Making Mouths Matter

An Investigation into Anti-Indigenous Racism and its Impacts in the Oral Healthcare of Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse People in Canada

NATIVE WOMEN'S ASSOCIATION OF CANADA

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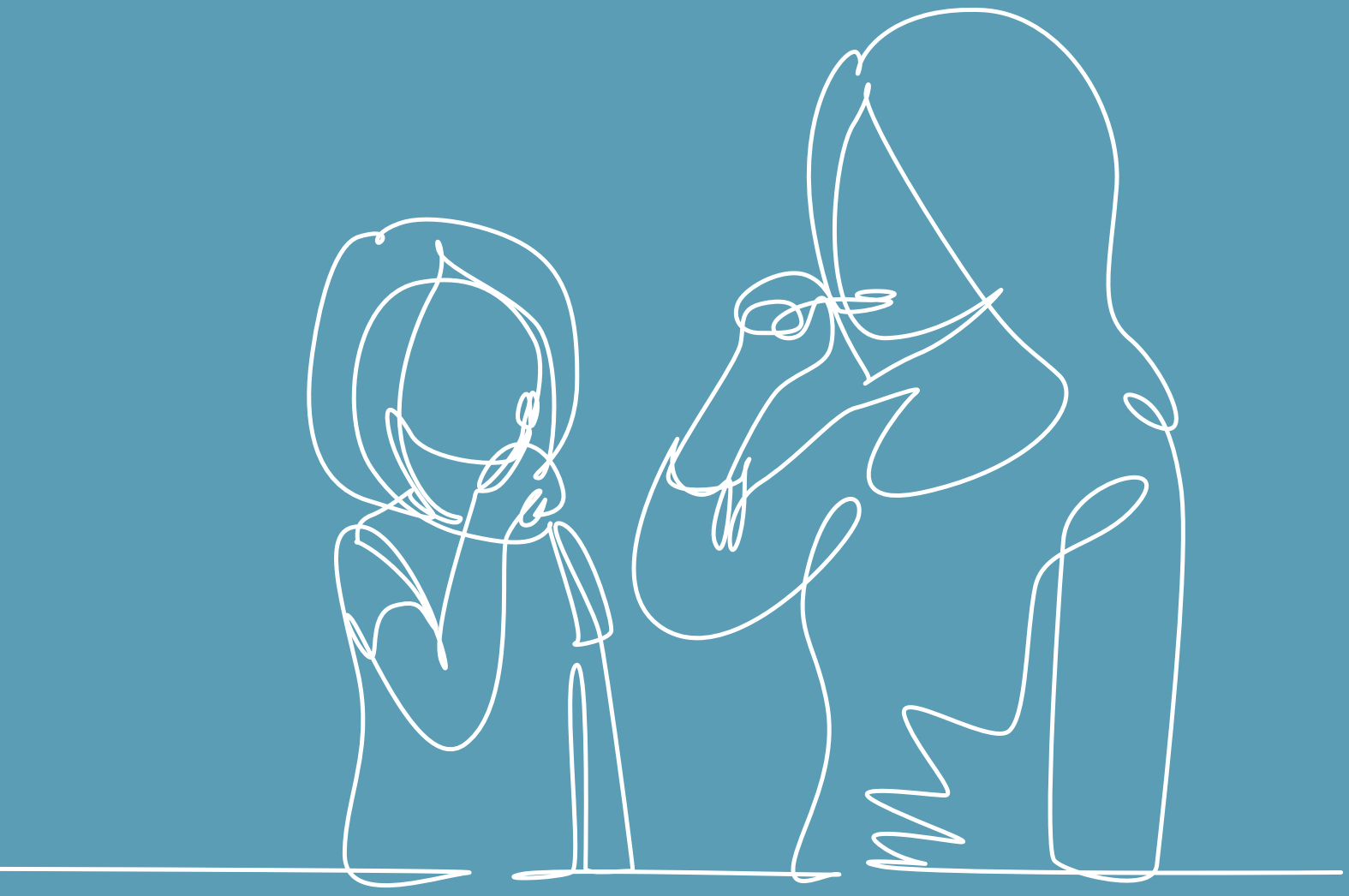

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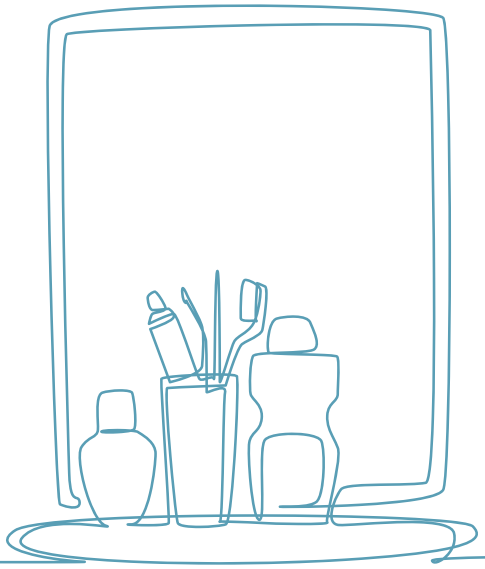
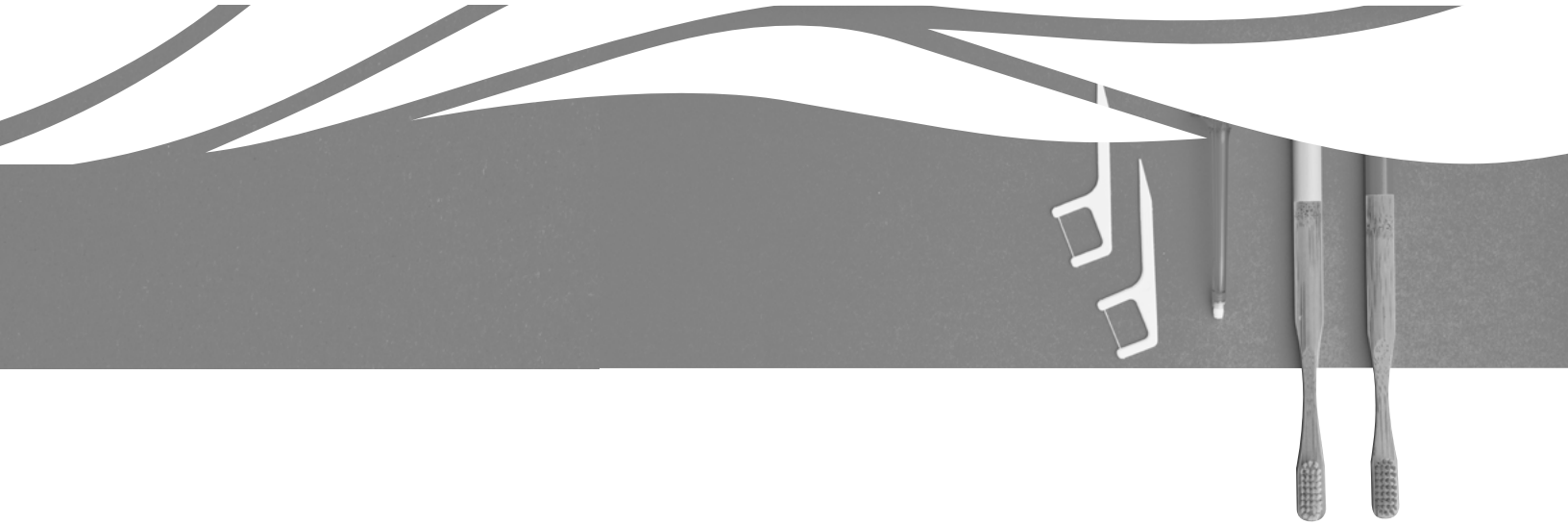




I: BACKGROUND

Anti-Indigenous racism (AIR) can be defined as "the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples within Canada" through the "ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers, and inequitable outcomes that stem from the legacy of colonial policies and practices" (Government of Ontario, 2022). Overall, AIR significantly impacts healthcare, with Indigenous Peoples experiencing the poorest healthcare services and a paucity of resources.

Oral healthcare is only one example of how AIR contributes to all aspects of healthcare for Indigenous communities. Indeed, few practical recommendations exist that would address the numerous ways that Indigenous Peoples across Turtle Island and Inuit Nunangat experience AIR in oral healthcare.

Despite this, much is known by Indigenous Communities about the realities of AIR and oral healthcare, including the strategies of resilience that Indigenous individuals have are employed to protect themselves from racism while patients are in the dentist's chair. AIR in oral healthcare is a reality across Canada, and previous research demonstrates the importance of community collaboration (Bhagdadi, 2016), the connection between overall poor health and poor oral health (Leck & Randall, 2017), and the severely increased risk of poor oral health among Indigenous Children (Macnab et al., 2008; Leck & Randall, 2017; Martin et al., 2018), especially those living on reserve (Lawrence et al., 2009) or in remote locations.

According to the Canadian Dental Association, 80% of people in Canada have a dentist, and 75% of those individuals were able to access a dentist at least once in 2010 (2017). However, First Nations, Inuit, and Métis Children are far more likely to experience early childhood oral healthcare concerns, which can be linked to underlying social

determinants of health (Pierce et al., 2019). In 2010, a study of four-year-olds living in the Sioux Lookout Zone found that the number of decayed, missing, and filled teeth was 11.9 for Indigenous Children compared to 5.9 for off-reserve children living in the Thunder Bay District (Lawrence et al., 2009). Various studies have found that Inuit children are 50% to 97% more likely to suffer from poor oral healthcare, including tooth decay and dental caries (Pacey et al., 2010). Studies have noted a lack of access to proper nutrition (Martin et al., 2018) and over access to sugar diets (Kyoon-Achan et al., 2021), lack of access to fluoridated water (Bhagdadi, 2016), lack of access to dentists (Martin et al., 2018), and general lack of oral health services (Mejia et al., 2010) are all barriers to proper oral health for Indigenous Communities. However, even when resources are available, many Indigenous Peoples experience forms of AIR when accessing oral healthcare (Lawrence et al., 2016). In a 2021 study, 18.5% of Indigenous Participants self-identified as having poor oral health—7% higher than the general population, who self-reported at 11.5% (Hussain et al., 2021). Results from the First Nations Oral Health Survey in 2012 found that 46.8% of First Nations Participants over 40 years of age had not been to the dentist in the last year (Canadian Dental Association, 2012).

Poor oral healthcare can be directly linked to other forms of overall poor health (Leck & Randall, 2017). Given the "higher rates of diabetes, cardiovascular disease, chronic respiratory diseases, musculoskeletal conditions, cancer, severe mental illness, HIV/AIDS and many other diseases" among Indigenous Peoples (Lawrence 2010, 230), not surprisingly, oral healthcare can be even more precarious.

As shown by the contributors to the research presented in this paper, there is a direct connection between oral healthcare and overall healthcare. For this reason, addressing oral healthcare is essential to ensuring the overall healthcare of Indigenous Peoples and strengthening trust and respect between Indigenous Communities and healthcare providers in general. Those who self-identify as having poorer oral health are more likely to make emergency visits to the dentist and are more "likely to be uncomfortable eating foods, avoiding particular foods, having persistent pain in their mouth, bleeding gums and bad breath" (Hussain et al. 2021, p. 433). Not only do Indigenous Communities and Individuals fear the dentist, but they also fear the same systemic and institutional racism in the healthcare setting by their doctors (NWAC, 2022).

To address oral healthcare for Indigenous Communities is to demonstrate an act of truth and reconciliation. This research attributes and addresses the following critical Calls to Action presented by the Truth and Reconciliation Commission of Canada:

Section 4.1: Ensure Indigenous Peoples have services and infrastructures to meet social and economic needs.

Section 4.4: Provide support and resources for educational and employment opportunities for Indigenous WG2STGD+ People.

Section 7.3: Support Indigenous-led preventative initiatives.

Section 18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the healthcare rights of Aboriginal People as identified in international law, constitutional law, and under the Treaties.

Section 19. We call upon the federal government, in consultation with Aboriginal Peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

Section 20. In order to address the jurisdictional disputes concerning Aboriginal People who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal Peoples.

Section 23. We call upon all levels of government to:

1. Increase the number of Aboriginal professionals working in the healthcare field.
2. Ensure the retention of Aboriginal healthcare providers in Aboriginal communities.
3. Provide cultural competency training for all healthcare professionals

This research on oral healthcare for Indigenous communities also speaks to the following Calls to Action issued by NWAC:

- Continue ongoing health, policy, research, training, and programs to support Indigenous-led health initiatives.
- Advocate for mandatory university courses on Indigenous women and MMIWG based on the student and youth engagement guide *Their Voices Will Guide Us.*
    - This is done through requesting cultural training on an education level, including during college courses and initial dental education.

AIR and healthcare have been directly connected by NWAC (2022). However, the experiences of Indigenous WG2STGD People continue to be under-investigated regarding oral healthcare. While Indigenous Women tend to access oral healthcare more often than their male counterparts (Shrivastava et al., 2019), the intersections between gender and Indigenous identity are nuanced for WG2STGD People. This is because accessing oral healthcare can be more troublesome for some Indigenous People, including those who are pregnant (Kong et al., 2019), as there are fewer programs to assist with oral healthcare for this collective (Shrivastava et al., 2020).

PURPOSE OF STUDY

Indigenous Peoples in Canada have overall poorer oral health than non-Indigenous people. In a recent study, 18.5% of Indigenous Contributors self-rated oral health as poorer compared to 11.5% of the general population (Hussain et al., 2021). This is, in part, due to existing barriers to accessing oral healthcare (access, safety, availability, education), as well as a lack of metrics or strategies available to improve the current First Nations and Inuit oral health program (Office of the Auditor General, 2017; Kyoon-Achan et al., 2021; First Nations Health Authority, 2014). While there is a lack of metrics or strategy on efficacy, there are recommendations that have yet to be implemented, one of which includes increased access to culturally safe and culturally adapted oral healthcare (Hussain, James and Crizzle, 2021; Ashworth, 2018; Mueller, 2019).

This research project sought to engage Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse (WG2STGD) People on experiences of oral healthcare to learn about shortcomings, accessibility, and service needs, as well as experiences of racism and discrimination when accessing care. In so doing, this research offers solutions and

recommendations to counteract problems or barriers, provides possible metrics for measurement The goal of this research was to reach those most impacted to understand gaps and barriers to accessing oral health care and provide tangible solutions for further action. Thus, this research could be viewed as a jump-off point to developing and implementing more comprehensive strategies in order to achieve equity in oral healthcare for Indigenous WG2STGD People.

AIMS AND GOALS

This research project aims to:

- demonstrate how to incorporate distinctions-based approaches when addressing the oral healthcare needs of Indigenous WG2STGD Communities
- explore how Traditional Knowledge and Teachings can be incorporated into community-based oral healthcare programs
- provide a better understanding of the needs of on- and off-reserve and urban and rural Indigenous WG2STGD People and what oral healthcare services, resources, and programs are desired
- determine how oral healthcare providers can engage in better practices and access the training and resources needed to provide culturally relevant oral healthcare to Indigenous WG2STGD People

II: METHODOLOGY

This research project utilized a series of meaningful and informed approaches in all aspects of the process. These methods include but are not limited to a culturally relevant gender-based analysis plus free, prior, informed consent model, intersectionality, trauma-informed care, and thematic analysis. Each method was used as a tool for bettering research practices and is essential in the work done with NWAC. Such methods demonstrate a dedication to Truth and Reconciliation, person-first, and culturally considerate practices.

While these methods were used throughout the research process, thematic analysis was the methodological tool used to analyze the data. Thematic analysis was used based on its flexible nature and ability to find key data trends, themes, and patterns. The research team had engaged in a literature review before beginning the analysis, and therefore, some themes were already selected employing deductive and inductive strategies. Thematic analysis was also chosen since the process is commonly used in data collection and can be employed in future research with this project.

CULTURALLY RELEVANT GENDER-BASED ANALYSIS PLUS (CRGBA+)

Until 2011, when NWAC recommended the CRGBA+ framework, many tools have not done proper justice to the complex intricacies of settler-colonialism and its implications on Indigenous WG2STGD People (Sanchez-Pimienta et al., 2021). An Indigenous gender-based analysis recognizes "the patriarchal histories, structures, and social norms imported from Europe that have been imposed on Indigenous communities since contact, which have had devastating consequences for their governance, community and family relations, with direct impacts on health and wellness" while also understanding "the specific cultural, geographical, historical, and spiritual contexts and strengths of diverse Indigenous communities that have survived and resisted the imposition of patriarchal worldviews" (Sanchez-Pimienta et al. 2021, p. 11575).

NWAC's distinctions-based gender-based analysis recognizes the uniqueness of Métis, First Nations, and Inuit Peoples, notes their shared experiences of AIR in Canada, and recognizes the impacts and experiences "before colonization, early colonization and attempted assimilation, current social and political realities, and strategies and responses looking into the future" (Sanchez-Pimienta et al. 2021, p. 11577). CRGBA incorporates a reflective lens that signifies the importance of settler-colonialism in the current experiences of AIR in healthcare.

A CRGBA+ framework provides a critical structure to ensure that investigations into oral healthcare and oral healthcare research consider the settler-colonialist events and legacies that have impacted the oral healthcare of Indigenous Peoples. More specifically, this framework notes how gender is central and considers how Indigenous WG2STGD People experience elevated rates of colonial violence and vulnerability, especially in healthcare settings. A CRGBA+ framework ensures space for the importance of how intersecting forms of AIR and gender can collectively manifest.

FREE, PRIOR, INFORMED CONSENT (FPIC)

As per the guidance of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), this research strived to include a free, prior informed consent (FPIC) model. FPIC is a process that centres on self-determination among Indigenous Peoples. It provides them with the space to "give or withhold consent to a research that may affect them or their territories," to "conduct their own independent and collective discussions and decision-making" in an environment that is culturally safe, and to "discuss in their own language, and in a culturally appropriate way, on matters affecting their rights, lands, natural resources, territories, livelihoods, knowledge, social fabric, traditions, governance systems, and culture or heritage (tangible and intangible)" (Food and Agriculture Organization of the United Nations, 2016, p. 13).

The FPIC process was crucial for this research project. Contributors were provided with a consent letter (Appendix B) before taking part in a Sharing Circle. All of them were informed about the topics being discussed in the Sharing Circles and were given the choice to disclose or share information. For the survey, contributors were asked why a difficult question was being asked (for example, a disclaimer indicating the relevance of the question was provided for the question on experiences in the foster care system). This approach meant that all contributors could determine for themselves if were comfortable discussing or answering sensitive questions.

Moreover, the researchers involved in the project self-identified. Thus, anyone who did not wish to participate because a non-Indigenous person was involved could excuse themselves from contributing. Given the corrupt and exploitative nature of non-Indigenous researchers' experiences with Indigenous communities, the reasons for not agreeing to participate were valid.

INTERSECTIONALITY

An Intersectional approach was also applied to program development. Originally coined in 1991, Kimberlé Crenshaw now defines intersectionality as "a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other," highlighting that "what is often missing is how some people are subject to all of these, and the experience is not just the sum of its parts" (Crenshaw, quoted in Steinmetz, 2018). Intersectional thinking recognizes the unique lived experience of each Indigenous person, noting their perspective based on such factors as gender, economic status, and geographic location. For Audre Lord (2018), "there is no such thing as a single-issue struggle because we do not live single-issue lives" (p. 138). Using intersectionality allows for an exploration of hetero-patriarchy and settler-colonialism and contributes to a strong correlation between race- and gender-based violence (Tuck & Yang, 2016). This can be revealed through unhealthy family and parenting practices, including abuse and neglect among Indigenous WG2STGD People (Parsloe & Campbell, 2021). Intersectional thinking in research means exploring how factors such as income, geographic location, language, and gender contribute to Indigenous WG2STGD People's experiences in navigating the oral healthcare system.

TRAUMA-INFORMED APPROACHES

NWAC defines trauma as "a single event that occurred either recently, in the past, or a long-term and chronic experience" (NWAC, 2022). Therefore, trauma-informed care (TIC) "is a strengths-based framework that is grounded in an understanding of and responsiveness

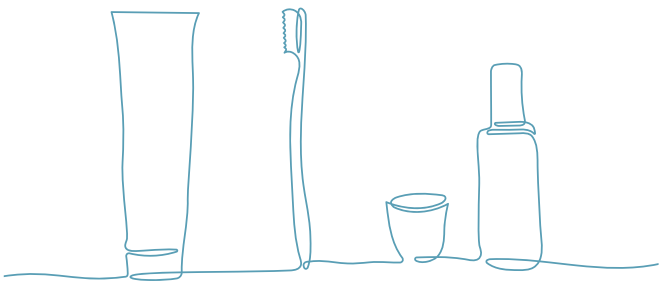
to the impact of trauma" and that seeks to "emphasize physical, psychological, and emotional safety for both providers and survivors, and create opportunities for survivors to rebuild a sense of control and empowerment" (Center for Health Strategies, 2006). TIC should also "aim at ensuring environments and services are welcoming and engaging for service recipients and staff" (Trauma Informed Oregon, 2016).

According to the Center for Health Strategies, the following 10 steps are required for TIC: lead and communicate; engage clients in planning; train all staff; create a safe environment; prevent secondary trauma; build an informed workforce; involve clients in treatment; screen for trauma; use trauma-specific treatment; and engage partners (Center for Health Strategies, n.d.).

TIC was incorporated into this research through Section II's dedication to teaching how AIR occurs during the education, training, and practice stages. TIC is a crucial tool that all healthcare providers require if they are to provide the most kind, informed, and considerate care to Indigenous Peoples. Applying these criteria to Indigenous care and support means allowing Indigenous people to speak for themselves and placing them at the centre as experts on their own needs. It also means acknowledging how intergenerational trauma or traumatic experiences influence the health and well-being of Indigenous Peoples and ensuring that individuals seeking support are not re-traumatized.

Trauma-Informed approaches and free, prior, informed consent were used in tandem. The research team sought to engage in practices acknowledging that all those who chose to participate in the Sharing Circles would come with their own lived experience. This meant that certain topics were more challenging. Those who experience forms of intergenerational trauma and are survivors of the residential school system, Sixties Scoop, and other colonialist events will have different responses which may require increased acknowledgment.

Trauma-informed approaches also make it possible for the researchers themselves to reflect on their own 'position' in the research and to consider how Indigenous experts and contributors will feel about being asked about their lived experiences. What does the researcher gain from this research? Why is it important? How will it improve the services and resources of a community?



III: METHODOLOGICAL TOOLS

In this research, qualitative and quantitative methodologies were employed. Qualitative data was collected using surveys and Sharing Circles, and quantitative data was collected from the surveys. To gain demographic, qualitative, and quantitative data for this research, the research team created two surveys. One survey addressed oral healthcare professionals' needs and resources, knowledge, and educational requirements. The second survey was intended for Sharing Circle contributors to provide information about their oral health history and demographic information. It was also useful for gaining insight before holding the Sharing Circles.

SURVEY FOR ORAL HEALTHCARE PRACTITIONERS

A survey was developed to target oral healthcare practitioners in Canada to gauge their understanding of Indigenous history and contemporary issues and ascertain if they are using any Indigenous Methods or Traditional Medicine and Teachings. Oral healthcare practitioners and staff were also given an opportunity to identify if they are Indigenous, have Indigenous staff members, or if they work on a reserve. We also used the survey to determine how many oral healthcare practitioners are servicing Indigenous communities and how many Indigenous People are working in oral healthcare (at a glance).

The oral healthcare survey was available from January 30 to February 22, 2023. Eligibility included anyone who was a member or was training to become an oral healthcare professional, including dentists, dental hygienists, oral surgeons, orthodontists, and members of their administrative team. The survey contained 20 questions. As an incentive, the first 40 contributors were provided with a $50 gift card to NWAC's Artisanelle gift shop.

SURVEY FOR SHARING CIRCLE MEMBERS

A survey was developed for individuals who wished to participate in Sharing Circles on oral health. Our goal was to gather key demographic information on those who shared their experiences in the Sharing Circles. Providing this type of quantitative data alongside qualitative data helped researchers better understand the gaps in services. The data also provided critical insight into the needs of Indigenous communities. All individuals who signed up for the Sharing Circles were asked to complete the survey before coming to the Sharing Circle. The exception was individuals in Rankin Inlet, NU, who did not speak English as their first language, where an interpreter was present during the Sharing Circles.

IN-PERSON SHARING CIRCLES

Sharing Circles took place in person at the following locations: Vancouver, Winnipeg, Happy Valley Goose Bay, and Rankin Inlet. The in-person Sharing Circles allowed individuals to come together. This was critical as many of the participants were older individuals, did not have access to reliable internet, and did not speak English as their first language.

Indigenous Peoples cherish in-person contact and interactions. Being in person for some of the sessions helped to establish a connection with communities and participants that is not possible with virtual sessions. The in-person sessions provided more space for empathy and kindness and made it possible for the research team to provide assistance.

In-person Sharing Circles lasted approximately one to two hours. Individuals were told about the research, the aims, the goals, and the desired outcome. The facilitator addressed the Sharing Circle questions using a semi-structured format. Based on the number of contributors, only one Sharing Circle was audio recorded (Rankin Inlet, NU). However, notes were taken during all Sharing Circles.

VIRTUAL SHARING CIRCLES

Virtual Sharing Circles were hosted for Ontario/Alberta, Quebec, and Northwest Territories. Sharing Circles lasted one hour and were facilitated by the primary research team. An Indigenous Elder provided emotional and spiritual support. Individuals were told about the research, the aims, the goals, and the desired outcome. The facilitator used a semi-structured format when posing the questions to Sharing Circle participants. As the sessions were not audio-recorded, the researcher took notes.

Virtual Sharing Circles made it possible for those unable to come to in-person Sharing Circles, including those living in remote areas, to contribute.

V: ETHICAL CONSIDERATIONS

This research did not require ethics board approval. However, the research team is dedicated to employing a trauma-informed, culturally relevant, and consent-based model, where contributors were to provide their consent for each research process or stage. After completing the survey, contributors were given information on the intent, goals, and potentially distressing aspects of the research project. All questions, except for one, could be skipped; the rest provided an option for answering either "prefer not to say" or "unsure."

Before the start of each Sharing Circle, contributors were given a consent form (Appendix B). The consent form had information about the research, including research goals, funding, and potentially distressing content. It also provided contact information for NWAC's Grandmothers. The consent form identified the heritage of the principal researcher, facilitator, and guest facilitator as well.

IV: RESULTS

A total of three in-person, five virtual Sharing Circles, and two sets of survey data were included in the analysis. NWAC researchers facilitated three in-person Sharing Circles, which took place in Vancouver, BC, Happy Valley-Goose Bay, NL, and Rankin Inlet, NU. An additional in-person Sharing Circle was held in Winnipeg, MB, and was facilitated by Manitoba Moon Voices Inc, a NWAC provincial membership association.

The virtual Sharing Circles reached Indigenous W2STGD People in Ontario, Alberta, British Columbia, Northwest Territories, and Quebec.

ORAL HEALTHCARE PRACTITIONERS RESULTS

Our survey sample goal was 40. A total of 94 surveys were included in the data set. Of the 94 survey respondents, 86 are practicing oral healthcare professionals in Canada and 13 are oral healthcare students. Of the collective, 67 identified as non-Indigenous, and 22 respondents as Indigenous. Twenty-five respondents currently had an Indigenous Person working in their facility, 51 did not, 15 needed clarifications, and three did not wish to disclose. Of these respondents, 71 mentioned having Indigenous patients, and 40 provided oral health care to Indigenous Patients living on a reserve. Of these respondents, only 25 and traveled to provide care.

Regarding the oral healthcare of Indigenous Patients, respondents noted that 60 could provide the best possible care to Indigenous patients. However, 66 respondents mentioned they are not promoting Indigenous oral healthcare or are unsure if they are promoting it. Only eight respondents mentioned incorporating Indigenous Teachings and Traditions into their office space and healthcare practice. When asked if there were ways, they wanted to

make their space more welcoming to Indigenous patients, 58 respondents said no or are unsure. Of the respondents, 65 felt they had never treated Indigenous Patients differently, 15 are unsure, and 14 said they had.

In this last group, respondents said they are ill-prepared to work with Indigenous Patients based on their lack of culturally relevant training. They also said they were given first-hand knowledge about previous experiences Indigenous people had with former oral healthcare providers and that they were unable to get the coverage they need for proper oral health. One oral healthcare practitioner stated:

> **"I provided care on reserves when I was unequipped to understand the patients I was treating. This may have been reflective of the colonialist attitude of the sponsoring organization, to send Southerners without any cultural competence to reserves, but it was also my responsibility to prepare myself better and reflect afterward about how it really went."** *Respondent 68*

Another stated:

> **"I feel very sorry for the children that are in care, and also the ones being brought up by kukums and mushums [grandmother and grandfathers] because they are scared of dentists from residential schools. They have dentures and oral hygiene is not important unless it hurts."** *Respondent 19*

Finally, a third noted:

> **"Speaking about myself I've seen many terrifying things happening to my schoolmates including myself at the hands of dentists that were sent to the reservation to help us with our dental services."** *Respondent 16*

One of the survey's findings demonstrated that while 38 respondents felt they were provided with enough training and education about Indigenous oral healthcare, 53 felt they did not or were unsure if they had.

Recommendations from oral healthcare professionals included:

- providing additional training that addressed AIR.
- receiving teachings about the specific needs of Indigenous communities when it comes to their oral health.
- providing additional time to have with Indigenous patients.
- finding accessible ways for Indigenous Peoples to be able to access proper oral healthcare more regularly and with confidence.

PROFESSIONAL RESPONDENTS BASED ON OCCUPATION

Dentist	53
Dental student	5
Orthodontist	3
Orthodontist student	2
Oral surgeon	6
Oral surgery student	1
Dental hygienist	3
Dental hygienic student	1
Reception worker	3
School for oral health reception	4
Other	18

PRE-SHARING CIRCLE RESULTS

A total of 29 contributors completed the online survey. Twenty-seven contributors identified as Indigenous Women and six as Two-Spirit (more than one option was available for identifying). Twenty-five participants identified as First Nations Persons and four as Inuit Persons. Ages ranged from 26 to 79 years of age. Nineteen contributors lived in Manitoba, one in British Columbia, one in Alberta, one in Nova Scotia, one in Nunavut, one in Quebec, one in Newfoundland and Labrador, and four in Ontario. Of the 28 contributors, three grew up on-reserve, seven grew up on- and off-reserve, and 16 grew up off-reserve. Of these contributors, 15 were never placed in the foster care system, 13 were in the foster care system for various lengths of time, and one contributor did not wish to disclose. This question aimed to determine connections between the foster care system and oral healthcare for Indigenous Children and Adolescents. Most contributors noted being raised by a parent, sibling, family member, or community member.

When asked about their current oral health status, 20 contributors reported "great," 32 reported "good," 24 noted "neutral, 10 said "poor," and two said "very poor." One of the most notable trends concerns oral health as a child versus as an adult. The number of contributors who noted having "great" oral health doubled from childhood to adulthood and the number of those experiencing poor oral health decreased. This improvement in oral health since childhood could be attributed to themes found in the Sharing Circle results, including childhood education about oral health. Nineteen contributors mentioned having gone to the dentist in the last year.

Only eight contributors noted having felt they had been treated poorly by dental office staff, 36 had neutral feelings, and 42 contributors claimed good or great treatment. Regarding treatment from their dentists, only four contributors felt they had been poorly treated by their dentist, 24 were neutral, 48 said they received good treatment, and 10 claimed they received great treatment.

Of the 29 respondents who answered, 20 mentioned having dentists or specialists they see regularly. Previous issues resulting in teeth extraction included cavities, chipped or cracked teeth, tooth decay, recurring mouth sores, and wisdom teeth removal. Over 19 contributors have had teeth pulled, 23 have fillings, nine have crowns, two had braces, and 20 have cracked or chipped teeth. One contributor noted having seven teeth extracted, which correlated with the 18 contributors who noted having an infection due to poor oral health, six of whom required a hospital to treat their issues.

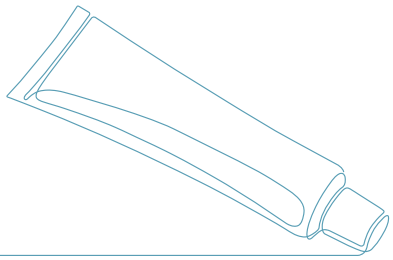
In terms of AIR, 49 contributors felt they would be treated poorly or neutrally based on their Indigenous Identity and 30 contributors felt they would be treated well or great. In the past year, only one contributor noted being denied oral health care due to being an Indigenous Person and one contributor in the past couple of years was denied.

However, when seeking out healthcare, contributors noted feeling suicidal, not being provided with painkillers, being in pain during procedures with no relief, experiencing rude and hurtful looks and comments, and being lied to about their oral healthcare needs. Some of the comments from contributors included:

> "They didn''t properly place my filling. Other dentist was dropping things in my mouth. Another was giving me mean looks." *Contributor 5*

> "Yes, I have very serious dental phobia and pain and anxiety at dentist so I don't go often." Contributor 9

> "I had an asthma attack while the impression of my dentures was being done. The dental hygienist brought up a concern about the impression and the dentist said 'that doesn't matter'. My denture never fit proper. My own teeth were ground down to make the denture fit. It caused cavities."
>
> Contributor 6



TRENDS OF ORAL HEALTH OVER CONTRIBUTOR LIFETIMES (TOTAL)

STATE OF ORAL HEALTHCARE	CURRENT OVERALL ORAL HEALTH	ORAL HEALTH OVER PAST 3 YEARS	ORAL HEALTH OVER PAST 5 YEARS	ORAL HEALTH OVER PAST 10 YEARS	ORAL HEALTH OVER PAST 15 YEARS	ORAL HEALTH OVER LIFETIME	ORAL HEALTH DURING CHILDHOOD
Very poor	2	0	1	0	0	0	0
Poor	10	16	8	16	10	12	14
Neutral	24	27	36	30	42	27	24
Good	32	32	24	36	24	44	36
Great	20	5	5	5	5	5	10

VIRTUAL AND IN-PERSON SHARING CIRCLE RESULTS

Sharing Circle results mirrored and elaborated on the experiences and thoughts of those who contributed to the pre-Sharing Circle Survey. Contributors could openly discuss their lived experiences in the Sharing Circle setting. Three themes emerged from these discussions.

CHILDHOOD EDUCATION

In 2013, the Canadian Paediatric Society pleaded to the Canadian government for improved oral healthcare for children, noting "functional, psychological and social dimensions of a child's well-being" (Rowan-Legg 2013, 37). Indigenous Children experience heightened impacts on their oral healthcare due to intersecting factors, including AIR, geographic location, and class (to name a few). Not only do Indigenous Children lack access to proper oral healthcare, but many Indigenous Children also lack knowledge and understanding regarding oral healthcare in general. One Inuit Contributor from Happy-Valley Goose Bay noted that she was unaware of oral healthcare as a young person. One Manitoba contributor stated, "I never got education and awareness in my oral health."

Many contributors to the Sharing Circles discussed how oral healthcare was not prioritized in their households since other needs had to come first. Some contributors stated the importance of parents being advocates for oral health for their children. However, many

had parents who were survivors of the Residential School System or are themselves survivors of the Sixties Scoop. Many children did not have access to information about the importance of brushing their teeth and the impacts that sugar has on teeth. They had little access to resources such as toothbrushes.

Many contributors mentioned feeling like their dentist did not care for them as children, with some discussing having teeth pulled without proper freezing, without parental or guardian consent, and at school. When asked if they believed other non-Indigenous children experienced the same treatment in schools, many participants believed it was the norm. While individuals in Canada did see dentists in schools, Indigenous Children's treatment remains vastly different from their non-Indigenous counterparts. Some contributors mentioned that due to their pregnant mothers taking certain medications, genetics, and poor luck, they have weaker teeth, making oral healthcare as a child even more difficult. One common thread among all participants over the age of 60 was the introduction of sugar into their communities; this was a turning point in their health.

ACCESS

Many contributors noted needing access to services and dentists regardless of geographic location. The need for dentists and oral healthcare professionals was noted, especially for those living in more remote locations such as Rankin Inlet. In fly-in communities, some reported only having access to a dentist once a year. With many community members seeking oral healthcare at the same time, access to dental care becomes harder. For some contributors, having access to a dentist was an issue.

However, the primary issue was not being able to brush their teeth. One contributor mentioned that they were gifted an electric toothbrush but could not buy the additional toothbrush heads, while others noted more overarching issues that Indigenous Communities continue to face. One contributor stated:

> "Growing up with not having a lot, so it would look as though you were poor or living in poverty. So you would be told why don't you brush your teeth, and also not having access to running water impacted this."
>
> Manitoba Contributor

FEAR

Fear of dentists and oral healthcare providers was a shared experience. However, some contributors noted horrific and traumatizing experiences with providers. One contributor from the Northwest Territories recalled that when she was at the dentist, the dentist said she would "slice open" the young girl's face if she moved. This contributor stated, "they traumatized me as a child" and made it difficult for her to wish to return for any reason. Many contributors commented on how they were told to do what they were told when it came to people of authority, including doctors and dentists; others anticipated poor treatment and were harder on themselves when they were treated poorly, claiming they should have known better.

Fear of the dentist and other oral healthcare professionals was shrouded in a blanket of shame—for not coming in sooner, for not seeking regular oral healthcare, or for not practising active oral healthcare. One contributor mentioned the need for a "trauma-informed" approach. Fear of the dentist was directly linked to experiences of AIR. Not only did contributors mention trauma-informed care, but they also mentioned the importance of humanity and empathy. One contributor felt "they were being punished for not going back" to the dentist, even though the previous dentist had allowed them to leave the dental office with blood on their face after an appointment.

INSTANCES OF ANTI-INDIGENOUS RACISM

AIR (AIR) continues to occur in oral healthcare and oral healthcare settings. One participant noted that "ignorance is the lack of knowing"—which many oral healthcare providers continue to demonstrate. Some participants said they had experienced overt forms of AIR, such as lack of consent for procedures, being provided additional procedures (explored below), and outright neglect; others experienced "stuck up" attitudes, "condescending" behaviour, glaring, inappropriate looks, and other forms of shaming.

Not wanting to enter the dental office for fear of discrimination was a huge concern for many participants who had experienced AIR. This was common at both a community and individual level. While some individuals had positive oral healthcare experiences, there were plenty of examples of adverse AIR experiences.

Contributors also shared stories related to having coverage through government programs, and being told they needed additional procedures, which would put more money in the dentist's pocket. One contributor in Happy-Valley Goose Bay talked about a dentist in the area who was found to be "double dipping" (the research team cannot substantiate the claims against these oral healthcare providers). With respect to the topic of coverage, several contributors said they could not access oral healthcare because their dental office

would not accept status-based coverage, while others felt that they were frowned upon for using the coverage they deserve in dental offices. Regardless of their coverage, all experienced forms of AIR.

More overt forms of AIR were evident in the lived experiences of those who spoke at the Sharing Circles. Many contributors commented on dentists and other oral healthcare professionals' general lack of informed consent practices during their appointments. Having teeth pulled was a common occurrence for Indigenous Patients or Clients; the feeling was that oral healthcare appeared to be less important to dentists. Teeth were pulled for seemingly no reason, and some were not listened to about their desires for their own oral health. Contributors claimed that dentists engage in the "extraction, and remove all our teeth; do not even want to save our teeth." Others stated, "Non-Indigenous people are able to get a lot of procedures before extraction." In short, compared to their non-Indigenous counterparts, there is an expectation among the Indigenous Contributors that their teeth will be pulled. If Indigenous Patients and Clients already feel their oral health is not taken seriously, they will not seek out care until the situation is dire.

The experiences of AIR in oral healthcare are only matched by the overarching issues that contribute to the poor oral healthcare of any community. While many communities in Canada have access to clean drinking water, this has been an ongoing human rights concern in Indigenous Communities. According to the Council of Canadians, over a period of 28 years, Canada has had 28 long-term water advisories that have impacted First Nations Reservations. Moreover, at a given time, these advisories can impact over 5,000 individuals each, with 73% of the water systems for First Nations at medium or high risk of contamination. Indigenous People cannot access clean drinking water for oral healthcare needs, including tooth brushing.

Many communities in Canada also benefit from the impacts of fluorination on their drinking water. According to the Centers for Disease Control, fluorinated drinking water can improve oral decay by 25% in those with fluorine additives (2020). Therefore, Indigenous Communities also lack the benefits of fluorinated drinking water that could aid in oral healthcare.

Another critical consideration when investigating AIR in oral healthcare is the remote nature of the locations. Indigenous Communities rarely have the luxury of being provided with a community-based oral health provider. This leads to a lack of rapport and relationship-building, as well as poor quality of care. Dyson et al. (2014) advocate for the "development of sustainable, innovative, quality-focused oral health care services" (p. 187) , which are lacking in Indigenous Communities. Participants noted wanting to have a trusted oral healthcare professional they could visit regularly. Implementing Indigenous-led oral healthcare programs in communities would be most beneficial.

RELATIONSHIP -BUILDING

One major recommendation was to encourage the building of relationships with dentists and other oral healthcare providers. As expressed, collaborative efforts with communities have shown to be incredibly helpful. Indigenous Communities want resources and services that are long-lasting and sustainable, and they want to be able to build rapport with oral healthcare teams.

For many contributors, a relationship built on respect is critical. Based on previous experiences, many said a judgment-free space is ideal for building relationships with all Indigenous Patients or Clients regardless of their oral health status. It is important that Indigenous Patients or Clients not have to explain themselves and to be trusted by their oral healthcare professionals. Given the continuing AIR experiences that Indigenous Peoples experience, trust is all important. Lasting, quality care for Indigenous Communities cannot be achieved by rotating oral healthcare professionals who are flown in. This practice hinders the ability to get an appointment, and many community members go underserved.

At the same time, oral healthcare professionals need to engage in trauma-informed and consent-based practices. Many contributors felt they were not consulted on their own oral healthcare; positive experiences with oral healthcare providers were based on an open discussion with the dentist, who provided information about their oral health in clear, concise language. Providing information in an accessible way can include using pamphlets, using different languages, removing medical jargon, and clearly explaining the reasons for a given procedure—why the procedure is important or essential, and how it will impact the person's oral health.

Providing the patient with options, reasons, and information assures them of your quality of care, kindness, and empathy. This in turn engenders confidence in the patient, who needs to feel comfortable with the decision as well. It also helps to build a relationship and rapport with a patient/client.

VI: LIMITATIONS

Several factors limited this research. One was the tight timeline, which meant that some preferences could not be accommodated. Unfortunately, NWAC's provincial and territorial member associations (PTMAs) could not be involved in the process as the research team had initially hoped, and so friendship centres were used as the locations for in-person Sharing Circles.

The research team recommends expanding on this research and important work.

VII: RECOMMENDATIONS

CULTURALLY RELEVANT CARE

Culturally relevant care provides a framework for oral healthcare providers to understand how cultural and gender-based experiences can change the needs of a given Indigenous Patient or Client. One Inuit contributor also noted that Inuit culture is conscious of personal space. Suppose a practitioner uses a culturally relevant and gender-based approach; in that case, they may tell the patient that they will come in close, what they will be doing and checking for. They may ask the patient to let them know if they experience discomfort. All oral and healthcare professionals should adopt this approach.

- Implement workshop training sessions in Indigenous Communities to teach about what culturally relevant care looks like to those entering and continuing in the oral healthcare field.
    - Provide tool kits and worksheets as reference tools – in the language of the Patient or Clients choice.

ANTI-INDIGENOUS TRAINING IN ORAL HEALTHCARE EDUCATION

Oral healthcare providers and professionals should receive training that specifically addresses the histories and ongoing legacies of settler-colonialism. This would include discussing the impacts of settler-colonialist events such as Residential Schools, the Sixties Scoop, and the ongoing MMIWG2S+ genocide. Oral healthcare professionals would be required to learn about how healthcare and, specifically, oral healthcare has been impacted by these events. Contributors also felt it was important for oral healthcare providers to learn about the importance of Traditional Knowledge and Teachings, so they may be informed on the different elements of Indigenous well-being.

- Develop and employ a curriculum about AIR in oral healthcare and how to prevent these practices.

- Have Indigenous Community members speak in classrooms about their experiences with oral healthcare and how Indigenous communities are unique and under-serviced.

ANTI-INDIGENOUS TRAINING AND COMMUNITY ENGAGEMENT

Many contributors and oral healthcare professionals mentioned the importance of adequately preparing those seeking to work in Indigenous Communities. Many who had worked in communities had noted how ill-prepared they were for the needs of Indigenous Peoples and the ways that historical and ongoing trauma influences their oral healthcare. Having knowledge about Residential School treatment, the Sixties Scoop, and the ongoing MMIWG2S+ genocide informs non-Indigenous healthcare professionals about the ways that events can impact multiple generations.

As well, poor healthcare disparities are intersectional and dynamic, and all oral healthcare professionals should be prepared to provide trauma-informed, culturally relevant, and considerate care. This will reduce the instances of abuse and neglect that Indigenous Peoples face when accessing, receiving, and recovering from oral healthcare treatment.

- Have Indigenous members of the community teach about oral healthcare in schools.
- Host workshops in Indigenous Communities, providing a way for community members to meet local oral healthcare providers, receive free oral healthcare tools, and ask questions.
- Provide campaigns that are inclusive and speak to the community that are being serviced. Representation will make community members feel heard, accepted, and safe.

EDUCATION IN SCHOOLS FOR CHILDREN

Include information in the school systems for Indigenous Children. One contributor, who is a retired teacher, discussed how much children enjoy learning practice skills. Providing education in schools can mean all children are learning about proper oral healthcare. Local Indigenous People could be invited to come into the classroom to talk about oral healthcare. It could involve providing family kits including toothbrushes, toothpaste, floss, and mouthwash, or keeping toothbrushes in smaller schools for children to learn healthy habits.

- Provide oral healthcare kits to students to take home.
    - This also means getting to know the family of students, including the number of family members and the unique oral healthcare needs of each household.
- Initiate a system in schools to have children brush their teeth twice a day when they arrive and leave school.

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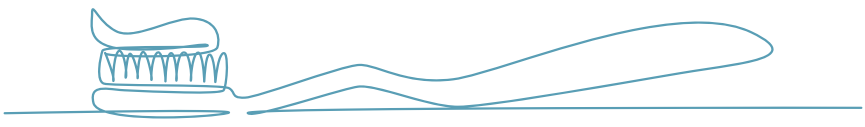
APPENDIX A: DENTAL HEALTHCARE PRACTITIONERS SURVEY

DISCLAIMER AND CONSENT

Health Canada funds this project. The purpose of this project is to collect urgent primary data about the oral healthcare needs and experiences of Indigenous Peoples across Canada, to find gaps in the education, training, experience, and knowledge of oral healthcare providers, and to provide advice about better oral healthcare practices when working with Indigenous patients/clients. Survey responses will be completely anonymous.

The more honest responses are, the more helpful our recommendations will be. The NWAC team acknowledges the work and dedication that allies put into ensuring all Indigenous patients/clients are treated with the respect, dignity, and affirming care they deserve. The risks of this survey are minimal for those who do not identify as Indigenous and/or have experienced health-related discrimination in the past based on race, ethnicity, or heritage. Terms with how settler-colonialism impacts oral health for Indigenous communities can be emotionally heavy. The NWAC team appreciates the commitment of many oral healthcare providers, and teams must provide the best oral healthcare possible.

The first forty individuals who complete the survey will receive an honorarium of $50 to Native Women's Association of Canada shop Artisanelle. This will be mailed to them.



4. **What is your current oral healthcare role? (Click all that apply)**

- ☐ I am a dentist
- ☐ I am a dental student
- ☐ I am an orthodontist
- ☐ I am an orthodontist student
- ☐ I am an oral surgeon
- ☐ I am studying oral surgeries
- ☐ I am a dental hygienist
- ☐ I am a dental hygiene student
- ☐ I am an oral health reception worker
- ☐ I am in school for oral health reception and services
- ☐ Other (explain below)

5. **Do you self-identify as Indigenous?**

- ☐ Yes, I self-Identify as
- ☐ No, I am not Indigenous
- ☐ Unsure/Do not wish to disclose

6. **To your knowledge, do you have any oral healthcare staff members who identify was Indigenous?**

- ☐ Yes
- ☐ No
- ☐ Unsure

7. **Do you currently have any patients/clients who identify as Indigenous?**

- ☐ Yes
- ☐ No
- ☐ Unsure

8. **Do you provide any oral health services to Indigenous patients/clients living on-reserve?**

- ☐ Yes
- ☐ No
- ☐ Unsure

9. **Do you currently travel to a reserve to provide oral healthcare?**

- ☐ Yes, if so to which territory/location
- ☐ No
- ☐ Unsure

10. **Have you ever been unable to provide the best possible oral health care you can to an Indigenous Person based on lack of knowledge about their unique oral healthcare needs?**

- ☐ Yes
- ☐ No
- ☐ Unsure

11. **Are there any resources or services that would assist you and your oral healthcare team in providing better oral health care to Indigenous patients/clients? If so, specify below:**

12. **Are there any ways you, your oral healthcare staff, and your office space promote the importance of oral health care for Indigenous People?**

- ☐ Yes (if so tell us how below)
- ☐ No
- ☐ Unsure

13. **Does your office space currently have any ways of including Indigenous Medicines in your oral healthcare? (For instance, images of medicine wheels, Traditional Teachings, spaces for smudging?)**

- ☐ Yes
- ☐ No
- ☐ Unsure

14. **Are there any ways you wish your space could be more welcoming to Indigenous patients/clients?**

- ☐ Yes (tell us how below)
- ☐ Yes, but I am unsure how
- ☐ No
- ☐ Unsure

15. **Have you had an experience as an oral health care provider where you felt you treated a patiently differently based on their Indigenous identity? (I.e. assumed behaviours or habits)**

- ☐ Yes, I have
- ☐ No
- ☐ Unsure

If so, explain.

If given the opportunity, how would you change this interaction?

16. **Do you feel your education and training provided enough information about the unique needs of different Indigenous Communities to provide adequate oral health care?**

- ☐ *Yes*
- ☐ *No*
- ☐ *Unsure*

17. **How could your education or training provide better resources and information to help you and your oral healthcare team provide the best possible oral healthcare to Indigenous patients/clients?**

1. **Would you like the Native Women's Association of Canada (NWAC) to send you training, resources, and information that come from this research project? If so, please provide your email address below:**

EMAIL:

2. **If you are in the first forty individuals to complete the survey, would you like to receive your honorarium of a $50 gift card to Artisanelle? If so, please provide a mailing address below:**

EMAIL:

APPENDIX B: PRE-SHARING CIRCLE CONTRIBUTOR SURVEY

Sharing Circle Survey Questions

DISCLAIMER AND CONSENT

The purpose of this survey is to see how Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse People, their families, and Communities access and experience oral health care. Some questions ask about your childhood experiences and act as a compass to let us know what resources are required, and that research should be done to improve oral health experiences. There exists a large gap in understanding oral health in a holistic manner in Canada. NWAC wishes to see if there are patterns across People and Communities so we can help with providing what is most needed.

You may choose to skip any question you do not wish to answer. The survey is 20 questions long and could take you about 15-20 minutes to complete. No ethics board approval is required for this survey as the project was already approved by Health Canada and their internal ethics review, however, we do ask you access the Survey Consent Form to ensure you are aware of the risks and benefits of the survey.

All surveys will be submitted anonymously, meaning we will not know who completed the survey. If you complete a survey in person, we will put the survey in an envelope and review the information later. All information you provide is confidential, meaning no names or identifying information will be used. Information from this survey will only be used to determine oral healthcare needs of Indigenous People and may influence what is discussed in Sharing Circles.

This research was funded by Health Canada.

SECTION ONE: DEMOGRAPHIC

1. **In terms of your Indigenous identity, how do you identify? (Click all that apply)**

- ☐ *First Nations*
- ☐ *Inuit*
- ☐ *Métis*
- ☐ *I also identify as: (specify below)*

2. **How do you identify in terms of your gender? (Click all that apply)**

- ☐ *Two-Spirit*
- ☐ *Woman*
- ☐ *Man*
- ☐ *Transgender*
- ☐ *Non-binary or gender-diverse*
- ☐ *I wish to use other words to describe my gender (write below)*

3. ***What is your current age?***

- ☐ *18-25*
- ☐ *26-30*
- ☐ *31-39*
- ☐ *40-49*
- ☐ *50-59*
- ☐ *60-69*
- ☐ *70-79*
- ☐ *80-85*
- ☐ *Over 85*

4. **Which province or territory do you currently live in?**

- ☐ *Alberta*
- ☐ *British Columbia*
- ☐ *Quebec*
- ☐ *Manitoba*
- ☐ *New Brunswick*
- ☐ *Newfoundland and Labrador*
- ☐ *Northwest Territories*
- ☐ *Nova Scotia*
- ☐ *Nunavut*
- ☐ *Ontario*
- ☐ *Prince Edward Island*
- ☐ *Saskatchewan*
- ☐ *Yukon*

5. **For folks who identify as First Nations, where did you grow up?**

- ☐ *On reserve*
- ☐ *Off reserve*
- ☐ *Both on and off a reserve*
- ☐ *Not applicable*

6. **What Traditional Territory do you currently have the honour of living on?**

7. **As a child, were you placed in the foster care system? (This question is here to determine if there is a connection between the child welfare system and oral healthcare)**

- ☐ *Yes*
- ☐ *No*

(If so for how long)

8. **As a child, who provided care for you? (Click all that apply) (This question is to determine if there is a connection between people who you lived with growing up and their current oral health)**

- ☐ *Parent(s)*
- ☐ *Sibling(s)*
- ☐ *A Family member or relative (such as kokum, auntie or an uncle)*
- ☐ *A friend or community member(s)*
- ☐ *A foster family/foster families*
- ☐ *A foster care home(s)*
- ☐ *Adopted family*

SECTION TWO: CURRENT ORAL HEALTH (SCALE)

Using a scale of 1 (very poor) to 5 (great), please answer the following questions:

9. How would you rate your oral health?

	Very Poor	*Poor*	*Neutral*	*Good*	*Great*
Currently	*1*	*2*	*3*	*4*	*5*
In the last 3 years	*1*	*2*	*3*	*4*	*5*
In the past 5 years	*1*	*2*	*3*	*4*	*5*
In the past 10 years	*1*	*2*	*3*	*4*	*5*
In the past 15 years	*1*	*2*	*3*	*4*	*5*
Overall, throughout your life	*1*	*2*	*3*	*4*	*5*
During your childhood	*1*	*2*	*3*	*4*	*5*

How did you feel you were treated when getting oral health care? (I.e., at a dental office, at a clinic, etc.).

	Very Poor	*Poor*	*Neutral*	*Good*	*Great*
When looking to find a dentist	*1*	*2*	*3*	*4*	*5*
By the staff at the dental office	*1*	*2*	*3*	*4*	*5*
By the dentist	*1*	*2*	*3*	*4*	*5*
By the dental hygienist	*1*	*2*	*3*	*4*	*5*

10. If you told your dentist, dental hygienist, dental receptionist, or other staff at your oral healthcare office that you are Indigenous, how do you feel you would be treated?

Very Poorly	*Poor*	*Not sure*	*Good*	*Great*
1	*2*	*3*	*4*	*5*

11. **If your dentist, dental hygienist, dental receptionist, or other staff at your oral healthcare office know you are Indigenous, how do you feel they have treated you after finding out your heritage?**

Very Poor	*Poor*	*Not sure*	*Good*	*Great*
1	*2*	*3*	*4*	*5*

- *This does not apply*

SECTION TWO: Oral Health history

12. **Do you currently have a dentist or oral care specialist that you see?**

- ☐ *No, I do not have a dentist or oral care specialist*
- ☐ *Yes, I have a dentist or oral care specialist*
- ☐ *I see the dentist or dental care provider who visits our community*

13. **Do you currently have: (Click all that apply)**

- ☐ *Braces*
- ☐ *Headgear*
- ☐ *Dentures*
- ☐ *A Cavity*
- ☐ *Gum disease (such as gingivitis)*
- ☐ *Tooth decay*
- ☐ *Tooth aches or pain*
- ☐ *Chipped or cracked teeth*
- ☐ *Hyperdontia (condition of having too many teeth)*
- ☐ *Recurring mouth sores or ulcers*
- ☐ *A type of oral cancer (mouth, tongue, throat, cheek, etc)*

14. Have you ever had any of the following: (Click all that apply)

- ☐ *A cavity*
- ☐ *A root canal*
- ☐ *Wisdom tooth removal*
- ☐ *Braces*
- ☐ *Headgear*
- ☐ *A tooth extraction (tooth pulled)*
- ☐ *Fillings for cavities*
- ☐ *A Crown (for tooth decay)*
- ☐ *Dentures*
- ☐ *Chipped or cracked teeth*
- ☐ *Hyperdontia (condition of having too many teeth)*
- ☐ *Recurring mouth sores or ulcers*
- ☐ *A type of oral cancer (mouth, tongue, throat, cheek, etc)*

As an adult, if you have had a tooth extraction (not including wisdom teeth), how many have been extracted?

15. Have you ever had an infection due to poor oral health care?

- ☐ *No, I have never had an infection due to oral health*
- ☐ *Yes, I have had an infection due to oral health*

If so, what kind of infection, how was it treated?

16. **Have you ever had to go to the hospital due to an oral health related issue? (I.e., a toothache, a tooth infection, issues with your gums, issues with your tongue? This does not include throat related issues such as strep throat, coughs etc.)**

- ☐ *No, I have never had to go to the hospital due to an oral health concern*
- ☐ *Yes, I have had to go to the hospital due to an oral health concer*

If so, what happened and how was it treated?

SECTION THREE: ORAL HEALTHCARE EXPERIENCE

Using a scale of 1 (very often - at least once a year or whenever needed), 2 (Rarely - once every 10 years), 3 (once every 5 years), 5 (once every couple of years) to 5 (never - never been to the dentist) please answer the following questions:

17. **How often have you gone to see a dentist or used oral health services:**

	Never	*Rarely*	*Sometimes*	*Often*	*Very Often*
In the past year	*1*	*2*	*3*	*4*	*5*
In the past 3 years	*1*	*2*	*3*	*4*	*5*
In the past 5 years	*1*	*2*	*3*	*4*	*5*
In the past 10 years	*1*	*2*	*3*	*4*	*5*
In the past 15 years	*1*	*2*	*3*	*4*	*5*
Overall, throughout your life	*1*	*2*	*3*	*4*	*5*

18. How often have you gone to see a dentist or used oral health services when you had an oral health emergency: (I.e., a painful cavity, a chipped tooth, required oral health surgery)

	Never	*Rarely*	*Sometimes*	*Often*	*Very Often*
In the past 5 years	*1*	*2*	*3*	*4*	*5*
In the past 10 years	*1*	*2*	*3*	*4*	*5*
In the past 15 years	*1*	*2*	*3*	*4*	*5*
Overall, throughout your life	*1*	*2*	*3*	*4*	*5*

19. Have you ever been denied oral health because you are an Indigenous Person?

	Never	*Rarely*	*Sometimes*	*Often*	*Very Often*
In the past 5 years	*1*	*2*	*3*	*4*	*5*
In the past 10 years	*1*	*2*	*3*	*4*	*5*
In the past 15 years	*1*	*2*	*3*	*4*	*5*
Overall, throughout your life	*1*	*2*	*3*	*4*	*5*

20. Has there been any healthcare experience (including oral, physical, emotional, psychological, or spiritual) that has had negative effects on your health?

21. Do you feel like your overall oral health could be better? If so, what resources, information, or services do you think would be helpful?

The research team is so grateful and honoured to have you complete the survey for us. We appreciate your time and energy to help better understand the oral health needs of Indigenous Communities across Turtle Island and Inuit Nunangat.

Should you feel you wish to speak to someone, please reach out to any of the following resources:

- **The Hope for Wellness Help Line** (24/7):
  - 1-855-242-3310 or the online chat at hopeforwellness.ca.
  - Both telephone and online chat services are available in English and French. Telephone support is also available upon request in: Cree; Ojibway (Anishinaabemowin); Inuktitut. (Note: Supports in Cree, Ojibway, and Inuktitut are not available 24/7, so you may need to call in to find out the next time that a language-speaker will be available.)

- **NWAC Toll Free Elder Support Hotline** (M-F 9:00-12:00 EST and 1:00-4:00 EST)
  - Grandmother Roberta Oshkawbewisens (1-888-664-7808)
  - Elder Esther Ward (1-833-652-1381)
  - Elder Isabelle Meawasige (1-833-652-1382)

APPENDIX C: CONSENT LETTER FOR SHARING CIRCLES

Consent Information Letter

Title of Project: *Addressing Racism and Discrimination (ARD) in Canada's Health Systems Program*

Names, Titles, and Contact Information of Researchers

Principle Investigator	**Researcher/Facilitator**	**Volunteer**
Lee Allison Clark (she/her) Director of Health Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K1 Phone: 343-996-4852 Email: **LClark@nwac.ca**	**Tamara McCallum-Nadon (she/her)** Sr. Project Coordinator Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K1 Email : **tmccallum-nadon@nwac.ca** **Elgin Pecjak (he/him)** Senior Researcher/ Senior Project Coordinator Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K1 Phone: 613-617-3384 Email: **epecjak@nwac.ca**	**Shruthi Poolacherla** **(she/her)** Volunteer Email: **spoolacherla@nwac.ca** **Talitha MacIntyre** **(she/her)** Volunteer Email: **tmacintyre@nwac.ca**

INTRODUCTION

You have been invited to participate in a research study in which we will facilitate a Sharing Circle to uncover challenges, barriers, concerns, and experiences that Indigenous People have to oral health. This program aims to provide research and recommendations regarding oral healthcare needs among Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse (WG2STGD) Individuals by having contributors complete an online or in-person survey and participate in one Sharing Circle.

BACKGROUND

This project is funded through Health Canada. This project addresses each of the program's objectives and expected outcomes. First, this project wishes to provide ways for Indigenous WG2STGD People to share their experiences about their oral health and dentistry. Conversations will be centered around experiences of racism and discrimination to ensure these experiences and perspectives are captured. This will help to show how Indigenous WG2STGD People experience racism and discrimination in oral health and dentistry and provide recommendations for better treatment. NWAC will produce resources that will be geared towards health system decision-makers to assist in existing and new policies, programs, and initiatives. The report that will be developed will voice recommendations from participants – for government, dentistry professionals, and academia – and a table will be provided with recommendations for possible metrics for measurement to explore further. This resource will also provide important information at the community level – providing increased access to information and knowledge that can be mobilized to further engage on community-level oral health priorities and concerns.

PURPOSE OF THE PROJECT

NWAC hopes to learn about the oral healthcare needs of Indigenous People based on a variety of influencing factors. Our research project has two main activities. First, NWAC will engage in Community Engagement by hosting four virtual and four in-person Sharing Circles. The four in-person Sharing Circles will be hosted in multiple geographic locations, in partnership with provincial and territorial membership associations. The four virtual Sharing Circles, hosted in each of the Four Directions, will seek to ensure accessibility to these engagements and ensure representation of distinct regional perspectives.

Using this information, NWAC will seek to mobilize and disseminate this information by developing a summary report (to be sent to Health Canada, the funder) of what was outlined through these engagements, including recommendations on moving forward. The recommendations will include possible metrics for measurement to explore further. This report will be published in both official languages on our website and promoted on social media to ensure accessibility. An academic journal article will also be developed and published to reach academic institutions.

Providing your lives experience will help in determining what oral healthcare research, services, and resources are needed and where they would be best located.

YOUR PARTICIPATION

No formal approval from an ethics board was required for this research, Health Canada; however, NWAC is dedicated to acknowledging participation in the Sharing Circle may be challenging due to the nature of the research topic. NWAC seeks to better the oral health of Indigenous People across Turtle Island and Inuit Nunangat and wants all who participate to feel safe, comfortable, and free to share their experiences and thoughts without judgement.

Each Sharing Circle participant will receive $100 honoraria for their contributions. All participants will be asked to complete a survey prior to the Sharing Circle and will be asked to actively participate during the Sharing Circle. Participation is voluntary.

WHAT IS BEING COLLECTED?

We will be asking you to share your experiences and challenges regarding your oral health and oral health history. Some of the topics discussed will include some of the contributing factors that cause poor or less accessible oral health resources and services to Indigenous Communities. This could include discuss previous experiences with healthcare systems generally which may cause distress. We will ensure that participants remain anonymous, and anything shared will be kept confidential. Your name and any identifiers will not be shared or used with anyone outside of the immediate research team nor recorded in any of the reports.

WHAT HAPPENS TO THE INFORMATION I PROVIDE?

The Sharing Circle session will not be recorded. The session will be audio recorded and transcribed using Otter.ai. After the session, all documents and notes will be securely stored, which only the research team can access. Once final reports are written and new programming developed and implemented, all research notes will be destroyed.

HOW IS THIS INFORMATION BEING SHARED?

The information we receive during the Sharing Circle sessions, once anonymized, will be shared with the research team and NWAC employees who are directly involved in creating recommendations about the needs for future research on oral health among Indigenous Communities. The reports generated from this project may also be shared through the NWAC website, social media, peer-reviewed journals and presentations. This information will also be shared with the funder, Health Canada. None of your personal or identifying information will be shared.

WHAT IF I CHANGE MY MIND AND I NO LONGER WANT TO PARTICIPATE?

In the case participants feel uncomfortable or uncertain about what they shared during the Sharing Circle session and do not wish to have it included in the session notes or project, they may withdraw at any time. Contributors may leave the Sharing Circle session at any time. If you choose to leave, you may decide what you have shared up until the point you left can be included in the study, some things included, or not included at all. Before or after leaving the Sharing Circle, you must inform us of your decision. This can be done by informing our facilitator within the Sharing Circle or later by emailing the main researcher Elgin Pecjak (he/him) **epecjak@nwac.ca**. and/or Tamara McCallum-Nadon at **TMcCallum-Nadon@nwac.ca**.

RESOURCES

Crisis Lines
Métis Crisis Line is a service of Métis Nation British Columbia. Call **1-833-MétisBC (1-833-638-4722)**.
Hope for Wellness Help Line offers immediate mental health counselling and crisis intervention by phone or online chat. **Call toll-free 1-855-242-3310** or start a confidential chat with a counsellor at **hopeforwellness.ca.**
National Women's Association of Canada Resources
National Women's Association of Canada Resiliency Lodges **Grandmother and Elders** Available Mon-Fri 9am-12pm and 1pm-4pm (EST). All numbers are toll-free. Roberta Oshkawbewisens **Grandmother** 1-888-664-7808 Esther Ward **Elder** 1-833-652-1381 Isabelle Meawasige **Elder** 1-833-652-1382

APPENDIX D: SHARING CIRCLE QUESTIONS

First Nations Persons

Part 1: Current oral health and oral health history

1. *How would you describe your overall oral health?*
    a. *What does good oral healthcare look like for you?*
    b. *How do you feel your current oral health could be improved?*
2. *Do you feel your well-being and overall health impacts your oral health?*
    a. *Do you experience a lack of access to nutrition, shelter, clean drinking water, or any other necessities of life?*
    b. *How do you feel oral healthcare is important to you and other community members?*
    c. *Do you feel this lack of access impacts your oral health? If so, how?*
3. *How would you describe the oral health of your community?*
    a. *Do you feel there are needs specific to First Nations folks that haven't been considered?*
4. *What oral health resources and services do you think would better the overall oral health of yourself and your community?*
    a. *Do you think there are any barriers to bettering your oral health?*
    b. *Do you feel you have access to everything you need to take care of your oral health?*
    c. *Do you feel you have been provided with the information you need to take care of your oral health in the way you need to?*

Part 2: Anti-Indigenous Racism in oral healthcare

5. *Do you feel that your identity as an Indigenous Person has impact in the past, or still impacts your ability to access the oral healthcare you need? Explain.*
6. *In what ways do you feel that anti-Indigenous racism has impacted your oral health?*
7. *Do you feel like anti-Indigenous racism in oral health has impacted your ability to access services or resources? If so, explain.*
8. *Do you feel that experiences of anti-Indigenous racism in oral health contribute to poor overall health? If so, explain.*
9. *Do you feel your community suffers because of experiences of anti-Indigenous racism when seeking out oral healthcare?*
    a. *Has there ever been a specific time when a community member described an incident they had with an oral healthcare provider or their staff?*
10. *What are some of the ways that dentists and other oral healthcare professionals could provide more culturally relevant care? I.e., would it be beneficial to have resources in Indigenous languages, using the medicine wheel, using Traditional Knowledge)?*

Métis Persons

Part 1: Current oral health and oral health history

1. *How would you describe your overall oral health?*
    a. *What does good oral healthcare look like for you?*
    b. *How do you feel your current oral health could be improved?*
2. *Do you feel your well-being and overall health impacts your oral health?*
    a. *Do you experience a lack of access to nutrition, shelter, clean drinking water, or any other necessities of life?*

b. *How do you feel oral healthcare is important to you and other community members?*

c. *Do you feel this lack of access impacts your oral health? If so, how?*

3. *How would you describe the oral health of your community?*

    a. *Do you feel there are needs specific to First Nations folks that haven't been considered?*

4. *What oral health resources and services do you think would better the overall oral health of yourself and your community?*

    a. *Do you think there are any barriers to bettering your oral health?*

    b. *Do you feel you have access to everything you need to take care of your oral health?*

    c. *Do you feel you have been provided with the information you need to take care of your oral health in the way you need to?*

Part 2: Anti-Indigenous Racism in oral healthcare

5. *Do you feel that your identity as an Indigenous Person has impact in the past, or still impacts your ability to access the oral healthcare you need? If so, explain?*

    a. *In what ways do you feel that anti-Indigenous racism has impacted your oral health?*

6. *Do you feel like anti-Indigenous racism in oral health has impacted your ability to access services or resources? Explain.*

    a. *Do you feel that experiences of anti-Indigenous racism in oral health contribute to poor overall health? If so, explain.*

7. *Do you feel your community suffers because of experiences of anti-Indigenous racism when seeking out oral healthcare?*

8. *Has there ever been a specific time when a community member described an incident they had with an oral healthcare provider or their staff?*

9. *What are some of the ways that dentists and other oral healthcare professionals could provide more culturally relevant care? I.e., would it be beneficial to have resources in Indigenous languages, using the medicine wheel, using Traditional Knowledge?*

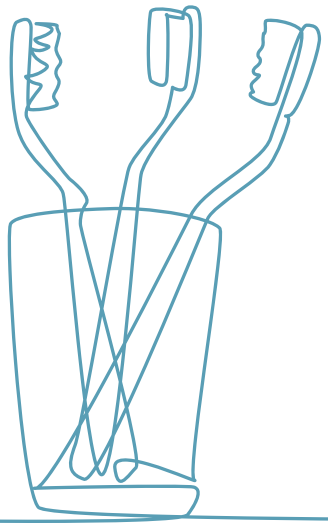
Inuit Persons

Part 1: Current oral health and oral health history

1. *How would you describe your overall oral health?*
    a. *How do you feel your current oral health could be improved?*
2. *Do you feel your oral health impacts your overall health and well-being?*
    a. *Do you experience lack of access to nutrition, shelter, clean drinking water, or any other necessity?*
    b. *Do you feel this lack of access impacts your oral health? If so, how?*
3. *How would you describe the oral health of your community?*
    a. *Do you feel there are needs specific to Inuit folks that haven't been considered?*
4. *What oral health resources and services do you think would better the overall oral health of yourself and your community?*
    a. *Do you think there are any barriers to bettering your oral health?*
    b. *Do you feel you have access to everything you need to take care of your oral health?*
    c. *Do you feel you have been provided with the information you need to take care of your oral health in the way you need to?*
5. *In what ways do you think your oral health has been impacted by where you live?*
    a. *Do you find living in a more remote location has a negative impact on your oral health?*
    b. *What are some resources that you find difficult to access?*
    c. *How can these resources or services be made more available?*

Part 2: Anti-Indigenous Racism in oral healthcare

11. *Do you feel that your identity as an Indigenous Person has impact in the past, or still impacts your ability to access the oral healthcare you need? If so, explain?*
    a. *In what ways do you feel that anti-Indigenous racism has impacted your oral health?*
12. *Do you feel like anti-Indigenous racism in oral health has impacted your ability to access services or resources? If so, explain.*
    a. *Do you feel that experiences of anti-Indigenous racism in oral health contribute to poor overall health? Explain.*
13. *Do you feel your community suffers because of experiences of anti-Indigenous racism when seeking out oral healthcare?*
14. *Has there ever been a specific time when a community member described an incident they had with an oral healthcare provider or their staff?*
15. *What are some of the ways that dentists and other oral healthcare professionals could provide more culturally relevant care? I.e., would it be beneficial to have resources in Indigenous languages, using the medicine wheel, using Traditional Knowledge?*



Making Mouths Matter

An Investigation into Anti-Indigenous Racism and its Impacts in the Oral Healthcare of Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse People in Canada

NATIVE WOMEN'S ASSOCIATION OF CANADA

June 2023