**Table2- Main characteristics of the included studies**

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| **Author** | **year** | **Study topic** | **Study design** | **Key Determinants of provision and utilization challenges** |
| Amarasena  [21] | 2015 | frequency of poor oral health according to Sociodemographic, behavioural, and psychological distress factors | Quantitative | * Frequency of poor OH was 73.7 %. * Associated with high levels of psychological distress, being older, being female, and visiting a dentist because of a problem |
| Amarasena  [22] | 2014 | oral health behaviours and perceptions | Quantitative | * A higher proportion of Indigenous Australians living in Darwin presented with non-optimal oral health behaviours and perceptions compared with both the Darwin and Australian general populations. |
| Butten  [12] | 2020 | experiences and perceptions of oral health from the perspective of urban, Aboriginal women | Qualitative | * Women face a number of barriers, including a lack of information and the costs of accessing dental care. * The teenage years and pregnancy were reported as important time periods for oral health support |
| Butten  [23] | 2019 | the impact of child oral health on families | Qualitative | * Oral health is an important issue for urban Indigenous families and maintaining oral health to a desired standard * financial concerns, worry about the future and juggling multiple priorities, all of which were inter-related and cyclical. |
| Campbell  [24] | 2015 | oral health care experiences and activities of Aboriginal Community Controlled Health Services (ACCHSs) | Mixed-method | * NSW ACCHSs are under-acknowledged providers of a range of oral health services to Aboriginal communities. |
| Dimitropoulos  [25] | 2018 | The oral health knowledge and attitudes towards oral health of parents/guardians and the perceived barriers and enablers towards oral health promotion for school children | Quantitative | * lack of toothbrush ownership, minimal fluoride toothpaste use, limited daily tooth brushing, frequent consumption of sugary foods and soft drinks. * Parents/guardians had limited oral health knowledge |
| Durey  [10] | 2016 | the social context of oral and general health inequalities for Aboriginal Australians | Critical review | * Oral health is constrained by challenges beyond their control as individuals, including accessing dental services. * Competing demands on limited budgets often led to oral health dropping off the radar unless there was an emergency. |
| Durey  [26] | 2017 | perceptions and experiences of Aboriginal parents of young children, mainly mothers, as they relate to the oral health | Qualitative | * oral health is compromised by structural factors, including policy and organizational practices that adversely preclude participants from making optimal oral health choices: limited education about prevention, prohibitive cost of services, intensive marketing of sugary products, and discrimination from health providers resulting in reluctance to attend services. |
| Ehsani  [27] | 2007 | Feasibility and costs of water fluoridation | Quantitative | * Effective management systems, including policy and funding responsibility is necessary * Reliable manufacturers and suppliers of equipment should be identified and contractual agreements should provide for ongoing technical assistance. * Water fluoridation units should be considered as a potential priority component of health-related infrastructure. |
| Green  [28] | 2010 | Etiologic of poor oral health amongst Aboriginal people in Australia | discussion paper | * The most effective interventions centre on water fluoridation and brushing education utilizing fluoride toothpaste that need adequate funding |
| Irving  [7] | 2017 | Oral health knowledge, attitudes and behaviour, accessibility of oral health services | Quantitative | * All participants agreed that healthy teeth were important. * Many thought oral disease leading to extraction was normal. |
| Jones  [29] | 2016 | self- reported factors contributing to Indigenous Australians' attendance and non-attendance at South Australian public dental clinics | Qualitative | * Barriers include: Low self-efficacy, Low Health literacy, Fear of mistrust   Language barriers, Transport problems |
| Parker  [9] | 2010 | Associations between oral health literacy and oral health outcomes | Quantitative | * Oral health literacy was risk indicator for poor self-reported oral health outcomes. |
| Patel  [30] | 2017 | Oral health interventions in Australian Aboriginal communities | Review | * Interventions include programs that aimed to reduce early childhood caries, increase services to remote communities, develop the role of Aboriginal health workers, improve oral health literacy, establish water fluoridation and provide periodontal therapy. * Implementing successful oral health interventions in Aboriginal communities is a challenge that is compounded by the complex interplay between psychosocial and cultural determinants. |
| Schluter  [31] | 2017 | Self-reported oral health behaviours, and impact. | Quantitative | * Cost is likely to be a significant barrier. * Availability and access to culturally appropriate services is likely to be a significant contributor. * Integration of the health care system, with dental services co‐located on‐site with other primary health services is seen as ideal. |
| Slater  [32] | 2001 | Pattern of access to public oral health care by indigenous status | Quantitative | * Indigenous people were more likely to attend dental clinics when a problem with pain existed, resulting in a high need for emergency services, more diagnoses of dental caries, and treatment more often involving oral surgery. |
| Smith  [33] | 2007 | Oral health in rural and remote Western Australian Indigenous communities | Quantitative | * Aboriginal oral health, both as stand-alone, and as part of a multifactorial risk factor approach where oral health is integral to general health activities |
| Tynan  [8] | 2020 | Perceived importance of oral health within a rural Aboriginal | Qualitative | * the perceived severity of symptoms of oral disease such as pain experienced due to tooth ache; lack of enabling resources such as access to finance and transport; the social impact of oral disease on individuals including impact on their personal appearance and self-esteem; and health beliefs including oral health awareness. |
| Jamieson  [34] | 2014 | Association between elf-efficacy and self-rated oral health | Quantitative | * Low self-efficacy persisted as a risk indicator for poor self-rated oral health after adjusting for confounding among pregnant aboriginal Australian women. |
| Jones  [35] | 2014 | Access, literacy and behavioural correlates of poor self-rated  oral health | Quantitative | * being aged 38+ years, holding a Government Health Concession card, avoiding the dentist due to financial constraints, not knowing how to make an emergency dental visit, and poor understanding of the prevention of dental disease |
| Parker  [36] | 2012 | Oral health needs of aboriginal children | Qualitative | * Difficulty contacting patients. * High rate of failure to attend appointments. * Attendance patterns. * Consent issues. * Difficulty communicating with parents and guardians. |
| Williams  [37] | 2011 | Barriers to good oral health among Indigenous people | Review | * Geographic barriers in accessing oral health services. One of these barriers includes having to travel long distances. * Diet. * Water fluoridation. * Living conditions. * Oral hygiene. * Costly oral health services |
| Jamieson  [38] | 2006 | role of location in Indigenous and non‐Indigenous child oral health | Quantitative | * Living in a rural location exhibited the strongest Association with poor oral health outcomes for young Indigenous children |
| Kruger  [39] | 2008 | assessing the oral health status and needs in an adult residents sample selected from the towns and remote communities among the Kimberley region of North-west Australia | Quantitative | * Dental history and previous dental health status * Poor status of oral health and high treatment needs in rural and remote Indigenous communities * Poorer oral health status of oral health of rural dwellers than that of urban dwellers |