Community Dental Health (2007) **24,** 149-155
Received 2 June 2005; Accepted 4 December 2005

Oral health acculturation in Albanian-speakers in south London

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Objective To explore the processes involved in oral health acculturation for Albanian-speakers in south London. ***Basic research design*** A qualitative study utilizing 10 in-depth, semi-structured interviews and two focus groups with a purposive sample of 23 Albanian-speakers. Participants were recruited through community groups and by a snowball technique. Data were analysed using the constant comparative method. ***Results*** Participants attended the dentist more regularly and brushed their teeth more frequently in the UK, particularly those from lower social class groups. However, young people consumed more sweet foods and drinks than in Kosovo. The priority of oral health was higher in the UK for most participants. Mothers of young children were more interested in prevention in the UK, mainly as a result of receiving oral health information from health visitors and agencies such as Sure Start. However, oral health priorities generally remained treatment focused. Participants mainly attributed behavioural and attitudinal changes to structural and material factors such as the absence of war, higher living standards, better access to oral health information, products and dental services, and the greater availability of highly desirable sweet foods and drinks in the UK. ***Conclusions*** Understanding changes in social context may be crucial for comprehending the processes of oral health acculturation in immigrant populations. Material and structural changes which impact on oral health behaviours may be overlooked. Improving oral health knowledge can be a crucial step in shifting oral health priorities from a treatment to a prevention focus. However, unhealthy choices may persist due to the impact of wider cultural norms.

Key words: Acculturation, Albanian, oral health, qualitative, social context

Introduction

When individuals migrate to other countries they have to adjust to living in a new context. Acculturation is 'the phenomena which results when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original cultural patterns of either or both groups' (Redfield *et al*, 1936). It is a highly complex process including *socio-cultural adjustment* e.g. language ability, cultural knowledge, formation of social relationships; and *psychological adjustment* e.g. change of beliefs, attitudes, and preferences (Searle & Ward, 1990).

Patterns of acculturation vary between and within immigrant groups. Berry (1997) suggests that an individual's acculturation strategy will depend on the intersection between the degree to which the individual desires to maintain the culture of origin and the extent to which he/she seeks interaction with members of the host culture. *Integration* (embracing and valuing both cultures) has been associated with lower acculturative stress than other acculturation strategies such as *separation* (maintenance of the culture of origin through rejection or avoidance of the new culture) or *assimilation* (completely acquiring new culture) (Berry, 1997). Acculturation outcomes vary according to education; wealth; occupational skills; language ability; individual personality traits; structure and resources of the immigrants' families and communities; cultural distance between the new and old society; political and economic contexts of the new and old societies; and the extent to which the immigrants' presence is resented by the host nation (Berry, 1997; Lara *et al*, 2005).

Studies examining the impact of acculturation on oral health show an overall positive effect (e.g. Marino *et al*, 2001; Cruz *et al*, 2004). Such studies have focused on immigrants to wealthy Western countries from relatively poor countries. Acculturation has been shown to make a unique contribution to oral health status above and beyond other socio-demographic variables. Higher levels of acculturation are associated with an increase in oral health knowledge and more frequent use of dental services (Marino *et al*, 2001). However, the wider acculturation literature suggests that acculturation effects on health are not always positive. For example, acculturated Latinos living in the United States are more likely to have undesirable dietary behaviours, engage in substance abuse, and experience worse birth outcomes compared with their less acculturated counterparts (Lara *et al*, 2005).

To date, all the published studies examining the relationship between acculturation and oral health are quantitative. Whilst the study by Marino *et al* (2001) elaborated the relationship in terms of breaking down acculturation into its behavioural and psychological components and relating them to oral health knowledge and behaviours, the authors suggest that their findings 'encourage more in depth study of the relationship between (oral) health and acculturation'. A qualitative approach can provide a better sense of context, suggest explanations for behaviour change and provide a deeper understanding of adaptation experiences (Lipson *et al*, 2003).

Albanian-speakers form one of the largest Eastern European groups in south London (National Statistics, 2004). Dental caries is a particular oral health problem in this population. Several studies indicate a high caries

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prevalence in recently arrived refugees in comparison to similarly aged citizens from the host country (e.g. Menghini *et al*, 2003; Sunday & Petersen, 2003). Research from other former Yugoslavian countries suggests that the civil war has had a detrimental effect on the oral health of the population, with a significant increase in caries experience (Ivankovic *et al*, 2003). There is little research into other oral diseases in Albanian-speakers. However, a recent study from neighbouring Croatia indicates that dental caries is a much more significant cause of tooth loss than periodontal disease (Spalj *et al*, 2004). World Health Organisation data suggest that there are higher levels of oral cancer in men from the former Yugoslavia in comparison to men from England and Wales (WHO, 2001).

Little is known about the oral health attitudes, knowledge, behaviours and experiences of Albanian-speakers, nor how these have changed as Albanian-speakers have settled in the UK. The purpose of this exploratory study is to explore the processes involved in oral health acculturation for Albanian-speakers in south London. The research objectives are as follows:

1. To describe changes in oral health behaviours and attitudes
2. To explore the factors involved in behavioural and attitudinal change

Method

A qualitative methodology was chosen as the most appropriate to answer the research questions. Ten in-depth, semi-structured interviews and two focus groups were conducted with a purposive sample of 23 Albanian-speakers.

Sampling

The participants were 13 female and 10 male first generation Albanian-speakers aged 16-60 years known to community organisations based in Lambeth, Southwark and Lewisham. The sampling was purposive and participants were recruited on the basis of different ages, gender, socio-economic and educational background (18 school only, 1 further education, 4 university educated), length of stay in England (3 ten to thirteen years, 14 five to six years, 4 one to four years, 2 less than 1 year), English language competence (3 excellent, 14 fair, 6 poor), parental status (8 not caring for children, 15 caring for children) etc. in order to obtain a wide range of views and experiences, and reflect the diversity within the Albanian-speaking population. The religion of the participant was also included as a variable but later dropped when initial analyses indicated that it was not important in explaining differences in oral health experiences. Most participants were ethnic Albanians from Kosovo, but two participants came from Albania, and two participants were ethnic Albanians from Macedonia and Serbia respectively. In the report, 'Kosovo' is used to represent all the countries of origin.

Recruitment

Local community groups and education colleges known to Lambeth, Southwark and Lewisham Councils as providing services for Albanian-speakers were approached and informed about the study through an introductory letter and follow-up phone call. Co-ordinators who were interested in participating were asked to identify Albanian-speakers who were willing to be interviewed. The co-ordinator arranged the interviews/focus groups with the participants in liaison with the researcher.

It was more difficult to access participants aged mid 20's and over who were not caring for children through this method. A snowball technique was used to identify members of this group but most potential participants were very mistrustful of the motives of the research team, and had other priorities such as not wishing to take time off work. In the event, Albanian-speakers aged mid 20s and over without children were poorly represented in the study.

Consent

Participants were given written (English and Albanian) and verbal information about the aims of the study and an assurance of complete confidentiality and anonymity. Participants were invited to ask any questions regarding the purposes of the study before written consent was obtained.

Interviews and focus groups

The interviews were reflexive, the interviewer (EB) exploring topics raised by the participants who were encouraged to speak freely about their beliefs, attitudes and behaviours in relation to oral health, use of oral health services, and the priority of oral health in relation to other issues both in Kosovo and in the UK. Participants were also asked about their understanding of the aetiology of dental caries and periodontal disease. A topic guide was used to ensure all areas of interest to the researchers were covered. The individual interviews were conducted in English. One focus group (7 mothers aged 20-40 years) was conducted in Albanian. An Albanian-speaker who worked for one of the community groups and was trusted by the participants facilitated the focus group. The other focus group (six men aged 16-19 years) was conducted mainly in English with an Albanian interpreter present. The focus groups were used to explore dominant cultural values and group norms and priorities in relation to oral health, features that are more difficult to obtain in a one-to-one interview.

The interviews and focus groups, which lasted between 45-60 minutes, were conducted in a non-clinical environment to suit the participants, such as a room at a local community centre. They were recorded on audio-tape and subsequently transcribed verbatim. The focus group conducted in Albanian was independently translated by two translators to improve reliability. Participants were reimbursed for any expenses they incurred through taking part in the study such as travel and child care expenses.

Analysis

The transcripts of the interviews and focus groups were analysed independently by both researchers to improve reliability. Preliminary themes were refined through discussion. The themes reflected apriori issues and ques-

tions derived from the objectives of the study as well as issues raised by the respondents themselves (Pope *et al*, 2000). The data were analysed using the constant comparative method, in which each item is checked or compared with the rest of the data to establish analytical categories. Data collection and analysis were concurrent allowing data collection in early interviews to inform sampling and data collection in the later stages of the study. This facilitated the development of theory through analytic induction as theoretical ideas were tested and re-tested using the data (Pope *et al*, 2000). Each community group was invited to respond to a summary of the key findings for respondent validation purposes.

Ethical approval

The project was approved by the King's College Hospital Research Ethics Committee (ref: 04/Q0703/64) and the research governance sponsor was King's College London.

Results

Behavioural change

Participants were aware of changes in four oral health behaviours in the UK: attending the dentist, tooth brushing, the consumption of sweet food and drinks, and smoking.

Attending the dentist

In Kosovo, most participants had only attended the dentist for relief of pain. This was particularly the case for participants from lower social class groups. Reasons given for this pattern of attendance were the prohibitive cost of dental treatment, economic deprivation, difficulties meeting basic needs, a lack of education on oral health issues, and a lack of dentists in some areas:

'*It was a difficult time in my country I should say now…our parents didn't have enough time to think about those things [dental treatment], and the war and everything. So much people they couldn't afford the prices, the rest of it, hmm, you know they are busy and so many families had so many kids so they couldn't afford. This is the main thing actually.' [P3]*

'I think it is more educational than anything else. It's like….at school we didn't have no education about oral education, you know. I'm not saying…my parents, they did whatever they could and they did their best, probably that's all they'd been taught, when they were brought up. The situation was difficult and everything was, you know, much hard for them to do – working all day, 8, 9 hours a day and having lots of children and kind of, it's been hard for them to keep a record of childrens' every state of health.' [P21]

The availability and structure of NHS dental services in the UK, such as free treatment for asylum seekers and a registration system encouraging regular attendance assisted the transition to a new cultural norm of attending the dentist more regularly:

'The children both of them, every month they been for the…to see how is the teeth. Or maybe, they send a letter – can you bring the child just to see how is the teeth. My wife as well.' [P6]

There was evidence that the cultural norm of more regular dental attendance continued after the participants were granted asylum in the UK and had to pay for their dental treatment, although for some participants, the cost of NHS dental care limited the frequency of dental attendance.

Tooth brushing

Some participants stated that they cleaned their teeth more regularly in the UK than when they lived in Kosovo:

'More importance is given to oral hygiene here. To tell you the truth, here I brush my teeth two or three times a day. I noticed brushing them makes me feel good. In my country I didn't have as much time. Here I have more time and I brush them more carefully. The children also brush their teeth regularly.' [Focus Gp 1]

Participants from lower social class backgrounds described a cultural norm in Kosovo of irregular or no tooth brushing:

'*It's hard to have to clean the teeth every day and many people don't do that, you know. For me not every…. sometimes it go two or three days you know I don't clean the teeth' [P22]*

The cultural norm was reinforced by a lack of education about oral health, the prohibitive cost of toothbrushes and toothpaste for some participants, and the low priority of oral health when faced with concerns such as meeting basic needs and civil unrest.

In contrast to most of the other participants, the oldest participant had not started to clean his teeth more regularly since arriving in the UK. He stated that he cleaned his teeth approximately once every two weeks. For him, oral health was a very low priority, in spite of having toothache at the time of interview. He had not settled well in the UK and his life was dominated by concerns about his immigration status and a serious illness. However, in order to manage his illness, he had changed other health behaviours such as stopping drinking alcohol on the advice of his GP. This change of practice reflected his priorities at the time:

'I have very big problems in my life and now I get this [tooth ache]. This is nothing! Nothing is teeth. Much problems I have.' [P1]

Dietary change

For participants who had arrived in the UK in the 1990s, a recurring theme was the increased consumption of sweet foods and drinks in the UK. Whilst some highly desirable 'Western' products such as Coke had been available in Kosovo in the 1990s, they were often too expensive to

buy and were regarded as treats. Children were mainly given water to drink in Kosovo, whilst adults drank water or sweetened hot drinks. One participant described being overwhelmed by the availability and choice of sweet foods and drinks on arrival in the UK:

'At first, so many things I came and taste here. I was so frustrated, not frustrated….I was surprised. I was like wow! you know.' [P23]

Such products are more available in Kosovo now, and the contrast for the youngest participants who had arrived in the UK more recently was not so great.

Some of the older participants continued to prefer more traditional drinks such as sweetened coffee or water throughout the day. In contrast, the younger participants and children of participants all preferred sweet cold drinks in the UK, irrespective of social class. This pattern of consumption is supported by a wider youth culture of consuming such products both in the UK and now in Kosovo. Some of the young Albanian-speaking men were aware of the cariogenicity of sweet drinks, but the potential oral health risks were outweighed by the pleasure of consuming such products. The following exchange from a focus group illustrates this point:

P17: '[My dentist] told me [Coke's] not healthy but I still have it.'

EB: What I want to know is, even though you know Coke is bad for your teeth, and Fanta is bad, why do you drink it?'

P16: 'Because I like the taste.'

P17: For example, smoking – it says so that it kills 2 millions in the world. Why do they smoke? It's because they don't believe it, isn't it.' [Focus gp 2]

Parents with knowledge of the cariogenicity of sweet foods and drinks were concerned about dental caries in their children, and felt that their childrens' diet had been better in Kosovo. Parental efforts to restrict intake of such products were hampered by the opposing influence of ubiquitous sweet foods and drinks in the UK:

'[In Kosovo] desserts were given to children as treats. Here they are tempted to eat sweets more often as they are on display in shop fronts. They are exposed to them more, they are right in front of their eyes and it makes children more disposed to eating sweets. Our children had healthier diets [in Kosovo].' [Focus Gp 1]

Smoking

Changes in smoking patterns were less obvious than for other oral health behaviours. Most of the participants did not smoke and current smokers were all male and came from lower social class groups. Some participants described a culture of smoking in Kosovo, particularly among men:

'In Kosovo, nobody will come to your house if you tell them they can't smoke in the room. It's an Albanian thing…they love it!' [Focus Gp 1]

Participants who had stopped or significantly reduced their smoking in the UK were all university educated. One male participant stated that he had cut down to social smoking for health reasons and two female ex-smokers had stopped smoking for the sake of their childrens' health, and because of the impact of health messages on cigarette packets.

Attitudinal change

Changes in the overall priority of oral health, and the balance between treatment and prevention in oral health priorities were discussed.

The priority of oral health

Most participants felt that the overall priority of oral health was very low on both an individual and a societal basis in Kosovo. The priority of oral health in the UK had increased for most participants, mainly because of the greater availability of dental services. However, some participants described how it was easier to make oral health a higher priority in the UK because of the general improvement in living conditions:

'Maybe everybody's got the basic needs here in this country…I think the stress of living affects people a lot and it make them think about what their priorities are. So that's why the first thing on my thoughts was….probably that's what the reasons was. Putting health second. I mean if you have something that's really stressing you about, you know, you can't think of anything [else].' [P21]

Although the priority of oral health had increased for most participants in the UK, oral health still remained less important than other pressing concerns such as settling in the UK, immigration status, education, gaining employment, English language competence etc.

The balance between treatment and prevention

Oral health priorities in Kosovo were described as predominantly treatment-focused, even for participants from the higher social class groups. There was a degree of shift to a prevention focus for some participants in the UK, particularly mothers caring for young children, but accessing quality treatment remained the higher priority for almost all of the participants. This participant, who had been in the UK for 13 years, was more aware of the treatment-focused oral health priorities of Albanian-speakers than most:

'I think again probably a lot of Albanians would have this intervention rather than prevention…they fix them and don't look after them until they come back next time and fix them again.' [P2]

The eagerness of participants to discuss the quality of dental treatment they had received in the UK rather than prevention issues also reflected this priority. This was particularly evident where participants were not happy with the quality of NHS care they had received. Newly arrived Albanian-speakers' expectations of NHS dentistry had been very high and sometimes unrealistic. Whilst

all the participants had experienced no difficulties in accessing NHS care, most were surprised and frustrated about the lack of availability of cosmetic treatment on the NHS, recently placed restorations failing, a lack of choice, delays in obtaining pain relief, and the length of time taken to complete treatment. Communication difficulties also exacerbated these problems:

The first time I came, probably because I didn't understand properly and the way it is between the communications I think it's frustrating for both of us and it make him nervous and me as well nervous you know…. now its easy because we can speak more English and its more easy for both parts.' [P23]

Where a shift to a prevention focus in oral health priorities was apparent, it was largely the consequence of improvements in oral health knowledge. Mothers caring for young children had better access to oral health knowledge than other participants. Health visitors and agencies such as Sure Start were mentioned often as helpful sources of oral health information rather than dentists. Mothers described how they were encouraged to stop bottle feeding their children after the age of one, and were informed of the role of sweet drinks in the aetiology of caries. Improvements in oral health knowledge enabled participants to have a greater sense of control of their oral health:

'I try to use healthy, like milk and fruits and vegetables and try to avoid those sweetie things and chocolate. My family used to like coca cola but we stopped that now…They have only water during the night. I mean, if they wake up it is only water.' [P3]

Sometimes oral health messages were rather mixed up. For example one participant stated that gum disease was caused by acidic drinks, and another participant thought that apple juice caused caries whereas Ribena did not.

Participants who demonstrated the least shift to a prevention focus were men from the lower social class groups. The older participants in this group had particularly poor oral health knowledge in spite of regular attendance at the dentist. For them, the dentist was the main source of oral health:

'I don't know about the teeth. That's what they do. I think they do their best. I know nothing about the teeth.' [P6]

The same participant did discuss prevention, but only in terms of dentists in the UK opting to save rather than extract teeth and spot dental problems early, rather than the need to adopt healthy oral health behaviours on a day to day basis:

'[In UK] it is more, like, save teeth. You know, for example, if you have so much pain, they take off straight away [dentists in Kosovo would extract tooth]. Here it is more to save the teeth and is asking us maybe every three or four months to come to check the teeth. Here a lot more care. Care more about for our teeth. England.' [P6]

Discussion

This study has taken a different approach to the other acculturation studies in the oral health field. Rather than relating the degree and/or type of acculturation to oral health status and/or knowledge and use of dental services (Marino *et al*, 2001; Cruz *et al*, 2004), the study has explored the processes of oral health acculturation in an immigrant population in order to understand how and why changes in oral health attitudes and behaviours have occurred.

The importance of structural and material factors in explaining oral health acculturation

Health behaviour is negotiated within its social context. Acculturation studies often fail to investigate the social context of the country of origin (Hunt *et al*, 2004). When this information is provided, explanations for changes in behaviour become much more meaningful (e.g. Lipson *et al*, 2003). For many participants in this study, particularly those from lower social class backgrounds, moving to the UK brought about significant improvements in their living conditions and access to oral health products, dental services, and oral health knowledge. Other studies have noted the relationship between acculturation and access to oral health services (e.g. Marino *et al*, 2001; Cruz *et al*, 2004). However, the impact of structural and material factors on oral health acculturation went beyond access to dental services and oral health information in this population to include the positive influence on oral health behaviours and attitudes of having basic needs met and experiencing an improvement in living standards. The evidence from this study suggests that such factors were important in contributing to oral health acculturation in addition to the influence of cultural norms in the UK. The importance of wider material and structural factors in explaining oral health behaviour change in people of other cultures living in the UK can be overlooked by studies that only examine access to services and/or oral health information in terms of explaining change in oral health beliefs, attitudes and behaviours.

The desirability of Western beverages in Kosovo was another important factor in shaping behaviour change, irrespective of social class. The potentially contradictory impact of acculturation for immigrants from low-income countries is well documented (Cruz *et al*, 2004; Lara *et al*, 2005). Better access to oral health products and services can improve oral health, yet the greater availability of cariogenic foods and drinks can be detrimental to oral health, particularly where such products are not readily available in the country of origin but are regarded as highly desirable. Whilst the current study did not measure oral health status, some participants articulated the same contradictory influences on their oral health. The impact of a greater availability of cold sweet drinks appeared to be moderated by age-related cultural norms. The influence of social class, ethnic and age-related cultural norms in shaping the influence of material and structural factors on health behaviour is widely recognised (Bartley, 2004).

Challenges for oral health promotion

An important step in the oral health acculturation process for Albanian-speakers was gaining oral health knowledge. This facilitated some shift in oral health priorities from treatment to prevention. Health visitors and agencies such as Sure Start appeared to be a much better source of oral health information than the dentist, but were generally only accessed by women with children. Better provision of written (in Albanian) and verbal oral health information at the dentist would reach a greater proportion of Albanian-speakers. There is also a need for written (in Albanian) information on the structure of NHS dental services, types of treatment provided, emergency provision, treatment for children etc. to enable Albanian-speakers to have realistic expectations of NHS dental services and benefit from such care.

Improving oral health literacy takes time and skill, particularly where there are communication problems (Gray, 2003). It remains to be seen whether the new NHS dental contract will provide sufficient incentives for the dental team to devote more time and energy to providing information and support for oral health behaviour change. The new Oral Health Assessment care pathway may help to support the provision of more prevention-orientated dental care (Hally & Pitts, 2005).

Many of the current oral health issues for Albanian-speakers are common to the wider society. Unless upstream health promotion campaigns to reduce the availability of sweet foods/drinks and cigarettes and change the consumption of such products are successful, health promotion efforts at an individual or community level will be undermined constantly, particularly where young Albanian-speakers are concerned.

Limitations of the study

The study has provided important information on the processes involved in oral health acculturation for Albanian-speakers in south London. However, the findings should be interpreted with some caution as difficulties in recruiting participants without children meant that the themes were not saturated (Silverman, 2000). Being a mother may be an important acculturation factor. It is likely that mothers access oral health services including health promotion services more often than other members of the Albanian-speaking population.

The study has relied on reported oral health behaviour rather than observation. The participants knew that the interviewer was a dentist, and it is possible that ideal rather than actual behaviours were reported. However, participants often reported behaviours which were detrimental to oral health, even when they knew such behaviours were not ideal, and participants were also critical about oral health services. This adds to the confidence with which the findings can be interpreted. Asking participants to recall life in Kosovo may have introduced recall bias into the findings, given the number of years since their emigration. However, several participants had visited family members in Kosovo recently which made them more aware of how their lives had changed.

Caution should be exercised in generalising the findings to the wider Albanian-speaking community in the UK, particularly where age, gender or social class differences in oral health behaviour, attitudes, and experiences have been suggested. The study is qualitative and therefore generates explanations and hypotheses rather than testing them (Silverman, 2000).

Further research

Further research is required to test the hypothesized relationship between oral health acculturation and structural/material changes in daily living, such as having basic needs met or greater access to sweet drinks. Testing the hypothesized relationship between improvements in oral health knowledge and the priority given to oral health prevention would be useful from a health promotion perspective, particularly if the findings are linked to oral health behaviour changes and clinical outcomes. Measuring the impact of general acculturation on the oral health status, oral health knowledge and dental attendance of a much larger sample of Albanian-speakers would be helpful for further elaborating the mechanisms by which acculturation impacts on oral health status. Widening the research focus to other Eastern European groups would also be useful for understanding cross-cultural norms, values, beliefs etc. relating to oral health and use of services.

The low priority of oral health for some Albanian-speakers and attitudes of mistrust are potential barriers to both further research and health promotion activities at a community level. Some participants viewed themselves as individuals rather than members of an Albanian-speaking community in London. The consequent lack of 'community' may be a barrier to generating research interest from within the population of Albanian-speakers in London (Hanley *et al*, 2004).

Conclusions

Exploring differences in social context between country of origin and host country may be crucial for understanding the processes of oral health acculturation in immigrant populations. In particular, material and structural changes which impact on oral health behaviours may be overlooked. For Albanian-speakers in this study, such factors were important in contributing to oral health acculturation in addition to the influence of cultural norms in the UK. Improving oral health knowledge can facilitate a shift in oral health priorities from treatment to prevention. However, unhealthy choices may persist due to the impact of wider cultural norms.

Acknowledgements

The authors are particularly grateful to Albanian Youth Action for supporting the study, assisting in the recruitment of participants, and providing interpreting services.

The authors are also grateful to Aylesbury Sure Start and Southwark Day Centre for Asylum Seekers for helping to recruit participants. The study was funded by the Department of Oral Health Services Research & Dental Public Health, GKT Dental Institute, London.

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