Advancing knowledge to improve the oral health of refugeed children:

Oral healthcare providers' perspectives

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Abstract

Background: Refugeed children often endure extreme circumstances during their journey to resettlement, making them exceptionally vulnerable to poor health. Once settled in their host country, they face a heightened burden of oral health conditions compared to non-refugeed children. Previous research has indicated higher caries prevalence, poorer oral hygiene, and unmet dental needs among refugeed children in contrast to their host country counterparts. This oral health disparity can result in pain, discomfort, and adversely affect a child's overall well-being. Once in Canada, refugeed children have limited healthcare coverage through the Interim Federal Health Program (IFHP), which therefore contributes to the healthcare disparities they face.

The United Nations Convention on the Rights of the Child underscores universal children's rights, including their right to express their views and opinions regarding their own health matters. The promotion of a child-centred approach to healthcare provision and shifting away from a solely disease-focused approach have been advocated in many health disciplines. However, child-centred approaches are less researched and practiced within Pediatric Dentistry. Engaging refugeed children in their own oral health matters can enhance their oral health experience and overall satisfaction. Moreover, the perspectives of dentists regarding the oral health of refugeed children have not been explored before.

Objective: The aim of this project is to better understand the perceptions, knowledge, and practices of oral healthcare providers regarding the oral health of refugeed children

Methodology: We employed a qualitative description methodology for our study, underpinned by the Childhood Ethics theoretical framework. We recruited 12 participants (9 females, 3 males). We conducted individual, semi-structured interviews with a purposeful sample of oral health providers who provide care for refugeed children. Data generation and data analysis occurred concurrently. Data were analyzed using an iterative thematic approach, including debriefing, transcript coding, and interpretation.

Results: Our findings include three main domains: 1) Participants' perceptions regarding refugeed children's oral health; 2) Participants' perceptions of the clinical practices during care provision for refugeed children; 3) If you had a magic wand. These domains offer a comprehensive description of how the participants viewed the unique oral health needs and challenges faced by refugeed children during the oral healthcare encounter, and how they perceive their clinical responsibilities towards this population.

Our results revealed that participants showed genuine care for refugeed children and their families. Participants indicated that they engaged refugeed children during the educational process of oral hygiene instructions; however, they acknowledged that only parents are mainly involved in the discussions regarding treatment planning and the decision-making processes.

Participants also emphasized their frustrations with the limitations of the IFHP and its lack of child specific dental procedures coverage. Further, they highlighted that this limitation leads to disparities in the dental treatments that the refugeed children receive compared with non-refugeed children. Many participants recommended providing refugeed children with the same health coverage as non-refugeed children in the province of Quebec, namely RAMQ.

Conclusion: Our participants voiced concerns with the limitations of the IFHP and the consequent disparity in treatment provision for refugeed children in comparison with non-refugeed children. Our results demonstrated that the involvement of refugeed children in their oral health is limited to oral health educational activities. Thus, more attention to children as active agents with capacities and interests to participate in decisions and discussions that affect them can be promoted.

Résumé

Contexte: Les enfants réfugiés subissent souvent des circonstances extrêmes au cours de leur voyage vers la réinstallation, ce qui les rend exceptionnellement vulnérables à une mauvaise santé. Une fois installés dans leur pays d'accueil, ils sont confrontés à des problèmes de santé bucco-dentaire plus importants que les enfants non-réfugiés. Des recherches antérieures ont indiqué une prévalence plus élevée des caries, une hygiène bucco-dentaire moins bonne et des besoins dentaires non satisfaits chez les enfants réfugiés par rapport à leurs homologues du pays d'accueil. Cette disparité en matière de santé bucco-dentaire peut entraîner des douleurs et une gêne et nuire au bien-être général de l'enfant. La Convention des Nations unies relative aux droits de l'enfant souligne les droits universels des enfants, y compris leur droit d'exprimer leurs points de vue et leurs opinions concernant leur propre santé. La promotion d'une approche des soins de santé centrée sur l'enfant et l'abandon d'une approche centrée sur la maladie ont été préconisés dans de nombreuses disciplines de la santé. Cependant, l'approche centrée sur l'enfant fait l'objet de moins de recherches et est moins pratiquée dans le domaine de l'odontologie pédiatrique. Le fait d'impliquer les enfants réfugiés dans leurs propres questions de santé bucco-dentaire peut améliorer leur expérience de la santé bucco-dentaire et leur satisfaction générale. De plus, les perspectives des dentistes concernant l'expérience de la santé bucco-dentaire des enfants réfugiés n'ont pas encore été explorées.

Objectif: Le but de ce projet est de mieux comprendre les perceptions, les connaissances et les pratiques des prestataires de soins bucco-dentaires concernant l'expérience de la santé bucco-dentaire des enfants réfugiés.

Méthodologie: Nous avons utilisé une méthodologie de description qualitative pour notre étude, étayée par le cadre théorique de l'éthique de l'enfance. Nous avons recruté 12 participants (9 femmes, 3 hommes). Nous avons mené des entretiens individuels semi-structurés avec un échantillon ciblé de prestataires de soins bucco-dentaires qui s'occupent d'enfants réfugiés. Les données ont été générées et analysées simultanément. Les données ont été analysées à l'aide d'une approche thématique itérative, comprenant le débriefing, le codage de la transcription et l'interprétation.

Résultats: Nos conclusions portent sur trois domaines principaux : Le premier domaine est la perception qu'ont les participants de la santé bucco-dentaire des enfants réfugiés. Le deuxième domaine est la perception qu'ont les participants des pratiques cliniques lors de la prestation de soins aux enfants réfugiés. Le dernier domaine est "Si vous aviez une baguette magique". Ces domaines offrent une description complète de la manière dont les participants perçoivent les besoins et les défis uniques en matière de santé bucco-dentaire auxquels sont confrontés les enfants réfugiés au cours des soins de santé bucco-dentaire, et de la manière dont ils perçoivent leurs responsabilités cliniques à l'égard de cette population.

Nos résultats ont révélé que les participants ont fait preuve d'une véritable attention pour les enfants réfugiés et leurs familles. Les participants ont indiqué qu'ils impliquaient les enfants réfugiés pendant le processus éducatif des instructions d'hygiène bucco-dentaire ; cependant, ils ont reconnu que les parents sont principalement impliqués dans les discussions concernant la planification du traitement et les processus de prise de décision. Les participants ont également souligné leur frustration face aux limites du PFSI et à son manque de couverture des procédures dentaires spécifiques aux enfants. En outre, ils ont souligné que cette limitation entraîne des disparités dans les traitements dentaires que les enfants réfugiés reçoivent par rapport aux enfants non-réfugiés. De nombreux participants ont recommandé que les enfants réfugiés bénéficient de la même couverture médicale que les enfants non réfugiés dans la province de Québec, à savoir la RAMQ.

Conclusion: Nos participants ont été profondément découragés par les limites du PFSI et par les disparités de traitement qui en ont résulté. Nos résultats ont démontré que les prestataires de soins bucco-dentaires pensaient avoir des niveaux élevés de compétences techniques et de soins à l'égard des enfants réfugiés. Cependant, une plus grande attention aux enfants en tant qu'agents actifs ayant la capacité et l'intérêt de participer aux décisions et aux discussions qui les concernent peut être encouragée.

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Contribution of Author

I, Asma Salem, the MSc candidate responsible for the authorship of all the chapters of this thesis. I designed this study with the guidance of my supervisors, Dr. Beatriz Ferraz Dos Santos and Dr. Mary Ellen Macdonald. I conducted the literature search, data collection, data analysis and wrote all the sections of this thesis.

List of Abbreviations

ACFD - Association of Canadian Faculties of Dentistry

BVOR – Blended Visa Office-Referred Program

CRDD – Convention Refugee Determination Division of Canada's Immigration and Refugee Board

CUAET – Canada-Ukraine Authorization for Emergency Travel

GAR - Government-Assisted Refugees Program

IFHP – Interim Federal Health Program

IRB – Immigration and Refugee Board

IRPA – Immigration and Refugee Protection Act

MCH – Montreal Children's Hospital

MOHP – Migrant Oral Health Project

OHCP – Oral healthcare provider

PCC – Patient-centered care

PSR – Private Sponsorship of Refugees Program

RAMQ – Régie de l'assurance maladie du Québec

REB-MUHC - Research Ethics Board of the McGill University Health Centre

UNCRC – United Nations Convention on the Rights of the Child

UNHCR – United Nations High Commissioner for Refugees

UNICEF – United Nations International Children's Emergency Fund

VoIP - Voice over Internet Protocol

WHO – World Health Organization

1. Introduction

According to the United Nations International Children's Emergency Fund (UNICEF), the number of countries experiencing violent conflicts has surged to unprecedented levels around the world in the past three decades (1). This surge has subjected millions of children to prolonged humanitarian crises, resulting in their forcible displacement from their home countries (2). UNICEF also states that over 30 million children uprooted by conflict are at risk of falling victims to enslavement, human trafficking, mistreatment, and exploitation (1).

UNICEF identifies two categories of displaced children who flee war, violence, conflict, or persecution. Children who are displaced within their recognized state borders are referred to as internally displaced children (2). On the other hand, children who are compelled to leave their country of origin and cross an international border to find safety in another country are called refugees and asylum-seekers (3).

In this thesis, I will adopt the term 'refugeed' instead of 'refugees.' The term is recommended by Action Réfugiés Montréal, a not-for-profit community organization that supports the rights of refugeed people in Montreal and beyond (4). This term signals the socio-political processes that force people to leave their homelands and transform them from citizens to 'refugees' (4).

In 2023, the United Nations High Commissioner for Refugees (UNCHR) reported a notable increase of forcibly displaced people globally (5). More than 110 million people worldwide are forcibly displaced, with children under the age of 18 accounting for 40% of this total, amounting

to approximately 43.3 million children (5). Canada assumes an important role in the resettlement of this population, serving as a safe home for approximately 30,000 refugeed individuals each year, 39% of whom are children (6).

Refugeed children often endure extreme circumstances and difficulties during displacement from their home countries and during the resettlement process (7). For instance, children affected by war and conflict are often more susceptible to developing adverse physical, mental, and social health impacts (8, 9). Owing to the nature of their experience, refugeed children often present compromised health conditions upon arrival to the host country due to trauma, stress, and the unsanitary living conditions in refugee camps (10). Studies have shown that refugeed children are at heightened risk of developing chronic diseases (e.g., anemia, diabetes) and more prone to infectious diseases (e.g., hepatitis, tuberculosis) (11, 12). In addition to their compromised general health, evidence shows that refugeed children worldwide often experience poor oral health, especially a high prevalence of dental caries and gingivitis, compared to non-refugeed children (13-18). Access to oral healthcare services for the refugeed families in the host country is hindered by language barriers, depleted financial resources, and difficulties in navigating a new healthcare system, contributing to poor oral health conditions in the refugeed population in general (19, 20).

In Canada, the Interim Federal Health Program (IFHP) is a government-funded initiative aimed at providing limited healthcare support to refugeed individuals during their first 12 months in Canada until they qualify for their provincial health insurance (21). The program offers certain

dental care benefits with important restrictions. Primarily, it covers dental treatments that aim to alleviate oral pain and is not intended to provide on-going regular or routine dental care (21). Since 2019, the IFHP has extended its coverage to include restorative treatments without pre-determination, allowing financial coverage for up to CAD 1000 (22). While the IFHP can provide support to refugeed people, it lacks comprehensive provisions for pediatric dental care, omitting critical treatments such as stainless-steel crowns, pulp therapy (e.g., pulpotomies), dental check-ups, and preventive dental services specifically tailored for children (22, 23).

This study was conducted at the Montreal Children's Hospital Division of Dentistry (MCH). The main pediatric dental clinic where this study took place offers specialized oral healthcare for children and adolescents. A sub-clinic there focuses specifically on immigrant and refugeed children, providing comprehensive oral healthcare. This care is free of charge to the patients, funded through philanthropy. The sub-clinic has been open since 2009 and currently operates twice a week, with an average of 1,000 visits per year. The dental care in the sub-clinic is performed by fourth-year dental students who are supervised by staff dentists. Given the level of training of these students, the complexity of the care needed determines if a child can be treated at this clinic. For example, children with underlying medical conditions and those who are overly anxious are referred to the main clinic where they will be cared for by a staff dentist. In those cases, the care follows the IFHP coverage (22).

In this research I have employed Childhood Ethics as my theoretical framework (24). This framework, pioneered by Carnevale and colleagues, promotes involving children in matters

important to them to gain a deeper understanding of their experiences and perspectives (25). The framework acknowledges and emphasizes the active participation of children and their role as contributors in matters that concern them (24). This recognition places great value on the children's agency and actively seeks their perspectives and individual experiences (26-28).

A recent Canadian study led by Dr. Saini and the team at the Migrant Oral Health Project (MOHP), a research initiative aimed at improving the oral health of refugeed people in Canada and internationally, has explored how refugeed children and their parents perceive accessing oral healthcare (29). Saini et al.'s study sheds light on the views of refugeed children and their families, revealing their insights into the barriers and facilitators related to the oral healthcare encounter. That study represents an important step in understanding how refugeed children access and experience oral healthcare in Canada (29).

In dental education literature, there is an absence of studies exploring the perspectives of oral healthcare providers (OHCP) regarding the oral health status and experiences of refugeed children. Recognizing this gap in knowledge, our study seeks to garner the insights and opinions of OHCPs. The aim of this study is to better understand the perceptions, knowledge, and practices of the OHCPs regarding the oral health experiences of refugeed children. The overall goal is to identify areas in need of improvement, thus making a meaningful contribution to the field of dental education and care of refugeed children in Canada and beyond.

1.1 Author's Background and Professional Experience

As an internationally trained dentist, my interest lies in addressing oral health disparities and social determinants of health. Driven by my desire to contribute meaningfully to the advancement of oral healthcare for humanitarian migrants, I sought a collaboration opportunity with my supervisors, Dr. Beatriz Ferraz Dos Santos and Dr. Mary Ellen Macdonald, whose work focuses on the oral health needs of vulnerable populations in Canada. In our current research, we aim to better understand the perceptions, knowledge, and practices of the OHCP at a Pediatric tertiary healthcare facility regarding the oral health of refugeed children. The overall goal is the advancement of knowledge regarding the oral healthcare of refugeed children.

1.2 Outline of the Chapters

Following this introduction, the next chapters of this thesis are a literature review, my methodology, results, discussion, and the conclusion. In the literature review chapter, I will explain key terms, policies, and concepts regarding refugeed people, refugeed children's oral health, and their access to oral healthcare in the host country. Additionally, I will describe oral healthcare benefits available to refugeed children in Canada, and their oral health status locally and globally. In chapter 3, I will present the research design and methodology employed in this study. Subsequently, chapter 4 describes the results and the main ideas derived from my data. The final chapters will discuss the results, limitations and strengths of the study and the conclusion considering the current literature.

2. Literature Review

This chapter begins with an introduction to refugeed children, by defining relevant concepts, legal conventions, and government programs. It proceeds to outline the Interim Federal Health Program (IFHP), which offers provisional health insurance to recently arrived refugeed persons in Canada who lack access to either provincial or private health coverage. Additionally, this chapter discusses the oral health of refugeed children in Canada, specifically Montreal. Moreover, I will highlight the importance of soliciting refugeed children's own voices and perspectives in dental research and practice. Finally, I will outline the gap in knowledge that my research endeavors to fill and state the objective of my study and the research question.

2.1 Explanation of Key Terms and Definitions

2.1.1 United Nations (UN) and the United Nations High Commissioner for Refugees (UNHCR)

The United Nations (UN) is an international organization founded in 1945 with the primary goal of promoting peace, security, cooperation, and development among its member states. It was established in the aftermath of World War II to prevent future conflicts and facilitate international collaboration. It serves as a platform for diplomacy and addresses various global issues, including human rights, climate change, and humanitarian crises (30). The United Nations High Commissioner for Refugees (UNHCR) is a specialized agency of the UN founded in 1950. Its mission is to protect, and assist refugeed and forcibly displaced populations worldwide (31). The UNHCR's work includes providing shelter, healthcare, and emergency relief; assisting in

resettlement, integration, and voluntary repatriation; and advocating for the rights and well-being of refugeed people (31).

2.1.2 The United Nations Convention on the Rights of the Child (UNCRC)

The United Nations Convention on the Rights of the Child (UNCRC) is an international treaty adopted by the United Nations General Assembly on November 20, 1989 (32). It was subsequently opened for signature and ratification by UN member states. Canada signed the UNCRC on May 28, 1990, and ratified it on December 13, 1991 (33). By ratifying the convention, Canada committed itself to uphold and protect the rights and well-being of children within its jurisdiction in accordance with the principles and provisions outlined in the UNCRC (33). The UNCRC outlines the fundamental rights and protections that should be afforded to all children, including those who are refugeed, and emphasizes their rights to survival, development, protection, and participation in decisions that affect their lives (32).

2.1.3 Refugeed People

Refugeed people are individuals who have fled their home countries due to reasons such as discrimination, war, conflict, and violence (34). These individuals are unable or unwilling to return to their countries of origin due to factors such as insecurity or the fear of persecution based on characteristics such as race, nationality, religion, political beliefs, or social group membership (34). According to the latest reports of UNHCR, at the end of 2022 there was approximately 108.4 million people around the world who have been forced to flee their homes (5). Low and middle-income countries host the majority of the world's refugeed and displaced people (5).

2.1.4 Non-refugeed people

In this study I will refer to all individuals who are not refugeed as non-refugeed people. This includes Canadian citizens, permanent residents, and international students.

2.1.5 Canada Resettlement Programs

Canada is a world leader in the resettlement of refugeed people (6). Canada has received more than 1,088,000 refugeed persons since 1980 (7). Canada has three different resettlement programs. Under the Government-Assisted Refugees (GAR) program, refugeed people are referred for resettlement in Canada by the UNHCR and other partners with which Canada has agreements. Refugeed people must be registered with UNHCR or the state authorities in the country where they found asylum to be considered for referral. Unlike in other provinces, Québec officials are responsible for screening potential candidates for the Government-Assisted Refugees (GAR) program to be resettled in Quebec.

The second stream, the Private Sponsorship of Refugees (PSR) program, allows Canadian citizens and permanent residents (in groups of five) and community organizations to sponsor the resettlement of persons with refugee status. Québec receives and approves its own applications for private sponsorship. Further, the Blended Visa Office-Referred (BVOR) program matches refugees identified for resettlement by UNHCR with private sponsors in Canada. Costs are shared between these private sponsors and the Canadian government, with each party providing six months of financial support. The province of Quebec does not have the Blended Visa Office-Referred (BVOR) program (35).

2.1.6 Convention Refugees and Refugee Claimants

Convention refugees are individuals who have left their home countries due to a well-founded fear of being persecuted for reasons such as race, religion, sexual orientation, and political opinion. They are recognized by the UNHCR as refugees under international law and granted refugee status before arriving in Canada (6). Convention refugees can either be sponsored by the federal government or privately sponsored to resettle in Canada (36). Privately sponsored refugeed individuals are approved outside of Canada by Canadian visa officers, and they become permanent residents upon arrival in Canada. Private sponsors are groups of Canadians or community organizations, including faith-based associations, ethnocultural groups or settlement organizations (36). A refugee claimant is a person who has made a claim for protection as a refugee. This term is equivalent to asylum-seeker and is standard in Canada, while asylum-seeker is the term more often used internationally (37).

2.1.7 The Canada-Ukraine Authorization for Emergency Travel (CUAET)

Following the onset of the war in Ukraine in February 2022, the Canadian federal government introduced the Canada-Ukraine Authorization for Emergency Travel (CUAET) in March 2022 to support Ukrainians in fleeing the war (38, 39). This temporary program fast tracked visa approval for Ukrainians, and since the creation of the program 198,642 Ukrainians have entered Canada through the CUAET (38, 39). People coming through this program to Canada are considered temporary residents, and are authorized to work, study, and have healthcare coverage in Canada for three years (open for renewal) (38-40). Further, as of October 23, 2023, Ukrainians

nationals and their families can apply for the new Canadian permanent residence pathway, which will provide them with permanent residence status (39).

2.1.8 Child Refugee Claimant

In Canada, children under 18 years old can seek refugee status through the Convention Refugee Determination Division (CRDD) of the Immigration and Refugee Board (IRB) (41). The Immigration and Refugee Protection Act (IRPA) is a Canadian law enacted in 2002 that governs immigration and refugee matters in Canada (42). IRPA does not establish distinct procedures or criteria for children compared to adult refugeed claimants, except for appointing a representative for the child claimants in CRDD proceedings. However, the international community recognizes that refugeed children have unique needs (41). The United Nations Convention on the Rights of the Child (CRC) obliges governments to provide appropriate protection to refugeed children, and the United Nations High Commissioner for Refugees (UNHCR) has issued guidelines for their care (32). There are three main categories of child claimants at the IRB, each with specific procedural and evidentiary considerations: accompanied children (arriving with or subsequently joining their parents), accompanied children by non-family members, and unaccompanied children (alone in Canada). These guidelines address representative designation, processing steps for unaccompanied children, and evidence assessment in child claims (41).

2.2 Children's Oral Health

According to the World Health Organization (WHO), oral health is "the state of the mouth, teeth and orofacial structures that enable individuals to perform essential functions such as

eating, breathing and speaking and encompasses psychosocial dimensions such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment" (43). I am adopting the WHO definition for this study as it highlights the complexity and intricacy of oral health and its impact on a child's well-being.

Oral health varies over the life course of a person from early life to old age, and is integral to the general health and well-being of a child (43). Common oral health concerns in children include dental caries, periodontal diseases, and orofacial trauma (43). Oral diseases are recognized as some of the most common chronic diseases in children worldwide and can lead to serious health issues (44), and they have a significant impact on the quality of life and well-being of children (45, 46). When a child's oral health is compromised, it can impact their life in various ways, including both immediate and enduring consequences (47). Dental research has substantiated that dental pain and untreated dental caries can result in diminished nutritional intake and loss of appetite, thereby hindering children's physical growth (48, 49). Further, children experiencing disturbed sleeping patterns due to dental pain often present with fatigue, tiredness and irritability which can potentially affect their daily activities, school attendance and academic performance (50). Moreover, a child's oral health can affect their social and emotional development (51). Dental problems, such as missing teeth or teeth affected by trauma, can lead to self-esteem issues and social insecurities, potentially affecting their confidence and interpersonal relationships (51, 52). Also, there is evidence supporting the association between periodontal issues and systemic diseases in adults, such as diabetes, cardiovascular diseases such as infective endocarditis, and bacterial pneumonia in adults (53, 54).

In 2022, the WHO recognized the global burden of oral diseases and released the Global Oral Health Status Report, a ground-breaking assessment that sheds light on the worldwide status of oral diseases and calls for universal coverage for oral health by 2030 (55). OHCP globally anticipate that this comprehensive assessment will benefit the oral health of children all over the world by providing crucial insights into the global burden of oral diseases through identifying patterns, disparities, and areas of concern. In addition, the report can guide oral healthcare provision for refugeed children in Canada and globally (55).

2.3 The Interim Federal Health Program and Quebec Medicare

In Canada, dental care services are not publicly funded. Unlike hospital-based medical care, the responsibility for funding dental care primarily rests with individuals, some of whom can rely on private insurance schemes (56). The Canadian federal government started funding the Interim Federal Health Program (IFHP) in 1957. This program provides temporary limited coverage of healthcare benefits including dental care for newly arrived refugeed persons who do not have provincial, territorial, or private healthcare coverage for their first 12 months in Canada (21). Newly arrived refugeed persons are qualified for urgent dental care under the IFHP. The IFHP is not intended for regular routine oral healthcare (21). It includes emergency dental exams once every six months per dental office, diagnostic radiographs (with a maximum of 16 radiographs per lifetime for periapical and bitewing radiographs, and one panoramic radiograph limited to once per lifetime), restorative treatments, (up to CAD 1000), pain management for caries or trauma, and emergency medication (22). Even though children have unique oral health needs and

requirements that are different than adults, the IFHP lacks child-specific services (e.g., pulpotomy and stainless-steel crowns) within its dental coverage. Hence, this results in unmet needs amongst refugeed children when compared to non-refugeed children (18).

The Régie de l'assurance maladie du Québec (RAMQ) is the public health insurance board in Quebec. It oversees healthcare services and insurance coverage for eligible residents of Quebec, including medical services, hospital care, prescription drugs, and some dental services for children under the age of ten years (57). Examples of dental services covered by RAMQ for children under the age of 10 are, annual examination and emergency examination, X-rays, local and general anesthesia, amalgam fillings, tooth extractions, root canal treatments, prefabricated crowns and oral surgery services is covered for all (57).

2.4 Social Determinants of Children's Oral Health

The WHO defines social determinants of health as the "non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems" (58). It is important to emphasize that beyond the biological factors contributing to oral health issues in children, there are intricate social dimensions that interact and influence the oral health of a child (59). A child's oral health does not exist in isolation from their lived realities and social factors; on the contrary, it is a window into a broader context of social issues, which can present in the form of dental caries or periodontal diseases (47). For

instance, studies have shown that children living in non-fluoridated area will be more susceptible to developing dental caries (60). Further, vulnerable children living in poverty are more likely to present with dental caries as they experience food insecurities and reduced access to oral healthcare (61). A Canadian study has shown that refugeed children who present at the dentist's office with poor oral hygiene reflect the myriad of underlying challenges and barriers they were affected by during their difficult journey to settle in Canada (62).

2.5 Examples of Models of Oral Healthcare Provision

2.5.1 The Biomedical Model in Dentistry

Dentistry gained formal recognition as a profession in Europe during the 18th century, followed by North America nearly a century later (63). The field of dentistry in its early years relied on advancements and discoveries in the medical sciences, and followed medicine in embracing a biomedical model of healthcare (63, 64). This biomedical model focuses primarily on the physical, chemical, and biological aspects of disease, and pays less attention to the psychosocial dimension of illness and the person's own subjective experience of health (65, 66). The dominance of the biomedical model has created a dichotomy of "health is good" and "disease is bad," which defines health and disease as distinct entities based on the presence or absence of specific biological factors (67-69). It also has led to a paternalistic approach to care, whereby oral healthcare providers assume the primary decision-making role, while patients play a passive role, relying on the dentist's expertise based on the notion that the doctor knows best (70). In recent years, there has been increased criticism from oral healthcare researchers and providers of conventional

dental practices and their conformity to the overly mechanistic and disease-focused biomedical model of care delivery (71-73). This trend emphasizes a shift towards more involvement of the patient in the process of decision-making and promotion of their wishes and desires (70).

2.5.2 Person-Centred Model of Care

The concept of patient-centred care (PCC) emerged in the 1950s, when Balint and his group highlighted the importance of understanding “what the patient thinks and feels about his condition” and examining the individual beyond their biological symptoms and to view them as “unique human beings” (74). Following this concept, others were introduced, such as person-centred care, introduced by George Engel in the late 1970s (75). This approach advocates a shift from the biomedical approach to care to more biopsychosocial model of health (75). In Dentistry, this concept has not been embraced to the same degree as in medicine and nursing (69). However, in the last decade, some dental-specific models focusing on person-centred care (PCC) have emerged (65, 76). These models advocate for the adoption of oral healthcare practices that place the individual and their overall well-being at the center of the oral healthcare provision process (77-79).

Notably, researchers such as Mills et al., Lee et al., and Apelian et al. use the term person- rather than patient-centred to emphasize the human instead of the disease (69, 80, 81). The person-centred model promotes the understanding of the various aspects that affect a person's dental experience, engaging in shared decision-making, and carrying out interventions that are based on a jointly developed treatment plan guided by the patient's values and expectations to

ensure personalized care (69). Moving away from the one-size-fits-all model, it is important to acknowledge that pediatric dentistry can benefit from a child-centred approach. This entails recognizing each child as a unique agential individual, capable of participating as competent beings in everyday decisions and co-construct in social situations (82-85).

2.6 Children's Voices in Dental Care and Dental Education

Since the emergence of the UNCRC, many international and national policies pertaining to children's rights have been developed (86). The UNCRC has brought children and their rights to the forefront of research, changing conventional views of children as incapable accessories to adults, into rights-bearing active agents (87, 88). The field of Childhood studies embraced the UNCRC and has shown immense interest in understanding the status of children through different theoretical frameworks and research fields (88). This multifaceted social science exploration resulted in progressive approaches to understanding children and childhood, with great emphasis on valuing children's perspectives and their unique experiences (89, 90). Despite these advancements in understanding children, there is still a lag in some fields of the applied sciences, such as in the field of Pediatric Dentistry. Marshman et al. have shown in a comprehensive systematic review published in 2007 that most oral health research is conducted on children rather than with children (90). In another study by Makansi et al., an examination of the predominant discourses in a Pediatric Dentistry textbook suggested a paternalistic, behaviorist approach, prioritizing surgical intervention over listening and engaging the child in their own oral health (91).

In this study, I will employ Childhood Ethics as my theoretical framework (24). This framework, developed by Carnevale and colleagues, promotes involving children in matters important to them to gain a deeper understanding of their experiences and perspectives (25, 92). The framework acknowledges and emphasizes the active participation of children and their role as contributors in matters that concern them (24). This recognition places great value on the children's agency and actively seeks their perspectives and individual experiences (27, 28).

2.7 Oral Health of Refugeed Children Worldwide

Oral health issues are recognized as a significant public health challenge due to their widespread occurrence across all parts of the world (55, 93). In the United States, children accompanied by their parents, are five times more likely to seek emergency department visits for dental issues than for asthma, often due to limited access to dental care, lack of insurance, or financial constraints, and half of all kindergarteners enter school with dental caries (94). Globally, oral diseases account for a substantial economic burden, with treatment costs estimated at US$298 billion yearly and indirect costs amounting to US$144 billion yearly, rivalling the economic impact of top global causes of death (94).

Refugeed children face a variety of risks in terms of their health and wellbeing due to their displacement (94, 95). They are susceptible to an array of communicable diseases (e.g., acute respiratory tract infections, hepatitis) and non-communicable diseases (e.g., diabetes, asthma) (96, 97). Studies carried out to investigate the oral health condition of refugeed children in industrialized hosting countries have shown a high prevalence of dental caries, periodontal

diseases, and poor oral hygiene (98-100). Poor oral health can have a negative impact on the quality of life; for example, pain from a carious tooth can lead to difficulty in eating and compromised nutrition (101). Also, periodontal disease in children is associated with and can increase the susceptibility to chronic diseases later in life through shared risk factors (102).

2.8 Oral Health of Refugeed Children in Canada

Canada continues to be a global leader in the resettlement of refugeed individuals. According to the UNCHR, Canada resettled more than 30,000 refugeed persons in 2019 (5). Many of these humanitarian migrants, especially those who are children, have endured extreme circumstances. Consequently, they often arrive in the host countries with significant health and oral health concerns (10, 62, 103)

Further, refugeed children's oral health status is worsened by reduced access to oral healthcare and limited financial resources (19, 104-106). Children's poor oral health can result in various negative effects, including physical pain, discomfort, social and psychological issues, and decreased productivity at school (98, 107-109). In Canada, approximately 2.26 million school days are missed annually due to dental-related illnesses (110). Tooth decay constitutes a significant portion of day surgeries performed on children aged 1 to 5, which has an impact on the healthcare system (110). Previous studies showed that refugeed children in multiple Canadian provinces have significantly higher unmet oral health needs and appear to be at greater risk for oral health concerns compared to their Canadian counterparts (18, 110, 111). Possible reasons for this disparity are the multiple barriers faced by this population when they arrive in Canada, such as

lack of sufficient dental insurance, limited access to dentists, and lack of awareness of available dental services (18, 62, 110, 112, 113).

2.9 Oral Health of Refugeed Children in Montreal, Quebec

Quebec is an active participant in Canada's resettlement of persons fleeing violence and persecution (114). Once in Quebec, most of the refugeed population settles in the Greater Montreal area; children represent a significant portion of this population (35). It is noteworthy that Quebec has one of the lowest rates of water fluoridation in Canada, despite evidence showing that water fluoridation significantly reduces dental caries prevalence among children (115, 116). In Montreal, Canadians citizens and permanent residents benefit from the provincial health insurance plan, RAMQ (Régie de l'assurance maladie du Québec). It covers children below the age of 10 for various dental services (57). These services include procedures such as a yearly comprehensive examination, tooth extractions, restorative treatments, and pulp therapy(57).

A study by Moreau and colleagues found that refugeed children in Montreal had poorer oral health compared to their native counterparts, and that factors such as refugee status and children's age were associated with caries experience (18). Hence, assessing and examining the oral health needs of refugeed children once they arrive in Montreal is crucial to develop effective practices and policies adapted to their needs (18). Another study conducted by Saini and colleagues explored the oral healthcare experiences of refugeed parents' and children in Montreal. The study collected the perspectives and opinions of the refugeed parents and children on accessing oral healthcare (29). The study revealed that parents struggle to find and afford (45,

101)dental care for their children, and many refugeed children had never seen a dentist before (29). Moreover, the study argued that refugeed children exhibited an awareness of their oral health and expressed their own views regarding their mouths (29).

2.10 Defining the Problem

Oral health research has demonstrated that refugeed children are at greater risk of developing oral health issues (95, 110). It is also well-documented in the literature that dental pain experienced by children exerts a multitude of impacts on their lives, including their overall quality of life, performance at school, social interaction, and self-esteem (45, 98, 101, 117, 118). Moreover, previous studies have demonstrated that multiple factors affect the oral health of refugeed children, including but no limited to high dental care costs, and insufficient government assistance for dental coverage (99, 106, 113, 119, 120). However, little is known about how the Oral Health Care Providers (OHCPs) understand the oral health of and practice for refugeed children.

The global refugeed population has considerably increased over the last two decades, primarily driven by ongoing conflicts, domestic instability, and political oppression (121). Almost half of the world's refugeed population is children, and they are subjected to numerous challenges and vulnerabilities due to displacement (2). Canada plays an important role globally in the resettlement of refugeed individuals. Canada has welcomed more than 1,088,000 refugeed and protected persons since 1980, approximately half of which have been children (122). Due to what can be an arduous migration experience, many refugeed children are prone to health issues

(123, 124). Oral health is a major concern for this population (17, 125, 126). Canadian studies suggest that refugeed children have higher burden of oral health disease, partly attributed to the barriers the refugeed people face in accessing oral healthcare (104, 110, 113, 127). In Canada, the IFHP remains the sole government-funded healthcare program available for refugeed children; however, it lacks children-specific dental coverage and it is limited in the amount ($1000) and the duration of 12 months (21, 22). A recent Canadian study that aimed to understand the oral health experience of refugeed children and their parents provided important insights into the difficulties faced by refugeed children and their parents, as well as their positive dental experience (29). Nevertheless, to gain a comprehensive understanding and to enhance the oral health experience of refugeed children, a crucial stakeholder perspective remains absent from the oral health literature. Specifically, the perspectives of the OHCPs who deliver care to refugeed children have not been previously explored, and this is the focus of our study.

2.11 Research Question

This study's research question is: How do oral healthcare providers perceive, understand, and provide care for refugeed children?

2.12 Objectives

- To explore oral healthcare providers understanding of the oral health of refugeed children.
- To explore oral healthcare providers perspectives on providing care for refugeed children.

3. Methodology

In this chapter, I begin by outlining the research design and the theoretical frameworks employed to address the primary research question: How do oral healthcare providers perceive, understand, and provide care for refugeed children? Subsequently, I present a comprehensive account of the chosen methodology, qualitative description, along with the methods used for data collection and analysis. Finally, I delve into the aspects of methodological rigor and ethical considerations that were crucial in conducting this study.

3.1 Research Design

For this study, I used qualitative description, an empirical method of investigation aimed at collecting the informant's perception and experience of the world and its phenomena (128). This research methodology is well suited for 'why,' 'how,' and 'what' types of questions about human behaviour, and a great strength of this method is its ability to enable deep exploration of healthcare phenomena and produce rich descriptions (128, 129). Accordingly, I sought to leverage these strengths in my pursuit of exploring and representing the perspectives of the oral healthcare providers (OHCP) regarding the oral health of refugeed children.

3.2 Theoretical Framework

This study's theoretical approach is informed by Childhood Ethics, an ontological framework developed by Carnevale and colleagues. Childhood Ethics recognizes children as active agents and advocates for their input and self-determination in matters that concern them (24).

According to Carnevale et al., “Childhood Ethics involves an interdisciplinary hermeneutic orientation towards examining the morally meaningful dimensions of matters pertaining to young people” (24). Childhood Ethics oriented my design of the research proposal, research question, and the interview guide. Additionally, using Childhood Ethics as a theoretical framework in my study presents a valuable opportunity to understand the oral health of refugeed children with a nuanced ethical lens.

Refugeed children often face unique challenges in accessing healthcare services, including oral healthcare (29, 130). By adopting the Childhood Ethics theoretical framework this research will prioritize the agency and voices of these young individuals, recognizing their experiences as socially embedded and culturally informed (24). While I conducted my interviews with the OHCPs, my attention remained focused on what matters to the children and their families during the design and analysis process. For example, in the interview guide we developed a series of questions and probes about how OHCPs perceive the involvement of refugeed children in their own oral healthcare in the dental clinic. We aim to advance knowledge for addressing issues particular to refugeed children through our interpretations of the data.

3.3 A Brief Description of the Dental Clinic

The pediatric dental clinic where this study took place is embedded in a tertiary care university-based pediatric hospital in Montreal, Quebec. This clinic offers specialized oral healthcare for children and adolescents. It has a sub-clinic specifically for the provision of comprehensive oral healthcare for recent immigrants and refugeed children. This care is free of

charge to the patients, funded through philanthropy. The dental care in this sub-clinic is performed by fourth-year dental students who are supervised by staff dentists. Due to the rotational nature of their attendance, the students may lack the sufficient opportunities for a thorough follow-up or in-depth understanding of individual cases. Given the level of training of these students, the complexity of needed dental care determines if the child can be treated at this clinic. For example, children with underlying medical conditions and those who are overly anxious and nervous, are referred to the main clinic where the client will be cared for by staff dentists. In those cases, the care follows the IFHP coverage of dental care benefits protocol.

3.4 Participant Selection and Recruitment

In this study, I have employed a purposeful sampling technique (131). Purposeful sampling allowed me to deliberately select participants who could provide rich and diverse insights into to the research topic. I recruited a purposeful sample of 12 clinical staff from the dental clinic, whose clinical experience overlaps both the main pediatric dental clinic and the immigrant and refugees sub-clinic. This intersection will be reflected in their accounts. It is noteworthy that the sub-clinic at the MCH Division of Dentistry is the only dental service in Montreal that provides free-of-charge comprehensive dental care for refugeed children.

To initiate the recruitment of participants, I reached out to the Chief of the Division of Dentistry through email, asking that they communicate details of the study with all clinical staff members. In the email, I provided a clear explanation of the study's purpose, outlined the expectations for participants, and emphasized provisions for respecting the confidentiality and

privacy of potential participants. I requested that interested individuals contact me directly via email.

Following, I sent individual emails directly to those who expressed interest in participating in the study, requesting their written informed consent via email. This approach ensured that all interested individuals were given the opportunity to fully understand the research project's scope and implications before making an informed decision to participate. Out of a potential pool of 20 clinical staff members, I recruited 12 participants. I was able to conduct semi-structured interviews with all 12 participants (comprising of 11 dentists and 1 dental assistant). Among the participants, there were 9 females and 2 males, and varying years of experience, ranging from 2 to 15 years in the field.

3.4.1 Inclusion and Exclusion Criteria

Specific inclusion criteria were established for the selection of eligible clinical staff members. Participants had to meet the following criteria: 1) being a clinical staff member at the MCH Division of Dentistry; 2) involved in providing oral healthcare to refugeed children 3) having internet access to facilitate communication; 4) being able to communicate in English; and 5) willing to provide informed consent to participate in the study. These criteria were designed to target individuals who possess the requisite expertise and experience regarding the oral healthcare of refugeed children and can offer valuable discernment of their perceptions and practices in this context. By adhering to these inclusion criteria, the research aimed to ensure a

focused and relevant exploration of the OHCPs perspectives, knowledge, and practices regarding oral health of refugeed children.

3.5 Interviews

In qualitative descriptive research, interviews are widely regarded as a useful method for data generation (129, 132, 133). They are essentially conversations with a purpose, focused on collecting knowledge and empirical data (133, 134). The interview type most frequently used in qualitative health research is semi-structured in-depth interviews (135). For this study, we used in-depth, semi-structured interviews to facilitate deep explorations of the participants' experiences and perspectives, and to provide rich and nuanced data that contributes significantly to the research process (135).

The development of the interview guide was informed by the research question and our theoretical framework and involved multiple fruitful deliberations with the research team. The final version of the interview guide included 6 sections, which cover the following domains: personal information; perceptions of refugeed children's oral health; knowledge of refugeed children's oral health; knowledge of the MCH multicultural clinic; practices of clinical staff regarding children's oral health; and the involvement of refugeed children in their own oral health (see Appendix A).

The interview guide evolved throughout interactions with the participants, allowing the participants to describe some of their emotions and feelings. For example, based on my interviews with the first four participants and their frustrations regarding the challenges that

refugeed children and their families face accessing oral healthcare, I introduced an additional question to the end of the interview guide. This question asks, 'If you had a magic wand and could change one thing about the oral healthcare for refugeed children, what would it be?' This adjustment allowed for a deeper exploration of the participants' aspirations regarding the research topic, as was evident from their subsequent responses.

Data generation took place between September 2022 and March 2023, soon after obtaining the approval of Research Ethics Board of the McGill University Health Centre (REB-MUHC) (see Appendix C). Given the ongoing impact of the COVID-19 pandemic on public health during that time, the interviews were conducted virtually to mitigate potential risks. Voice over Internet Protocol (VoIP) technologies, particularly Zoom, were used to facilitate these interviews. Further, having the interviews virtually with the participants offered advantages in terms of flexibility and convenience, considering the busy schedules of the participants.

Following the acquisition of written consent via email from each participant, I conducted my interviews exclusively in English, as I did not speak French and our research team did not have the sufficient resources to provide an interpreter. I used a semi-structured and open-ended format for questions, with varying durations lasting anywhere between 35-80 minutes. I initiated the interviews by expressing my gratitude to the participants for volunteering their time to take part in the study. I then introduced myself and my background and provided a brief explanation of the research project. This introduction was designed to create a comfortable and open atmosphere for the ensuing discussion.

After the initial introduction, I inquired about the participant's personal information, asking, “What role do you hold at the dental clinic, and how long have you been working here?” This question proved instrumental in gaining a complete understanding of the participant's responsibilities within the clinic, while also setting the tone for the rest of our interaction. In addition to the main questions outlined in the interview guide (see Appendix A), I employed various strategies throughout the interview to gain a deeper understanding of the participants' perspectives. One of the strategies recommended by Rubin et al. (136), involved asking follow-up questions to allow the participant to elaborate and reach deeper information. For example, when one participant stated that “Refugeed children have a less good experience in general,” I followed up with the questions: “how so?” and “can you tell me more, please?”

Another strategy was the use of probes to manage the conversations; these probes could be verbal or non-verbal (136). Verbal probes like “oh!”, “really?”, and “I understand” were used to encourage participants to express themselves further. Additionally, I used non-verbal cues such as facial expressions, nodding, and maintaining eye contact during the Zoom calls, to demonstrate my genuine engagement and interest in their responses. I felt that these measures collectively fostered an atmosphere of openness and trust during our interactions. Participants were at ease and forthcoming with their accounts, which allowed for a more meaningful exchange of information.

At the conclusion of each interview, I invited the participants to share any additional thoughts, comments, or suggestions. Some participants shared further information, along with

their personal views on how to improve care for refugeed children. Afterward, I expressed my gratitude to them for generously providing their time and for sharing their valuable experiences with me. After interviewing 12 participants, I concluded data generation after consulting with the research team. We agreed that new ideas had stopped emerging from the interview, and we were reaching a point of adequate understanding of the perspectives of my participants regarding the research topic (137, 138).

3.6 Data analysis

In qualitative research, the analytical process often starts concurrently with data generation (139, 140). In our study, we used an integrated approach to qualitative coding, employing both deductive and inductive coding strategies (141). Green and Thorogood capture the interplay between the inductive and deductive orientations to data analysis, saying, “It is impossible to come to your data completely ‘fresh’: there will be concepts from theory, your previous experiences and reading that influence what you identify in the data” (135). Our integrated approach meant that analysis was guided by the study’s theoretical framework, but with openness and flexibility for emergent points of focus.

I started data analysis soon after the first interview, as a cyclical and reflexive process (139). The iterative nature of the data analysis required me to continuously revisit preliminary interviews while I continued collecting further data (140, 142, 143). Soon after an interview with a participant concluded; I transcribed the conversations verbatim (141, 144, 145). During this task, l started organizing and editing my data in the Word document. In addition, I used precise

punctuations and symbols to ensure the text was clear and conveyed the participants' feelings and dispositions throughout the data (146-148). For instance, I added words in parentheses, (e.g., laughing, frustrated), indicating the participants' non-verbal emotions while making a statement (135). This process of transcribing and editing the interviews was a necessary and advantageous step that allowed me to familiarize myself with the data and be attentive to the nuances of the research encounter (140, 142, 143).

I completed an interview report form created by one of my supervisors, Dr. Mary Ellen Macdonald (see Appendix B) within 48 hours of each interview. This meticulous practice, initiated data analysis and facilitated reflexivity. Reflexivity is essential in qualitative description research as it enables the researcher to account for their own social location and acknowledge how it influences the research interaction (149, 150). The next step of data analysis was to code the transcribed interviews. According to Green & Thorogood, coding "is the process by which data extracts are labelled as indicators of a concept" (135). Initially, the coding process was challenging due to its inherent ambiguity (145). It demanded continuous, in-depth examination and interpretation of the data to derive coherent and meaningful insights from (145).

I used multiple strategies to summarize and code my data to stay true to the participants' accounts while analyzing the data. I initially started with reading my data line by line, identifying and highlighting any repetitions and patterns (143). Following, I summarized and annotated the data to develop my understanding of the text. Later, I uploaded the data to the software MAXQDA and used it to centralize all my data and generate more codes. My initial codes were deductive,

derived from my literature review, research question, and theoretical framework (e.g., perceptions, knowledge, and practices). In contrast, my inductive codes were constructed directly from my analysis and interpretation of the data. I continuously consulted with my supervisors regarding the coding and theme development process.

Subsequently, I arranged the codes into main ideas and larger categories, “the recurrent concepts which can be used to summarize and organize the range of topics, views, experiences or beliefs voiced by participants” (135). For example, a theme that we found to be prominent in the data was “participants' perceptions of the dental needs of refugeed children vs. non-refugeed children.” We developed this theme from the code “Refugeed children oral health compared to non-refugeed children” which was expressed frequently by different participants. I shared my interpretations of the data with the research team and sought their expertise in developing the main ideas. Finally, our developed codes were arranged into themes that correspond to our research question and theoretical framework.

3.7 Reflexivity and Positionality

England proposed that "research is a process, not just a product," emphasizing the dynamic nature of qualitative research (151). Qualitative research involves continuously iterative analysis beyond the simple collection of data (152). In my own research, I recognized the importance of engaging in self-reflection and self-critique, as well as articulating my positionality as it relates to the study to ensure the integrity of the analytical process (153, 154). Positionality refers to how differences in social position shape identities and relative power in society

generally, but also within the research process. A researcher's positionality, be it professionally or personally, may affect their access to and interactions with research participants as well as interpretation of the data. Self-location encourages a researcher to consider how aspects of their identity and social position might affect the research process, either positively or negatively (154, 155).

My unique identity as an immigrant, middle-aged mother, scholar, and pediatric dentist made me aware that my research would be influenced by more than just my academic interests. My background involves biomedical, positivist-inspired training, which emphasized an impersonal and neutrally detached researcher stance to achieve unbiased research outcomes. Yet I found myself embracing the active role of a qualitative researcher through critical reflection (155). This introspective process led me to acknowledge that my personal circumstances, worldviews, and perspectives would inevitably shape how I approached and engaged with the research results. Further, writing the interim report forms and discussing my data with the research team enhanced my reflexivity. This allowed me to acquire deeper understanding of the ethical and moral aspects of the interactions between OHCPs and the refugeed children. Specifically, I gained insights into how the OHCPs perceived refugeed children during the oral health encounters and how they considered the children's perspectives and experiences throughout treatment provision.

3.8 Ethical Considerations

I implemented several measures to ensure that the treatment of participants during this research project met the highest ethical standards. This study was conducted in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2 (2018), and in accordance with the requirements set out in the standard operating procedures of the Research Institute of the McGill University Health Centre and the Research Ethics Board of the McGill University Health Centre. Throughout the research process, I respected the consent and autonomy of the participants. I presented each participant with a detailed consent form that included an overview of the study and its objectives, the study procedure, potential benefits and risks of participation, the measures taken to ensure the confidentiality of data, and the contact information of the research team.

Consent forms were emailed to participants before the interview, giving them enough time to read, reflect, and ask questions if needed. I reassured the participants that they had the right to withdraw from the study at any time prior to data analysis, although this did not happen during the interviews. To maintain the confidentiality of the participants, audio recordings and notes from the interviews were destroyed once they had been transcribed and transferred to a password-protected Microsoft Word document on a password-protected computer. Additionally, I used alphanumeric codes to replace participants' identifying details, and participants' names were kept strictly confidential among the research team. Participants were not compensated financially for their participation in the study. All interview transcripts, notes, and other written

data were saved in password-protected Microsoft Word documents, and access to these documents was only provided to the research team. Data and transcript exchange, as well as communication, was done through the McGill OneDrive platform.

After completing my study, all physical data, including electronic signed consent forms, will be immediately destroyed after being copied to a password-protected, encrypted external hard drive. This external hard drive will be stored in a secure, locked cabinet located at the Division of Dentistry, Montreal Children's Hospital by Dr. Beatriz Ferraz dos Santos for seven years post final publication. Transcriptions with pseudonyms will be saved in a password-protected folder in a computer located in the same institutional walls for seven years. After this time, all electronic data will be destroyed.

4. Results

The following chapter describes the results of our analysis of the data generated through interviews with the oral healthcare providers (OHCP). Participants in this study included 12 OHCPs (9 women and 3 men). This included 11 dentists and 1 dental assistant, and their professional experience ranged from one to thirty years. All dentists were trained in providing specialized clinical oral healthcare for children and had clinical experience providing oral healthcare to refugeed children. The one dental assistant had multiple years of experience working with refugeed children and was involved in the coordination and early inception of the sub-clinic (the refugee and immigrant dental clinic). To maintain the confidentiality of the participants, I will refer to them with a numerical code when reporting these results, and I will use non-binary pronouns.

4.1 A Brief Description of the Dental Clinic

As mentioned previously, this study took place at a pediatric dental clinic that is embedded in a tertiary care university-based pediatric hospital in Montreal, Quebec. This clinic offers specialized oral healthcare for children and adolescents. A sub-clinic there focuses specifically on immigrant and refugeed children, providing them with comprehensive oral healthcare. This care is free-of-charge to the patients, and funded through philanthropy.

4.2 Main Domains

Through our analysis of the data generated from interviewing the participants, we identified three main domains. The first domain is *participants' perceptions regarding refugeed*

children's oral health. Under this domain, we will be discussing (i) refugeed children's oral health compared to non-refugeed children (ii) participants' expressions of care towards refugeed children and (iii) participants' views on the dental profession's responsibilities towards refugeed children. The second domain is *participants' perceptions of the clinical practices during care provision for refugeed children.* Under this domain we will be discussing (i) the importance given to a child's age during clinical dental practices, (ii) shortcomings of the Interim Federal Health Program (IFHP) and the resulting inequities in oral healthcare provision, and (iii) how refugeed children's cooperation influences access to dental care. The final domain is *if you had a magic wand*. These three domains offer a comprehensive description of how the participants viewed the unique oral health needs and challenges faced by refugeed children during the oral healthcare encounter, and how they perceive their clinical responsibilities towards this population.

4.2.1 Participants' Perceptions Regarding Refugeed Children's Oral Health

The participants expressed their opinions and perspectives on multiple aspects of the oral health of the refugeed children that they treated at the dental clinic. Participants discussed the oral health of refugeed children, generally and specifically, highlighting several key points. Firstly, they mentioned that refugeed children face challenges accessing dental care, as one participant said, "*Patients have difficulty having access."* Secondly, participants specified the oral health problems refugeed children frequently present with, including dental caries and related issues, such as dental abscesses, pain, and other pathologies. As one participant said, *"Some of them come [with] full mouth cavities."* Thirdly, participants highlighted the interplay of social and

economic factors, detailing how they indirectly influence the refugeed children's oral health, in their opinion. One participant articulated this as follows, "*certain aspects are not directly related to oral health, but still impact [oral health] indirectly, [such as] the socioeconomic factors.*"

4.2.1.1 Refugeed Children Oral Health Compared to Non-refugeed Children

While participants outlined their specific concerns about the oral health of refugeed children, they frequently mentioned that they perceived commonalities between these dental needs and those of non-refugeed children (i.e., Canadian citizens and permanent residents). Multiple participants added comments to that effect, for example: *"I can't really distinguish," "I see a lot of similarities," and "I don't see a huge difference."* Participants felt that both refugeed children and non-refugeed children could present at the dental clinic with *"a mouth full of caries."* In the following quotation, the participant is conveying that both refugeed and non-refugeed children seen at this dental clinic tend to have poor oral health and require the same type of dental care:

> *"I find that refugee children, their teeth are like, they're like any other patient. I don't know if they're worse or not, but I would say, like the patients in Montreal, in Quebec in general, the health, the oral health is very, I mean the ones we see at [the clinic] is very poor. So, the refugee children, they need the same type of work that the regular children need." P03*

Although participants emphasized the commonalities of the oral health conditions of refugeed and non-refugeed children, they also stressed important differences. To begin, refugeed children's

experiences of dental caries was typically more extensive. Further, participants also pointed out that refugeed children have limited coverage for dental services, and many of them have never seen an OHCP before. As one participant reported:

> *"What's covered is limited, and usually the caries is more extensive [for refugeed children]. Whether it's been because they haven't seen a dentist forever like first time dental appointment, and what's needed is not covered and there is a financial cost there." P09*

4.2.1.2 Participants Expressions of Care Towards Refugeed Children

During the interviews, participants highlighted the need for "*more understanding,* [and] *more compassion"* towards refugeed children. At the same time, participants expressed their belief that they displayed such characteristics. As articulated by one participant: *"We are compassionate, and we want to help."* Further, participants asserted that their colleagues at the dental clinic showed a sincere sense of care towards refugeed children and their well-being. They also suggested that the OHCPs' caring approach helps refugeed children feel more comfortable and at ease when receiving dental care, despite existing language barriers. One participant summed this up as follows:

> *"I think the dentists that work at our clinic are very caring, and they care about like the well-being of the child. So, I feel that even though they're not [from] the same country or we don't speak the same language, I think they feel that we care for them*

and that we're compassionate and that we want to try to help. So, I think that helps them to be more comfortable with us." P11

Participants also shared their opinions on the general atmosphere of the clinic, describing it as a respectful and welcoming environment, and that they believe the oral healthcare team has a patient-centred approach towards refugeed children. As such, the OHCP are concerned about making the refugeed children feel comfortable and at ease, and making their families feel welcomed. As a participant stated:

"I think they have a good team of people who are very patient-centered. So, they're very concerned about making the child comfortable, about welcoming the parents to making them feel welcome in the setting. That's what you get if you walk through the clinic, you really get that atmosphere of care, of respect." P02

A few participants reflected on their own personal background as a way of relating to the refugeed individuals' barriers and difficulties. For example, one participant highlighted that because they were second generation immigrants themselves, they were able to be more understanding of the refugeed children's circumstances. This participant recounted:

"I think I understand well their social economic background, [and] *the barriers that they encounter [because] I come from a family of immigrants, so I think I in a certain way I can relate to them, and through the years, just having like families that are refugees just talking to them, I understand more and more what is their reality like, what challenges they are facing." P10*

Most participants recognized the numerous challenges and obstacles that refugeed families encounter upon their arrival in Canada. One participant expressed their attempt to understand the perspectives of refugeed families by "*trying to put myself in their shoes*." They thought about the multifaceted and overwhelming demands they would encounter in the host country, including to "*find a home, trying to find a job, trying to make sure my kids go to school, the language barrier".* The participant said that they doubted their own ability to prioritize oral healthcare if placed in a similar situation: *"If I have four kids, I don't know if I would have time to think about getting their teeth checked if they're not in pain." P11*

4.2.1.3 Participants' Views on the Dental Professional Responsibilities Regarding Refugeed Children

Participants held a variety of viewpoints on what it meant to be an OHCP who provides care for refugeed children. One participant shared their opinion regarding their role as a dentist, saying *"for me I work in a hospital, I mean, I am a dentist, patients come, I see them."* They added, "I'm not a psychologist, I don't have to go into the depth of the person's feelings, and most of the time we give relatively basic information." Conversely, others highlighted that their role extended beyond just treating teeth, encompassing the comprehensive care of the refugeed child and the entire family as well, as indicated in the following quotation:

> *"I think that taking care of refugees, yeah we're dentists, we're treating teeth, but I think with refugees like we need like more compassion, more understanding, we're*

not treating only like teeth, we are taking care of the patient, we are taking care of the family." P10

Another participant underscored the importance of what they called *"allyship and partnership"* in the context of providing oral healthcare to refugeed people. They emphasized that it is not enough for oral healthcare professionals to merely talk about being more culturally sensitive or improving their practice; they need to actively engage with refugeed individuals. This means seeking input from refugeed people themselves to understand their experiences and needs when it comes to oral health. This participant highlighted the importance of involving refugeed people in conversations that pertain to them, as their insights can be valuable in shaping a more inclusive and effective healthcare approach. This participant acknowledged that OHCP may have well-intentioned ideas, but these may not align with the actual experiences and feelings of the refugeed patients they aim to serve. True allyship involves listening and collaborating with those directly impacted to ensure their voices are heard and their needs are met, as the participant stated:

"I think it's all about allyship and partnership. So, it's one thing to talk about trying to be more open to cultures and trying to be a better healthcare professional. It's another thing to actually get in touch with refugee groups, refugee people and have them involved and ask them how they feel when they go to the dentist, what is their perception of how they're being treated, what do they think would be best to improve

their experience. It's one thing for me to say what I think, but it might be completely off from what they're experiencing and what they feel." P02

The same participant underscored the importance of integrating cultural awareness and social understanding into higher education, particularly in dental schools. Further, they pointed out the ethical responsibility of the OHCPs to treat the children holistically, considering their broader well-being, rather than solely focusing on the technical aspects. According to this participant, by adopting a person-centred care approach that considers the diverse cultural backgrounds and social contexts, OHCP can be more sensitive to refugeed children's needs. To this effect, this participant said:

"Once you're in higher education, when you're at the level of a dental school, you need to be sensitized, and you need to be taught about different cultures, different social issues. Because we have a responsibility to treat patients properly as a whole, you know, a very patient centred and a holistic type of treatment, I think is what's the best way." P02

Another participant stressed the importance of introducing the concept of social responsibility in dental education as a way to improve oral healthcare. They also acknowledged the need for fair remuneration for the OHCPs. This participant underscored the OHCP's responsibility to contribute positively to their societies, as articulated in the following quotation:

"Another way we could improve [oral healthcare] is to reinforce within education the importance of giving back. I understand dentists, we work hard, and you know, we want

to be remunerated for our responsibilities, but at the same time, I think people need to remember that we need to give back as well." P12

4.2.2 Participants' Perceptions of their Clinical Practices during Care Provision for Refugeed Children

Throughout the interviews, participants described how they involve refugeed children in their own oral healthcare. For example, participants explained the measures taken to engage and educate refugeed children, particularly those who are attending their first dental appointment. They explained that the process begins with showing the children their own teeth through mirrors and radiographs to initiate a conversation. Further, they endeavoured to impress upon the children an understanding of the importance of dental care, gradually instilling a sense of responsibility for their oral hygiene routine. Participants pointed out that children's motivation can wane over time, making the involvement of parents crucial in maintaining their dental care routines. Overall, the participants highlighted the multifaceted approaches used to engage, educate, and motivate children in their dental care, with an emphasis on procedural involvement of both the refugeed child and their parent. As described by a participant:

"We start by engaging them, take a mirror, see what we're doing, see how I brush, how I floss, all of these things, we engage them by showing them the radiographs, for example, so these are your teeth, this we start as a conversation starter. So, these are your teeth, you see them, these are baby teeth, these are the adult teeth, then we start to educate more, you see the black ones that's a cavity, this is what we do." P05

Yet, when it comes to the treatment discussions and choices, the discussions were primarily with the parents. As one participant pointed out, *“it’s the parents who are in charge, so then I will be speaking to the parents.”* When I directly asked if refugeed children are actively involved in their own oral healthcare decisions, one participant responded with a definitive *"No.”* They commented further, *"I feel that we don't have the time."* This response showed a potential gap in the inclusion of refugeed children in discussions about their dental care. This lack of involvement may inadvertently disregard individual views and preferences of refugeed children. This gap is alluded to in the following quotation that highlights a pattern where parental involvement takes precedence in dental treatment discussions:

> *“Well, you know the discussion is usually quite extensive. And also, a lot of focus, mostly on what's going to be happening with the next steps will be, how we're going to do it, the costs. Those are usually the primary the discussion with the parents I would say. Not a lot of discussion with the children.” P09*

According to the participants, parents make the decisions regarding the refugeed children’s oral health treatment with the dentist; the child is not involved at this level. Further, according to one participant, assent is not sought either. As they stated, *“I make the decision with the parents, but like, I don't really check with the child, if he understood or not.”* Refugeed children’s opinions and views may not be solicited when advanced behaviour management techniques, such as protective stabilization devices (e.g., papoose board) are used either. I directly asked one of the participants about the papoose board, “*Do you ask the child?”* The participant replied, *“No, we*

don't ask the children. And we see that it has a lot of negative effect." I followed up by asking, *"How do you think this affects the children?"* To which the participant replied, *"it's very strange […] they are scared, they scream, but compared to the children born here I think they understand that it's necessary."* This participant added that consent is primarily sought from the parents:

> *"Most of the time we always ask the parents, either you want to do it, or you don't want to do it. And 90% of the time they agree to just do it, and they leave the room, and they tell us do what you have to do, even if we have to grab the child and if we have to use force." P04*

When I asked the participants about the possibility of increasing the involvement of the refugeed children in their own oral healthcare, they had various perspectives and opinions that were generally focused on refugeed children's teeth. One participant suggested *"by brushing teeth and flossing."* Another participant underscored a different aspect, stating that there should be more focus on *"preventative aspects… and oral hygiene instructions",* to enhance their involvement. Another commented saying, *"by doing presentations about oral health, oral hygiene habits, about nutrition, and to sensitize them about being careful about their oral health."* Further, one participant added that emphasis on the *"dental education part"* is needed. Notably, some participants were confused by the inquiry about involving refugeed children in their own oral healthcare, they mentioned *"I don't understand [what] involve means."*

4.2.2.1 The Importance Given to a Child's Age During Clinical Dental Practices

Participants expressed that children's abilities to engage in discussions about their oral health is limited, especially when they are under the age of 10. As one participant expressed when asked about involving refugeed children: "*It's age related." A*nother participant added, *"it depends on the child's age."* I probed further with one participant, asking, *"What if we have a more direct conversation with the child and they have a role?"* The participant's reply was: *"but then what is the cut off age in which you can have a conversation with the child?"*

According to the participants, it may not be realistic to expect young children to fully understand or take responsibility for their own oral health. As one participant conveyed, *"for the younger ones, I don't think they understand."* Instead, they rely more on parents and caregivers to appreciate the importance of the dental care being provided. For example, one participant explained how OHCPs' expectations and level of engagement vary based on the child's age:

> *"At the end of the day, they continue to be children. So yes, we engage them, but it's limited. How much can I expect from the child? Again, we only see children younger than 10, so, I don't have huge expectations from the 6 years old or the 5 years old when it comes to their own oral health. I would rather wait for it to come from the parents, from the caretakers, the amount of appreciation of the importance of what we're delivering is limited just because they're children." P05*

4.2.2.2 The Shortcomings of the IFHP and the Resultant Inequities in Oral Healthcare Provision

As mentioned in the literature review chapter, the IFHP is a federal government-funded initiative aimed at providing limited healthcare support to humanitarian migrants during their first 12 months in Canada, until they qualify for their provincial health insurance (21). Many participants expressed their frustration with the lack of child-specific coverage; for example, essential pediatric dental procedures such as pulpotomies and stainless-steel crowns are omitted from the IFHP. One participant described the program as follows:

> *"The fact that the government, their federal program, doesn't cover for essential care that even people on welfare [get] cover[ed] for, it's just the program is very weird and crazy." P01*

Many participants agreed with the sentiment stated by one participant: as a result of these limitations, OHCPs *"have done some of the work pro bono."* They added: *"unfortunately, with the amount of refugees we have, it is hard; we can't do pro bono for everybody."*

One participant voiced their disappointment with the lack of improvement of IFHP policies over the years, and the lack of accommodation for child-specific dental procedures. This participant reported that they had tried to advocate unsuccessfully for the IFHP to be better tailored to children's specific oral health needs. They expressed their frustration, saying:

> *"We're confronted with this problem that I would like the federal government to cover pulpotomies and stainless steels and I've called them, and I've written to them many*

times, but I never hear back, I never hear back from [them], and it's been years, it's been many years, which doesn't make sense. The program, the federal program is, I'm going to say the word stupid." P03

When I asked the participants whether there were variations in the dental treatments offered to refugeed children as opposed to non-refugeed children at the clinic, participants affirmed that such discrepancies exist. One participant noted, *"I don't think we can say that refugee children are neglected, but I do see that there is a discrepancy in the quality of care that we offer."* Further, they shared their frustration with the limitations of the IFHP and the subsequent inequities. Participants felt that they were expected to provide less than optimal dental treatment because of the lack of specific dental procedures coverage within the IFHP. One participant shared that they felt as though their role was compromised: *"As a dentist, I don't feel good about compromising the child."* They added that these disparities were due to the difference in the financial coverage that non-refugeed children in Quebec receive compared to refugeed children. As one participant said, *"there is a difference because the treatments aren't covered."*

Another participant qualified this point by distinguishing between the treatments offered and the treatments provided. This participant said that OHCPs consistently suggest the most optimal treatment options based on their professional judgment. However, due to the financial constraints imposed by the IFHP, the actual treatment provided to refugeed children may diverge from these recommendations. The participant summed it up by saying: *"The easy answer is that*

there is no difference in care that we offer. But, there is a difference in care that we end up providing."

Another participant expressed dismay when providing different types of dental care for refugeed children because of the limitations of the IFHP compared to non-refugeed children. This participant described that the challenges to providing the necessary and required pediatric dental procedures are *"heartbreaking"* for them. They felt they had to compromise their professional integrity, as a result of the restricted coverage. For example, they had to extract a tooth that could have been saved, as the participant recounted:

> *"So, unfortunately, with these patients [refugeed children], sometimes we must extract teeth that could be saved with a pulpotomy. So, to answer your question, I would say yes, that the care that I give to this patient are not the same that I will give to a patient that is covered by RAMQ [Quebec Medicare] for example. So yes, it breaks my heart to pull out a tooth that can be saved." P10*

Interestingly, one participant described a discrepancy they perceived within the refugeed population's access to healthcare coverage. The participant pointed out that, "*if someone is coming from Ukraine, they automatically get RAMQ [Quebec Medicare]. Someone who comes from other than Ukraine they might have to wait for a year or two to get it*." This participant critiqued what they described as "arbitrary rules" that grants automatic coverage for one group of people in contrast to others, and they call for more equitable and fair approach without any biases:

"There are wars everywhere and refugees from everywhere coming. So if you're going to treat one like that and give them automatically RAMQ then, why not treat everyone the same you know, or maybe the others are I think pigmentally challenged, so that's why they don't get RAMQ." P07

OHCPs expressed that the disparities in dental treatment extend to the choice of pediatric behavior management techniques, making the experience of the refugeed children *"difficult for sure,"* as one participant articulated. As the IFHP does not cover pediatric dental techniques such as conscious sedation, Nitrous Oxide inhalation sedation or oral sedation with benzodiazepines, participants explained that OHCPs are more likely to use protective stabilization (papoose board) with refugeed children during the dental procedure. The stabilization board involves physically restraining the child to accomplish the dental procedure. A participant said about using the papoose board (protective stabilization), *"We always have this bias, when there's a refugee child. Sometimes, the papoose board is already ready in the corner of the room, so it's just that."*

Another participant expressed a desire to avoid using methods like protective stabilization with refugeed children, which involves physically restraining the child during dental procedures and forcefully extract the teeth. Instead, this participant advocates for using "GA" (i.e., general anesthesia) as an alternative approach which has limited coverage under the IFHP. This participant emphasized that financial constraints should not be a reason for the refugeed children to receive what they saw as 'traumatizing' dental experience:

"If we're able to do it under GA instead of like using protective stabilization and yanking the teeth out of their skulls and traumatizing them just because they can't pay for them." P07

Another issue that participants raised is the limited available time they have due to the high volume of children seen at the pediatric dental clinic. As one participant articulated, *"We don't have time to cater to people individually."* Several participants commented on the high patient volume at the pediatric dental clinic, with participants remarking, *"if you notice the volume of children is crazy,"* and, "we're busy." Yet another accentuated the same point, stating that, *"if we have proper time and we sit down and we explain and we play with the child and we show things it could make a big difference."* These excerpts from the participants' interviews show that it is often a challenge for OHCPs to have time to spend with each child, as well as how this might influence the care provided for the refugeed children.

4.2.2.3 Refugeed Children's Cooperation Influences Access to Dental Care

Participants explicitly discussed the importance of the child's compliance and cooperation during the dental encounter. This 'cooperation' is a pivotal factor in determining whether the child will receive care or not at the refugee sub-clinic, as one participant emphasized: *"You need to have patients that are cooperative and healthy to be in that clinic because they are [treated by] students. They are 4th year students; they are not very fast."* Cooperation, in this context, involves the child's ability to remain calm and be receptive during the dental visit. If this is not achieved, refugeed children will be referred to a staff dentist and the coverage will be limited to the IFHP.

This referral could result in certain consequences for the refugeed child and their family, potentially resulting in a financial burden. As one participant conveyed:

> *"Any difficult patients, they're not able to [be] seen [at the sub-clinic]. So, that does mean for those patients that [have] more difficult behavior [and must] be seen by the staff [at the main clinic], there are financial costs [involved]." P09*

4.2.3 If the OHCP Had a Magic Wand

After reflecting on the insights provided by the first four participants on the obstacles and difficulties encountered by refugeed children and their families, I suggested the inclusion of a concluding question for the remaining interviews to my research team. The question I proposed was, "if you had a magic wand and could change one thing about the oral care for refugeed children, what would it be?" The aim of this question was to elicit the participants' thoughts on how to improve the current situation if they had the means. Participants expressed different aspirations and desires - some even magical. One participant wished for, *"[refugeed children's] teeth to have a special property whereby they don't get any cavities."* Other participants stressed the significance of ensuring access to care, the important role that community OHCPs have, and securing financial aid for the refugeed children to obtain the care they are entitled for. As one stated:

> *"It would be, honestly, access to care along with financial aid. I think if there was easier access to care for them or the right information for them and providers that could provide that care to them, needing more involvement from providers with not just within*

the hospital, but within the community along with the financial resources for these families to obtain the care that they deserve and need, I think that would be my magic wand." P12

Many participants expressed that their wish would be to see the refugeed children receiving the same dental coverage as non-refugeed children residing in Quebec. As described above, children under the age of ten years in Quebec have RAMQ health insurance and access to several dental services. However, this insurance is not available to refugeed children as they are not eligible for RAMQ. Consequently, one participant said that their wish was *"that everything would be covered like for RAMQ patients, definitely, that's the first thing that comes to my mind."*

Another participant focused more on education and personal responsibility. They felt the ability to maintain good oral health falls on the refugeed children, as stated below:

"If I could change one thing, I would, again even with the magic wand I don't see me doing it, but I would finally convince them of their own role when it comes to maintaining good oral health. So actually, make them comprehend or understand that it's all in your hands if you do what you're supposed to do in terms of oral hygiene, in terms of diet, in terms of habits." P05

4.3 Summary of the Results

Our results revealed that participants showed genuine care for refugeed children and their families. Participants indicated that they engaged refugeed children during the educational process of oral hygiene instructions. However, they acknowledged that mainly the parents are

involved in treatment planning and the decision-making processes. Participants also emphasized their frustrations with the limitations of the IFHP and its lack of child-specific dental procedure coverage. Further, they highlighted that this limitation leads to disparities in the dental treatments that the refugeed children receive compared with non-refugeed children. Many participants recommended providing refugeed children with the same health coverage as non-refugeed children in the province of Quebec, namely RAMQ.

5. Discussion

To my knowledge, this is the first empirical study exploring the viewpoints and perceptions of OHCP in Canada on refugeed children's oral health. This study aimed to gain insights into OHCPs' perspectives on their clinical encounters with refugeed children and their opinions regarding the primary obstacles and facilitators experienced by refugeed children and their families. In the following chapter, I will discuss the results of this study in the context of the existing literature on the oral health of refugeed children and their care. This discussion will include four main domains: (i) the dominance of the biomedical approach in the OHCPs' clinical practices towards refugeed children; (ii) how child-centred care is understood in dentistry; (iii) the absence of refugeed children's participation in care provision; and (iv) the inequity of care provided for the refugeed children.

5.1 Dominance of the biomedical approach in the OHCPs' clinical practices towards refugeed children

While questioning our participants about refugeed children and how they perceive these children's oral health needs, we unearthed a finding that surprised us. Their opinions and replies implied a possible tension between how OHCPs view these children when they are speaking from a personal perspective and when they are assuming their roles as dentists.

When the OHCPs shared their thoughts about the refugeed children from a personal standpoint, they seemed to present them as full 'beings.' They implied a sense of empathy and understanding to the refugeed children as a whole person living in unique circumstances. They

acknowledged the challenges that the refugeed children faced in accessing oral healthcare, while also expressing concerns about the difficulties refugeed children experienced more broadly during resettlement in Canada. Interestingly, when the participants assumed their professional stance as dentists, their focus shifted. They become primarily concerned with the oral diseases presented by the refugeed children. In this professional capacity, they tended to view the children more as 'mouths', than as a whole being. This perspective focused primarily on the oral health aspect, as if it was isolated from the broader context.

We also discerned a possible discrepancy between what the OHCPs think should be done and what their clinical practices endorses. According to the description offered by participants, their clinical practices were dominated by a disease-focused approach. Such an approach is consistent with the reductionist biomedical model of care provision. In the biomedical model, the biological causes of the disease are emphasized, and the healthcare provider's attention is directed towards eliminating the disease and restoring functions through clinical mechanistic procedure (64, 91, 156). The biomedical approach neglects the other humanistic dimensions of illness, such as the role of the environmental, social, and cultural factors that affect health and wellbeing (68, 75, 157).

The biomedical approach has been the target of incisive criticism over the past 25 years within healthcare literature; however, it still dominates much of the dental education and practice (65, 68, 158). Indeed, a Canadian study concluded that the dental profession may be dominated by the tooth-oriented practice, whereby, dentists do not receive sufficient educational or research

support for incorporating patient preferences and holistic approach to oral healthcare (65). This leads to a lack of focus on patients' viewpoints in the oral health encounter (65).

The results of our study suggest that although the OHCPs acknowledged some differences between the oral health condition of refugeed children and non-refugeed children, they asserted that they treated all children the same way. This lack of differentiation between the needs of the refugeed children and the non-refugeed children may stem from viewing the child as *'a mouth,'* and not as a whole person. That is, refugeed children can present with similar 'dental conditions' as non-refugeed children; however, their circumstances and context are very different. This stance requires some attention, because the OHCPs struggled to recognize or acknowledge the distinct conditions and needs of the refugeed children.

Refugeed children have often fled a history of oppression and may have experienced difficulties, such as abuse, violence, and neglect. A recent Canadian study highlighted the importance of investigating the associations between the risk of refugeed children developing poor oral health and their exposure to physical, sexual abuse, insecurity, crime, exploitation, torture, and displacement (159). That study found a high prevalence of early childhood caries among refugeed children who experienced abuse and neglect (159). Thus, it is essential to recognize the uniqueness of refugeed children's circumstances, in order to provide care that is tailored and effective for them (160).

Employing a child-centred approach has the potential to foster trust, enhances the relationship between the OHCPs and the refugeed children, and ensures that oral health

interventions are part of a holistic healthcare strategy, resulting in better outcomes and improved well-being for refugeed children (161). In recognizing the multiple factors that impact the oral health of refugeed children, the OHCPs have a chance to address individual traumas, cultural sensitivities, language barriers, and socioeconomic factors through a multidisciplinary collaborative team effort, that may enhance their care provision. It is worth noting that it is established in the dental education literature that the dental training remains dominated by the biomedical model with its separation of the body and mind (68, 156, 162). This approach has been criticized for dehumanizing oral healthcare provision and may provide an explanation to the dualistic nature of the OHCPs perspectives.

5.2 How Child-Centred Care is Understood in Dentistry

According to the Association of Canadian Faculties of Dentistry (ACFD) in its educational framework for the development of competency in dental programs, competency is “a global statement of the complex knowledge, skills and attitudes required of a beginning general dentist” (163). The following five competencies are considered essential for dental education and accreditation in North America for practicing dentistry: (i) patient-centred care (PCC), (ii) professionalism, (iii) communication and collaboration, (iv) practice and information, and (v) health promotion. Each element of this framework has been explored extensively in the dental education literature (79, 83, 164-167).

Patient-centred care (PCC) is recognized as a key dimension of competency within healthcare. According to the Institute of Medicine Committee on Quality of Health Care in

America, PCC is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (168, 169). Different kinds of ‘centeredness’ have increasingly been proposed within healthcare and oral healthcare, including but not limited to patient-centred, family-centred, and child-centred care (69, 80, 158, 170-172). These approaches to care provision try to focus on the individual’s needs and concerns, and strongly promote patients’ rights to participation rights and shared decision-making (67, 68, 84, 171, 173, 174). Over the past decade, child-centred approaches to oral healthcare have been gaining attention. Oral health researchers advocate for the incorporation of this approach that this approach should be incorporated into dental training to promote tailored prevention and therapy to the child (83, 175).

Despite this academic literature and the practical dental guidelines endorsing PCC, the extent to which this concept has transferred into pediatric dental practices remains limited. For example, the ACFD framework does not address the relationship between the dentist and children specifically, nor does it address how children can be involved in the decision-making process (163). Consequently, this lack of clarity regarding the meaningful engagement of children translates to child’s views and perspectives not being solicited or promoted in clinical dental practices as was reflected in our results.

Ortiz’s study explored children’s experiences receiving treatment from dental students in an educational dental clinical setting in Canada (176). The results revealed that children had a positive experience of the dental encounter when they felt that they participated in the process.

One example highlighted by children was allowing them to hold the dental instruments, in addition to the kindness of dentists and the level of information provided (176). These results are echoed by another recent study that investigated the perspectives of refugeed children on their oral healthcare experiences and access to oral healthcare. It has been found that refugeed children have positive experiences during their dental encounters, especially because of the kind and respectful behavior of the OHCPs. This is expected to influence their future encounters with oral healthcare and their willingness to return for additional dental care (29). These results show that seeking the opinions of children and the use of child-centred approaches in dentistry can offer a valuable insight into their oral healthcare experiences, ultimately enhancing their future engagement with oral healthcare and overall satisfaction (177).

Our participants consistently reported efforts to involve the refugeed children in their own oral healthcare, focusing on education activities and oral hygiene instructions (i.e., showing children how to brush and floss their teeth). Their understanding of what it means to engage children in oral healthcare reflects their dental training, which is heavily influenced by the disease-focused and mechanical adequacy approach (79, 158). Although we could not find any studies focusing on the perspectives of OHCPs on their role in care provision for refugeed children, we recommend that OHCPs adopt a more child-centred approach to ensure the involvement of refugeed children in the oral healthcare encounter.

5.3 Absence of Refugeed Children's Participation in Care Provision

Article 12 of the Convention on the Rights of the Child (CRC) mandates that children have the right to express their views freely in all matters concerning them, and to have those views heard and taken seriously (32). Since the introduction of this landmark convention in 1989, there has been a growing focus on children's rights and the importance of their participation in decision-making within the healthcare environment (178-180). However, multiple studies have shown that operationalizing children's involvement presents a complex challenge in healthcare generally (179, 181, 182). This complexity arises from the dominance of paternalistic approaches to decision-making on children's health concerns; the decisions made are likely to prioritize the beliefs and perspectives of their caregivers over the genuine views and desires of the child (178, 181). The inclination of parents and healthcare professionals may be protective when making decisions for children; this stance can be driven by their desire to act in what they assume is the child's best interest (182). Further, parents' decision-making approaches can be influenced by their trust in the healthcare professionals' special expertise (183, 184).

There is ample evidence in the healthcare literature underscoring the significance of involving children in consultations, treatment planning, and decision-making (179, 180, 185, 186). This proactive engagement not only fulfills children's desires and needs to feel respected and valued, but also enhances their healthcare experience and reduces their healthcare-related anxieties (182, 187, 188). Carnevale et al. suggested that the elicitation and interpretation of children's voices to enhance their agency and comprehension of their experiences, as well as

adopting a holistic perspective on children's well-being, could foster child-centred approaches to clinical practice (26).

The results of our study suggest that OHCPs and parents primarily lead the care provision decisions. Little effort of involving children in the care provision process or seeking assent from them was evident. In the last two decades, there has been a growing interest in children's assent as a way to foster their involvement in the decision-making process within healthcare research (189-197). However, we could not find any studies on seeking assent from children in the realm of oral health literature. One study by Adewumi et al., resonates with the importance of involving children in the decision-making process. This study emphasized that actively listening to children's views and opinions contributed positively to their oral health experience (198).

Our results showed that OHCPs had limited expectations of children's ability to participate in their own oral healthcare. The OHCPs were more likely to allow children to participate in dental educational activities, i.e., brushing, and flossing techniques, rather than the treatment choice, i.e., the type of procedure they will be receiving. These results align with Makansi et al.'s discourse analysis of one of the main reference textbooks used in undergraduate and postgraduate dental curricula across North America. This study revealed the dominance of the conception of children as incomplete adults who lack maturity (91). These views of children undermine their rights to be effectively listened to and actively engaged in their oral healthcare (199). Notably, a recent Canadian study - the first of its kind to solicit the refugeed children's experience of oral healthcare - found that refugeed children had a good understanding of their oral health and were aware of

the dental procedures carried out during their dental visit (29). Further, this study showed that the children appreciated the respectful and courteous attitude of the dentists towards them, increasing their willingness to visit the dentist, thus potentially improving their oral health (29).

Our results also alluded to a common narrative within dental clinical practice, whereby the developmental model guides the relationship between the OHCP and the child (200). Developmentalism, championed by Piaget, posits that a child's performance can be assessed by aligning it with the corresponding chronological age, often referred to as the 'ages and stages' approach (201). Adhering to this approach leads to the use of the child's chronological age as the main indication of the child's ability and capacity. In our results, the age of the child appeared to be a criterion for the degree of their involvement in their own oral health matters (28, 91). To advance the engagement of children in their oral health, the promotion of a clinical approach that recognizes children as active agents is recommended (28, 91). According to Montreuil et.al, "Agency widely refers to the ability to attend to one self's needs, in addition to the capacity to make an informed decision" (28). It is an inherent ability for every child (28). Hence, the views, wishes and desires of refugeed children is a basic human right (28).

5.4 Inequity of Care Provision

Our participants expressed frustration with the limitations of the Interim Federal Health Program (IFHP), specifically the lack of financial coverage for child-specific dental procedures (e.g., pulpotomies and stainless-steel crowns) (21). Due to these limitations, participants mentioned offering pro-bono treatments for refugeed children on numerous occasions; however

they highlighted that this approach is not a sustainable practice. In addition, participants indicated that they are more likely to perform tooth extractions on refugeed children compared to non-refugeed children due to their families' financial limitations, leading to disparities in care provision. The dental literature consistently reports that refugeed children experience more oral health inequities in host countries worldwide for a multitude of reasons, including - but not limited to - difficulties accessing dental care, language barriers, and socio-economic status (17, 202, 203).

A Canadian report by Amin et al. detailed the limitations and challenges associated with the IFHP, affecting both OHCPs and newcomer patients. This aligned with our participants' frustrations with the limitation of the IFHP (204). However, there is currently a dearth of research on how the limitations of the IFHP affect refugeed children's oral healthcare in Canada. Nevertheless, the findings of a study on the dental care pathways of adult refugees and asylum seekers in Montreal showed that dentists find the financial coverage of the IFHP insufficient, and that it compromised their treatment decisions (23).

Our results suggest a discrepancy in healthcare coverage eligibility among different groups of refugeed children. Since March 2022, 185,000 Ukrainian citizens arrived in Canada through a temporary measure called the Canada-Ukraine Authorization for Emergency Travel (CUAET). As of October 2023, the Canadian government has launched a new permanent residence pathway to allow eligible Ukrainian nationals to build their lives in Canada with the support of their families (38, 39). In provinces like Québec, British Columbia, and Ontario, Ukrainians are provided

immediate access to provincial health insurance when they arrive in Canada. In Alberta, health-care providers have been instructed not to bill Ukrainians while the government figures out coverage (205). This immediate eligibility for healthcare coverage is a privilege that is not extended to refugeed populations from other countries (206). This disparity in accessing healthcare was also raised by Tim Holland, the medical director of the Newcomer Health Clinic in Halifax, who stated: “refugee health providers are seeing the attention and compassion that our world is giving to the Ukraine crisis and we’re very happy, but there’s frustration that so many other crises have gone ignored” (202). This critique is consistent with the frustration expressed by our participants.

Our participants also described that they tended to use advanced behavior management techniques such as protective stabilization (207) more often during dental encounters with refugeed children compared to non-refugeed children. One possible explanation for this finding is the IFHP’s lack of coverage for pediatric conscious sedation, including Nitrous Oxide inhalation sedation or oral sedation with benzodiazepines (208). The use of protective stabilization in dentistry is highly controversial and prohibited by Pediatric dental associations in several countries, such as the United Kingdom (209). It has been described as a ‘barbaric practice’ by some dental specialists (210). Further, another study conducted at the MCH dental clinic on parental experiences of papoose stabilization boards highlighted the possible adverse outcomes associated with their use, and recommended that the dental profession contemplate the practice and its ethical implications (211).

Participants also highlighted systemic barriers facing refugeed families, such as limited access to oral healthcare. This echoed a Canadian study that explored the systemic barriers to healthcare access experienced by refugeed populations. That study unveiled limitations in healthcare services and available options for refugeed population, as well as the complexities and challenges associated with the IFHP coverage (123). Additionally, the oral healthcare in the MCH sub-clinic is delivered by fourth-year dental students in an educational setting. The dental students' lack of experience leads to the oral health encounters being longer, and the intake of the refugeed children being limited. This contributes to the long appointment waiting times faced by refugeed children.

OHCPs receive large numbers of patients at the main pediatric dental clinic, resulting in the OHCPs being overworked and potentially not having the time to attend to the individual needs of child patients, including the refugeed children. Additionally, our participants have noted that providing timely oral healthcare to refugeed children is a challenge at the refugee sub-clinic. This challenge arises because the treatments are provided by less clinically experienced students. In essence, there is an unmet demand for specialized pediatric oral healthcare among the refugeed population, resulting in extended waiting periods for treatment appointments.

6. Strengths and Limitations

6.1 Strengths

To the best of my knowledge, this is the first study in Canada to elicit the perspectives of OHCPs on the oral health of refugeed children. This study took place in a pediatric dental clinic embedded in a tertiary care university-based pediatric hospital, and we solicited the perspectives of experienced OHCPs (ranging from 1-30 years) who treat a high volume of refugeed children. The results of this study provided distinctive and valuable insights into OHCPs' understandings of refugeed children and their practices providing them care. Additionally, the research served as an opportunity for the OHCPs to express their views, concerns, and recommendations on how to improve oral health for refugeed children.

My own background as a pediatric dentist helped me understand the participants' perspectives, and according to feedback, helped participants feel comfortable and forthcoming when explaining clinical terms and procedures. I conducted all interviews virtually through Zoom instead of meeting in person due to COVID-19 restrictions. Surprisingly, this approach proved advantageous as it provided the participants with the flexibility to choose a convenient and comfortable setting for the interviews, which contributed to a positive experience.

6.2 Limitations

While this study has notable strengths, it also has limitations that need to be addressed. Firstly, all the interviews were conducted in English, and no provision was made for conducting

them in French. For those who did not speak English as their first language, the absence of a French language option may have compromised the expression of their thoughts and experiences. The second limitation is that we only recruited participants from one clinic. As a result, our data may not be generalized to other dental professional contexts.

8. Knowledge Translation and Future Directions

Our study focused on the perceptions and understandings of OHCPs regarding the oral health of refugeed children in a particular setting. Similar studies investigating the perspectives of OHCPs in the private sector and in other Canadian jurisdictions, especially provinces that accept more refugeed people, are warranted. The growing body of knowledge provided by the MOHP team, including this study and the insights from the study by Saini et al. (29), has the potential to build a comprehensive understanding of refugeed children's experiences and challenges in accessing oral healthcare. This in turn can contribute to the development of strategies that aim at improving coverage and overall oral health satisfaction of the refugeed children and their families.

We plan to share our findings with the dentists and dental staff at this clinical location, as well as local community organizations involved in care for refugeed populations. We also hope that the publication of our study and its submission to provincial and international conferences, will inspire change within dentistry's governing bodies and dental educators. This change should address the need for reform in current dental practices, including a shift from the dominance of disease-focused approaches to a more child-centred approach of oral healthcare practices and education. We also recommend adopting dental education approaches that promote meaningful involvement of children in the discussions, decisions, and actions that matters to them.

To date, I have presented my results at multiple events, including the McGill University Faculty of Dentistry Annual Research Day (Montreal, 2022, 2023) and the Network for Oral and

Bone Health Research (RSBO) Annual Scientific Day (Montreal, 2022), where I won first prize. I also presented my study at the Crossroads Interdisciplinary Health Research Conference (Halifax, 2023) and the annual North American Refugee Health Conference (Calgary, 2023). In the future, we plan to submit our research to the International Association for Dental Research conference, as well as a manuscript to a scientific journal for wider dissemination of knowledge.

9. Conclusion

The global population of forcibly displaced individuals continues to grow, leading to numerous challenges (5). Refugeed people often face physical, mental, and social health disparities, as well as obstacles in accessing healthcare services in their host countries (212). Among this population, refugeed children are at higher risk of experiencing oral health problems (9, 16). These oral health concerns can have long-term consequences, affecting not only their adult oral health, but also aspects of their overall well-being and development (108).

Our research team has previously explored the oral healthcare experiences of refugeed children and their parents in the same location as this study. In that study, Saini et al. described the challenges encountered by refugeed children and their parents in seeking oral healthcare in Montreal, as well as their positive experiences at this particular health facility (29). As part of our research team's holistic approach to understanding the oral health challenges faced by refugeed children, our study sought the perspectives and viewpoints of the OHCPs, recognizing their significance as crucial stakeholders in this subject. The results from our study suggest that the OHCPs believe they are technically skilled and knowledgeable about the dental issues experienced by refugeed children. Additionally, they showed concerns about the challenges and difficulties that the refugeed children face in accessing oral healthcare in Montreal, Canada.

Further, Saini et al. highlighted the inequity in care provision experienced by the refugeed children in comparison to the non-refugeed children, due to the limitations of the IFHP coverage. The participants were deeply disheartened by this situation, conveying that they were compelled

to extract teeth when there could have been alternative treatments to preserve them. They added that these disparities extended to the pediatric behavior management techniques they use. Due to the IFHP's lack of coverage of pediatric conscious sedation, they tended to use the stabilization board more frequently with refugeed children compared to non-refugeed children. Additionally, our results suggest that refugeed children's opinions, views, and wishes regarding their oral health were not solicited by the OHCPs. The refugeed children's involvement was sought only during preventive educational activities.

Based on our results, we advocate for a transformative change in dental education and governance. We encourage dental schools to learn from other health care fields that are embracing a more child-centered approach to care (91). Following the theoretical approach used in this study, refugeed children should be seen as active moral agents with inherent capacities and abilities that entitle them to be meaningfully involved in their own oral healthcare process. Further, we believe that dental governing bodies should advocate for changes to the IFHP. These changes should address refugeed children's unique circumstances, barriers, needs, to improve on the current oral healthcare situation.

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11. Appendix A

11.1 Interview Guide

Interview guide for semi-structured interviews with clinical staff (i.e., dentists and dental assistants) at the Montreal Children's Hospital's Division of Dentistry

Interviews will address the following topics and questions. (Note, as is common in qualitative research, these questions may evolve as interviews progress.)

1) Personal Information
    - What role do you have at the dental clinic? How long have you been working here?

2) Perceptions of Refugeed Children's Oral Health
    - What proportion of your monthly schedule consists of caring for refugeed children? (Research Objective #1)
    - What are the most common oral health concerns among refugeed children attending the dental clinic? (Research Objective #1)
    - Have these common oral health concerns changed since you have been affiliated with the dental clinic? (Research Objective #1)
        - Probe: If not, why not? If so, how and why have they changed? (Research Objective #1)
    - What do you think works well for refugeed children at this clinic? (Research Objective #1)
        - Probe: e.g., Do families feel welcomed here? Do children feel cared for/respected? (Research Objective #1)
        - Probe: Do children receive comprehensive care here? (Research Objective #1)
    - Have you noticed, or have patients and their families mentioned, difficulties they have accessing oral health care? (Research Objective #1)
        - Possible probes:
            - How do you think families hear about this clinic? (Research Objective #1)

- What are the barriers they face (e.g., transportation, work, time, financial, knowledge, language, waiting lists)? (Research Objective #1)
- How do you think (the mentioned) barriers could be overcome? (Research Objective #2)
- Are there approaches that you, other staff at the dental clinic, and/or health care providers at other clinics have employed that seem to increase oral health accessibility for refugeed children? (Research Objective #2)

3) Knowledge of Refugeed Children's Oral Health
    - How would you describe your level of knowledge regarding refugeed children's oral health? (Research Objective #1)
    - What opportunities have you had for improving your knowledge regarding the oral health of refugeed children? (Research Objective #1)
    - Are there areas where would you like to improve your knowledge regarding refugeed children's oral health? If so, what are these areas? (Research Objective #2)

4) Knowledge of the MCH Multicultural Clinic
    - Do you know of the MCH Multicultural Clinic? (Research Objective #1)
        - Probe: Do you know of any connections that currently exist between the Division of Dentistry and Multicultural Clinic? (Research Objective #1)
            - Probe: If so, can you imagine ways in which the MCH Division of Dentistry and Multicultural Clinic could work in collaboration for the oral health of refugeed children? (Research Objective #2)
            - Probe: If not, do you see an advantage to working with other health care providers regarding the oral health of refugeed children? (Research Objective #2)

5) Practices of Clinical Staff Regarding Refugeed Children's Oral Health
    - Are there any differences in the types of treatment that you provide to refugeed children compared to other children? (Research Objective #1)
    - Are there any ways that you care for refugeed children or their families that are different than with other children and their families? (Research Objective #1)

        - Probe: If so, what are these (e.g., medical, administrative, interpersonal, etc.)? (Research Objective #1)
    - Are there other ways to improve the care for refugeed children provided at this clinic? (Research Objective #2)
        - Probe: If so, what would these be? (Research Objective #2)

6) Involving Refugeed Children in Their Own Oral Health Care
    - Do you feel that refugeed children are involved in their oral health care? (Research Objective #1)
        - Probe: If so, how are they involved? If not, why are they not involved? (Research Objective #1)
    - How could refugeed children be better involved in their own oral health care? (Research Objective #2)
        - What role do their families play in the children's oral health care? (Research Objective #1)
        - Probe: How do you partner with refugeed children's families to involve children in their own oral health care? (Research Objective #1)
        - Probe: How could you partner differently with them? (Research Objective #2)

12. Appendix B

12.1 Interview Report Form

Title of project:

Code/Interview #:

Name of interviewer:

Date / time of interview:

Location of interview:

Recruitment strategy:

Description of participant: [e.g., pertinent information such as gender, age, profession, relevance of participant to project, language of interview]

Time since interview (aim to fill the form within 24hrs of interview):

1- How did the interview unfold?
   a. Was the participant on time? Were you?
   b. Were you alone with the participant; if not, who else was there and why? What was the impact of any additional people on the encounter?
   c. How did the participant seem to you: e.g., At ease? Nervous? Anxious? Tired? Engaged? Did this change in any way as the interview progressed?
   d. How would you characterize the atmosphere of the conversation; why/how?: e.g., a chat or a debate? Was there anger? Suspicion? Laughter?
2- During the interview, were there events that upset the flow? (e.g., phonecalls, visitors arriving?) If yes, what happened and how did this affect the conversation?
3- Was there important information that was discussed when the audio recorder was turned off? If yes, please describe.
4- Was the participant shy or intimidated by you? By the subject of the conversation? By the audio-recorder? How may this have affected the data?
5- Reflexivity: What strategies did you use to prompt the participant? How well did they work? Were there times when you felt the interview was going particularly well / not well? Why was this the case? What do you have in common with this participant? How might this have shaped the interaction (Positively? Negatively?)?
6- In your opinion, what were the main issues and important topics and queries that came up during the interview?
7- Summarize the information in each of the main domains of the interview guide.
8- What new ideas or hypothesis or intuitions were suggested to you through this encounter?
9- Methodological reflections: What did this encounter teach you about the strengths and limits of this tool (e.g., individual interviews, or focus group interviews)? What/how might you change in future encounters?

a. Any questions to add to the interview guide?

10. Miscellanea

13. Appendix C

13.1 Research Ethics Board Approval

Centre universitaire de santé McGill | McGill University Health Centre

2022-06-07

Dr. Beatriz Ferraz Dos Santos

email: beatriz.ferrazdossantos@muhc.mcgill.ca

Re: MUHC Authorization (Advancing Knowledge on the Oral Health of Refugeed* Children / 2022-8663)

"Advancing Knowledge on the Oral Health of Refugeed* Children: A Partnership Between the Montreal Children's Hospital's Division of Dentistry and the Multicultural Clinic"

Dear Dr. Ferraz Dos Santos,

We are writing to confirm that the study mentioned above has received research ethics board approval and all required institutional approvals.

You are hereby authorized to conduct your research at the McGill University Health Centre (MUHC) as well as to initiate recruitment.

Please refer to the MUHC Study number in all future correspondence relating to this study.

In accordance with applicable policies it is the investigator's responsibility to ensure that staff involved in the study is competent and qualified and, when required, has received certification to conduct clinical research.

Should you have any questions, please do not hesitate to contact the support for the Personne mandatée at personne.mandatee@muhc.mcgill.ca.

We wish you every success with the conduct of the research.

Sincerely,

Sheldon Levy

S. Levy for K. Woolrich, Personne Mandatée
Sheldon Levy
for:
Keith Woolrich
Personne Mandatée
Centre Universitaire de Santé McGill

Signed on 2022-06-07 at 16:09

NAGANO PM / Final Authorization Single Site 1 / 1