter three will articulate the progression from discursive discussion to the informed research design and methodology of the thesis. Chapter four introduces the collated data, discusses the outcome of its analysis, and illustrates the author's educational strategy for leaning into a paradigm shift via a brief auto-ethnography. Chapter five provides a summary of the thesis, emphasising key findings and how these may contribute to future work, future recommendations are given, and a description of the limitations. Chapter six serves as a platform for addressing the research questions and considers future implementations considering the findings.

Chapter 2

Literature Review

As discussed above in the introduction, *'inclusion oral health'* is an emerging philosophy that promotes the idea that silencing of voices, compounding disadvantage due to intersectionality of issues for disadvantaged people, and the othering of people, are the fundamental underpinnings of poor oral health outcomes for those suffering social exclusion (Freeman et al., 2019 p.4). The publication of '*Inclusion Oral Health Advancing a Theoretical Framework*' (IOHATF) by Freeman, et al. (2019 p.1) signified a shift in approach by the Oral Health discipline away from traditional discipline-focused paradigms to a more expansive model.

2.1 Introduction & Background

As the prevalence of poor oral health outcomes continues to increase for those experiencing social exclusion, traditionalist oral health, and dental researchers, have continued to implement top-down interventions to address oral health disparities. The intent of this project is contrary to that traditional approach, as it gives focus to educating undergraduate Bachelor of Oral Health students on social exclusion, health justice issues, bottom-up interventions, understandings of intersectionality, the importance of voice, and the impact of othering.

Traditionally, oral health education has generally limited its exploration of the social sciences to providing evidence of the social determinants of health (SDH) by linking isolated SDH to the impact

they have on oral health outcomes. The push made by Freeman et al., (2019) was to acknowledge intersectionality and its compounding effects on oral health outcomes, which is best viewed from a social science lens. The social determinants of health are referred to by the World Health Organisation (WHO) as:

> The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems (WHO, 2022).

This emergent shift in philosophy is paralleled by the Australian Dental Council's (ADC) revision of the 'Professional competencies of the newly qualified Dental Practitioner', making it timely to investigate how social determinants have been taught up until this point. Dental programs across the country must be led by the ADC to re-evaluate, revise and implement more socially aware curricula that acknowledge complex societal issues, such as colonialism and personal bias. This is an opportunity for oral health educators to develop curricula that influences undergraduates' understanding of the overlapping and interdependent systems of discrimination and disadvantage that combine to create different oral health outcomes.

Various authors have contributed to contemporary understandings of intersectionality. Intersectionality became a prominent theme in Black feminist movements in the 1960s and 1970s, emphasizing the interconnectedness of sexuality, race and class, ethnicity, and gender. It was a term coined by Crenshaw in 1991, but has its roots in Sojourner Truth's '*Ain't I a Woman?*' speech (1851), (Brah & Phoenix, 2004). Truth, (1851) brought to the fore and deconstructed the notion that race, ethnicity and gender are mutually exclusive, acknowledging that these intersections were instead layered complexities with nuances that had previously remained hidden.

A key focus of the literature review has been on the transition towards inclusion oral health within the oral health discipline. The primary goal of this review was to evaluate emergent themes and how

these themes could address the ADC's focus on a greater acknowledgement of societal complexities. Previously, various authors have contributed to developing an understanding of BOH curricula within the Australian context. The first attempt was by Satur and colleagues (2010), this research drew on contributions made by academics teaching into each of the programs. The evolution of the profession was outlined along with the current curricula and the prospective directions (Satur, 2010). More recently, Bracksley-O'Grady et al. (2021), conducted a content analysis within the Oral Health and Dentistry health promotion in content and mapped these against the 2019 Australian Dental Councils (ADC) competencies. Bracksley-O'Grady et al. (2023 p. 14) conclusions were that: *'a change is needed in the ADC health promotion competencies and ethos of academics involved in the development of curriculum to include and give appropriate attention to health promotion theory especially advocacy.'*

The literature search sought to identify all articles that cited IOHATF and resulted in thirty-five publications that required investigation. Duplications and theses did not inform this literature review and were excluded. The remaining twenty-seven articles were organised by various themes including Understanding Intersectionality, Othering and Voice, Higher Education, Homelessness, COVID-19, and Leaning into Another Paradigm.

2.2 Understanding Intersectionality, Voice & Othering

The term '*paradigm shift*' was highlighted by Thomas Kuhn in '*The Structure of Scientific Revolutions*', and various other authors have evolved the term since (Kuhn, 1962 p.150). This term signifies a series of alternating phases of normal science and revolutions that overturn and replace old models in favour of new models, which is evident in the establishment of new norms (Kuhn, 2012). Freeman et al. (2019), publication of '*Inclusion Oral Health Advancing a Theoretical Framework*' (IOHATF), when combined with the revised accreditation standards and graduate competencies of the Australian Dental Council (ADC), can be viewed as a paradigm shift in theorising effective oral health practices. This new direction emphasised a movement towards an Interpretive

paradigm away from positivism within Oral Health research and education, creating an opportunity to establish new norms. The emergent knowledge has been expanded and applied by researchers embracing reflexivity, culture, social structure, and social consciousness, which were previously barely evident in the discipline of Dentistry and Oral Health.

At the core of the Freeman et al. (2019) paradigm shift is an understanding of the following key terms; intersectionality, voice, and othering. Several authors have contributed to these terms in the wider humanities and social sciences disciplines, but the historic nature of dental research means the discipline is with knowledge gaps that have not been addressed until recently.

In 2020, significant contributions were made toward this paradigm shift. One of the most important, in my view, was Bastos et al. (2020), '*Advancing racial equity in oral health (research) more of the same is not enough'*. This paper articulates the frustrations of socially minded oral health researchers as it described the complex interactions between inter and intrapersonal factors that impact oral health outcomes of people from specific racial and/or ethnic groups from both macro and micro perspectives or for people experiencing intersectional identities that cause exclusion (Bastos et al., 2020). Furthermore, it spotlighted the common dental mentality of '*no data, no problem*' (Bastos et al., 2020, p. 464), which maintains the power distribution of the status quo in oral health institutions and in the allocation of its resources.

Similar observations and arguments are echoed by Beaton et al. (2021), who stated that people experiencing homelessness utilise dental services less often and implied that this may be due not only to their precarious living conditions but the characteristics of the United Kingdom's (UK) National Health Service (NHS) – namely its inflexibility regarding appointment making and other various socio-political phenomena. Bastos and colleagues provided four recommendations that would support the initiation and fostering of future anti-racism narratives (Bastos et al., 2020):

1) Fostering anti-racism in Oral Health (Bastos et al., 2020, p. 462)

Here the authors called for an improvement to the instruments used by researchers to operationalize 'discrimination'. This includes engagement with the humanities and social sciences to overcome oppressive systems (Bastos et al., 2020).

> 2) Studies should not imply that racial oppression is bad because it harms oral health (Bastos et al., 2020, p. 463).

Although this recommendation appears contrary to the underpinning theme, with further explanation Bastos and colleagues' thoughts are revealed. Bastos et al. (2020) explained that if investigators fail to provide context and measurement of racial oppression linking it with oral health inequities a linear conclusion is drawn, which indicates that oppression is bad because it harms oral health. The authors argue that oppression is fundamentally wrong, not because it underlies poor oral health outcomes and oral health inequalities, but because it is oppression. A delicate nuance that is rarely highlighted, but significant in framing perspective.

The authors dive deeper and bring to the fore the underlying hidden power imbalances that plague oral health. Here it is highlighted that ethically there is no justification for investigators to continue with the scientific activity that perpetuates social injustice or the status quo, such as power and control remaining in the hands of a select few social actors and the corresponding social groups (Bastos et al., 2020). This understanding of how oral health investigators are contributing to the compounding effects of social exclusion can no longer be ignored, it is unethical.

> 3) Oral Health researchers must assume that systems of oppression conjointly operate to shape oral health (Bastos et al., 2020, p. 463).

The authors recommend a pivot by researchers away from individualising social factors impacting oral health outcomes, to embracing intersectionality and its complex nature. Further, reference is made to the greater umbrella of interlocking matrices of domination, the article suggests that by contributing to the dismantling of overall organizational power within dental institutions and

systems, support will be given to the elimination of all forms of (oral) health inequalities (Bastos et al., 2020).

4) Raced based oppression is a multi-level system with inter, intrapersonal and structural/institutional ramifications (Bastos et al., 2020, p. 464).

This recommendation highlights that the oral health scholarly literature relies solely on interpersonal discrimination, with no studies investigating the institutional or structural dimensions of racial oppression and the oral health consequences this perspective brings. Here it is recommended that researchers investigate the latter as a matter of urgency (Bastos et al., 2020).

Contributing to Bastos et al. (2020) standpoint on the intricacies of power found within oral health systems and institutions are Muirhead, Freeman, and Doughty's (2020), observation of the relevant research literature – *'no attention to power, no intersectionality'* (Muirhead et al., 2020 p. 466). It raised the point that oral health research had been slow to embrace intersectionality, when compared to other health disciplines and provided public health as an example. Muirhead et al. (2020), directed future socially minded oral health researchers to step outside of the oral health discipline into the humanities, as Bastos and colleagues did with great success (Muirhead et al., 2020).

A team of Australian interdisciplinary authors, Bourke et al. (2021) responded to this call in the publication of *'Building readiness for inclusive practice in mainstream health services: A pre-inclusion framework to deconstruct exclusion'*. Their research identified that to reach the '*hardly reached*' not only do health services need to become inclusive, by acknowledging intersectionality, but health systems need to challenge their contributions to exclusion (Bourke et al., 2021, p. 1). They applied Peace's (2001) definition of exclusion as:

> …ways of naming the collective processes that work to deprive people of access to opportunities and means, material or otherwise, to achieve well-being and security in the terms that are important to them (Peace, 2001, p. 34).

Similar to Bastoet al. (2020) outcomes, this paper called for a deconstruction of exclusion practices, which it postulates, would have a power rupturing impact that could potentially deconstruct the colonial legacy within health services (Bourke et al., 2021). The authors recommended taking a *'cultural humility*' approach, where cultural humility was defined as:

> …incorporating a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient–physician dynamic, and to develop mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of the individuals and defined populations (Tervalon & Murray-Garcia, 1998, p. 117).

There were three common sub-themes across the above-mentioned research, one was a move towards greater cognizance of and discourses applying understandings of intersectionality within the oral health discipline. The second was the need to identify how oral health systems and institutions currently compound poor oral health outcomes of socially excluded people and communities and the third was a clear message to oral health researchers to expand their knowledge from other disciplines, engage the humanities and social sciences and embrace the collective knowledge of multidisciplinary research teams. These papers serve as a starting point for further contributions, to a paradigm shift. Clearly, further evidence and discourse needs to be conducted which has intersectionality at its core, this would serve to address knowledge chasms identified in the research above.

The addition of Freeman et al. (2019) core concepts into the oral health literature recognizes the importance of language and how this can shape future research investigations and practices. The original authors of IOHATF reconvened to investigate and dissect the use of language and its impact

on the socially excluded. The authors raised some key points which included, how the term *'vulnerable population'* is a commonly used descriptor that conceals the 'how', 'why' and 'therefore' that leads to and from vulnerability (Macdonald et al., 2022 p. 469). They reported that with such concealments comes harm and the quietening of strengths, agency, and power of individuals and populations, dismissing the potential of the *'vulnerable*' to care for themselves and each other (Macdonald et al., 2022 p. 469). The authors explain how the phrase *'vulnerable population*' enables misdirection or dismissiveness through semantics, averting the research lens away from social processes that produce vulnerability towards a downstream product – the vulnerable population (Macdonald et al., 2022 p. 469). Primarily the term *'vulnerable population*' is investigated and solutions to overcome the conventional research/practice misgivings are given which included co-engagement, and co-production with people who have been *'vulnerabilized'* (Macdonald et al., 2022 p. 472). The impact of engaging in *'vulnerabilizing'* practices, inevitably leads to multiple intersectional identities layering and compounding one's vulnerability (Macdonald et al., 2022 p. 472).

Finally, Macdonald et al. (2022) proposed that labelling and/or homogenising people and groups as belonging to a '*vulnerable population*' is in fact how *'othering'*, creates a binary construct that makes the vulnerable individual not *'normal'* and creates further distance between the labeller from the labelling (Macdonald et al., 2022 p. 472). This can misrepresent populations and *'(re)produce harms'* (Macdonald et al., 2022 p. 469). The following example illustrates the complexity of this issue. Commonly, within the oral health profession and oral health research, clinicians and researchers alike, are asked to address the oral health care needs of '*vulnerable populations*' (Macdonald et al., 2022 p. 472). This approach positions our clinical and research interventions downstream. Which eclipses the other characteristics and complexities that make people citizens, and conveniently sweeps intersectionality under the mat, (Macdonald et al., 2022). In other words, belonging to a *'vulnerable population',* as a designated state of being, compels our research and intervention after the label has been assigned (Macdonald et al., 2022 p. 469). While such a strategy may help to

address immediate dental emergencies such as toothache, it does not fundamentally change the *'vulnerabilizing*,' intersecting conditions that caused the toothache (Macdonald et al., 2022 p. 472). Future consideration should be given to how population health and epidemiology perpetuates this through the use of multiple regression data analysis.

Another example of *'vulnerabilizing*' was illustrated in a recent South Korean article that investigated retrospective data from a nationwide survey held in 2016 (Lee et al., 2020). The study's primary aim was to explore how the South Korean homeless population utilised medical and dental services using Gelberg, Andersen, & Leake, (2000) behavioural model for vulnerable populations. Like Mejia-Lancheros et al. (2020), the researchers sought to discover solutions that overcame identifiable barriers to accessing these services. The article cites IOHATF's definitions of *'extreme oral health*', *'social exclusion',* and *'intersectionality'* (Freeman et al., 2019 p. 4). Further, it mentions the compounding effects these factors have on oral health outcomes (Lee et al., 2020). So, although researchers were able to contribute to key concepts of IOHATF, their choice of model would indicate that *'vulnerablizing',* and it's effect on the socially excluded was not considered (Macdonald et al., 2022 p. 472).

Recent Canadian research had the primary objective of understanding the experiences and expectations of underprivileged people living in Montreal Canada. The population being investigated attend the Jim Lind Dental Clinic (JLDC), which provided free dental services to low income and homeless Montrealer's (Noushi & Bedos, 2020). The population was investigated to assist in the further development of person-centred care and the benefits of acknowledging the voices of those being served (Noushi & Bedos, 2020). Their research raised a specific point that aligns with one of Freeman et al. (2019) key ideas. That is that historically, various researchers and clinicians have developed multiple models of care in which despite the person being at the centre of those projects, their voices have not been sufficiently heard, considered, or amplified. History informs us that this strategy understandably and consistently leads to sustainability issues and a lack of engagement

(Noushi & Bedos, 2020). The term othering is mentioned with importance placed on broader social contexts that perpetuate the oppression of people living in poverty (Noushi & Bedos, 2020).

More research is clearly needed to provide clarity around the core concepts of othering and supporting voice in the oral health profession (education, research and clinical practice) and for a defined step away from *'vulnerabilizing'* to be made (Macdonald et al., 2022 p. 472). From the above-mentioned literature, there are only two publications that attempt to create understanding around the complex issues of voice and othering. This research fills a gap in developing a clearer understanding of how these core concepts are currently promoted in oral health research, practice, and higher education. The discipline would benefit from a much deeper understanding of how to identify, acknowledge and address these inherent issues.

2.3 Inclusion Oral Health & Higher Education

Throughout the higher education literature an important alignment begins to appear between '*patient-centered care*' (Bedos et al., 2020 p. 465), and '*inclusion oral health*' (Freeman et al., 2019 p. 4). A team of Canadian authors, which included Bedos, who is also noted above as contributing to the scholarly literature on voice, introduced a biopsychosocial model of patient care referred to as the '*Montreal-Toulouse Model for dentistry*', (Bedos et al., 2020 p. 465). Here the authors introduce an education-focused innovation that invites dental practitioners, educators, and researchers to take a holistic view of patients on an individual level, a community level, and a societal level (Bedos et al., 2020). The *'Montreal-Toulouse Model'* focuses on communication and mutual respect building between practitioner and patient, it asks practitioners to scrutinize the stigma that the patient may be experiencing and how it may impact not only their personal oral health outcomes but also the clinical relationship they have with the patient (Bedos et al., 2020). This model asks all dental practitioners to build partnerships with those whom they serve – the individual patient (in all of their complexities), and the community – including local oral health epidemiological profiling and by having a deep understanding of the socio-political demographics of the local area (Bedos et al.,

2020). According to the model, at a societal level, the dental practitioner should understand and identify the socio-political and economic structures that shape oral health outcomes of the general population and specifically impact the lives of those within the community being served (Bedos et al., 2020).

This research proposed that the term '*extreme oral health'*, refers to '*extreme levels of morbidity'* (Bedos et al., 2020 p. 467), as opposed to the more specific definition of *'extreme oral health'* outlined in Inclusion Oral Health Advancing a Theoretical Framework (IOHATF), which is:

> …characterized by an increased risk of oral cancer, rampant dental caries, dental pain, many missing teeth, and is compelled and compounded by reduced access to mainstream dental services (Freeman et al., 2019, p. 2).

Clarity needs to be achieved for terminology to be adopted and understood by communities and academics alike. *'Extreme Oral Health*' as Freeman et al., (2019), originally defined the term, could be renamed *extreme oral ill-health,* serving to eliminate a contradiction in terms.

In a second follow-up 2021 article published by the same Canadian authors, IOHATF is cited whilst explaining what can be expected from person-centred care, the authors refer to *'inclusive dentistry*', (Bedos et al., 2021, p. 250), as opposed to the original authors' term *'inclusion oral health'* (Freeman et al., 2019, p. 1).

What is outlined here is that although there are some clear similarities in thought between Bedos et al. (2020) and Freeman et al. (2019), there are some clear misalignments mostly around the definition of key terms. It would be of great benefit if definitions were consistent, particularly in relation to a pedagogical model.

The focus of Bedos et al. (2021 p. 249), second research paper, was to introduce the *'Montreal-Toulouse wheel of expectations*' and support people to '*emancipate*' during their dental experience. Here the authors sought to support service user voices that had been shuttered by paternalistic

approaches and intersectional contexts of oppression by the introduction and provision of person-centred tools to dental educators and professionals (Bedos et al., 2021).

Holden and Leadbeatter (2021) were able to ascertain through student reflective practice, that first-year dental students potentially lacked the language necessary to express their understanding of the social determinants of health (SDH) in a sophisticated and actionable manner. They suggested that dental educators lean into *'inclusion oral health'* and that interprofessional learning should be explored as a tool to utilise and overcome the disconnection students are experiencing (Freeman et al., 2019, p. 1). Through student's reflections, the authors were able to identify deterministic thinking and/or judgment, suggesting a whole curriculum approach be implemented to overcome this outcome (Holden & Leadbeatter, 2021).

It was also suggested that transdisciplinary research be adopted to generate *'new framings'* (Holden & Leadbeatter, 2021, p. 11), for future analysis of the issues and in order to disentangle their complexities. The article utilised Metzl and Hanson's structural competency as its theoretical underpinning and referred to the definition of *'inclusion oral health'* in the discussion section of the paper (Freeman et al., 2019, p. 1). Holden and Leadbeatter (2021) indicated that students could be directed by educators to appreciate the inter-sectoral nature of the social determinants of health, via greater collaboration within the curriculum and other health professions. This insight is timely in the Australian context, as the Australian Dental Council (ADC) leads dental education institutions toward creating graduates who are more socially cognizant.

Paisi et al. (2020) took a phenomenological approach, in developing a model of care for people experiencing homelessness in Plymouth (UK). The 'PDSE (*Peninsula Dental Social Enterprise) Model of care for people experiencing homelessness'*, was implemented and evaluated as an educational strategy, that pursued an innovative solution for those experiencing social exclusion (Paisi et al., 2020 p.1292). The researchers implied but did not state that homeless individuals experienced intersectional issues, referring to *'a number of factors (eg socioeconomic and political environments)*'

that led to *'disproportionate difference'* in oral health outcomes between population groups (Paisi et al., 2021 p. 1290). Their research aligns with key concepts from IOHATF, acknowledging that oral health service research and education serve as powerful catalysts for reducing oral health inequality. It also reports aligning that the Non-for-Profit organisation Peninsula Dental Social Enterprise (PDSE), a community dental clinic located in Devonport within a dental education faculty could act as an agent of social inclusion (Paisi et al., 2020). The authors concluded that the PDSE model made dental service delivery more responsive and all encompassing (Paisi et al., 2020).

2.4 Homelessness

Since its publication in 2019, IOHATF has been most commonly cited in publications that introduced community interventions aimed at reducing oral health disparities in the homeless population. Such interventions have occurred globally, contributing countries have included Canada, South Korea, the United Kingdom (UK), and the United States of America (USA).

A scoping review of community-based oral health interventions for people experiencing homelessness was published in February 2020. This research referred to explanations of extreme oral health as described in IOHATF and indicated that homelessness relegates people to high levels of oral disease and co-morbidities, which come as a result of being embedded in multiple social inequalities (Beaton et al., 2020). The results of this review highlighted gaps in the literature and suggested increasing non-clinical oral health promotional activities. Recommendations include multidisciplinary collaborations, with stakeholder input throughout the entire project journey, and the adoption of these practices will increase acceptability, feasibility, and sustainability.

A Canadian randomized control trial focused on Toronto's homeless population, specifically those experiencing intersectional issues involving chronic disease, dental problems, and mental health issues (Mejia-Lancheros et al., 2020). It utilized Freeman et al. (2019) definition of social exclusion in its description of how social exclusion affects oral health outcomes (Mejia-Lancheros et al., 2020). The authors stated that *'critical barriers'* impeded Toronto's homeless people from seeking,

accessing, and obtaining the necessary and appropriate dental health services to meet their complex health and psychosocial needs (Mejia-Lancheros et al., 2020 p.2).

Hall et al. (2021) employed retrospective cohort study strategies and longitudinal regression modelling to compare the dental service use of participants placed in a supportive housing program with eligible applicants who did not receive supportive housing. All participants had applied to the New York City Human Resources Administration (HRA) for their eligibility to be considered and have it determined by the HRA if they would be assigned supportive housing (Hall et al., 2021). Data was collected from all participant's pre-housing applications including demographics and clinical characteristics. The goal of this evaluation was to assess the factors associated with dental care amongst unstably housed persons with behavioural conditions (Hall et al., 2021). It was also determined that both physical disability and hospitalization in a state psychiatric facility were negatively associated with dental visits (Hall et al., 2021). The following possible solution was suggested by the researchers:

> Oral Health education and service referrals in primary care settings and the supportive housing program itself should be examined as strategies to improve oral health service delivery to persons experiencing social exclusion due to chronic homelessness, mental illness, and poor oral health (Hall et al., 2021, p. 76).

Muirhead and Doughty (research lead) were included in a research team that aimed to identify the various types of services that had provided dental and oral health care for people experiencing social exclusion in England UK and the various models of delivery adopted by these services (Doughty et al., 2022). This team broadly introduced, key IOHATF concepts of *'inclusion oral health'* and how they have been developed in the UK to address the complexities of *'cliff edge'* extremely poor oral health outcomes (Doughty et al., 2022 p.1). It further drilled down to the inclusion oral health framework and noted that it had made recommendations for actions for service delivery and research. The

research project investigated adults experiencing homelessness, people misusing substances, travellers, vulnerable migrants or asylum seekers, refugees, and sex workers (Doughty et al., 2022).

The discussion section referred to Freeman et al, (2019) original work and highlighted the importance of not relying on charity as a substitute for the state taking responsibility for the complex issues associated with social exclusion (Doughty et al., 2022). A similar conclusion was drawn by Gamarra et al. (2021), in their research which will be discussed further, in Chapter two, under the heading *'Leaning into another Paradigm'*. They included the International Institute for labour studies United Nations Development Program's definition of social exclusion:

> …a state in which a person is unable to fully participate in the economic, political, social and cultural aspects of mainstream society (Gamarra et al., 2021 p. 1).

The paper concluded with acknowledgement that the current dental service models of delivery in the UK may not be sufficiently flexible to meet the needs of those being socially excluded. It also indicated that the UK's National Health Service (NHS) staff would benefit from bespoke training aimed at overcoming judgemental attitudes and negating inflexibility (Doughty et al., 2022).

2.5 COVID-19

It can only be expected that research conducted over the past three years will have been affected by COVID-19 in some way, regardless of whether the research was conducted in the community or in educational institutions. In reviewing current literature, COVID-19 appeared to have decreased participant numbers but also led to new reflections on the oral health sector and its workforce utilizations.

An editorial piece by Marcenes (2020 p. 239), during the pandemic, included a *'call to action'* directed at policy makers with influence at local, national, and international levels, it identified population oral health as historically neglected and pointed out that the burden of dental disease can only be controlled by addressing failed dental health systems. Worthy of note here, is that failed

health systems were an issue previously highlighted in Bastos et al. (2020). This editorial piece, published in the British Dental Journal called for *'good representation'* in all sectors of society, placing emphasis on the importance of dental health professionals working with local services across the globe (Marcenes, 2020 p. 240).

Marcenes (2020) specifically highlighted the inherent detachment between academic leaders and the reality of the delivery of oral health services locally, which is also paralleled by Bastos et al. (2020). Marcenes (2020) and Bastos et al. (2020) both suggest that the daily practice of oral health services at a local level is highly relevant in the development and implementation of new oral health strategies. The idea that global advancement of dental health cannot be achieved by individuals or small groups working in silos is also discussed (Marcenes, 2020). Marcenes (2020) suggested a new approach to address oral health inequities where he recommended joining forces in collective action under the leadership of the World Health Organisation (WHO) with the aim of improving current dental health systems. Marcenes (2020) refers to Freeman et al. (2019) as a logical approach to controlling the burden of dental caries, which addresses social exclusion and intersectionality, thus suggesting that tackling oral health inequities across the world would have a major positive impact on the oral health of the whole population.

Interestingly, Marcenes (2020) reports that the redeployment of dental therapists, dental hygienists, and dental assistants during the pandemic was a step towards the integration of dental and general health and should be *'seized'* upon as an opportunity to further engage interprofessional and collaborative practice (Marcenes, 2020 p. 240). The suggestion of interprofessional and collaborative practice was highlighted previously by Holden and Leadbeatter (2021), as an educational strategy for improving students understanding of the social determinants of health.

Paisi et al., (2022) UK research, although limited by its small sample size of only twelve participants, who had become displaced and forced to seek asylum in the UK identified social exclusion referred to Freeman et al. (2019). It is important to mention that one of the authors of this paper, also co-

authored IOHATF. Here intersectionality is loosely implied, but not deeply investigated, referring to lessening power imbalances between researcher and participants and further supporting a paradigm shift. The research methodology aimed to achieve this by conducting interviews and involved data analysis by *an 'academic dental researcher from a non-clinical background'* (Paisi et al., 2022, p. 2). The study was affected by COVID-19, resulting in a decrease in participant numbers. It is noted that several challenges were incurred during the research period. The authors noted that their ability to interactively and reflectively develop a nuanced understanding of the intersectional factors relating to asylum seeker's and refugees oral health outcomes was impaired due to the small sample size (Paisi et al., 2022).

Paisi et al., (2021) drew on the concept of intersectionality and demonstrated the various barriers and facilitators experienced by people suffering homelessness. Here the authors noted that there were several sociopolitical factors contributing to people who experienced homelessness in a high-income country. Noting that inequalities occurred across various health conditions not just oral health (reference). A systematic review of '*socio-political phenomena*' as contributors to extreme health inequalities in high-income countries had a primary aim:

> To identify and understand the perceived barriers and facilitators for accessing and utilising SRH (sexual and reproductive health) for people who experience homelessness from their perspective, and the perspective of support staff/volunteers and healthcare professionals (Paisi et al., 2021, p. 211).

Here IOHATF was referenced to provide support to the idea that sexual and reproductive health is not the only health inequality felt by people experiencing homelessness in high income countries (Paisi et al., 2021).

2.6 Leaning into Another Paradigm

Traditionally, research and education in the disciplines of dental and oral health have held a strong commitment to the Positivist paradigm, with only some movement towards post-positivism after the work of Popper and Kuhn, although taking a post-positivist approach is still considered by some in the discipline as less valuable. The inclusion of Freeman et al. (2019) work, into the scholarly literature, asks the discipline to further reflect and embrace other paradigms – Interpretivism, Postmodernism, and Radical or perhaps even Indigenous approaches. History tells us that the discipline has been rigid and lacked theoretical mobility in its approach to both education and practice, this alone is interesting and worthy of thought. The following discussion considers research that moves its theoretical orientation away from a positivist doctrine and begins to implement Freeman et al. (2019) theory as a source of definitions and reflection.

Bulgareli et al. (2021) aim was to investigate the factors that influenced adherence to dental treatment in socially underprivileged adolescents in primary care. Their research included a longitudinal study conducted between 2014 and 2015 in Piracicaba, Sao Paul Brazil. Four hundred and seventy-four participants engaged in the study, and the results indicated that the behaviour of non-adherence was not contributed to by socioeconomic conditions, but rather non-compliant behaviour. The authors highlighted the importance of health teams understanding the determinants that may interfere with adherence, cementing that this acknowledgment would contribute to greater adherence to treatment and help in providing recommendations, and improve communication between patient and practitioner (Bulgareli et al., 2021).

Further, the research emphasised the importance of health service interventions addressing social inequalities and understanding the IOHATF. It emphasised how social exclusion, intersectionality, and othering can lead to extreme situations ultimately affecting oral health outcomes, and described how *'social care*' can positively affect the social determinants that affect access to health (Bulgareli et al., 2021 p.4).

In their research Ribeiro et al. (2021) applied transitional analysis of latent classes to analyse two cross-sections of external evaluations of the *'Program for Improvement of Access and Quality of Primary Care (PMAQ-AB)'*, in order to identify completeness classes for structural and work process' related to oral health. Participants were recruited from Brazilian municipalities (similar to local councils in Australia), and in all Federative units (similar to Australian states, but with more autonomy). It concluded that increases occurred in the indicators of potential access to oral health services when patients' ability to access oral health services was increased. The article cites IOHATF in the introduction:

> Although oral health policies are fundamental to the guarantee of health rights, difficulties in accessing these services are a major challenge in Brazil (Ribeiro et al., 2021, p. 2).

The authors reported that the study was limited by several biases and stated issues with data collection (Ribeiro et al., 2021).

Further support for the argument that future works should embrace the humanities and in so doing embrace intersectionality, is supported by Arora et al. (2020) research titled '*Depression, drugs and dental anxiety in prisons: A mediation model explaining dental decay experience'.* Intersectionality was highlighted here as a co-morbidity (Arora et al., 2020). The primary objective of this research was to test a theoretical mediation model. It also investigated if drug use and/or dental anxiety contributed as mediating factors between depression and dental decay amongst Scottish prisoners. It was recommended that future work should include multidisciplinary groups, involving health care providers, the prison estate, and social care. With the intent of incorporating oral health into health and social care policy, which would lead to the oral health and psychosocial needs of Scottish prisoners being more adequately addressed. The authors recommended that future researchers should concentrate on building a firmer picture by replicating and extending the framework presented (Arora et al., 2020).

A team of international researchers addressed their outcomes by examining the experiences, motivations, and challenges of volunteer dentists engaged in short-term missions to low- and middle-income countries. This research refers to Freeman et al. (2019) work, citing the criticisms raised by them regarding sustainability, effectiveness, accountability, and ethical appropriateness. Further, it highlights that charitable approaches do little to change fundamental inequalities such as accessing care. The study concluded that although there is a pool of dentists keen to conduct charitable work in low- and middle-income countries, these dentists would benefit from greater training whilst in the field. The authors recommended greater provision of materials, and more support be given to volunteers, which should include accurate descriptions of potential situations that may arise whilst practicing in the field. Emphasis was placed on the importance of increasing capacity in local dentistry to address sustainability issues (Gamarra et al., 2021).

A further study carried out in Belo Horizonte Brazil, investigated the sociodemographic information of sixty parents and caregivers of deaf (16) and 'normal' hearing (48) children. Additionally, the authors used a self-reporting questionnaire to collate data (Miranda et al., 2022). The article referred to IOHATF, stating that:

> …based on this perception, oral health care is sometimes ranked as being secondary and is even approached as being a luxury item (Miranda et al., 2022, p.7).

It concluded that caregivers report hearing-impaired children's oral health last clinical dental visit occurred because of dental pain or clinical treatment requirements (Miranda et al., 2022).

Yuan et al. (2020) investigated the complex relationships between oral health care providers and their patients, drawing on social rank theory as the precursor to dental anxiety and health care providers soft skills as complex variables that may give rise to poor social outcomes, which may exacerbate feelings of shame, loss, and exclusion, regardless of a patient's socioeconomic position (Yuan et al., 2020). The authors aimed at proposing and testing an explanatory model to predict dental attendance behaviours using person-centred and socio-economic position factors. The

following quotation best expresses the research team's deep dive into patient-centred care, a term that is used differently than previously outlined:

> The trusting relationship between the healthcare provider and the patient serves as a cornerstone for providing effective communication and therefore enabling a successful delivery of person-centred care. Patient's psychosocial needs are a critical aspect of person-centred care, which is often expressed as dental anxiety (Yuan et al., 2020, p. 7).

The final study aimed at validating a French shortened form of the '*Child Oral Health Impact Profile',* known as '*COHIP-SF-19*', which assessed how oral health conditions affect school children in New Caledonia (NC) (Skandrani et al., 2022, p. 2). The article refers to the IOHATF in the background section stating that in relation to oral health:

> …inequalities persist into adolescence and adulthood, with a cumulative process that in the absence of prevention or treatment accentuates the social gradient over time (Skandrani et al., 2022, p.2).

In its conclusion, the article identified that COHIP-SF-19 showed satisfactory psychometric characteristics and allowed for the identification of high impacts of oral disease in NC children suffering social deprivation (Skandrani et al., 2022).

2.7 Conclusion

This chapter has demonstrated that in countries like the UK, the USA, Brazil, Canada, South Korea, and Australia, recent trends show a desire for a paradigm shift that is more encompassing of social justice. There is only a small body of research devoted to this contemporary shift away from traditional Positivism. As the body of research grows there is the potential for change to occur not only in oral health education and practice but in the discipline's ability to be flexible and innovative when planning and implementing community oral health interventions. Whilst '*Inclusion oral health'* is a relatively new concept to the discipline, similar theories are well established within the social

sciences, and should be investigated by oral health researchers and educators. The small number of oral health researchers who are implementing this shift are doing so from a stable foundation, the value of looking outside of the oral health discipline literature can only be of benefit to those that the profession serves and future researchers.

The international researchers who have leaned into this paradigm shift are demonstrating that core concepts such as social exclusion and access to appropriate oral health care should be reflected upon and embraced. Interventions involving homelessness featured strongly in the literature, which highlighted how social exclusion is compounded and the role that inflexible oral health care systems and emergency housing systems contribute to poor oral health outcomes. The UK and the USA both produced evidence of this phenomenon, with Canada and South Korea also contributing (Paisi et al., 2021; Beaton et al., 2020; Hall et al., 2021; Mejia-Lancheros et al., 2020; Lee et al., 2020). In countries such as Australia, there are now the necessary drivers in place for real change, this has been initiated by the introduction of the revised Australian Dental Council program accreditation standards, and research outputs from Bourke et al. (2021) and Holden and Leadbeatter (2021). The new direction has provided an opportunity for oral health academics to research and teach the next generation of graduates the value of intersectional perspectives, the compounding nature of social exclusion, the importance of voice, and how othering contributes to extremely poor oral health outcomes for marginalised groups. Freeman et al. (2019), have provided clarity around some of the key terms and core concepts for the paradigm shift, including a clear definition for '*Inclusion Oral Health*', *'Intersectionality', 'Othering',* and *'Social Exclusion'*. The research conducted demonstrates a need for oral health theory educators to embrace the paradigm shift, acknowledging that '*More of the same is not enough*', (Bastos et al, 2020, p. 459). This perspective expresses not only the desire for change but the willingness of researchers to lean into the theoretical paradigm shift presented by Freeman et al. (2019).

The following chapter introduces and explains the research methodology for this study, how the data was collected and analysed, the tools used in data collection, the data analysis and why such methods were adopted.

Chapter 3

Methodology

The second chapter provided insights into the current scholarly literature that included ideas and strategies from Freeman et al. (2019). It is clear from the literature review that much of the contemporary research literature has drawn on the seminal ideas challenging conventional oral health education and practice developed in Freeman et al. (2019) framework. Fewer authors implemented inclusion oral health as the theoretical underpinning of their interventions. As a key indicator of exclusion, homelessness featured frequently in the research literature, as did the desire, by various authors to address '*extreme oral health*'. It would be interesting to further unpack homelessness, its temporal relationship to social exclusion, and extreme oral health. Future studies could examine the relationship between the two. There is also a reference to the aforementioned paradigm shift in higher education, notably toward improving reflective practice for undergraduates. This chapter seeks to illustrate why a content analysis was selected as the primary data collection strategy. It goes further to address how the content analysis was conducted, and from where the sources of data were generated. The data collection method sought to answer the first of the previously mentioned questions. Secondarily, in Chapter Four, an autoethnography was employed to highlight my journey of pedagogic discovery, whilst exploring the *'inclusion oral health'* paradigm shift (Freeman, et al 2019 p. 4). Ultimately, this strategy led to the emergence of a pedagogical tool that fellow oral health academics could implement when facilitating students toward greater self-reflection and social justice learning.

3.1 Research Questions

Content analysis was implemented as an empirical method, it was chosen to assess the presence and absence of key themes in the learning outcomes of Australian Bachelor of Oral Health programs. A clear definition of this research process is:

> Content analysis is a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use (Krippendorff, 2012, p. 24).

The content analysis enables researchers to examine large amounts of data in a systematic fashion, which helps to identify and clarify topics of interest (Drisko et al., 2016). When implemented as a descriptive strategy it allows researchers to establish standards or goals, which can be drawn on during future analysis comparisons (Drisko et al., 2016). Content analysis, as a research methodology, dates to the 1940s, but it did not become frequently applied to teaching and learning until the 1980s and 1990s (Rodriguez, 2014).

Content analysis has been applied in oral health research previously, for example, Sukotjo et al. (2020) conducted a content analysis of 253 dental education journal articles from 2003 and 2008. The authors were looking for evidence of innovation in dental curricula. In their conclusions, they made a plea for more systematic studies of the effectiveness of instructional and curricula innovations and more clarification studies to better understand why certain initiatives or interventions work or not (Sukotio et al., 2020).

Australian oral health undergraduate education is currently at a critical moment in its development, it is undergoing a paradigm shift instigated by the ADC's move towards greater social cognizance. This will fundamentally change the way dental schools across the country are required to enrol, teach, and graduate students. The content analysis offers an immediate way of assessing how much of the Inclusion Oral Health framework has been absorbed into curricula at the very start of this significant period of change. To support teaching academics in Australian Bachelor of Oral Health

programs make this transition an autoethnography is provided below. Adams et al. (2015) referred to 'autoethnography' as a method of research that involves describing and analysing personal experiences to understand cultural experiences' (Adams et al., 2015, p.1). Adams et al. (2015) described the value of autoethnography, noting that it:

- Uses a researcher's personal experience to describe and critique cultural beliefs, practices, and experiences.
- Acknowledges and values a researcher's relationships with others.
- Uses deep and careful self-reflection— typically referred to as "reflexivity"—to name and interrogate the intersections between self and society, the particular and the general, the personal and the political,
- Shows people in the process of figuring out what to do, how to live (in this case teach), and the meaning of their struggles.
- Balances intellectual and methodological rigor, emotion, and creativity.
- Strives for social justice and to make life better (Adams et al., 2015 p.1).

Content Analysis Research and Method:

An example of how the content analysis was conducted is provided in Table 1 below. Each teaching institution's website was accessed and searched for the program's publicly available learning outcomes. Also, when available, the overarching institutional graduate qualities were downloaded on the same day. The following key themes for analysis were developed from the research literature:

- Social Justice,
- Social Exclusion and,
- Cultural Competency (inclusive of safety, processes, diversity, and sensitivity).

Social exclusion is a key term from Freeman et al. (2019) research and was included as an indication that educators had referred to the most recent literature and were including '*Inclusion Oral Health*' in their learning outcomes (Freeman et al., 2019 p.4). The cultural codes were included for evaluation to ascertain the retrospective frequency of terms being used in Australian learning outcomes. This retrospective data collection allows for a direct comparison with future studies and provided key indicators of the effects that the Australian Dental Councils (ADC) revisions have had on the Australian Bachelor of Oral Health program's learning outcomes. Social justice is the overarching theme of this study and as such evidence of its inclusion in the program's learning outcomes would indicate that health inequality was being addressed in some form.

As outlined in the introduction of this thesis, the objectives of this research were:

1. To conduct a content analysis of the learning outcomes of Australian Bachelor of Oral Health programs, aiming to reveal the extent of key terms used that align with health justice - social exclusion, understanding intersectionality, recognising the need for voice, and the impact of othering.

2. To explore Bachelor of Oral Health (BOH) learning outcomes, that aim to reorientate students towards a social justice focus and explore potential changes in future curricula based on the current Australian Dental Councils guidelines.

The research questions were as follows:

1. What is the current scope of contemporary pedagogy in relation to inclusion oral health in Australian oral health therapy and dental hygiene curricula?

2. What approaches can begin to emerge that will facilitate students in greater self-reflection and social justice learning?

3.2 Research Strategy & Design

In a case study of oral health curricula across Australia, a retrospective approach has been taken, this study investigates a snapshot of data found in Australian Bachelor of Oral Health programs and their learning outcomes. The descriptive account of this single case study does not assume any representativeness of future learning outcomes and does not aim to be generalisable. A brief autoethnography is utilised to illustrate the journey of transition within the curriculum into a new theoretical paradigm.

3.3 Research Focus

All Australian universities that offered the Bachelor of Oral Health (BOH) degree to prospective students in 2021/2 were included in the sample (N=9). The Advanced Diploma in Dental Hygiene offered vocationally by the Technical and Further Education, South Australia (TAFESA) program was excluded at this point, as its website does not publish its learning outcomes publicly. Data was collated from the University's websites, between July 26, 2022, and August 26, 2022, in the form of learning outcomes and graduate qualities. Table 1 identifies each of the Australian Oral Health programs that were included in this analysis and provides a general institutional course profile.

Table 1

Australian Bachelor of oral health Programs - a current profile

Name of Institution and Program[2]	Year of the first intake of students[3]	Duration of Program[4]	Primary Geographic Location[5]	Registration division[6]
University of Melbourne Bachelor of Oral Health from 2005	1996 - Diploma 2005 – Bachelors Degree	Diploma - 2 years Degree - 3 years	major city	Dental Hygienist, Dental Therapist, Oral Health Therapist
Newcastle University Bachelor of Oral Health Therapy	Dental Hygiene – 2005 Post-graduate (Therapy) - 2010 Oral Health Therapy - 2015[7]	3 years	inner regional	Dental Hygienist, Dental Therapist, Oral Health Therapist
TAFE SA Advanced Diploma of Oral Health (Dental Hygiene)	1980	2 years	major city	Dental Hygienist
University of Adelaide Bachelor of Oral Health	2002	3 years	major city	Dental Hygienist, Dental Therapist, Oral Health Therapist
La Trobe University Bachelor of Oral Health Science	2006	2.5 years	inner regional	Dental Hygienist, Dental Therapist, Oral Health Therapist
Central Queensland University Bachelor of Oral Health	2012[8]	3 years	outer regional	Dental Hygienist, Dental Therapist, Oral Health Therapist
Charles Sturt University Bachelor of Oral Health (Therapy and Hygiene)	2008	3 years	outer regional	Dental Hygienist, Dental Therapist, Oral Health Therapist
University of Sydney Bachelor of Oral Health	2006	3 years	major city	Dental Hygienist, Dental Therapist, Oral Health Therapist
Curtin University Bachelor of Science (Oral Health Therapy)	2011 (1971- 1995) – Western Australian Institute of Technology, Ass. Dip in Dental Therapy with a significant periodontal component. (1995-2011) – Curtin University, Associate Degree in Dental Hygiene	3 years	major city	Dental Hygienist, Dental Therapist, Oral Health Therapist
Griffith University Bachelor of Dental Hygiene	2004	3 years	major city	Dental Therapy/Hygiene Dental Hygiene currently

[2] Australian Dental Council

[3] Satur & Moffat (2010)

[4] Australian Dental Council

[5] Australian Bureau of Statistics

[6] Australian Dental Council

[7] Wallace, Cockrell, & Taylor (2010)

[8] Australian Dental Council

3.4 Data Collection

Initially, priori coding was determined, and theme categories were established prior to accessing the universities websites, the analysis was based upon Inclusion Oral Health, and Social Justice theory. The supervisory colleagues and researcher agreed upon the themes drawn from the literature review, and the coding was applied to the data. Then each individual Australian Bachelor of Oral Health program was identified, and the corresponding university websites were accessed. From the landing page, a search was conducted which allowed navigation to the program, and the program's current learning outcomes. The learning outcomes and graduate qualities were downloaded or 'copied and pasted', then added to a primary 'Google Doc' for further analysis, (n=1,135). This unobtrusive data collection allowed the key themes – Social Justice, Social Exclusion and Cultural Competence/Safety/Processes/Diversity/Sensitivity to be recorded, tallied, and checked for reliability. Revisions were made as necessary, and the categories were tightened up to the point that maximized mutual exclusivity and exhaustiveness (Weber, 1990). This approach was accepted, in part for its ability to assist in the tracking of changes or developments in Australian BOH learning outcomes, providing a chronological narrative analysis that could be drawn upon in future research initiatives.

3.5 Data analysis

Based on key themes (as indicated in Table 2 below), and drawn upon from the literature review, a content analysis was applied. The process of data collection included identifying all teaching programs across Australia. The data of each program was stored on an individualised 'Google Doc'. Exploratory data analysis revealed that the key theme, which was originally 'Cultural Competency' should be widened to include not only 'Cultural Competency', but 'Cultural Safety/Processes/Diversity/Sensitivity'. The key themes were then entered into the 'Ctrl F' or 'Control Find' search field. The 'Control F' tool was then used to find the key themes within the data.

The tallies were tabulated as the example shown in Table 2. A second table was created that assisted with consolidating the information, which can be seen in Table 3.

Table 2

An Example of Curricula Analysis Tally Strategy

Institution & completion date[9]	**Course**[10]	**Inclusion/Theme**		
Central Queensland University (CQU)	**Number and Title**	***Social Justice***	***Social exclusion***	***Cultural Competency/Safety/ Processes/Diversity/Sensitivity***
First Year – 1st term	HLTH11027 - Foundations of Health	**X**	**X**	**X**
First Year – 1st term	BMSC11010 - Human Anatomy and Physiology 1	**X**	**X**	**X**
First Year – 1st term	ORAL11001 - Introduction to Oral Health Therapy	**X**	**X**	**X**
First Year – 1st term	ORAL11004 - Oral Anatomy 1	**X**	**X**	**X**
First Year – 2nd term	BMSC11011 - Human Anatomy and Physiology 2	**X**	**X**	**X**
First Year – 2nd term	ORAL11006 - Introduction to Oral Health Practice	**X**	**X**	**X**
First Year – 2nd term	ORAL11003 - Introduction to Oral Disease	**X**	**X**	**X**
First Year – 2nd term	ORAL11005 - Oral Anatomy 2	**X**	**X**	**X**
First Year – 3rd term	HLTH12031 - Community Engaged Learning	**X**	**X**	**X**
Second Year – 1st term	ORAL12001 - Oral Disease Prevention and Management	**X**	**X**	**X**
Second Year – 1st term	ORAL12002 - Oral Health Pre-Clinical Practice 1	**X**	**X**	**X**

[9] Central Queensland University

[10] Central Queensland University

Institution & completion date[11]	Course[12]	Inclusion/Theme		
Central Queensland University (CQU)	**Number and Title**	***Social Justice***	***Social exclusion***	***Cultural Competency/Safety/ Processes/Diversity/Sensitivity***
Second Year – 1st term	ORAL12003 - Oral Health Clinical Practice 1	**X**	**X**	**X**
Second Year – 2nd term	MBIO12013 - Microbiology for Health Care	**X**	**X**	**X**
Second Year – 2nd term	ORAL12004 - Orthodontics, Prosthodontics and Pharmacology	**X**	**X**	**X**
Second Year – 2nd term	ORAL12005 - Paediatric Dentistry for the Oral Health Therapist	**X**	**X**	**X**
Second Year – 2nd term	ORAL12006 - Oral Health Clinical Practice 2	**X**	**X**	**X**
Third Year – 1st term	ORAL13001 - Oral Health Clinical Placement 1	**X**	**X**	**X**
Third Year – 1st term	HLTH13031 – Population Health Epidemiology	✓	**X**	✓
Third Year – 2nd term	ORAL13002 - Oral Health Clinical Placement 2	**X**	**X**	**X**
Third Year – 2nd term	HLTH12028 - Health Promotion Strategies	**X**	**X**	**X**

During the data collection period each of the programs that offer graduates registration with the Australian Health Practitioner Regulation Agency (AHPRA) as an oral health professional were accessed. The programs varied in that not all undergraduates would be awarded the title of registered Oral Health Therapist, upon graduation.

The desired programs webpages were accessed, and the learning outcomes for all the programs were downloaded and added to a Google document as raw data. When publicly available the overarching graduate qualities were also accessed, downloaded, and included. This data was then

[11] Central Queensland University

[12] Central Queensland University

searched, using the 'Control F', function of Google Docs to locate the number of times each key theme appeared throughout. It was then recorded in the appropriate institution, course, year (1st, 2nd, or 3rd), semester/trimester, and course title, then tallied how often the key term had been used.

Chapter 4

Findings

Chapter three has illustrated the methodological strategies that were implemented to provide evidence within this study. These strategies addressed the research objectives via a content analysis of Australian Bachelor of Oral Health curricula. This chapter provides a brief background of Dental and Oral Health Therapy education in Australia and highlights emergent concepts from the content analysis data. To add depth to the paradigm shift, this chapter also includes a reflective narrative of my ever-evolving trajectory toward health equality pedagogy through an autoethnographic account and an example of the '*Photovoice Critical Reflective Journal'* assessment (Appendix 1).

4.1 Background

The Dental Therapy profession has long been a part of Australian Dentistry history, the origins beginning with the 1966/67 establishment of two Dental Therapy Schools, one in Tasmania and one in South Australia. From these early years, the profession has been largely responsible for the delivery of key oral health messages to Australian communities, via Oral Health Promotional activities (Satur et al., 2009). Initially, most Dental Therapists were employed only in state-operated school dental programs, a limitation imposed by state legislation (Satur et al., 2009). By the year 2000, state legislation in Victoria and Tasmania removed limitations around employment allowing Dental Therapists to enter the private sector (Satur et al., 2009). Prior to this date, Western Australia was the only state that had legislation to support Dental Therapists practicing in the private sector (Satur et al., 2009). Nationwide regulation occurred in 2010, which recognised Oral Health Therapy, as one profession as a posed to a 'Dual Practitioner' and removed all employment limits across

Australia (Satur, 2002). Other more recent legislation changes have increased the clinical scope of Oral Health Therapists to include specific restorative practices for all age groups, having previously been age restricted. The Oral Health profession has undergone an enormous amount of change since its introduction in the mid-1960s, this was most recently highlighted in the education sector by changes to the Australian Dental Council (ADC) Program Accreditation Standards.

This project investigated publicly available learning outcomes that aligned with the paradigm shift toward inclusive oral health education and are consistent with the new criteria presented by the ADC, which focused on students graduating with an increased social awareness capacity. This reorientated project included the learning outcomes from the previously mentioned Australian universities that offered the Bachelor of Oral Health program to prospective students in 2021 for the 2022 intake of students.

4.2 Emergent concepts

Creating a reference point for contemporary thinking in curricula across universities in Australia will support the discipline and profession in addressing the issues that were identified in the literature. The Oral Health discipline will face future challenges, especially during the transition into becoming more socially cognizant and culturally safe, in terms of services and educational practices that will require the profession to be flexible in approach and agile in response. This project specifically focused on the current scope of Australian Bachelor of Oral Health curricula, their similarities, and differences, and how they can begin to emerge in a manner that facilitates greater self-reflection and social justice learning.

4.3 General contextual data

Table 3 illustrates the data collated from the previously described content analysis; it lists the frequency of key terms and where they can be located within the various curriculums. Being

represented in this manner allows the data to be compared across institutions and makes quick reference achievable.

Table 3

Key Themes & Frequencies in Australian Bachelor of Oral Health Programs

Institution	Social Justice	Social Exclusion	Cultural Competency/Safety/ Processes/Diversity/Sensitivity
University of Sydney	0	0	1x in 2nd year 1x in 3rd year 1x at an institutional level
University of Melbourne	0	0	2x in 1st year 2x in 2nd year 1x in 3rd year Institutional graduate qualities are not available on the website, without a login
University of Adelaide	0	0	4x in 1st year 2 x 2nd year 2x at an institutional level
Curtin University	0	0	1x overarching course learning outcome 6x in 1st year Institutional graduate qualities are not available on the website, without a login
Griffith University	1x in 3rd year	0	1x in 3rd year 2x at an institutional level
Newcastle University	0	0	3x in 1st year 3x in 2nd year 5x in 3rd year Institutional graduate qualities are not available on the website, without a login
La Trobe University	1x in 3rd year	0	2x in 1st year 1x in 3rd year Institutional graduate qualities are not available on the website, without a login
Central Queensland University	1x in 3rd year	0	3 x overarching course objectives 1x in 1st year 2x in 3rd year Institutional graduate qualities are not available on the website, without a login
Charles Sturt University	1x in 3rd year	0	2x in 1st year 3x in 3rd year 1x at an institutional level

There were a total of 1094 unique learning outcomes included in this project and 41 graduate qualities. These were collected from nine Australian universities public websites that offered a Bachelor of Oral Health (BOH) to prospective students in 2021, who would be able to enrol in 2022.

Of these learning outcomes, only four institutions made any reference to *'social justice'*, Griffith University, Charles Sturt University, La Trobe, and Central Queensland University, which equates to just 0.37% of all learning outcomes analysed. Interestingly, *'social justice'* could only be located within the third-year curricula. No Australian Bachelor of Oral Health (BOH) programs included the term *'social exclusion'* in their learning outcomes.

Of all three key themes analysed, *'Cultural Competency/Safety/Processes/Diversity/Sensitivity'*, was included the most frequently throughout Australian learning outcomes for BOH programs. The University of Sydney (USYD), mentions the term once in the second year, and once in the third year. Whilst Griffith University (GU) mentioned the term only once in third-year learning outcomes. Both programs mentioned the term at an institutional level; USYD once, GU twice. The learning outcomes of the University of Newcastle (UON) identified the key term most frequently, with a total of 12 mentions, these were across all three years of the program. Of the 1094 learning outcomes analysed in this project, 46 included a cultural theme, which is 4.2% of Australian BOH learning outcomes. The verbatim learning objective, overarching course learning outcomes, and graduate qualities/attributes are listed in Appendix 4.

These results provide perspective to educators on their curriculum and how it compares to other programs across the country. It also allows programs to set new goals that will align with the revised Australian Dental Council's clear objective of ensuring that oral health graduates have a greater connection with cultural safety as outlined in the Australian Dental Council, *Accreditation standards for dental practitioner programs:*

> Domain six – 6.3
>
> Cultural safety is integrated throughout the program and clearly articulated in learning outcomes (ADC, Accreditation standards for dental practitioner programs, 2021, p. 15).

4.4 A brief autoethnography – a lived experience.

The original intent of this research was to develop a health equality driven assessment methodology. This was not possible due to several factors, which included my position being made redundant during the research period and having to relocate from the University of Sydney (USYD) to the University of Newcastle (UON). This created complexity around the recruitment of consenting student participants at the University of Sydney, as, at the time of my departure, the number of consenting participants was only four, from a possible fifty-two. Barriers were incurred throughout the year-long implementation period of a USYD BOH academic external review and subsequent change proposal, which affected data collection.

As a result of the previously mentioned barriers, the entire project had to be reorientated toward examining the current environment for changes toward a more socially just curriculum. As outlined above, the relevance of oral health undergraduates becoming more socially cognizant prior to graduation has been given priority by peak Australian accreditation authorities. Freeman et al. (2019) have provided a theoretical framework that supports the theme which is now being addressed from an international perspective. Future researchers and teaching academics have been provided the necessary tools to align with what is now a global movement (paradigm shift) towards *'Inclusion Oral Health'* (Freeman et al., 2019 p.4).

This autoethnography describes the application of this theoretical framework to teaching and learning in the USYD BOH program and some examples of student reflections based on the data that was available to this study. This movement is best illustrated via a brief autoethnography that illustrates my experience as a teaching academic in the oral health discipline, as a way of embracing this significant period of change. Autoethnography is defined by Wall as:

> …an intriguing and promising qualitative method. Emerging from postmodern philosophy, in which the dominance of traditional science and research is questioned and many ways of

> knowing and inquiring are legitimated, autoethnography offers a way of giving voice to personal experience to advance sociological understanding (2008, p. 38).

Oral Health in Society (OHS) at the University of Sydney (USYD) has historically involved specifically designed educational experiences that facilitated students developing their conceptualisation of self-reflection, and the social determinants of health (SDH) and has always been underpinned by the most up-to-date theoretical perspectives in health promotion and health inequalities. The Oral Health in Society (OHS) curriculum at USYD historically included oral health promotional student placements, which on review added value, as a form of work-integrated learning and would continue to add value in future iterations. In February 2020, two oral health promotion placement sites were procured. The first was the Flintwood Disability Respite Facility (located in Castle Hill, Sydney, NSW) and the second was at the Aboriginal Health Hub (Mt Druitt, Sydney, NSW). It is well documented that Australian oral health inequities are widespread, with multiple priority populations being recognized in the literature (Australian Institute of Health and Welfare. 2023). The previously mentioned organisations were deemed appropriate from a security perspective, and they both offered conducive geographic locations for students to investigate the complex nature of communities suffering '*extreme oral health'* (Freeman et al., 2019 p. 2).

Prior to engaging with either organisation consideration was given to the approach that would be taken. Although the Aboriginal Health Hub had provided previous placements to students from USYD BOH, several complex changes had taken place within the BOH academic team and the wider dental community over the previous year. Personally, I wanted to become more culturally competent and enrolled in several USYD staff development online modules, face-to-face professional development programs (via Zoom, due to COVID-19 restrictions in 2020), and workshops including the USYD Culturally Competent Leadership Program (CCLP).

The USYD CCLP gave me the opportunity to develop my capability, capacity, and resilience in culturally competent leadership and the time to reflect and process the impact of colonisation on

the Australian Aboriginal and Torres Strait Islander communities. This important program allowed me to consider Aboriginal ways of knowing, belonging, and being. It was here that I was able to engage with a new and innovative discourse about culturally competent leadership, with other leaders who were also committed to transformative change. I was given the tools to become a culturally competent champion in my faculty. This program empowered me to become the type of leader I strive to be, one that has the desire to drive cultural competency initiatives as an agent of change. I learned to think about and articulate my role as a culturally competent leader. The opportunity to network and yarn with other change-makers and similarly minded academics gave me the confidence to approach the community at the Aboriginal Health Hub in a new and refreshed culturally appropriate manner. The fundamental takeaway message that I received through these various educational experiences was the importance of listening to Aboriginal and Torres Strait Islander people's voices. Upon completion of the program, I understood the value of regular and deep reflection where I could consider the historical impact that poor access to Oral Health care has had on Aboriginal and Torres Strait Islander people. The Oral Health Therapy and Dental Hygiene professions of Australia continue to provide only limited culturally safe oral health care services to Aboriginal and Torres Strait Islander people. Therefore, the oral health and dental hygiene professions are compounding social exclusion. Through reflective practice and exploring worthy ideas the oral health professions must address this limitation at its core. Taking a grassroots approach, I had a strong desire to co-design student's experiences with the Aboriginal and Torres Strait Islander community of Mt Druitt, respectfully referred to as the Dharug people from here on.

Initial conversations with the Aboriginal Health Hub management staff took place over the phone or via Zoom and started in November 2019. I recognised it was important to meet face-to-face with the community and this occurred approximately three times prior to the student's arrival at the facility. These face-to-face meetings led to yarning with staff at the hub and included me making a concerted effort to understand the team dynamics, services provided by the team, and the communities Oral

Health priorities as expressed by health care professionals and the Dharug Elders. Yarning is described by Walker et al., (2014)

> … a conversational process that involves the sharing of stories and the development of knowledge. It prioritizes indigenous ways of communicating, in that it is culturally prescribed, cooperative, and respectful (p. 1216).

Listening was fundamental in my approach, in which I made the conscious effort to remain the naive enquirer as opposed to the authoritarian enforcer of key oral health care messages. My internal monologue guided this approach with regular reminders that the Dharug people had taken care of and maintained their oral health for approximately 65,000 years prior to colonisation. Taking an appropriate decolonising approach made it easy for me to remember that in fact, I had a lot to learn from the Dharug people and was privileged to be doing so. This perspective has been maintained throughout this project and served me to remain open-minded, inquisitive, and always respectful.

A historic formal 'Student Placement Agreement' existed between USYD and the Aboriginal Health Hub, which makes provisions for ongoing student placements. The student placement negotiations with the Flintwood Disabilities Service followed a typical 2020 business negotiation process. Here communications were mostly held via email and phone conversations, regarding a range of topics. Only one face-to-face meeting took place prior to the arrival of students. The agenda items of this meeting included: gaps in oral health care for people living with disability, the importance of a co-design strategy, communication pathways establishment, and the fostering of positive working relationships. Three members of the academic team collaborated with management at the Flintwood facility where the management team and academics co-designed key outcomes that would meet the oral health promotional needs of the participants whilst providing an immersive student experience. Worthy of note is the fact that all three academics present at the face-to-face meeting had recent extensive experience with people with disabilities. This included a wide range of settings and contexts, one academic was at the time engaged in research with people with Cerebral

Palsy and its impact on Oral Health outcomes and was able to educate the team on the most recent scholarly literature prior to the face-to-face meeting. At the conclusion of this meeting, the terms and conditions of the arrangement were finalised and a third year USYD 'Student Placement Agreement' was completed in compliance with the USYD 'Student Placement and Project Policy 2015'. This agreement was signed by both parties in February 2021 (See Appendix 2). Initial contact with Flintwood Disability Service occurred after a staff member reached out to the school for guidance and possible placement of students at their facility in Castle Hill, Sydney NSW. Flintwood Disability Service is a private sector organisation that provides respite care for people with physical and intellectual disabilities. This care is given in the form of shared accommodation, short-term accommodation, and day programs.

The development and implementation of a critically reflective assessment task was designed to engage and support students in their reflective practice. The facilitation of student's deep learning from experiences, about themselves, and the way they relate to home and work and wider society and culture was given priority. The third-year assessment was referred to as the '*Photovoice Critical Reflective Journal*', was developed and peer-reviewed by USYD BOH academic staff (Appendix 1) it formed part of the Oral Health Promotion unit of study in 2021. Dewey (1933), defined reflection as:

> Active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and further conclusions to which it leads…it includes a conscious and voluntary effort to establish belief upon a firm basis of reasons (Dewey, 1933, p. 11 & p. 6).

The assessment used prompt words for reflective practice which included 'cultural competency'. It should be acknowledged that these prompt words can be easily manipulated to include other key terms that are likely to reinforce the student's growth in social justice. In relation to the use of students' assessments ethics approval was gained for the original project as it was intended. The Human Ethics Committee of the University of Sydney approved their use, Protocol Number:

2021/844. The original ethics approval document has been included in Appendix 3. The following extracts are from consenting participant's reflective practice on cultural competency:

> During our group's research, I was intrigued by the similarities in cultural and social determinants faced by Indigenous communities living in both suburban areas and rurally. I was surprised with the number of similarities between the two communities being in completely different locations. Barriers specific to oral health experienced by these included limited access to healthy foods, fluoridated water, educational facilities and healthcare. Cultural similarities included deferring eye contact and not directly saying "no" to community members whereas more traditional customs were only practiced rurally (like spear hunting for food). One similarity that really stood out to me was the willingness of both communities to share their culture with non-Indigenous Australians to better their understanding of Indigenous culture (2021, third year BOH student from USYD, student 1).

Deep reflective practice was observed within the students' submissions:

> Upon reflection of my previous thoughts about being culturally competent, I realised that cultural competence can only be achieved through multiple exposures to different communities within a cultural ethnicity. Only then can an individual fully comprehend and respect the culture's customs, beliefs, values and attitudes towards life of that particular community (2021, third year BOH student from USYD, student 1).

One student's reflective photo was of a sunrise over the ocean, with the following reflection:

> The concept of rising beyond differences to appreciate people for who they are rings especially true to my heart. Throughout my experience within the Oral Health in Society assignment, I've had the opportunity to work with many people from different backgrounds. Some of these people I've come to deeply admire, and I feel this was only possible because we understood the concept of diversity. We realised that although we may hold opposing

> beliefs and cultural values from one another, this is not a difference to look down on but to instead, appreciate because it is what makes us all unique. The benefit of having these differences is that it helped us approach the assignment with various perspectives, and ultimately this is what helped it run so smoothly. Once again, the symbolism of the sun rising rings true here again, since we rose beyond our differences to appreciate the beautiful end result, which in this case was our promotion programme (2021, third year BOH student from USYD, student 2).

Strategies to encourage tertiary students to engage in self-reflection are well documented throughout the scholarly literature. These approaches, provide concrete strategies for educators to enthusiastically harness diversity and amplify student learning. The implementation of this intentional strategy for reflection is considered successful in its ability to motivate and cultivate understanding amongst final year Bachelor of Oral Health students. The examples above provide evidence that the assessment was pedagogically valuable and achieved the intended outcome of enhancing greater self-reflection and social justice learning.

4.5 Conclusion

The key aims of this chapter have been to provide a historic account of Dental Therapy and Oral Health Therapy and Dental Hygiene education in Australia and highlight the emergent concepts from this research. Depth has been given to the previously illustrated paradigm shift, via an autoethnographic account of my journey thus far, further student reflective accounts have been provided as an example of the expected outcomes of third-year students engaging in the '*Photovoice Critical Reflective Journal'* assessment (Appendix 1). The primary aim of this project was to conduct a content analysis of BOH curricula and report on the inclusion of the key concepts – social justice, social exclusion, and cultural safety. It is evident from the data collected that Australian BOH programs vary greatly in prioritizing these key concepts. Worthy of note, no BOH programs included 'social exclusion' in the program's publicly available learning objectives, and four programs included

'social justice', all of which occur in the 3rd year of the respective programs. The University of Newcastle BOHT program mentions cultural competency a total of twelve times, and it is widely dispersed across all years of the program. Therefore, the University of Newcastle demonstrated the strongest commitment to cultural competency across all curricula analysed.

Chapter 5

Discussion

As outlined in the previous chapter, this project analysed Australian Bachelor of Oral Health curricula and provided an autoethnography of lived experience. These methods brought into focus several key elements, the original intent of this research, a reflective narrative of my evolution toward an inclusive oral health teaching perspective, and examples of student submissions. It offers other researchers and teaching academics an example for assessment, which could be utilised in Bachelor of Oral Health programs when social justice is given priority. This chapter draws the threads together and presents the final analysis of the overall research project.

5.1 Summary

This project specifically focused on investigating the most recent literature that cites *'Inclusion Oral Health Advancing a Theoretical Framework*' (IOHATF) since its publication in 2019. It gives a comprehensive account of how IOHATF is being drawn upon internationally and how future researchers need to focus on participatory action research, which will anchor the sustainability and engagement of future interventions. The literature review highlighted the need to seek collaboration from the social science discipline and listen to the voices of people experiencing social exclusion. Creating awareness around the status of Australian Bachelor of Oral Health (BOH) program curricula plays an important role in addressing uniquely Australian social justice issues. Teaching academics in the oral health discipline face many challenges, especially whilst making the changes outlined in the Australian Dental Council (ADC) revised program accreditation standards. The focus here has been on guiding BOH academics as they transition into this new paradigm, providing pedagogical tools, reflexive accounts, and examples of student assessment outcomes, that can be drawn upon for support during this shift.

Overall, the effort of this study has been to highlight how often key social justice terms can be found in the learning outcomes of Australian BOH programs. It is from these findings that the discipline can reflect on and navigate the changing landscape. It is inevitable that Australian BOH programs will need to engage in a paradigm shift to align with the ADC program accreditation standards, here the process is demystified by addressing its original aim of reorientating students towards a social justice focus and exploring the most current literature for guidance.

5.2 The relevance of these findings

The literature review highlighted the current emergence of *'inclusion oral health*' and its implementations internationally (Freeman et al., 2019 p. 1). The research conducted in this study most closely aligns with the higher education literature. This study acknowledges the complexity of leaning into a paradigm shift and stresses the importance of educators first understanding their own personal biases, assumptions, stereotypes, and prejudices, as the first step towards providing care and education that is social justice oriented and holistic.

Based on higher education literature, this project aligns with the work of Holden and Leadbeatter (2021), who acknowledge the critically reflective processes outlined by Brookfield (2017) and consider the issue from a student's lens. These authors suggested a '*transdisciplinary'* approach be adopted to research (evident in this study), to generate *'new framings'*, that would assist with the layered complexities involved in drawing out the critically reflexive practices of students as they attempt to articulate a level of social cognizance (Holden & Leadbeatter, 2021 p.11).

The intervention described by Paisi et al. (2020), was included under the Higher Education subheading, because it was implemented in a United Kingdom dental school, for people experiencing social exclusion due to their homelessness. It is difficult to draw any conclusions about how it aligns with this study because it speaks limitedly of the educational background or theoretical framing.

Although Kontaxi& Esfandiari,(2022), did not cite Freeman et al, (2019) they do consider Social Justice Education (SJE) in the Canadian undergraduate Higher Education context. These authors outlined the participants perceived barriers to SJE, and proposed solutions to these barriers. The perceived barriers included a lack of time, lack of receptiveness/interest, application, training educators, and financial considerations (Kontaxis & Esfandiari , 2022 p. 126). It is likely that these perceived barriers would align in the Australian context, and the proposed solutions should be considered by institutions in Australia when implementing a more inclusive curriculum. Interestingly, Kontasix and Exfandiari (2022) discuss a focus on students motivations for becoming oral health practitioners, and suggest that this is given focus during the recruitment phase of enrolment. The suggestion is that this strategy may increase the proportion of oral health practitioners interested in social justice (Kontaxis & Esfandiari, 2022).

5.3 Recommendations

Literature and research interrogating the course content of Australian Oral Health programs are currently limited. This is primarily due to the lack of time that the Bachelor of Oral Health (BOH) programs have been offered at Australian Universities. Dental Therapy programs being offered via Vocational Training institutions in Australia have served communities for a far greater period. Prior to the implementation of changes propagated by the Australian Dental Council (ADC) revisions, it was deemed appropriate to collate baseline data, it is recommended that similar analysis is conducted in the future. This will illustrate how BOH programs evolve to meet the requirements of the ADC's competency framework and accreditation standards. To better understand and meet the needs of students, and teaching academics more research is essential on current Australian BOH programs, including assessment and other learning tasks, to ensure the Oral Health profession is developing in a socially cognizant manner and can serve communities and the needs identified by the ADC.

There are gaps in understanding as to why Oral Health and Dental Research, up until recently, has not embraced the humanities and social sciences research and theory more deeply for improved patient and student outcomes. The overall lack of funding for research toward a more socially aware profession prevents the rapid development of perspectives on the oral health needs of those who experience social exclusion and how the profession can better meet those needs.

It is recommended that educators teaching in the Bachelor of Oral Health programs in Australia, develop a greater understanding of the concepts underpinning intersectionality, voice, and othering and how top-down models of care only compound social exclusion. It is also recommended that future researchers embrace the humanities and social sciences scholarly research literature, prior to implementing more top-down models – '*more of the same is not enough'* (Bastos et al., 2020 p. 459). Elaborating on the process of engaging with stakeholders and the expression of their lived experiences would also serve future researchers, this data could be collected via surveys or by the publication of the primary researcher's reflective scholarship. The benefits of undertaking such tasks would support future implementations of interventions in the development of standardized practices in the field.

More research is required to provide information on the outcomes of bottom-up oral health promotion interventions and the education of undergraduates in '*Inclusion oral Health*'. It is recommended that the curriculums of Australian BOH Oral Health promotion programs express their agility and flexibility by embracing participatory action research underpinned by the key concepts of intersectionality, voice, and othering. To achieve this, there is the need for Australian BOH academics to acknowledge that previous top-down models are inherently flawed and have the potential to undermine future research on community/stakeholder relationships as they limit sustainability and compound social exclusion. Outcomes of future studies may bring more awareness of the theoretical engagement with the impact of othering, the impact of intersectional

issues and identities, and the need for voices to be heard, as ways of seeing and doing in communities and thus promoting participatory action research projects.

5.4 Limitations

The original project was limited by several unforeseeable events within the teaching context and hence characteristics of design and methodology that affected both the originally planned research project and the findings. These included reflecting on the challenge of assessing content in curricula, not all the curriculum content is visible, not all of the programs are visible and the initial design required the consent of the University of Sydney (USYD) Bachelor of Oral Health (BOH) students which was not forthcoming. In the time available after gaining ethics approval (Appendix 3) from the University of Sydney Ethics Committee, within the cohort of 52 students only 4 gave consent to have their 'Photovoice Critical Reflective Journal' assessment task analysed (Appendix 1). This appeared to be influenced by several factors:

1. The graduating 2021 class of USYD BOH students had been heavily affected by the impact of the COVID-19 pandemic.
2. The researcher's position was made redundant and she was forced to cease working at USYD during the research period.
3. The USYD BOH program underwent structural academic change during 2019, 2020, and 2021 which may have affected students' perceptions and negatively affected the number of consenting participants.

These limitations affected the overall trajectory of the project, as the sample size was far too small to find significant outcomes from the data, as statistical rigor required a larger sample size to ensure a representative distribution of the population and to be considered representative of groups of students to whom the results may be generalized or transferred. However, it was justifiable to include some of the student's responses to the critically reflective assessment as it showed the

potential success of such an assessment exercise in achieving the sought-after paradigm shift. Selecting a simple content analysis as the primary research tool created some limitations, specifically regarding drawing conclusions. The presence (or lack of) content relating to inclusion oral health could have been overcome by further examination of other documents relating to subject outlines and assessments, this would have provided a fuller picture of the coverage of inclusion oral health in current oral health educational programs.

Chapter 6

Conclusion

Australian Oral Health professionals are acutely aware that the levels of '*extreme oral health*' suffered by people experiencing social exclusion are unacceptable (Freeman et al., 2019 p. 4). As stated clearly in the introduction to this thesis, there is ample evidence of how excluded communities fare in oral health outcome and effective treatment. The statistics on Indigenous oral health outcomes in Australia emphasises the need to shift the paradigm of learning, provision, and care to be more inclusive and open to shifting paradigms. As Bastos and colleagues suggested in 2020, *'more of the same is not enough*'. The consequences of the Australian oral health discipline not leaning into this paradigm shift will ultimately mean that those who are least able to afford oral health care, will continue to suffer the greatest burden of disease. This study identified the following: a paradigm shift within the oral health discipline - specifically within the Australian context, the current scope of Australian Bachelor of Oral Health (BOH) programs learning outcomes, and significant gaps in the current scholarly literature.

Brookfield (2017) provided academics with guidance on becoming a critically reflective teacher, emphasising the need to investigate teaching practice from various lenses. This is complicated for the oral health academic, who very often must consider the lenses of their patients, the profession, technique-sensitive clinical procedures, and the community in which they serve, in addition to Brookfield's lenses; the student, the colleagues, personal experience, and teaching theory. This expertise somehow becomes second nature to oral health academics, and further extension of the self may have been easy to avoid, up until this point. The ADC's revisions no longer allow this dismission. Brookfield (2017), provides us with his insight into what difficulties we might face when addressing critical reflection on race and racism:

> For most whites being told that they live in a racist world where their unearned power and privilege causes them to perpetuate an unjust system is, quite literally, inconceivable (Brookfield, 2017. p. 208).

As difficult as it may be to dive this deep into critical reflection, the oral health profession, as a whole and as individuals must be courageous enough to contemplate and examine, via honesty and humility how our attitudes, beliefs, and behaviours contribute to the health disparities in this country. Oral health academics can be seen as important community leaders, it will be through example-setting and changes in practice that we forge a new inclusive approach to oral health. By including an autoethnography and by sharing my lived experience, it is hoped that other oral health academics discover value in the pursuit of social justice when endeavouring to align with the ADCs revised program accreditation standards. Growth in this direction is sought to assist the reorientation of oral health research and education, by engaging in interdisciplinary literature and by all of us providing fellow academics with lived experiences to assist in this transitional phase.

This research has also provided a practical pedagogic strategy that incorporated students reflective accounts in the hope that it will support the needs of teaching academics as they lean into a radically changing environment. It is hoped that this is viewed as a valuable resource and a driver for others that can be drawn upon as we make this transition. Also highlighted here is the imperative of understanding *'Inclusion Oral Health'* and its key concepts – the value of voice, understanding intersectionality, and recognising the impact of othering by teaching academics, and oral health practitioners, by undergraduate and postgraduate students. Greater social cognizance will facilitate a deeper understanding of why traditional 'top-down' interventions are not sustainable, and how they compound social exclusion, whilst they may be well intended, we must question whether they are providing *'more of the same*'.

The paradigm shift as described throughout this thesis is one that is embodied in the Australian Dental Council's revised program accreditation standards, which requires educators and

practitioners to be cognizant of the impact of colonialisation as fundamental causes of social exclusion. These standards include, but are not limited to:

1. demonstrate that the interests of the person receiving care are paramount in all decisions and actions

2. acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health

3. acknowledge and address individual racism, your own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism

4. recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community

5. foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues

6. provide culturally safe care to diverse groups and populations, recognising barriers to accessing care and responding to the distinct needs of those at increased risk of poor oral health

8. incorporate a self-reflective approach to dental practice that recognises and supports life-long learning for all members of the dental team

9. practise in an ethical and professional manner consistent with the Dental Board of Australia's Code of conduct

11. recognise the environmental impacts of health care provision and use resources responsibly making decisions that support environmentally sustainable healthcare (ADC, 2022)

Historically, Australian oral health practitioners have proven their adaptability and agility. The new challenges that face our profession, provide us with yet another opportunity to demonstrate leadership and once again solve problems that seem insurmountable. It is through Freeman et al. (2019) research that the profession can begin to understand its historic contribution to social exclusion, this should be facilitated by collaborations with other disciplines, as Freeman et al. (2019) recommends. The social sciences, for example, can broaden our understanding of the how and why of social exclusion, it should be explored, then real changes can be made to the way we conduct oral health promotional research activities and educational strategies. Freeman et al. (2019) highlighted education as playing a pivotal role in operationalizing inclusion oral health, suggesting that:

> …dental education action focuses on education and training of undergraduate, postgraduate and qualified dental health professional levels to raise awareness of social exclusion, intersectionality, and othering in order to foster and advocate for inclusion oral health. Dental education that emphasizes the theoretical and practical dimensions of extreme oral health for oral health providers has the potential to reduce the intensity of exclusion faced by people when they access dental services (Freeman et al, 2019 p. 4)

As educators, we cannot underestimate the role we play in shaping the oral health outcomes of those suffering social exclusion. It was through Brookfield's (2017) lenses of critical reflection that the seeds of change were planted for this study, seeking out student feedback, consulting with peers, and the scholarly literature allowed for facilitated change. The process of being critically reflective empowered the USYD BOH to begin addressing the changes to the Australian Dental Councils (ADC) revised accreditation standards, in a systematic way. Members of the Australian Dental Council are to be congratulated on their progressive thinking and leadership in social justice thinking.

The numerous external factors that contributed to the reorientation and subsequent pivot of this project coupled with the multiple intersections of my own life have at times felt unbreachable.

When I consider the struggles, we all face as individuals, professionals, as a discipline, and within our broader Australian community, the most obvious solutions must evolve from humility, kindness, courage, and compassion. Our first 'bottom up' project must be our own, it's time to reflect, become humble, and acknowledge our contributions to social exclusion. It is only after this that we can begin to implement strategies that affect Australian oral health inequalities positively.

The scope of Australian Bachelor of Oral Health programs curricula has been investigated and emergent approaches have been given that will facilitate students in greater self-reflection and social justice learning. Findings of the content analysis revealed that the key theme '*social justice*' was rarely seen in the current contemporary learning outcomes and that *'social exclusion'* was not expressed at all in Australian BOH programs learning outcomes and that the frequency of use of the key theme 'Cultural competency, safety, processes, diversity, sensitivity', varies greatly across programs. This is not to say that lower frequency institutions are not embedding the key themes in their teaching, simply that this is not currently being reflected in the publicly available programs learning outcomes.

The second research question was answered most fully in the literature review, content analysis, and autoethnographic accounts of lived experience (my own) and students' reflective assessments. It has been evidenced here that self-reflection practice begins with the individual (educator, student, or professional). Social justice learning scored a low frequency among contemporary BOH learning outcomes, which leads us to consider the conclusion that it is given little priority in the program's curricula. A greater understanding of the key themes of social justice and social exclusion can be sort from the social science discipline, as suggested by Freeman et al. (2019). Remaining current with dental education literature, as Brookfield (2017) suggests, specifically oral health promotion, will empower educators to create additional pedagogical strategies in self-reflection and social justice learning. This study provided one such strategy, referred to as the '*Photovoice Critically Reflective Journal'* (Appendix 1). Student's engagement in the assessment and subsequent submissions

illustrated a movement away from absolutist views of knowledge to relativistic conceptualisations of the key terms presented.

This research begins to unpack the complex issues around social justice, social exclusion, and cultural safety in BOH programs across Australia. This study emphasises the need for critical self-reflexive practice to be implemented firstly by educators and secondarily by students. It gave an in-depth account of the most recent literature in Chapter Two, noting significant gaps, and made several recommendations regarding future community engagement and participatory action research. It also demonstrated that the previously mentioned key themes are unreliably dispersed in the nine programs learning outcomes.

It is also hoped that our future research efforts will strive to develop a clearer understanding of how social exclusion is currently being compounded in oral health research, practice, and higher education in the Australian context and bring to the fore solutions for those suffering extreme oral health.

References

Adams, T. E., Holman Jones, S. L., & Ellis, C. (2015). *Autoethnography*. Oxford University Press.

Arora, G., Humphris, G., Lahti, S., Richards, D., & Freeman, R. (2020). Depression, drugs and dental anxiety in prisons: A mediation model explaining dental decay experience. *Community Dentistry and Oral Epidemiology*, 48(3), 248–255. https://doi.org/10.1111/cdoe.12522

Australian Bureau of Statistics (2023, February). *Remoteness structure.* https://www.abs.gov.au/statistics/statistical-geography/remoteness-structure

Australian Dental Association. (2022, April 15). *Special needs dentistry spotlight (part 1)*. https://www.ada.org.au/News-Media/News-and-Release/Latest-News/Special-needs-dentistry-spotlight-(part-1)-1504202

Australian Dental Council. (2016, February). *Professional competencies of the newly qualified dental hygienist, dental therapist and oral health therapist: health promotion.* https://www.adc.org.au/sites/default/files/Media_Libraries/PDF/Accreditation/Professional%20Competencies%20of%20the%20Newly%20Qualified%20Dental%20DH%20DT%20OHT_rebrand%20Final,pdf

Australian Institute of Health and Welfare. (2023). Oral health and dental care in Australia. Retrieved from https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia

Bastos, J. L., Constante, H. M., Celeste, R. K., Haag, D. G., & Jamieson, L. M. (2020). Advancing racial equity in oral health (research): more of the same is not enough. *European Journal of Oral Sciences*, 128(6), 459–466. https://doi.org/10.1111/eos.12737

Beaton, L., Humphris, G., Rodriguez, A., & Freeman, R. (2020). Community-based oral health interventions for people experiencing homelessness: a scoping review. *Community Dental Health*, 37(2), 150–160. https://doi.org/10.1922/CDH_00014Beaton11

Beaton, L., Humphris, G., Rodriguez, A., & Freeman, R. (2021). Implementing the Smile4life intervention for people experiencing homelessness: a path analytical evaluation. *BMC Oral Health*, 21(1), 1–383. https://doi.org/10.1186/s12903-021-01747-1

Bedos, C., Apelian, N., & Vergnes, J.-N. (2020). Towards a biopsychosocial approach in dentistry: the Montreal-Toulouse Model. *British Dental Journal*, 228(6), 465–468. https://doi.org/10.1038/s41415-020-1368-2

Bedos, C., Apelian, N., & Vergnes, J. N. (2021). What should people expect from person-centred dental visits? The Montreal-Toulouse Wheel of expectations. *British Dental Journal*, 231(4), 249–253. https://doi.org/10.1038/s41415-021-3322-3

Bourke, L., Mitchell, O., Mohamed Shaburdin, Z., Malatzky, C., Anam, M., & Farmer, J. (2021). Building readiness for inclusive practice in mainstream health services: A pre-inclusion framework to deconstruct exclusion. *Social Science & Medicine* (1982), 289, 114449–114449. https://doi.org/10.1016/j.socscimed.2021.114449

Bracksley-O'Grady, S., Anderson, K., & Masood, M. (2021). Oral health academics' conceptualisation of health promotion and perceived barriers and opportunities in dental practice: a qualitative study. *BMC Oral Health*, 21(1), 165–165. https://doi.org/10.1186/s12903-021-01508-0

Bracksley-O'Grady, S., Dickson-Swift, V., Anderson, K., Masood, M., (2023) Mapping of health promotion curriculum in Australian BOH programmes. *The Australian and New Zealand Journal of Dental and Oral Health Therapy,* Vol 11 Special Conference Edition, 1

Brah, A., & Phoenix, A. (2004). Ain't I a woman? Revisiting intersectionality. *Journal of International Women's Studies*, 5(3), 75.

Brookfield, S. (2017). *Becoming a critically reflective teacher (Second edition.)*. J*ossey-Bass,* A Wiley Brand.

Bulgareli, J. V., Cortellazzi, K. L., Guerra, L. M., Ambrosano, G. M. B., Kaieda, A. K., da Cunha, I. P., Vazquez, F. de L., & Pereira, A. C. (2021). Determinants of adherence to dental treatment of

socially vulnerable adolescents: a cohort study. *BMC Research Notes*, 14(1), 116–116. https://doi.org/10.1186/s13104-021-05525-8

Central Queensland University (n.d) *CQUNI HANDBOOK, CB29 - Bachelor of Oral Health.* Retrieved https://handbook.cqu.edu.au/he/courses/view/Cb29?_gl=1*358q4q*_ga*OTk3NTQwMjU1LjE2Nzg0MzA3Mjc.*_ga_HZ0LQNHND8*MTY4MDU3NTczMi4zLjEuMTY4MDU3NTc1MS40MS4wLjA.&_ga=2.187945256.1491388485.1680575736-997540255.1678430727&_gac=1.213850342.1680575736.Cj0KCQjw8qmhBhClARIsANAtboc7rXRlmIt5CIqXYzy6n7BnQQwgiDZEb5xz8_mPvpmBTJWTkTmz9HQaAp2dEALw_wcB

Charles Sturt University (2016) *Bachelor of oral health (therapy and hygiene)*, Oral health flyer. Retrieved https://www.csu.edu.au/__data/assets/pdf_file/0019/1048213/Oral-Health-flyer.pdf on 10/03/2023.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Rev.* 43(6):1241–1299.

Dewey, J. (1910, 1933). *How we think*. https://archive.org/details/HowWeThink

Doughty, J., Grossman, A., Paisi, M., Tran, C., Rodriguez, A., Arora, G., Kaddour, S., Muirhead, V., & Newton, T. (2022). A survey of dental services in England providing targeted care for people experiencing social exclusion: mapping and dimensions of access. *British Dental Journal*, 1–8. https://doi.org/10.1038/s41415-022-4391-7

Drisko, J. W., & Maschi, T. (2016). *Content analysis*. Oxford University Press.

Ekmekci, P. E., & Arda, B. (2015). Enhancing John Rawls's Theory of Justice to Cover Health and Social Determinants of Health. *Acta Bioethica*, 21(2), 227–236. https://doi.org/10.4067/S1726-569X2015000200009

Forsyth, C., Irving, M., Short, S., Tennant, M., & Gilroy, J. (2019). Strengthening Indigenous cultural competence in dentistry and oral health education: Academic perspectives. *European Journal of Dental Education*, 23(1), e37–e44. https://doi.org/10.1111/eje.12398

Freeman, R., Doughty, J., Macdonald, M. E., & Muirhead, E. (2019). Inclusion oral health: Advancing a theoretical framework for policy, research and practice. *Community Dentistry and Oral Epidemiology,* 48(1), 1–6. https://doi.org/10.1111/cdoe.12500

Freeman, R. (2021). Oral Health as a Door to Promoting Psychosocial Functioning for People in Custody: Lessons Learnt from the Development of the Mouth Matters Intervention. In M., Maycock, Meek, R., Woodall, J. (eds) *Issues and Innovations in Prison Health Research*. (pp. 211–233). Palgrave Studies in Prisons and Penology. Palgrave Macmillan, Cham. https://doi-org.ezproxy.library.sydney.edu.au/10.1007/978-3-030-46401-1_10

Gamarra, S., Bärnighausen, K., Wachinger, J., & McMahon, S. A. (2021). "We had to take a hammer to get some roots out" - experiences, motivations and challenges among volunteer dentists: a qualitative study. *British Dental Journal,* https://doi.org/10.1038/s41415-021-3222-6

Gayatri Chakravorty Spivak. (1999). *A Critique of Postcolonial Reason: Toward a History of the Vanishing Present.* Harvard University Press.

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The Behavioral Model for Vulnerable Populations: application to medical care use and outcomes for homeless people. *Health services research*, 34(6), 1273.

Griffith University (2023, March) *The first Australian School of Dentistry in nearly 60 years opens.* Retrieved https://griffitharchive.griffith.edu.au/items/first-australian-school-dentistry-opens-nearly-60-years/

Hall, G., Dai, W. F., & Lim, S. (2021). Association between primary heath [sic] care and dental service use among supportive housing tenants with behavioral health conditions. *Community Dentistry and Oral Epidemiology*, 49(1), 70–77. https://doi.org/10.1111/cdoe.12579

Holden, A. C. L., & Leadbeatter, D. (2021). Conceptualisations of the social determinants of health among first-year dental students. *BMC Medical Education*, 21(1), 164–164. https://doi.org/10.1186/s12909-021-02602-1

Hankivsky, O., (2014). Intersectionality 101. *The Institute for Intersectionality Research & Policy*, SFU

ISBN: 978-0-86491-355-5 Retrieved https://resources.equityinitiative.org/bitstream/handle/ei/433/2014%20Hankivsky%20Intersectionallity%20101.pdf?sequence=1&isAllowed=y

Kontaxis, K. L., & Esfandiari, S. (2022). Social Justice Education in Dentistry: A Qualitative Analysis and Conceptual Framework. JDR Clinical and Translational Research, 8(2), 123–130. https://doi.org/10.1177/23800844211072778

Kuhn, T. S. (1962). *The Structure of Scientific Revolutions.* Foundations of the Unity of Science (Volumes I—II of the Encyclopedia) Vol. II, No. 2. *Chicago* (University of Chicago Press) 1962.

Kuhn, T. S. (2012). *The structure of scientific revolutions*. Chicago, IL: The University of Chicago Press.

Krippendorff, K. (2012). Content analysis: An introduction to its methodology. *Beverly Hills,* CA: SAGE.

Lee, S.H., Ryu, J.I., & Jung, S.H. (2020). Differences in Utilization of Medical and Dental Services among Homeless People in South Korea*. International Journal of Environmental Research and Public Health,* 17(15), 5304–. https://doi.org/10.3390/ijerph17155304

Lister, A. (2013). The "Mirage" of Social Justice: Hayek Against (and For) Rawls. *Critical Review (New York, N.Y.),* 25(3-4), 409–444. https://doi.org/10.1080/08913811.2013.853859

Macdonald, M. E., Muirhead, E., Doughty, J., & Freeman, R. (2022). Critically engaging vulnerability: Rethinking oral health with vulnerabilized populations. *Community Dentistry and Oral Epidemiology*, 50(6), 469–475. https://doi.org/10.1111/cdoe.12703

Marcenes, W. (2020). The impact of the COVID-19 pandemic on dentistry*. Community Dental Health*, 37(4), 239–241. https://doi.org/10.1922/CDH_Dec20editorialMarcenes03

Miranda, M. S. S., Mourão, A. M., Lamenha-Lins, R. M., Nogueira, R. F., Carcavalli, L., Lisboa, S. O., Ferreira, F. M., & Serra-Negra, J. M. (2022). *Pediatric* Oral Health Self-reported by Caregivers of Normal Hearing and Hearing-Impaired Children. *Pesquisa brasileira em odontopediatria e clínica integrada*, 22. https://doi.org/10.1590/pboci.2022.024

Mejia-Lancheros, C., Lachaud, J., Nisenbaum, R., Wang, A., Stergiopoulos, V., Hwang, S. W., & O'Campo, P. (2020). Dental problems and chronic diseases in mentally ill homeless adults: a cross-sectional study. *BMC Public Health,* 20(1), 419–419. https://doi.org/10.1186/s12889-020-08499-7

Muirhead, E., V., Milner, A., Freeman, R., Doughty, J., & Macdonald, M. E. (2020). What is intersectionality and why is it important in oral health research? *Community Dentistry and Oral Epidemiology*, 48(6), 464–470. https://doi.org/10.1111/cdoe.12573

Noushi, N., & Bedos, C. (2020). Developing Person-Centred Dental Care: The Perspectives of People Living in Poverty. *Dentistry Journal,* 8(3), 82–. https://doi.org/10.3390/dj8030082

Paisi, M., Baines, R., Wheat, H., Doughty, J., Kaddour, S., Radford, P. J., Stylianou, E., Shawe, J., & Witton, R. (2022). Factors affecting oral health care for asylum seekers and refugees in England: a qualitative study of key stakeholders' perspectives and experiences. *British Dental Journal,* 1–7. https://doi.org/10.1038/s41415-022-4340-5

Paisi, M., Baines, R., Worle, C., Withers, L., & Witton, R. (2020). Evaluation of a community dental clinic providing care to people experiencing homelessness: A mixed methods approach. *Health Expectations : an International Journal of Public Participation in Health Care and Health Policy*, 23(5), 1289–1299. https://doi.org/10.1111/hex.13111

Paisi, M., March-McDonald, J., Burns, L., Snelgrove-Clarke, E., Withers, L., & Shawe, J. (2021). Perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness: a systematic review. *BMJ Sexual & Reproductive Health,* 47(3), 211–220. https://doi.org/10.1136/bmjsrh-2020-200799

Peace, R. (2001). Social exclusion: a concept in need of definition? *Social Policy Journal of New Zealand*, (16), 17–35.

Ribeiro, A. G. A., Martins, R. F. M., Vissoci, J. R. N., da Silva, N. C., Rocha, T. A. H., Queiroz, R. C. de S., Tonello, A. S., Staton, C. A., Facchini, L. A., & Thomaz, E. B. A. F. (2021). Progress and challenges in potential access to oral health primary care services in Brazil: A population-

based panel study with latent transition analysis. *PloS One,* 16(3), e0247101–e0247101. https://doi.org/10.1371/journal,pone.0247101

Satur, J. (2002). *Australian dental policy reform and the use of dental therapists and hygienists.* (11343) [Doctoral Thesis, The University of Melbourne]. Melbourne. http://hdl.handle.net/11343/57382

Satur, J. & Moffat, S. (2010). Development of oral health therapy. In A. K.L. Tsang (Ed.), *Oral health therapy programs in Australia and New Zealand* (pp. 17-26). Knowledge Books and Software.

Satur, J. & Moffat, S. (2010). History of OH professions in Australia and New Zealand. In A. K.L. Tsang (Ed.), *Oral health therapy programs in Australia and New Zealand* (pp. 1-16). Knowledge Books and Software.

Satur, J. (2010). University of Melbourne. In A. K.L. Tsang (Ed.), *Oral health therapy programs in Australia and New Zealand* (pp. 149-179). Knowledge Books and Software.

Satur, J. (2007). The development of the dental Therapy profession: *ResearchGate* website, https://www.researchgate.net/publication/265446314_The_development_of_the_dental_therapy_profession

Satur, J., Gussy, M., Mariño, R., & Martini, T. (2009). Patterns of Dental Therapists' Scope of Practice and Employment in Victoria, Australia. *Journal of Dental Education*, 73(3), 416–425. https://doi.org/10.1002/j.0022-0337.2009.73.3.tb04713.

Skandrani, A., El Osta, N., Pichot, H., Eschevins, C., Pereira, B., & Tubert-Jeannin, S. (2022). Validation of the French version of COHIP-SF-19 among 12-years children in New Caledonia. *BMC Oral Health,* 22(1), 1–358. https://doi.org/10.1186/s12903-022-02370-4

Sukotjo, C., Yuan, J. C., & Bordage, G. (2010). A Content Analysis of Dental Education Research as Reported in Two Journals. *Journal of Dental Education*, 74(10), 1106–1112. https://doi.org/10.1002/j.0022-0337.2010.74.10.tb04965.x

Tervalon, M., & Murray-García, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of*

Health Care for the Poor and Underserved, 9(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

Wall, S. (2008). Easier Said than Done: Writing an Autoethnography. *International Journal of Qualitative Methods,* 7(1), 38–53. https://doi.org/10.1177/160940690800700103

Walker, M., Fredericks, B., Mills, K., & Anderson, D. (2014). "Yarning" as a method for community-based health research with indigenous women: the indigenous women's wellness research program. *Health care for women international,* 35(10), 1216-1226

Wallace, L., Cockrell, D., & Taylor, J. (2010). The University of Newcastle's first cohort of Bachelor of Oral Health students: a social profile. *Australian Dental Journal,* 55(4), 436–440. https://doi.org/10.1111/j.1834-7819.2010.01266.x

Williams, S., Jamieson, L., MacRae, A., Gray, C. (2011) Review of Indigenous oral health. Australian *Indigenous Health Bulletin* 11(2).

Weber, R. P. (1990). *Basic Content Analysis, 2nd ed*. Newbury Park, CA.

Young, R. (2020). *Postcolonialism: a very short introduction (Second edition.)*. Oxford University Press.

Yuan, S., Freeman, R., Hill, K., Newton, T., & Humphris, G. (2020). Communication, Trust and Dental Anxiety: A Person-Centred Approach for Dental Attendance Behaviours. *Dentistry Journal,* 8(4), 118. https://doi.org/10.3390/dj8040118

Appendix 1

Dear Placement Providers and Students,

During the final third year of the Bachelor of Oral Health (BOH), students are required to participant in several community placement/observations as part of the mandatory requirements of the degree. Specifics around these placements are outline in the relevant Unit of Study outline for ORHL3101/ORHL3201 and ORHL3102/ORHL3202, which can be located on Canvas.
ORHL3101/ORHL3201 Foundations of Oral Health 5 & 6
https://canvas.sydney.edu.au/courses/29774

ORHL3102/ORHL3102 Integrated Oral Health Clinical Practice 1 & 2
https://canvas.sydney.edu.au/courses/29773

The aim of this document is to provide students and placement providers with the information outlined in Sydney Universities 'Student Placement and Projects Policy 2015' which can be found at the following link:
https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2015/405&RendNum=0

This document will inform students and placement providers of the following:

- The Outcomes of the placement or observation, including:
  I. learning outcomes;
  II. assessment requirements; and
  III. attendance requirements; (students/providers)
- How to apply for special consideration or special arrangements in relation to the placement or project; (students)
- Any obligations of confidentiality which will apply to them during or after the placement or project; (students/providers)
- Whom to contact in the faculty if there are any concerns while undertaking the placement or project, and how contact may be made; and (students/providers)
- The circumstances under which a placement or project may be terminated by any of the placement supervisor, the project partner, or the placement or project co-ordinator; and (students/providers)
- The circumstances under which a student would be considered to have failed any assessment relating to the placement or project (students)
- Communication channels (students/providers)
- Work health and safety expectations (student/providers)
- Insurance (students/providers)
- Feedback after placements (students/providers)

Please contact me if you require any further information.

Kind regards

Kelly-Jean Burden Associate Lecturer
Sydney Dental School, The University of Sydney Email: Kelly.burden@sydney.edu.au
Mob: 0401 875 225
Address: 1 Mons Road, Westmead NSW 2145

Student Placement Guidelines & Information

Aims

The overarching aim of placements for students is to provide undergraduates with certain skills, exposure to technologies or environments, or to enhance soft skills, problem solving, leadership, organisation, perseverance, motivation, reflection, and confidence.

> Enriching health professional students' placement experiences through targeted community-engagement has the potential to help develop their preparedness to provide healthcare to the broader community.

Fisher, K., Smith, T., Brown, L., Wakely, L., Little, A., Wakely, K., Hudson, J., & Squires, K. (2018). Value-adding to health professional student placement experiences: Enhancing work readiness and employability through a rural community engagement program. Journal of Teaching and Learning for Graduate Employability, 9(1), 41-61. https://doi.org/10.21153/jtlge2018vol9no1art698

Student placements for placement providers, may aid in future recruitment, assist with maintaining ongoing interprofessional relationships, and may lead to enhancement of the patient/participants perception of the organisation.

Outcomes

The overarching Oral Health in Society learning outcome, which will be achieved over both semesters:

- conduct a needs analysis, program plan, deliver and evaluate an oral health promotion project within a metropolitan community, conscious of diverse cross- cultural communication and interactions

The overarching Integrated Oral health Clinical Practice learning outcomes, that will be achieved over both semester:

- Comprehend the role of the Oral Health Therapist in Orthodontic practice

ORHL3202 - Oral Health in Society - 2 Semester

Learning outcomes for Oral Health in Society

On successful completion of this subject, you should be able to:

- apply sociological concepts and theories to oral health inequities
- define key concepts of oral health promotion, with a deeper understanding on assessments of oral health and planning an intervention
- discuss and describe strategies of health promotion in a community setting
- discuss and describe effective team / group approaches to health promotion
- demonstrate the ability to identify behavioural models of oral health
- establish key concepts of cultural perspectives on health, and how these relate to overall health outcome
- enact one's professional roles and responsibilities, by demonstrating an appreciation of the roles of other health professionals
- always demonstrate professional behaviour and attitudes in all learning environments

Assessment item 1

Photovoice Critical Reflective Journal
Value: 5%
Due Date: Sunday August 8, 2021 at 23:59
Length: 300-500 words per prompt word
Submission method: Via CANVAS

Task:

You will be required to create a 'Photovoice' critical reflective journal entry; this reflective piece will become works of art to be exhibited in a 'Photovoice virtual gallery'. Prompt words will be given, to help direct you deeply reflect upon the social determinants of health, oral health inequalities and social justice. The Oral Health in Society 'Photovoice virtual gallery' will invite a wide range of guests, including those in powerful positions within the oral health and academic communities as well as guests in powerless positions that suffer oral health inequalities. The goal of holding a 'Photovoice virtual gallery' is to:

1. enable people to record and reflect their communities strengths and concerns
2. promotes critical dialogue and knowledge about important issues through large and small group discussion of photographs
3. reach policy and decision makers

Wang and Burris (1997).

The benefits of reflective practice are widely recognised in the scholarly literature of higher education and have been shown to assist in student's conceptualisation of complex concepts. Reflection also aids in the development of deep insights and perspectives.

Students are asked to attend the lectures scheduled for Thursday July 22 and July 29, as a matter of priority. These lectures will outline the ethical, professional, and legal (consent) considerations that must be understood prior to engaging in this type of assessment. All photos taken/reflective entries should strictly adhere to the specifics detailed in this lecture.

Write a 300-500 word critical reflection for each of the following prompt words:

1. Personal and professional growth
2. Ethical and personal identity
3. Cultural competence
4. Privilege

Take one photo that captures what you have written, you will need to create your own image, (not a 'stock' image). All images should be taken with safety at the forefront of your mind and should observe the criteria outlined in lecture 1 and 2 of OHS, semester 2. The intention here is that these reflections will be shared with various audiences – peer-to-peer, the dental school and more widely members of the dental community, please submit a piece of work that you feel happy to show to all. On submission, photos and there aligning written reflection should be paired together and easily identified as your response.

Rationale:

This assessment addresses learning outcome 1 (LO1)

'Engage in self-reflective practices that are deep and meaningful, that promote personal and professional growth'

This assessment also aligns with two of the Sydney Universities graduate qualities 'Cultural Competency' and 'Integrated professional, ethical and personal identity'.

Cultural Competency - Cultural Competence is the ability to actively, ethically, respectfully, and successfully engage across and between cultures. In the Australian context, this includes and celebrates Aboriginal and Torres Strait Islander cultures, knowledge systems, and a mature understanding of contemporary issues.

Integrated professional, ethical, and personal identity –

> An integrated professional, ethical and personal identity is understanding the interaction between one's personal and professional selves in an ethical context.

University of Sydney. (2021). Graduate Qualities. Retrieved May 23, 2021, from https://www.sydney.edu.au/students/graduate-qualities.html

The benefits of reflection are widely recognised in the field of adult education, it is of importance in fostering new ideas, encouraging connection across ideas and engenders voice.

Steven, D.D., & Cooper, J. E. (2009). Journal keeping: How to use reflective writing for learning, teaching, professional insight and positive change. Sterling, VA: Stylus Publishing, LLC

Marking criteria

This assessment item will be marked against the following criteria.
NB. You will receive an individual mark for your critical reflective task based on the rubric below to a total of 10 marks (section 1, 2 & 3). Your reflection will be marked out of 10.

NOTE: submission of the individual written report must be via CANVAS by the due date, late submissions will attract penalties outlined below.

Assessment 1	HD (85% +)	D (75-84%)	CR (65-74%)	P (50-64%)	F (0-49%)
Content and context of the reflection (4 marks)	Context and content given, illustrating a deep understanding of oral health inequality and/or social injustice.	Context and content given, illustrating a sound understanding of oral health inequality and/or social injustice.	Context and content given, illustrating an emerging understanding of oral health inequality and/or social injustice.	Context and content given, illustrating a shallow understanding of oral health inequality and/or social injustice.	Context and content given, not clearly given. Limited understanding of oral health inequality and/or social injustice.
Personal reflections and responses to community perspectives (3 marks)	Clear and concise analysis of a personal reflection and response to patient/community perspective that addresses all prompt words.	Clear and concise explanation of personal reflections and response to patient/community perspectives that addresses all prompt words provided.	Clear and concise description of personal reflections and response to patient/community perspectives that addresses all prompt words provided.	Description of personal reflections and response to patient/community perspectives that addresses all prompt words provided.	Description of personal reflections and response to patient/community perspectives not provided. Responses to all prompt words not provided.
Reflective write-up (3 marks)	Adheres to word count and image count. Paragraphs are succinct with excellent control over grammatical structures, technical vocabulary, and spelling.	Adheres to word count and image count. Paragraphs are succinct with substantial control over grammatical structures, technical vocabulary, and spelling.	Adheres to word count and image count. Paragraphs are succinct with general level of control over grammatical structures, technical vocabulary, and spelling.	Adheres to word count and image count. Paragraphs are succinct with adequate level of control over grammatical structures, technical vocabulary, and spelling.	Does not adhere to word count and/or image count. Paragraphs are off point with inadequate level control over grammatical structures, technical vocabulary, and spelling.

Consent Pass/fail	Obtained appropriate consent - PASS	Did **not** require any consent - PASS	Did not obtain appropriate consent - FAIL

Placement Termination

This situation was addressed in comprehensive detail last year as a result of COVID-19. Students should be aware that if it is necessary to terminate a placement, as placement coordinator I will arrange for the student/s to be assessed on the basis of the completed component and inform the student as soon as possible of any remaining requirements to be met in order to complete the placement.
If the placement is terminated because the placement provider or facilities provided are determined to be unsuitable, the relevant co-ordinator will work with the student/s to provide options for the student to meet the placement requirements of their course without penalty.
It is the responsibility of students to inform the placement co-ordinator of any pre-existing relations between the placement provider (or relevant member of their staff) and any student proposed for placement with that provider.

What constitutes a Fail in Oral Health in Society?

Assessment will be evaluated solely based on students' achievement
against criteria and standards specified to align with learning outcomes. Assessment practices address issues of equity and inclusiveness to accommodate
and build upon the diversity of the student body so as not to disadvantage any student.

Unit of study lecturers and tutors are responsible for:

- Assessing student work fairly, consistently and in a timely manner
- Providing timely feedback which enables students to further improve their learning and performance wherever possible and
- Advising students in relation to expectations relevant to specific assessment tasks.

Students are responsible for:

- Actively engaging with assessment tasks, including carefully reading the guidance provided, spending sufficient time on the task, ensuring their work is authentic and their own (whether individual or group work) and handing work in on time
- Actively engaging in activities designed to develop assessment literacy, including taking the initiative where appropriate (e.g. asking for clarification or advice)
- Actively engaging with and acting on feedback provided
- Providing constructive feedback on assessment processes and tasks through student feedback mechanisms (e.g. student surveys or student representation on committees) and
- Becoming familiar with University policy and faculty procedures and acting in accordance with those policy and procedures. Students must sign the electronic form provided to indicate they understand all relevant policies and procedures
- Students must attend their scheduled all placement rotations, including IPL zoom sessions

Students must achieve an aggregate mark assessment mark of 50%, determined in the 'Assessment 1', 'Assessment 2' and 'Assessment 3' and have attended both their scheduled metropolitan placement and the interprofessional learning (IPL) workshops.

Attendance and class requirements

Attendance is a professional responsibility required of all students admitted to academic programs within the Sydney Dental School. All programs in the Sydney Dental School have a 90% attendance

policy, for all compulsory components of Units of Study, as detailed in the Faculty of Dentistry Attendance Provisions 2015. This includes all clinical and practical sessions. The course requirements cannot be satisfied if more than 10% of any section of a course is missed for any reason.

https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2014/370&RendNum=0

What constitutes a Fail in Integrated Oral Health Clinical Practice 1 & 2

Students must attend their scheduled all clinician rotations. As outlined in the above.

Professionalism
Students in all Sydney Dental School programs are subject to the Faculty of Medicine and Health Professionalism Requirements 2019 and the Faculty of Medicine and Health Professionalism Provisions 2019. Professionalism is an essential component of developing competency to practice. It is important for students to demonstrate professional behaviour in all contexts and environments. In accordance with these local provisions: candidates who demonstrate serious or repeated unprofessional behaviour may be required to show cause as to why their enrolment should be continued. Failure to show cause may result in exclusion from the course.

https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2014/370&RendNum=0

https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2019/492&RendNum=0

Work Health and Safety

Students at a workplace must:
- take reasonable care for their own health and safety, and that of others;
- comply with instructions about work health and safety;
- use personal protective equipment and clothing as instructed;
- promptly report work related hazards, injuries and incidents, including near misses; and co-operate with emergency procedures.

Work health and safety responsibilities – placement provides:

Placement Providers who supervise others at work must, within their area of responsibility:
- Demonstrate active and visible leadership in work health and safety;
- Identify hazards and work health and safety risks from activities under their supervision;
- Students are provided with an orientation and made familiar with WHS regulations
- Assess and control identified risks in consultation with those involved or affected, and with reference to University work health and safety procedures, standards and guidelines;
- Inform and as appropriate students and academics, about work health and safety requirements and expectations, and provide relevant guidance, information and training;
- investigate work related incidents, seeking to identify the root causes and take steps to prevent recurrence;
- promptly address work health and safety issues raised with them, in consultation with those involved or affected and
- report all information back to the university in a timely manner

Please see relevant University of Sydney policy
https://www.sydney.edu.au/policies/showdoc.aspx?recnum=PDOC2011/231&RendNum=0

Feedback after placement

It is requested that students complete the 'Student Placement Evaluation 2021' electronic form on completion of placements, only once. This is to occur shortly after completion of both placements. Please take reflective notes on a daily basis throughout your placements at both sights so as not to forget your experience.

The 'Student Placement Evaluation 2021' electronic form, can be located on CANVAS, a link will be provided.

Placement providers are asked to complete the 'BOH Student Placement Evaluation' form for each student on completion of their placement. A soft copy can be completed and returned via email to kelly.burden@sydney.edu.au

Appendix 2

THE UNIVERSITY OF SYDNEY

OFFICE OF CLINICAL EDUCATION SUPPORT

Kelly-Jean Burden

Associate Lecturer

The University of Sydney School of Dentistry

Faculty of Medicine and Health

1 Mons Road | Westmead | NSW | 2145

+61 2 8890 4311 | +61 2 9891 4214 (fax)

kelly.burden@sydney.edu.au | sydney.edu.au

20 January 2021

Kay McPartland
Flintwood Disability Services
4/10 Gladston Road
Castle Hill NSW 2154
kay.Mcpartland@flintwood.org.au

Ph: 86338919

Dear Kay

Thank you for agreeing to allow students from the University of Sydney (**Student**) to undertake their practical placement (**Placement**) at Flintwood Disability Services (**Placement Provider**) as part of their studies at the University of Sydney (**University**).

1. BACKGROUND

1.1 The University encourages students to experience practical placements in a variety of settings. Practical education is a critical aspect of a Student's education and provides a valuable opportunity for placement providers and the University to work together to share knowledge and expertise. The University is seeking the Placement Provider's participation and assistance in its student placement program.

1.2 The Placement Provider is a Disability Service Clinic and will provide provision of a safe and supportive environment for students to observe services.

1.3 The Parties anticipate that this Agreement will cover Students from the University of Sydney.

2. PURPOSE OF LETTER AGREEMENT

The purpose of this Letter Agreement (**Agreement**) is to set out how the Placement Provider and the University will work together to provide a high quality practical education experience for Students.

3. DETAILS OF THE PLACEMENT

3.1 The details of a Placement will be set out in the Placement Schedule (**Placement Schedule**).

3.2 The Placement Schedule sets out the details of the relevant Placement for each Student.

3.3 A Placement must not commence until the parties have completed and signed a Placement Schedule.

3.4 A Placement Schedule may be in the form attached to this Agreement (Schedule 1), or in any other form (including electronic communication) provided that it contains substantially all the information set out in the Placement Schedule in Schedule 1.

3.5 The number of Placements that will be made available to the University by the Placement Provider will be determined mutually by the parties acting reasonably.

(iii) details of any changes or absences with respect to a Student(s);

(iv) the stage of learning of a Student(s);

(v) the names of the University staff assigned to assist with the practical education (if applicable); and

(vi) the contact details of the University staff assigned to assist with the administration of the Placement.

(c) ensuring that Students are advised of the requirement to undertake relevant obligations students are required to undertake prior to commencing placement, e.g. relevant vaccinations, criminal record check and working with children check prior to commencing a Placement, and that a successful result may be a prerequisite for a Placement at the Placement Provider; and

(d) taking reasonable steps to ensure Students are informed of the obligation to observe any Placement Provider's regulations, policies and procedures which are binding on them and if requested, provided to the University beforehand by the Placement Provider.

4.2 The University may withdraw a Student from a Placement with immediate effect and without penalty if:

(i) it considers, on reasonable grounds, that the health, safety or well-being of the Student may be at risk if he or she was to continue with the Placement; or

(ii) it has reasonable concerns that the Placement Provider may not be complying with its obligations under applicable occupational health and safety, equal opportunity and/or anti-discrimination laws in respect of the Student.

Placement Schedule means the template schedule attached. Other documents may include but not restricted to e.g. the handbook, electronic documents or other supporting materials relevant to the student placement to be provided to the Placement Provider prior to a Student commencing a Placement.

5. PLACEMENT PROVIDER RESPONSIBILITIES

5.1 The Placement Provider will be responsible for:

(a) where relevant, nominating appropriate projects and/or patients/clients for the purposes of the Placement;

(b) ensuring all use and disclosure of health information to Students is in accordance with the Statutory Guidelines on training issued under the Health Records and Information Privacy Act 2002 (NSW) (**HRIP Act**) by the NSW Privacy Commissioner;

(c) ensuring that all applicable laws are complied with, particularly, where relevant, in regard to access to any patient/client treatment records and consent from patients/clients;

Placement Schedule means the template schedule attached. Other documents may include but not restricted to e.g. the handbook, electronic documents or other supporting materials relevant to the student placement to be provided to the Placement Provider prior to a Student commencing a Placement.

5. PLACEMENT PROVIDER RESPONSIBILITIES

5.1 The Placement Provider will be responsible for:

(a) where relevant, nominating appropriate projects and/or patients/clients for the purposes of the Placement;

(b) ensuring all use and disclosure of health information to Students is in accordance with the Statutory Guidelines on training issued under the Health Records and Information Privacy Act 2002 (NSW) (**HRIP Act**) by the NSW Privacy Commissioner;

(c) ensuring that all applicable laws are complied with, particularly, where relevant, in regard to access to any patient/client treatment records and consent from patients/clients;

(d) ensuring that the Placement achieves the objectives set out in the Placement Schedule.

(e) ensuring the proposed supervisor/s hold the required accreditation;

(f) where Placement Provider staff are involved in the practical education of a Student, providing the University with formal written feedback for the purposes of the University being able to assess the Student's performance during their Placement;

(g) providing a safe working environment and systems of work in accordance with all applicable work health and safety requirements as required by law for all Students;

(h) providing a Student with copies of, or access to, any relevant policies or procedures at the commencement of the Placement and ensuring they are reasonably informed of any obligations under applicable regulations, policies or procedures, to observe as part of the Placement;

(i) providing Students (and where applicable, University Staff) access to the Placement Provider facilities (including cafeteria, conference and changing facilities and any emergency medical care) for the purposes of any Placement;

(j) promptly notifying the University if a Student is the subject of a complaint or makes a complaint regarding mistreatment, harassment, bullying or discrimination;

(k) promptly notifying the University if a Student is involved in a work, health and safety incident;

(l) assisting with a Student's practical education and ensuring Students are appropriately supervised during the Placement; and

8. USE OF LOGO

8.1 Any use of the logo and name of a party requires the prior written consent of an authorised delegate of that party.

9. INSURANCE

9.1 Each party agrees to effect and maintain the following insurance policies during the term of this Agreement:

(a) public liability insurance coverage of $1,000,000 in respect of any one occurrence and in the aggregate; and

(b) professional indemnity, including medical malpractice insurance coverage, of $1,000,000 in respect of any one claim and in the aggregate for any one period of cover with its insurer.

10. INDEMNITY

10.1 Each party indemnifies the other for all losses it directly sustains or incurs as a result of any negligent, unlawful act or omission by the indemnifying party or of its officers, employees and subcontractors, except to the extent that any negligent act or omission of the indemnified party or its officers, employees and subcontractors contributed to the relevant liability.

10.2 For the avoidance of doubt, the University will not be liable for any losses that arise from any treatment of Placement Provider patients/clients by Placement Provider Staff and/or University Staff, unless, in the case of University Staff, they are acting in the course of their employment.

10.3 In addition to the indemnity in clause 11.1, the University indemnifies the Placement Provider against any third party claims arising as a direct result of a Student's conduct while on their Placement, except to the extent that any such claim arose out of an act or omission of the Student which occurred while under the supervision of a person employed or contracted by the Placement Provider.

10.4 Other than in respect of third party claims in clause 11.3 and to the extent permitted by law, neither party shall be liable for any claim for any loss of profit, data, goodwill or business, for any interruption to business, for any failure to realise anticipated savings or for any consequential, indirect, special, punitive or incidental damages.

11. GENERAL

11.1 To the extent that this Agreement is inconsistent with any other agreement made by either Party in relation to the Placements, this Agreement shall prevail.

11.2 The parties agree that neither the Placement Provider nor the University are required to pay any tuition fees, costs or levy in connection with the Placement at the Placement Provider.

11.3 The Placement Provider may terminate this Agreement or a particular Placement at any time and for any reason, by providing [3] months written notice.

11.4 The University may terminate this Agreement or a particular Placement at any time, on notice, without the need to provide any reasons for the termination.

11.5 Unless terminated earlier, this Agreement will remain in force for 3 years from the date it is signed by the parties, and the parties agree to discuss in good faith the renewal of this Agreement at least 6 months prior to its expiry.

11.6 The terms of this Agreement may be amended by written agreement of an authorised delegate of each party.

11.7 Nothing contained or implied in this Agreement is intended to create a partnership between any of the Parties or, except as otherwise provided in this Agreement, establish any of the parties as an agent or representative of any other party.

11.8 Neither party has the authority to represent that it is affiliated with the other party or to disclose the terms of this Agreement, other than with the prior written consent of the other party.

11.9 If any terms of this Agreement are invalid or unenforceable, it may be severed without affecting the enforceability of the remainder of the letter.

11.10 This Agreement may consist of a number of counterparts and the counterparts taken together form one agreement. An executed counterpart may be delivered by electronic means.

11.11 An electronic signature of a party included in this Agreement is intended to authenticate this

writing and to have the same force and effect as a manual signature.

11.12 The identity of an electronic signatory and the authenticity of an electronically delivered counterpart may be verified by using the signatory's email address to send the signed Agreement to the other party.

Acceptance

Please confirm your acceptance of the terms of this Agreement by signing a copy of this Agreement and returning it to:

The Office of Clinical Education Support

Clinical.education@sydney.edu.au

Via Docusign

EXECUTED as an agreement on the terms of the General Terms.	
SIGNED for and on behalf of **THE UNIVERSITY OF SYDNEY** by its duly authorised representative: DocuSigned by: Robyn Ward B00ZS3E9DFA24BA... .....(Signature) Robyn Ward .....(Printed Name) Executive Dean .....(Position) 12/2/2021 | 9:36 AM AEDT .....(Date)	**SIGNED** for and on behalf of **PLACEMENT PROVIDER** by its duly authorised representative: DocuSigned by: [redacted] 0EA7536DB8EC482... .....(Signature) Jackie Romein .....(Printed Name) CEO .....(Position) 12/2/2021 | 8:04 AM AEDT .....(Date)
Note: By executing this Agreement each signatory represents that he or she is authorised to sign on behalf of its entity. The date of this Agreement will be the date this Agreement has been executed by both parties and if executed on different dates, the date on which the last party executes this Agreement.	

Appendix 3

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
HUMAN RESEARCH ETHICS COMMITTEE

Tuesday, 5 July 2022

Assoc Prof Ruth Phillips
Social Work; Faculty of Arts and Social Sciences
Email: ruth.phillips@sydney.edu.au

Dear Ruth,

Your request to modify this project, which was submitted on 18/05/2022, has been considered.

After consideration of your response to the comments raised, this project has been approved to proceed with the proposed amendments.

Protocol Number: **2021/844**

Protocol Title: **SELF REFLECTIVE PRACTICE IN A SOCIAL JUSTICE CONTEXT FOR ORAL HEALTH EDUCATION**

Annual Report Due: **02/02/2023**

Documents Approved:

Date Uploaded	Version Number	Document Name
17/06/2022		Email clean
17/06/2022	Version 4	PIS - clean

Please contact the ethics office should you require further information.

Sincerely,

[redacted]

Associate Professor Kieron Rooney
Acting Chair
Modification Review Committee (MRC 2)

The University of Sydney of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's Australian Code for the Responsible Conduct of Research (2018)

Appendix 4 – Verbatim Learning Outcomes

Australian University	Key Term Identified – Learning Outcomes	Key Term Identified - Graduate Qualities/Attributes
University of Adelaide	1st Year ORALHLTH 1201AHO Dental and Health Science IOH Part 1 Explore the role of nutrition for a variety of age groups, relate this to *cultural factors* and lifestyle choices, explain why modifications may need to be made and develop recommendations and alternatives for patients to optimise their oral and general health using your developing knowledge of current Australian dietary guidelines ORALHLTH 1201BHO Dental and Health Science IOH Part 2 explore the role of nutrition for a variety of age groups, relate this to *cultural factors* and lifestyle choices, explain why modifications may need to be made and develop recommendations and alternatives for patients to optimise their oral and general health using your developing knowledge of current Australian dietary guidelines ORALHLTH 1204AHO Professional Studies IOH Part1 Implement into practice the personal requirements for health professionals today (including *cultural sensitivity* and patient centered care) in an Australian context. ORALHLTH 1204BHO Professional Studies IOH Part 2	5.*Intercultural* and ethical competency 6.Australian Aboriginal and Torres Strait Islander *cultural competency*

	Implement into practice the personal requirements for health professionals today, including *cultural sensitivity* and patient centred care in an Australian context. 2nd Year ORALHLTH 2202AHO Clinical Practice IIOH Part 1 Practice in a *culturally competent* manner with a diverse range of individuals and community groups ORALHLTH 2202BHO Clinical Practice IIOH Part 2 Practice in a *culturally competent* manner with a diverse range of individuals and community groups	
University of Sydney	ORHL2201: Foundations of Oral Health (IV) LO4. recognise Aboriginal and Torres Strait Islander peoples' ways of knowing, being and doing in the context of history, *culture* and diversity ORHL3201: Foundations of Oral Health VI LO2. conduct a needs analysis, program plan, deliver and evaluate an oral health promotion project within a metropolitan, rural or overseas community, conscious of diverse cross-*cultural* communication and interactions	*Cultural Competence* is the ability to actively, ethically, respectfully, and successfully engage across and between cultures. In the Australian context, this includes and celebrates Aboriginal and Torres Strait Islander cultures, knowledge systems, and a mature understanding of contemporary issues.
University of Central Queensland	Course Learning Outcomes APPLICATION OF KNOWLEDGE & SKILLS Engage in reflective self-evaluation of own *cultural values* and perspectives to proactively	Not publicly available

	create an inclusive workplace that affirms and celebrates *cultural diversity* APPLICATION OF KNOWLEDGE & SKILLS Display leadership by creating inclusive work environments and work with Aboriginal and Torres Strait Islander people in a *culturally respectful* manner 1st Year Community Engaged Learning Demonstrate communication and *culturally competent* skills and knowledge appropriate to the volunteer experience. 3rd Year Population Health Epidemiology Interpret epidemiological data within theories and frameworks of *social justice* and *cultural diversity* for effective knowledge transfer and exchange. Health Promotion Strategies Recommend *culturally appropriate* strategies to be applied in a variety of settings, including schools, workplaces, health service organisations and entire communities	
Charles Sturt University	1st Year Clinical Practice and Theory 2 be able to undertake safe and ethical patient care that is inclusive of a range of *cultural* and linguistic diversities;	engage meaningfully with the *culture*, experiences, histories and contemporary issues of Indigenous Australian communities;

	Community Oral Health 2 be able to describe key concepts of *cultural perspectives* on health, and how these relate to overall health outcome 3rd Year Clinical Practice and Theory 3 be able to demonstrate *cultural competence* in the clinical environment; Community Health Oral Health 3 be able to determine and apply respectful and supported practices which demonstrate *cultural competency*; Community Oral Health 3 be able to exercise critical thinking and judgement in identifying and exploring *social justice*, participation and empowerment issues as it relates to oral health research	
La Trobe University	1st Year WOMINJEKA LA TROBE: INDIGENOUS CULTURAL LITERACY FOR HIGHER EDUCATION 3.Understand the need for and value of appropriate and effective *intercultural* communication 4. Reflect critically on your own *cultural attitudes*, values and beliefs 3rd Year	Not publicly available

	GLOBAL PERSPECTIVES IN ORAL HEALTH 3. Interpret values of fairness, *social justice,* and inequalities based on gender, socio-economic status, culture, religion, age, access to care and other issues particularly related to oral health.	
University of Melbourne	Yr1 Sem 1 - *Comprehend the key social, economic, and *cultural* processes that influence health and oral health *Interpret empirical evidence on the key social, economic and *cultural processes* that influence health 2nd Year *Apply *culturally sensitive* approaches in promoting oral health *Demonstrate effective patient management while respecting the psychosocial, social and *cultural differences* of individuals; 3rd Year * Intercultural sensitivity and understanding;	Not publicly available
Curtin University	Course learning outcomes Demonstrate *cultural awareness* and understanding in the provision of patient care 1st Year Indigenous Cultures and Health Behaviours Identify the diversity of Australian Aboriginal and Torres Strait Islander peoples and cultures and recognise the significance of	Not publicly available

	cultural awareness, *cultural understanding*, cultural safety and *cultural security* Relate the impact of policies and history to the current *cultural* and health contexts of Australian Aboriginal and Torres Strait Islander peoples and the impacts of these policies on health, illness and disability Analyse determinants of health, *cultural influences* and models of health behaviour in relation to current health outcomes for, and the utilisation of health services by, Aboriginal and Torres Strait Islander peoples Reflect on own personal development of *cultural understandings* as a health professional working inter-professionally in partnership with Aboriginal and Torres Strait Islander peoples in a primary health care model	
University of Newcastle	1st Year Oral Health Therapy Clinical Skills IX – Clinical Practice 6.Demonstrate sound *cultural,* social and age appropriate communication skills with child, adolescent and adult patients, carers and team members Oral Health Sciences I 9. Discuss the social, *cultural* and environmental factors that contribute to oral health or ill health Oral Health Therapy Clinical Skills I – Introduction to the Clinical Environment	Not publicly available

	1.Describe the social, *cultural* and environmental factors that contribute to health or ill health; 2nd Year Oral Health Sciences II 1.Demonstrate appropriate and effective communication with social and *cultural sensitivity*, with patients, carers and team members Oral and Community Health 1.Describe and apply appropriate and effective communication with social and *cultural sensitivity*, with patients, carers and team members; Oral Health Therapy Clinical Skills VI – Clinical Practice 6.Demonstrate sound *cultural,* social and age appropriate communication skills with child, adolescent and adult patients, carers and team members 3rd Year Foundations of Aboriginal and Torres Strait Islander Health 1.Discuss Aboriginal and Torres Strait Islander peoples history, *cultural identity*, beliefs and values with a particular focus on the burden of disease. 6. Describe the principles of *cultural capability* and *cultural safety* in order to provide *culturally competent* health care to Aboriginal and Torres Strait Islander peoples. This must include identifying the impact of racism and effective communication strategies.	

	Oral Health Therapy Clinical Skills IX – Clinical Practice 6. Demonstrate sound *cultural*, social and age appropriate communication skills with child, adolescent and adult patients, carers and team members	
Griffith University	3rd Year Advocacy - Analyse how the health system is responsible for improving Aboriginal and Torres Strait Islander health including how health professionals can advocate for equitable outcomes and *social justice* for Aboriginal and Torres Strait Islander peoples and actively contribute to social change. Communication - Discuss the principles of *culturally appropriate*, safe and sensitive communication that facilitates trust and the building of respectful relationships and effective partnerships with Aboriginal and Torres Strait Islander peoples.	Griffith University Graduate Attribute 5: *Culturally Capable* when working with First Australians. Further to meet the requirements of your relevant professional bodies competency standards and codes of professional conduct to provide culturally safe care in Australia. Griffith University Graduate Attribute 6: Effective in *culturally diverse* and international environments