An ethnographic study on the oral health and access to oral healthcare of Indigenous people in Montreal

Thesis submitted to McGill University in partial fulfillment of the requirements of the PhD degree in Craniofacial Health Sciences

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Dedication

This work is dedicated to my parents, Adel Danish and Begum Nawab, for their support, sacrifice, and encouragement in this journey. I also dedicate this to my grandmothers, Mariam Eskandar and Wahba Alsarraj, who passed away in 2019, for having kept me in their prayers and for the love and care they gave me throughout my studies.

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Many people contributed to my academic journey. I would like to immensely thank my supervisor, Dr. Christophe Bedos, for accepting me as a trainee and for your invaluable support over the past years. You guided me through my first steps in qualitative research and let me take control of my research project. You have been a supervisor, a mentor, a colleague, an elder brother, and a life teacher who taught me how to be a better human being before being a successful dentist and academic. Indeed, you are a role model to me. Although a highly qualified professional dentist and researcher, you are humble and put serving the community first among your priorities. I will remain indebted to your insight and support on various issues during my journey.

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Preface

This thesis represents original research that has been solely written by the candidate in partial fulfillment of the requirements of the Doctor of Philosophy in Craniofacial Health Sciences. I as a candidate was involved in all stages of the research process, including identification of the research topic, conceptualization of the study, preparation of the proposal, collection and analysis of data, and writing the document.

My thesis supervisor, Dr. Christophe Bedos, provided guidance throughout the process.

Dr. Mary Ellen Macdonald provided guidance on Chapters 1 to 4, including the earlier version of Chapter 5.

Upon the recommendation of my thesis supervisor, I had my work reviewed by Dr. Martine Lévesque and Dr. Mark Keboa. Dr. Lévesque provided feedback on the first section of Chapter 5, while Dr. Keboa provided feedback on all Chapters of the thesis.

Abstract

Background: Although the population of Indigenous people living in urban centres has significantly increased over the past decades, limited research exists about their oral health and access to oral health services. We thus know very little about their perspectives, experiences, and needs concerning oral health. However, this knowledge is needed to guide oral health policies and service delivery for urban Indigenous people.

Objectives: Our objectives were to (i) understand how urban Indigenous people perceived and experienced oral health and (ii) describe their oral healthcare pathway, including their experiences with dental professionals.

Methodology: We conducted a focused ethnography, a useful and practical approach that is sensitive to cultural and social diversity and enables researchers to understand how people from certain cultures integrate health beliefs and practices into their lives. We organized individual in-depth interviews with a purposeful sample of 20 Indigenous people living in Montreal, Québec. The interviews were in English, lasted approximately 90 minutes, and were audio-recorded to be transcribed verbatim and analyzed. In addition, we conducted participant observation of various Indigenous cultural events and health conferences in Montreal. Field notes were taken during these events and analyzed. The data analytic process comprised several stages, including summarizing the text, coding it into categories, and merging these categories to create themes.

Findings: The participants had a bicultural perception of oral health, although the Western perspective seemed to dominate the Indigenous culture. Through the Indigenous lens, participants tended to understand oral health around the concepts of holism and balance. According to them, good oral health was important to achieve well-being and equilibrium between the physical, mental, emotional, and spiritual aspects of life. Applied to oral health, participants emphasized eating and drinking in moderation to maintain equilibrium and stressed the role of teeth in eating

traditional diets. In agreement with Western culture, they mentioned the importance of teeth for function and aesthetics and valued personal oral hygiene as well as regular visits to the dentist. Concerning access to dental care, participants reported experiencing challenges in their lives, such as discrimination, unemployment, or chaotic life experiences, which prevented them from searching for a dentist. Finding a dentist was another issue, with participants indicating a shortage of dentists who accepted Non-Insured Health Benefits (NIHB) program beneficiaries. Because of this limited availability of dentists, some participants would return to their home communities to access dental services. Regarding the dental care episode, participants mentioned preferring dental professionals who knew and respected Indigenous culture and had good interpersonal skills. While the NIHB covered the cost of most dental treatments, some participants were required to pay for ineligible services, and some dentists refused to accept NIHB eligibility documents.

Conclusions and recommendations: Urban Indigenous people face challenges and needs that require recognition by oral health professionals and policymakers. We invite these stakeholders to draw on our findings to support policies and services that facilitate access to and improve the oral health of urban Indigenous people.

Résumé

Contexte: Bien que la population des Autochtones vivant dans les centres urbains ait considérablement augmenté au cours des dernières décennies, il existe peu de recherches sur leur santé buccodentaire et l'accès aux services dentaires. Nous en savons donc très peu sur leurs perspectives, leurs expériences et leurs besoins en matière de santé buccodentaire. Toutefois, ces connaissances sont nécessaires pour orienter les politiques de santé buccodentaire et la prestation de services aux Autochtones vivant en milieu urbain.

Objectifs: Nos objectifs étaient de (i) comprendre comment les Autochtones vivant en milieu urbain percevaient et connaissaient la santé buccodentaire et (ii) décrire leur parcours de soins dentaires, y compris leurs expériences avec les professionnels dentaires.

Méthodologie: Nous avons mené une ethnographie ciblée, une approche utile et pratique qui est sensible à la diversité culturelle et sociale et qui permet aux chercheurs de comprendre comment les gens de certaines cultures intègrent les croyances et les pratiques en matière de santé dans leur vie. Nous avons organisé des entrevues individuelles approfondies avec un échantillon ciblé de 20 Autochtones vivant à Montréal, au Québec. Les entrevues ont été réalisées en anglais, ont duré environ 90 minutes et ont été enregistrées pour être transcrites textuellement et analysées. De plus, nous avons observé les participants à divers événements culturels autochtones et conférences sur la santé à Montréal. Des notes de terrain ont été prises pendant ces événements, et analysées. Le processus d'analyse des données comprenait plusieurs étapes : résumer le texte, le coder en catégories, et fusionner ces catégories pour créer des thèmes.

Résultats: Les participants avaient une perception biculturelle de la santé buccodentaire, même si la perspective occidentale semblait dominer la culture autochtone. Du point de vue autochtone, les participants avaient tendance à comprendre la santé buccodentaire en fonction des concepts d'holisme et d'équilibre. Selon eux, une bonne santé buccodentaire était importante pour atteindre

le bien-être et l'équilibre entre les aspects physiques, mentaux, émotionnels et spirituels de la vie. Concernant la santé buccodentaire, les participants ont mis l'accent sur la consommation modérée d'aliments et boissons pour maintenir l'équilibre, et ont souligné l'importance du rôle des dents dans les régimes alimentaires traditionnels. En accord avec la culture occidentale, ils ont mentionné l'importance des dents aussi bien dans le fonctionnement que dans l'esthétique, et apprécient une bonne hygiène buccodentaire personnelle aussi bien que des visites régulières chez le dentiste. En ce qui concerne l'accès aux soins dentaires, les participants ont déclaré avoir vécu des difficultés dans leur vie, comme de la discrimination, du chômage ou des expériences de vie chaotiques, qui les ont empêchés de chercher un dentiste. La recherche d'un dentiste était un autre problème, les participants indiquant une pénurie de dentistes qui acceptaient les bénéficiaires des Services de santé non assurés (SSNA). En raison de la disponibilité limitée des dentistes, certains participants retourneraient dans leur collectivité pour avoir accès à des services dentaires. En ce qui concerne l'épisode des soins dentaires, les participants ont mentionné qu'ils préféraient les professionnels dentaires qui connaissaient et respectaient la culture autochtone et qui avaient de bonnes compétences interpersonnelles. Bien que les SSNA aient couvert le coût de la plupart des traitements dentaires, certains participants devaient payer pour des services non-admissibles, et certains dentistes ont refusé d'accepter les documents d'admissibilité des SSNA.

Conclusions et recommandations: Les Autochtones vivant en milieu urbain font face à des défis et des besoins qui doivent être reconnus par les professionnels de la santé buccodentaire et les décideurs. Nous invitons ces intervenants à tirer parti de nos constatations pour appuyer les politiques et services qui facilitent l'accès la santé buccodentaire des Autochtones vivant en milieu urbain et l'améliorer.

CHAPTER 1. INTRODUCTION

This dissertation documents my doctoral research project, which explored the perspectives and experiences of Indigenous people in Montreal regarding oral health and oral health care.

1.1. Who I am and why I wanted to undertake this study

I was drawn to this subject because I have been working with and for underserved communities to promote equitable oral health and access to oral health care throughout my career as a dentist. I began my work in 2006, as a dentist for the Ministry of Education's dental clinics in Saudi Arabia. Among my main duties were conducting daily oral health promotion and education for primary school children, who are among the most underserved groups in terms of oral health. In 2007 and 2008, I was selected to join the committee to conduct a Saudi national oral health promotion program. The program, titled "Clean Your Teeth All Your Days", focused on primary school children in rural, urban, public, and private schools and included students from diverse socioeconomic and cultural backgrounds. This experience increased my awareness of oral health inequalities among the population.

My sense of social responsibility led me to pursue an MSc in Dental Public Health at University College London, England, in 2010. I was keen to tackle inequality, so my supervisors, Professors Aubrey Sheiham and Richard Watt, introduced me to the social determinants of oral health inequalities. I quickly appreciated the importance of promoting social equity and social justice. My passion to contribute to the improvement of oral health and access to oral health care for those in need was amplified when I arrived in Montreal. I soon learned that Indigenous people in Canada are among the underserved groups who experience high rates of dental problems and social inequality.

My lack of knowledge about Indigenous Canadians, before the commencement of this study, was

a challenge. As a foreign Saudi student, I had never been exposed to the history of Canada; neither did I know about the health inequalities affecting Indigenous Canadians. In contrast to Canada, Indigenous people in Saudi Arabia constitute the privileged majority rather than the underserved minority. With the aid of my PhD supervisor, Dr. Christophe Bedos, who has expertise in studying the health of underserved Canadians, I was motivated to start my exploration journey. I spent the first two years of my PhD learning about Indigenous people's health in Canada and their history of colonization, attending conferences about Indigenous health, and visiting Indigenous centres such as the Native Friendship Centre in Montreal (NFCM) and McGill University's First People's House. As this engagement enriched my knowledge about Indigenous health issues, I was amazed by the similarities between the rich Indigenous culture and my own culture and background in terms of spirituality, family ties, and worldviews. These common elements established an invisible bond that increased my interest in learning more about and helping the Indigenous population, while I also felt welcomed and accepted by them.

1.2. Setting the study context

Surveys have found that Indigenous populations had nearly double the prevalence of caries and periodontal disease and more unmet oral health needs compared with other Canadians (Canadian Dental Association, 2017; CAHS, 2014; Well Living House, 2018). This oral health inequality is linked to factors such as less access to affordable and nutritious food, higher rates of smoking, geographic barriers, lower education levels, and fewer regular dental visits by Indigenous people (Auditor General, 2017; Canadian Dental Association, 2017; CAHS, 2014; Well Living House, 2018). In 1945, the federal government agency Health Canada established the Non-Insured Health Benefits (NIHB) program. The program funds dental care, aiming at improving the oral health of Indigenous Canadians and closing the oral health inequality gap (Government of Canada, 2019a).

Health Canada also implemented the Children's Oral Health Initiative (COHI), which was first piloted in 2004. The COHI's objectives are to reduce and prevent oral disease through prevention, education, and oral health promotion and to increase access to oral health care (Mathu-Muju et al., 2016). Despite these programs, the oral health of Indigenous Canadians continues to lag far behind their non-Indigenous counterparts, and utilization rates in the NIHB are far lower than the rates for non-Indigenous sponsored dental plans (Canadian Dental Association, 2017; Federal, Provincial and Territorial Dental Directors [FPTDG], 2013; Well Living House, 2018).

In response to such persistent oral health inequalities, the Auditor General of Canada conducted a recent audit on the dental benefits of the NIHB and the COHI. Although the audit report critically crafted recommendations to improve the NIHB and the COHI, it disclosed that it did not consider the social determinants that may impact Indigenous people's oral health and access to dental services, nor the quality of dental services provided to Indigenous Canadians (Auditor General, 2017). The report also did not capture the views, concerns, or expectations of the Indigenous community regarding NIHB dental benefits.

Importantly, it seems that the provision of free dental services does not solely address the complicated nature of the oral health inequalities affecting Indigenous Canadians. To understand health inequalities between Indigenous and non-Indigenous people, it is important to contextualize them within the historical, political, social, and economic conditions that have influenced Indigenous health (Pan-Canadian Public Health Network, 2018; Wilk et al., 2018). The determinants of Indigenous people's oral health are deeply rooted in the colonial structure, which sought to assimilate Indigenous people into the dominant Euro-Canadian culture (Government of Canada, 2018a; CAHS, 2014).

Cultural groups have certain understandings and beliefs about oral health and dental care (Butani

et al., 2008; Place, 2012; Watt, 2012). The available literature indicates that Indigenous traditional health beliefs (e.g., the Medicine Wheel) influence the population's view about general health and measures to ensure good health (NETWORK, 2019b; Place, 2012; Well Living House, 2018). However, whether similar beliefs exist for the oral health of Indigenous people is unknown.

As of 2016, 44% of Indigenous people in Canada lived in urban areas (Anderson, 2019; Statistics Canada, 2016). Many have moved from rural isolated Indigenous communities, into which they were forcibly displaced by colonial powers, to urban areas in search of employment and education. Health information specific to urban Indigenous people is sparse, given that Canadian national health surveys do not fully capture the population (Rotondi et al., 2017; Statistics Canada, 2016). However, researchers are increasingly recognizing the health challenges that Indigenous people face in urban areas (Kitching et al., 2020; Lawrence et al., 2016; Well Living House, 2018). Extant literature suggests that urban Indigenous people may encounter unique challenges that impact their oral health and access to dental services. For example, although many Indigenous communities have a resident dentist or regular visiting dentist, this may not be the case for Indigenous people who relocate to the city. In addition, the population may experience racism, discrimination, cultural barriers, and social exclusion when navigating health care in urban areas (Kitching et al., 2020; Lawrence et al., 2016; Snyder & Wilson, 2015). In Quebec, a 2019 report by the (Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec) concluded that prejudice in the health care system and cultural barriers were having alarming consequences for Indigenous people. The most recent tragedy was the death of Joyce Echaquan in 2020, an Indigenous woman who accidentally died in a hospital outside of Montreal due to mistreatment and racial prejudice. Commenting on the incident, the Government of Canada acknowledged that systemic discrimination and racism in Canadian health care systems continues

to impact Indigenous people (Indigenous Services Canada, 2022).

Researchers still know little about such negative experiences regarding access to dental services. Overall, sparse empirical literature exists regarding the process through which urban Indigenous people find a dentist or navigate the dental care system.

Finally, recent studies suggest that urban living has shifted young Indigenous people's health beliefs from the traditional healing model to the Western biomedical model (Environics Institute, 2010; NETWORK, 2019b; Well Living House, 2018), which may influence how they maintain health and deal with illness. However, whether such changes apply to oral health and oral healthcare is still unknown.

Currently, Indigenous oral health literature mostly includes statistical data that demonstrate inequalities in oral health and access to oral health care services. Such quantitative indicators of health inequalities do not adequately incorporate Indigenous concepts of health and wellness, are insufficient for establishing programs and policies that contribute to improving the health of the Indigenous population, and may even be harmful if incorrectly used because they risk labelling Indigenous peoples with negative stereotypes (Government of Canada, 2018a). My doctoral research project explores the oral health perceptions of urban Indigenous people in Canada and their experiences with access to dental services. We hope that this study will help us to better serve this population and promote its oral health and well-being.

Based on my review of the published Indigenous health literature in Canada, this is potentially the first study of its kind. I conducted this study in Montreal, which has the largest Indigenous community in Québec and the second-largest Inuit population among Canadian cities (Statistics Canada, 2016). It needs to be noted that the Indigenous population in Montreal is spread across

the city and have no organized governing structure; besides, it comprises many groups, which is reflected by the high number of languages spoken (more than 70). (NETWORK, 2019a).

1.3. Organization of this dissertation

This dissertation consists of seven chapters. After this introduction, Chapter 2 presents a literature review, including general information about the oral health inequalities affecting Indigenous people in Canada, historical information about colonization and urbanization and their ongoing impact on Indigenous people's health, a review of the general and oral health of urban Indigenous communities in Canada, and an overview of the Indigenous communities in Montreal. In Chapter 3, I present the purpose of the study, the research question, and the study objectives. Chapter 4 describes the methodology, theoretical framework, recruitment process, data collection, and

CHAPTER 2. BACKGROUND AND LITERATURE REVIEW

The literature review presents some key terms and concepts in addition to general background information about Canada's Indigenous people's oral health and oral health care.

2.1. Key terms and concepts

'Indigenous people' is a collective term for the original people of areas such as North America and their descendants. The Canadian Constitution recognizes three groups of Indigenous people: Indians (more commonly referred to as First Nations people); the Inuit, who were the first Indigenous groups in the territory now called Canada; and the Métis, who are descendants of inter-marriage between Indigenous people and Europeans (Angell, 2019). These three distinct peoples have unique histories, languages, cultural practices, and spiritual beliefs. Thus, in the Canadian context, the word Indigenous should only be used when collectively referring to these groups (Indigenous Corporate Training Inc., 2017).

Indigenous communities are in urban and rural locations across Canada. First Nations people generally live in rural communities called reserves: lands held by the Federal Government for Indigenous people (Angell, 2019). More than 630 First Nations communities exist, with more than 50 distinct cultural groups and 50 Indigenous languages. The Inuit generally live in remote, rural, northern communities. These Inuit communities are not government but are spread across huge, settled land claims (based on old treaties and agreements between Indigenous people and the Europeans) in Nunatsiavut (Labrador), Nunavik (Québec), Nunavut, and the Inuvialuit Settlement Region of the Northwest Territories (NWT; Angell, 2019; Crown–Indigenous Relations and Northern Affairs Canada, 2017). Métis communities are mostly spread across cities or towns; Métis generally do not live on reserves or specific land territories. Some Métis settled land claims but live in northern Alberta and the NWT (Métis Nation, 2014). Urban Indigenous communities

are formed by Indigenous people from all three categories who are living in cities that are not part of reserves or traditional territories (Angell, 2019; Crown–Indigenous Relations and Northern Affairs Canada, 2017). In the Indigenous health literature, some terminology has particular meanings. For example, the term 'off-reserve Indigenous people' is common. This refers collectively to Indigenous people who do not live on reserves. However, the use of the term as such is inaccurate, given that only First Nations live on reserves (Mccue, 2018; National Aboriginal Health Organization, 2011). Thus, I use the terms 'off-reserve' and 'on-reserve' when describing First Nations people only. For collective referral, I will use the terms 'out of Indigenous-specific communities' and 'in Indigenous-specific communities.'

Another common inaccuracy in the literature is the conflation of the terms 'off-reserve' and 'urban.' These are not synonymous. Although three out of every four off-reserve First Nations people mostly live in urban areas, some reside in rural areas (Statistics Canada, 2013a). Similarly, the term 'on-reserve' is not necessarily synonymous with 'rural.' Although on-reserve First Nations people mostly live in rural areas, some reserves are located on the borders or suburbs of urban areas (2% of reserves). An example is the Kahnawake and Kahnastake reserves, which are very close to Montreal (Statistics Canada, 2013b). However, the term 'urban Aboriginal,' as defined by the Government of Canada, refers to urban Indigenous people living out of Indigenous-specific communities, regardless of urban or rural dwelling area (Angell, 2019; Crown–Indigenous Relations and Northern Affairs Canada, 2017).

Some First Nations people are entitled to certain benefits from the Canadian Government. To be entitled to such benefits, however, a First Nations individual must be registered as a Status Indian according to the Federal Government (National Aboriginal Health Organization, 2011). Only those First Nations people who comply with distinct standards of government regulation are recognized

as Indians under the Indian Act and thus are eligible to register as Status Indians, also called Registered Indians. Those who are not eligible to register are referred to as Non-Status or Non-Registered Indians (National Aboriginal Health Organization, 2011).

The Indian Act (1876) is the main federal statute that deals with Indian status, local governance, and the management of reserve land and communal monies (Government of Canada, 2020a). It was initially meant to help the Federal Government assimilate Indigenous people into Western culture. A new version of the Act was passed in 1951 (Government of Canada, 2020a), and amendments were made in 1985 that changed the definition of Indian status, as will be explained later in this literature review.

Under the Indian Act, reserves are referred to as 'Indian Bands,' and residence on a reserve is governed by Band councils. Although the Federal Government still uses the term 'Band,' many reserves or Bands are now referred to as First Nations (Government of Canada, 2020a). According to the Indian Act, Registered Indians have the right to live on reserves, and they automatically become Band members. Non-Status Indians can also be granted Band membership and can live on reserve upon approval by Band councils, according to the Indian Act amendments in 1985 (Government of Canada, 2020a). However, Non-Status Indians are not entitled to the special governmental benefits and health services provided to Status Indians.

The term 'Aboriginal people' is also sometimes used in Canada. 'Aboriginal peoples' became popular as the collective noun for First Nations, Inuit, and Métis and was widely adopted by the government and many national groups (Crown–Indigenous Relations and Northern Affairs Canada, 2017). This distinction was made legal in 1982; Section 35 (2) of the Constitution Act states: "In this Act, 'Aboriginal peoples of Canada' includes the Indian, Inuit, and Métis peoples of Canada" (Indigenous Corporate Training Inc., 2014). Currently, the Federal Government has

moved to use ‘Indigenous.’ For example, in November 2015, it changed Aboriginal Affairs and Northern Development to Indigenous and Northern Affairs Canada (IANC; Government of Canada, 2016). Further, in August 2017, the government split the IANC into Crown–Indigenous Relations and Northern Affairs Canada along with Indigenous Services Canada. These changes indicate the intent of a changing relationship with Indigenous peoples in Canada (Crown–Indigenous Relations and Northern Affairs Canada, 2017).

Importantly, the term ‘Indian’ when referring to First Nations people in Canada is considered outdated by many. It was coined by the explorer Christopher Columbus, who confused the original inhabitants of the Americas with people from India, the land for which he was searching (Government of Canada, 2019b; Hoxie, 1996). However, the term Indian remains referring to First Nations people in some legal instruments in Canada**.** Hence, I will only use this term if the distinction is important for discussing legislative issues. Other terms such as ‘Native,’ ‘Indigenous,’ and ‘Amerindian’ are more commonly used in other parts of the Americas when referring to their original inhabitants (National Aboriginal Health Organization, 2011).

Further, in Québec, it is common to refer to Indigenous ‘communities,’ not ‘reserves,’ because Indigenous communities in northern Québec are not reserves that are regulated by the Indian Act; reserves are only found in southern Québec (Bartlett, 1990; C. Lévesque et al., 2001). First Nations and Inuit people in northern Québec, instead, live in villages with recognized rights. They are covered by laws based on the *James Bay and Northern Québec Agreement* and the *Northeastern Québec Agreement*, which superseded the Indian Act in the 1970s (Bartlett, 1990; Crowe, 1991). These laws granted the people full title to some lands and reserved adjacent land territories (e.g., Terres réservées aux Cris and Terres réservées aux Naskapis) where they can exercise rights such as hunting and fishing (Government of Canada, 2020b; Québec, 2020).

In addition to these specific Indigenous terminologies, I would like to define some of the main concepts that I will be discussing throughout this thesis. The terms 'social determinants of health' (SDH) and 'health inequity' are important when aiming to understand Indigenous people's health. According to the World Health Organization, SDH are "the circumstances in which people are born, grow up, live, work, and age and the systems put in place by people to deal with illness. These circumstances and systems are in turn shaped by a wider set of forces: economics, social policies, and politics" (World Health Organization, 2013).

The term health inequity is often confused with 'health inequality,' but they are not interchangeable. Health inequalities can be defined as differences in health status or the distribution of health determinants between different population groups; sometimes they can be attributable to biological variations or free choice (Global Health Europe, 2014; World Health Organization, 2013). Health inequalities become health inequities whenever these are avoidable inequalities that arise from social and economic conditions such as poor governance, corruption, or cultural exclusion (Global Health Europe, 2014; World Health Organization, 2013).

Oral health has long been described as an integral component of general health (Canadian Dental Association, 2017). Oral health and general health can be affected by the same risk factors (Sheiham & Watt, 2000; CAHS, 2014). For example, high intake of refined sugars affects, although through different etiological pathways, dental caries, obesity, and diabetes. Individuals with unhealthy teeth may experience an inability to chew food properly; this may lead to malnutrition and decreased immunity against diseases (Azzolino et al., 2019; Canadian Dental Association, 2017). Furthermore, people with diabetes are more susceptible to gum disease, which in turn can put them at greater risk of diabetic complications (Azzolino et al., 2019).

2.2. Influence of social and cultural aspects on oral health

Studies have examined the social determinants of Indigenous people's health in Canada (Greenwood & de Leeuw, 2012; Kim, 2019; Pan-Canadian Public Health Network, 2018). Although not specific to oral health, their findings are important because general and oral health share the same social determinants (Watt, 2012). However, these studies mostly focused on Indigenous people living in rural Indigenous-specific communities, although more than half of the Indigenous population in Canada now live in urban areas. The social determinants of Indigenous people's health (e.g., education, employment, income) may differ between urban and rural Indigenous communities and between different cities (Place, 2012).

The SDH model used for understanding the health of general populations fails to explain the health of Indigenous people (Butani et al., 2008; Place, 2012). A report by Statistics Canada showed that factors such as education, income, and lifestyle could not fully explain the difference in health status between Indigenous and non-Indigenous people in urban areas (Garner et al., 2010). The social determinants of Indigenous people's health are deeply impacted by the colonial history of Canada (Place, 2012; CAHS, 2014). Social exclusion and racism experienced by Indigenous people have directly impacted their health (De Leeuw et al., 2010; Environics Institute, 2010; Place, 2012, Indigenous Services Canada, 2022). De Leeuw et al. (2010) emphasized that the Western construct of the SDH does not account for some important health determinants linked to colonization, which impacted Indigenous people's health, such as Indigenous people's loss of control over their culture, physical environment, and healthy development (De Leeuw et al., 2010). In addition, the oral health literature suggests that the traditional cultural beliefs, values, and practices of culturally disadvantaged communities may influence how community members maintain oral health and deal with oral illness (Butani et al., 2008; Carteret, 2013; Smith et al., 2013). Although the SDH framework recognizes the cultural influences of factors such as dental

education, employment, and income, certain emphasis should be placed on the traditional cultural beliefs of disadvantaged cultural groups (e.g., Indigenous people). Their traditional cultural beliefs may influence their oral health beliefs and oral health care-seeking practices in a way that may be significantly different from the biomedical dental model (Butani et al., 2008). For example, Indigenous Canadians tend to have a holistic worldview that can be represented by the Medicine Wheel. Indigenous cultures across the world embraced the Medicine Wheel for thousands of years (Joseph, 2013). Shown in Figure 2.1, this is a circle with four coloured quadrants that represent a set of holistic beliefs encompassing the mind, body, emotions, and spirit. These are the foundational aspects of the human being and the self. In the centre of this circle are balance and harmony. The circle represents the interconnectivity of all aspects of the self (i.e., physical, emotional, mental, and spiritual). Further, the circle influences how Indigenous people view and make sense of the natural growth of the world. Specifically, Indigenous people see and respond to the world in a circular fashion and are influenced by the examples of the circles of creation in their environment (Joseph, 2013).

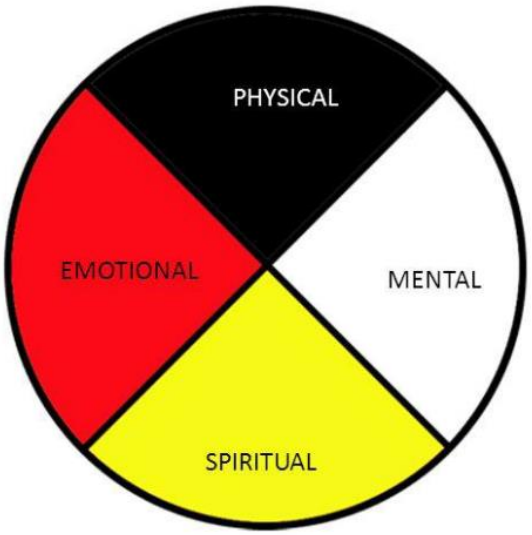

Figure 2.1. The Medicine Wheel.

Traditional Indigenous healing requires an understanding of the self. Each aspect of self is intricately interconnected to the others, and they are inseparable. The concept of holism is an integral part of Indigenous Canadian culture, and every aspect of the self requires careful and specific attention to maintain balance and harmony (Hill, 2014; Morrisseau, 1998; Nabigon & Mawhiney, 1996). Therefore, healing must address issues of the spiritual, emotional, physical, and mental aspects of the self (Hill, 2014).

The Medicine Wheel thus helps Indigenous people understand the self and maintain health (Hill, 2014). Recent literature has focused on its use to recover from illness and regain health. For example, researchers used the Medicine Wheel in diabetes education (Kattelmann et al., 2009) and end-of-life care for Aboriginal people (Clarke & Holtslander, 2010). However, oral health researchers do not know whether the Medicine Wheel has any implications on how Indigenous people maintain their oral health or deal with oral illness. Furthermore, the Medicine Wheel has seemingly not yet been used in oral health education.

2.3. Oral health inequalities affecting Indigenous people in Canada

The FPTDG (2013) developed the second national oral health strategy, the Canadian Oral Health Framework 2013–18 (COHF). This strategy acknowledges that Indigenous people experience higher oral disease rates than their non-Indigenous counterparts. Oral health has become an Indigenous health priority recognized by Indigenous communities and federal, provincial, and territorial governments in Canada (Canadian Institutes of Health Research, 2019).

The COHF report by the FPTDG and a report by the Canadian Academy of Health Sciences established an important comparison between Indigenous people's oral health and that of the rest of the Canadian population (CAHS, 2014). In both reports, the comparison was based on data from the Canadian Health Measures Survey (CHMS) 2007–09, the 2008–09 Inuit Oral Health Survey (Inuit OHS), and the 2009–10 First Nations Oral Health Survey (First Nations Information Governance Centre, 2012). Excerpts from the FPTDG report are presented in Table 2.1.

Table 2.1: Comparison of dental caries experience among Indigenous and non-Indigenous Canadians.

Indicator	**Non-Indigenous Canadians**	**Inuits**	**First Nations**
Proportion of 6-year-olds with dmft/DMFT >0	46.6%	86.1%	92.4%
Proportion of 6–11-year-olds with dmft/DMFT >0	23.6%	60%	67.1%
Average DMFT in 12-year-olds	1.0	2.01	3.9
Average DMFT in 12–19-year-olds	2.49	9.49	6.15
Proportion of 12–19-year-olds with DMFT=0	41.2	3.3	8.6

Note: The DMFT is the index of decayed, missing, and filled teeth. It is an indicator of oral health commonly used in dentistry for individuals with secondary teeth. It indicates the experience of dental decay and its consequences. It is referred to as dmft when used with primary teeth (i.e., young children).

As shown in Table 2.1, across the different age groups, First Nations and Inuit people generally had much higher DMFT scores than their non-Indigenous counterparts; higher DMFT scores mean

more experience of dental caries. Among the age group 12–19 years, for example, 41.2% of non-Indigenous Canadians had not experienced caries on permanent teeth (DMFT=0), whereas only 3.3% of Inuit and 8.6% of First Nations people were in the same situation.

The 2014 CAHS report presents a similar trend, supporting that oral health inequalities exist between Indigenous and non-Indigenous Canadians. Concerning oral health prevention, for example, 73% of non-Indigenous participants reported brushing their teeth at least twice a day, compared to 55% of First Nations and 42% of Inuit participants. In addition, whereas 12% of non-Indigenous participants reported avoiding food because of pain in their teeth or mouth, the proportion was 40% and 30% for First Nations and Inuit people, respectively. Furthermore, 84% of non-Indigenous participants reported having good or excellent oral health, compared to 60% of First Nations and 65% of Inuit people. Notably, the CAHS and FPTDG reports did not present any specific data for urban Indigenous populations. In other words, national Canadian health surveys did not recognize the specific health needs of urban Indigenous communities, meaning a lack of population-based health datasets for urban Indigenous people. The situation has changed over time, with recent surveys focusing on the health of urban Indigenous populations.

2.4. Oral health care services for Indigenous people in Canada

In Canada, several interventions have been implemented in Indigenous communities to improve the oral health of Indigenous people. For example, the First Nations and Inuit Branch (FNIB) of Health Canada established the COHI as a policy response to the oral health needs of First Nations and Inuit children living on reserves (Auditor General, 2017; Mathu-Muju et al., 2016). The objective of the COHI is to reduce and prevent oral disease through education, prevention, and oral health promotion and to increase access to oral health care. The preventive services include fluoride treatments and sealants for children aged 7 years and under. Oral health education is

delivered to children, their parents and caregivers, and pregnant people. In 2004, the COHI was piloted in 41 Indigenous communities and had expanded to 320 First Nations and Inuit communities in 2014, representing 55% of all eligible such communities. For example, in 2012, 23,085 children had received COHI preventive oral health services. This initiative has reduced decay rates in children and increased awareness of the importance of oral health (Auditor General, 2017; Mathu-Muju et al., 2016). The proportion of Indigenous children who were caries-free increased from 39.4 % in 2006–07 to 44.4 % two years later (CAHS, 2014). However, an audit of the COHI found that enrolment in the initiative and the number of services it delivered had declined. The report suggested that the decline in enrolment could indicate problems with the way Health Canada managed the initiative and communicated with eligible communities (Auditor General, 2017).

2.5. The Non-Insured Health Benefits program and dental care

The NIHB program was established by Health Canada to help First Nations and Inuit people reach an overall health status that is comparable with other Canadians (Government of Canada, 2019a). The NIHB provides coverage for a limited range of health services, including dental, that are not covered by private insurance plans or provincial or territorial health or social programs. These services are provided by salaried dentists and dental hygienists who are employed by the First Nations and Inuit Health Branch of Health Canada, Department of Indigenous Services Canada (Government of Canada, 2019c). The eligibility criteria for NIHB can be complicated. Only First Nations people with Indian status are covered. For an Inuit individual to be eligible, they must be a beneficiary of either the Nunavut Land Claim Agreement or the Inuvialuit Final Agreement. Métis are not covered under this federal program (Government of Canada, 2018b). In some cases, the provincial or territorial government takes responsibility for Indigenous people’s health

benefits, including dental. For example, the NWT Government provides health coverage for their Métis population under the Métis Health Benefits (MHB) program. This program follows the benefit guidelines of the federal NIHB services (NWT Health and Social Services, 2020).

In addition, the James Bay Cree living in the northern villages of Québec have a dental clinic in each village, and services are covered by a provincial dental plan (NIHBCree; personal communication with a Health Canada representative, 2014). When Cree are living outside of their territory (e.g., for studies or temporarily), they are still covered by the NIHBCree service. If they permanently move out of the villages, they then become eligible instead under the federal NIHB. On the other hand, First Nations (other than Cree) and Inuit people in Québec are covered by the federal NIHB even if they move out of their reserves or villages.

In summary, all eligible First Nations and Inuit people in Canada who live in urban areas can receive dental health benefits through federal, provincial, or territorial governments (Personal communication with a Health Canada representative, 2014). However, some dental treatments are not covered under the NIHB or require pre-approval. An example is orthodontic treatment for individuals over 18 years old. Applying for and obtaining the pre-approval can be time-consuming and, in some instances, the patient can pay in full and then apply for a refund if the approval is received (Government of Canada, 2019c).

The CAHS report discusses some explanations of why Indigenous people have poorer oral health and why they visit the dentist less frequently than non-Indigenous people, even though the cost is less of a barrier for Indigenous people who benefit from the NIHB (CAHS, 2014). Importantly, the Auditor General of Canada (2017) conducted an audit of the NIHB dental benefits and COHI, making two important conclusions: (1) Health Canada did not demonstrate the extent to which the NIHB helped maintain and improve the overall oral health of Inuit and First Nations people at the

population level, and (2) although the COHI helped some First Nations and Inuit children improve their oral health, both enrolment in the initiative and the number of services it delivered had declined (Auditor General, 2017). Although the audit report proposed recommendations for improving the NIHB and COHI, it did not consider that SDG may impact Indigenous people's access to the NIHB. The report also did not consider the quality of services that dentists provided to Indigenous people (Auditor General, 2017).

2.6. Demographics and history of Indigenous people in Canada

In the following section, I will present the demographics of Indigenous people in Canada according to the most recent 2016 census. I will also explain how the histories of colonization and urbanization have influenced Indigenous people's health to date.

Data from the 2016 census indicate that 1,673,785 people reported an Indigenous identity, representing 4.9% of the total Canadian population (Statistics Canada, 2016). First Nations people represented 58.3% of the Canadian Indigenous population, Métis formed 35.1%, and Inuit represented 3.8% (Statistics Canada, 2016). Previously, Indigenous people accounted for 4.3% of the population enumerated in the 2011 census, 3.8% in the 2006 census, 3.3% in the 2001 census, and only 2.8% in the 1996 census (Statistics Canada, 2013a). Overall, the Indigenous population increased by 42.5% between 2006 and 2016, more than four times the growth rate of the non-Indigenous population over the same period (Statistics Canada, 2016).

Notably, however, the increase in census counts of Indigenous people may be partly related to legislative changes. For example, Bill C-31 in 1985, an amendment to the Indian Act, reinstated some individuals who had lost their Indian status. This change included women who had previously lost their Indian status after marrying non-Indigenous men (Statistics Canada, 2013a). Similarly, the enaction of Bill C-3 in 2011 ensured that eligible grandchildren of women who lost

their status because of marrying non-Indian men were entitled to registration for Indian status (Statistics Canada, 2013a). As a result of Bill C-31 and C-3, approximately 45,000 persons became newly entitled to register for the census. Another reason for the census increase may be that more Indigenous people have been identifying themselves as Indians, possibly to receive certain exclusive benefits from the Canadian Government (Statistics Canada, 2013a) or because of the Indigenous pride movement (Environics Institute, 2010). Importantly, the 2011 census indicated that off-reserve Indigenous people were a fast-growing population. In 2016, 867,415 Indigenous people lived in a metropolitan area of at least 30,000 people, accounting for over half (51.8%) of the total Indigenous population. From 2006 to 2016, the number of Indigenous people living in metropolitan areas increased by 59.7% (Statistics Canada, 2016).

Understanding the present circumstances and oral health inequalities of Indigenous people in Canada is impossible without understanding the history of colonization and its ongoing impact on their health in general. Therefore, I will now examine the major events in the history of Indigenous populations in Canada.

2.7. Indigenous people's history of colonization and its health impact

Historians suggest that North America was home to Indigenous people 30,000 years ago, who arrived from Asia by a land bridge between Siberia and Alaska (Canadian Museum of History, n.d.). Indigenous people originally had nomadic hunting and fishing lifestyles. By the 16th century, European explorers such as Jacques Cartier and Samuel de Champlain arrived at the land that would become Canada and started to settle and colonize (Crossley, 1996).

Upon the Canadian Confederation in 1867, the Canadian Government created policies such as the Indian Act (1876) that gave the Crown sweeping authority over land belonging to Indigenous people ; (Government of Canada, 2020a). The federal and provincial governments now had the

authority to decide how land that belonged to Indigenous people would be developed. The significant reduction of the Indigenous territory also limited the extent of traditional Indigenous activities such as hunting, trapping, and capture of wild horses. In addition to controlling the land, the federal and provincial governments determined Indigenous nations and groups and imposed different sets of rights and obligations on Indigenous people without prior consultation with their chiefs. Fundamentally, the Indian Act was designed to assimilate First Nations and Inuit people into the dominant Euro-Canadian standards of civilization. Indigenous people were forced to speak and write English and adopt European-based cultures, although most of the new values and morals conflicted with traditional Indigenous values and customs (Silver et al., 2006). The strategic plan to assimilate Indigenous people became more evident in 1920 when the Indian Act amendments imposed the mandatory 'residential school system' on Indigenous children (Government of Canada, 2020a; Truth and Reconciliation Commission of Canada, 2016; Wilk et al., 2017).

2.8. The residential school system

More than 150,000 Indigenous children (aged 4 to 16 years) were removed from their communities and families to attend Indian residential schools. The goal was to "civilize the Indians" and break their links to their culture and identity (Government of Canada, 2019d; Truth and Reconciliation Commission of Canada, 2016). For example, children were forbidden to speak their Indigenous languages and required to use English or French; they were also required to adopt the religious denomination of the school and forced to wear uniforms. Although the residential school system only became mandatory in 1920, they operated since the 1870s (Government of Canada, 2019d; Truth and Reconciliation Commission of Canada, 2016; Union of Ontario Indians, 2013). The 139 schools were funded and operated by the Canadian Government and the Canadian Church entities church. While most stopped operating by the mid-1970s, the last federally run residential school closed in 1996 (Truth and Reconciliation Commission of Canada, 2016).

In May 2006, the Canadian Government approved the Indian Residential School Settlement Agreement with the aim of bringing a fair and lasting resolution to the legacy of the schools (Government of Canada, 2019d). For example, the settlement agreement provided financial compensation to Indigenous survivors of the schools and those who experienced sexual or physical abuse in them (Government of Canada, 2019d).

On June 11, 2008, the Canadian Prime Minister acknowledged the inter-generational damage caused to former students of Indian residential schools and their families and communities, offering an apology in the House of Commons. He asked for forgiveness from the Indigenous people of Canada for failing them so profoundly (Truth and Reconciliation Commission of Canada, 2016).

2.9. Impact of colonization on Indigenous general and oral health

Historical research clearly indicates a link between colonization and the disease and death experienced by Indigenous people (Grygier, 1994; Kelm, 1998). Colonization led to the loss of Indigenous lives caused by wars and the rise of many foreign diseases to which they lacked immunity, such as smallpox, malaria, tuberculosis, and cholera (McGhee, 1994).

The effects of colonization on health became especially evident in the first half of the 20th century, when an Indigenous health crisis occurred. A tuberculosis epidemic severely infected the Indigenous people, with 80% of its victims under 30 years old (Grygier, 1994; Kelm, 1998). By the 1940s, Indigenous people in Canada were seven times more likely to die of pneumonia, 13 times more likely to die of whooping cough, nine times more likely to die of influenza, and 46 times more likely to die of measles than non-Indigenous people (Kelm, 1998). These diseases had a devastating effect on Indigenous people, who neither were immune to them nor knew how to cure them (Kelm, 1999; McGhee, 1994).

The residential school system had a clear impact on Indigenous people's general and oral health. Some of the documented experiences by students of these schools included the lack of a nutritious diet, being served spoiled food, and exposure to contagious illnesses. For example, students with tuberculosis did not receive proper medical attention and were not separated from their classmates, thereby increasing the risk of spread (Truth and Reconciliation Commission of Canada, 2016).

Mosby (2013) revealed details of significantly unethical nutrition experiments conducted on Canadian Indigenous children at six residential schools between 1942 and 1952. The experiments were undertaken by the Department of Indian Affairs of Canada and performed by two physicians. Parents were not informed about these experiments and never provided consent, and the experiments continued even when children died (Mosby, 2013). In these experiments, treatment

and control groups of malnourished children were denied adequate nutrition. In one, the treatment groups were given supplements of riboflavin, thiamine, and ascorbic acid to determine whether these mitigated their problems. In another, children received a flour mix containing added thiamine, riboflavin, niacin, and bone meal. Instead of improving nutrition, the children became more anemic, likely impacting their development and leading to more deaths. Those who conducted the experiments made all efforts to control as many factors as possible, even when the subjects were harmed. For example, children were denied available dental care because the researchers intended to monitor the state of dental caries and gingivitis with malnutrition (Mosby, 2013).

Historical data specific to the oral health of Indigenous people is scarce. However, health surveys among the Inuit in Northern Québec provide an idea about their oral health. For example, adult Inuit suffered from significant tooth loss due to extractions: a survey in 1983–1984 suggested that many Inuit did not have any upper or lower teeth (Blanchet et al., 1992). Another survey in 1991–1992 showed that 63.8% of those aged 45 years and older no longer had teeth (Sante Quebec, 1994). Twelve years later, the Nunavik Health Survey in 2004 found that 30% of Inuit aged above 50 years were unable to chew either meat or apples (Institut national de santé publique du Québec, 2007).

2.10. The Oka crisis

Many conflicts have occurred for decades between First Nations people and the Canadian Government. For example, one major violent conflict that occurred close to Montreal in the late 20th century became known as the Oka crisis (Conradi, 2009; Marshall, 2013). In July 1990, Montreal's mayor requested to establish a golf course and residential developments in the town of Oka on land that partially belonged to Indigenous people, near the Mohawks community of

Kahnastake, northwest of Montreal. However, the mayor's orders failed due to the resistance of the community members, who used armed defence against Québec's police and the Canadian army (Marshall, 2013). The Oka crisis led to the establishment of the Royal Commission on Aboriginal Peoples and has directed attention to the shared challenges Indigenous people face across Canada (Royal Commission on Aboriginal Peoples, 1996).

The effects of colonization continue today. The various forms of abuse that took place in some residential schools and the destruction of family ties and cultural identity have been linked to increased violence and suicide in First Nations and Inuit communities (NETWORK, 2019b; Partridge, 2010; Wilk et al., 2017). Generations of Indigenous people experienced profound changes in their cultural and family lives, and now experience social exclusion and racism in urban areas, which are vital components of the SDH (Well Living House, 2018, Indigenous Services Canada, 2022). Indigenous people have been working to change the social and economic disruption, the loss of languages, and the assimilation of their cultures (Carmen, 2016).

I will now describe the urbanization process of Indigenous people, which refers to their movement from Indigenous-specific communities to urban centres. This brief description will help the reader to understand how urbanization and living in urban areas may have influenced the health, including oral health, of Indigenous people.

2.11. Indigenous people's history of urbanization and its health impact

In the 1950s, Indigenous people began what has been referred to as the first wave of migration into urban centres (Newhouse, 2003). The reasons for this migration included poor housing, inadequate resources, unemployment, and alcohol abuse in their home Indigenous communities. The 1951 census indicated that only a few hundred Indigenous people resided in any metropolitan area: 7% of the total Indigenous population in Canada (Norris & Clatworthy, 2011). The urban Indigenous

population steadily grew in the following decades. In recent years, the increase has been significant. Urban Indigenous people comprise approximately 51.8% of the Canadian Indigenous population today, according to the 2016 census (Statistics Canada, 2016).

Urban Indigenous people face similar challenges to other migrants to Canadian cities, such as finding appropriate employment, housing, and education; learning new languages; and interacting with people from diverse backgrounds (Newhouse & Peters, 2003). These are all important SDH. Urbanization of Indigenous people, however, differs from that of other migrants to Canadian cities. Indigenous people as the original inhabitants of North America are migrating within their own territories (Cooke, 2013). Indigenous urbanization is directly related to historical conditions caused by colonial strategies that removed Indigenous people from emerging urban areas and located reserves far from urban centres (Newhouse & Peters, 2003; Silver et al., 2006). Thus, when Indigenous people migrate to urban areas, which for some are their traditional lands, their sense of ownership and identities can be expected to "make a difference to the ways they structure and live their lives in these urban areas" (Newhouse & Peters, 2001, p. 6). Indigenous people's sense of ownership and identity are also important SDH in urban areas. These may be reflected by their social exclusion and experience of racism, which affect their health and access to health care services (Loppie, 2015).

In addition, some Indigenous migrants are continuously mobile between their rural home communities and urban areas; their migration patterns are not unidirectional like other migrants (Graham & Peters, 2002). Thus, urban Indigenous people are usually underrepresented in census counts. Their continuous mobility also makes providing them with accessible health care services challenging. Conducting research and health promotion programs to understand this population's health needs are also difficult (Browne, A et al., 2009).

2.12. History of Indigenous urbanization in Québec's cities

Browne et al. (2009) described the urbanization of Indigenous people in Canada as a "Western Canadian phenomenon." Indigenous urbanization in Western Canada dates back to the 1950s; it only intensified in Québec in the early 1980s (Lévesque, 2003). Although Indigenous people in some Québec cities are becoming more visible, 72% of Québec's First Nations people still live on reserves today, the highest proportion among Canadian provinces (Statistics Canada, 2013b). A study of the Montreal Indigenous community in 2012 showed that most participants were newcomers or 'first-generation' (NETWORK, 2019b).

In contrast, urban Indigenous people in the West often have been born and lived in cities for several generations (Lévesque, 2003). Many no longer maintain strong ties with their Indigenous communities of origin. On the other hand, 90% of Québec's urban Indigenous population were born or have lived in an Indigenous community, and close ties exist with their communities of origin and ancestral hunting grounds (NETWORK, 2019a). Therefore, unlike in Western Canadian cities, Indigenous people in Québec's cities are highly mobile and may retain their traditional cultural beliefs. These factors may influence their oral health and access to oral health care services.

Some authors describe Indigenous 'urban living' in Québec as an extension of 'community living' (Regroupment des centres d'amitie autochtones du Québec, 2017). As such, urban living is no longer seen as incompatible with Indigenous people's culture, in contrast with popular views in the immediate post-colonial era (NETWORK, 2019b). As Lévesque (2003) put it, "In this meeting of cultures, we are seeing new modes of expression that are more closely associated with a strengthening of Indigenous cultural identity than with its fragmentation and disintegration" (p. 32). Hence, it is reasonable to expect that Québec's urban Indigenous people are still attached to

their traditional cultural beliefs, which may influence their oral health (Levesque, 2003).

2.13. Review of urban Indigenous people's general and oral health

Although data specific to urban Indigenous health has been lacking because such information was not identified in the datasets of Canadian health surveys, this is not the case anymore. Recent surveys have specifically focused on urban Indigenous health.

Health status of urban Indigenous populations

The "Our Health Counts" (OHC) project was conducted to gather baseline health and well-being information about urban Indigenous populations in the province of Ontario (Well Living House, 2018). Carried out in collaboration with an urban-based Indigenous organization, the study highlighted the gaps in reported chronic disease conditions among urban Indigenous people compared to non-Indigenous Canadians. The study found that urban Indigenous adults in Toronto were up to 10 times more likely to report at least one chronic health condition compared to non-Indigenous Canadians. The authors associated the high prevalence of chronic diseases with a disproportionate burden of poverty, racism, and adverse living conditions (Well Living House, 2018). For example, the reported rate of diabetes mellitus in the survey of urban Indigenous adults was double that of the same age category in the general Canadian population.

The mental health of 31% of Indigenous people versus 72% of non-Indigenous participants was reported as very good or excellent. This implies that Indigenous adults were twice less likely to perceive their mental health as suboptimal, compared to non-Indigenous Canadians. The gap is even wider when looking at specific mental health conditions. For example, the reported prevalence of anxiety disorder and post-traumatic stress disorder were at least three times higher among Indigenous adults compared to the same age category in the general Canadian population.

In the study, 54% of Indigenous participants reported experiencing racism. Specifically, one in

every four Indigenous participants indicated unfair treatment by a health care professional that they attributed to their Indigenous identity. The majority (71%) of those who felt discriminated against indicated that they either were reluctant to or never returned to the health service provider for continued care. Overall, over half of the individuals who had experienced racism suggested that the encounter had a negative impact on their self-esteem. Further, they indicated that racism towards Indigenous people was a serious issue in Toronto.

The authors of the OHC study concluded that culturally based health care and health promotion initiatives are important to increase treatment uptake and health literacy. These measures, according to them, may improve the overall health and well-being of Indigenous people (Well Living House, 2018).

Inequalities in health status and access to health care services between Indigenous people and non-Indigenous Canadians have existed for decades. Statistics Canada has investigated reasons for the health gap between urban Indigenous and non-Indigenous people. It found that Inuit, Métis, and off-reserve First Nations adults remained in poorer health than non-Indigenous adults even after adjusting for socioeconomic characteristics, access to health care, and lifestyle risk factors. The study suggested that other factors could be involved and health determinants may vary between First Nations people, Métis, and Inuit (National Collaborating Centre for Indigenous Health, 2011).

Wilson and Cardwell (2012) examined the inequalities between urban Indigenous populations and their non-Indigenous counterparts. The study found that although health inequalities existed between Indigenous and non-Indigenous populations in urban areas, they were not as large as those between Indigenous people living in Indigenous-specific communities and non-Indigenous people. Their study suggested that culturally specific determinants of health were one potential explanation

for inequalities in health between urban Indigenous and non-Indigenous people (Wilson & Cardwell, 2012).

In Montreal, where my research took place, the Montreal Urban Aboriginal Health Committee (MUAHC) conducted a health needs assessment of the Indigenous community in 2012 (Montreal Urban Aboriginal Health Committee, 2012). Quantitative and qualitative data were collected from Indigenous people and health services providers in Montreal and analyzed. Overall, participants in the study rated their general health as low. The two major findings of the study were that (i) around half of the service users and service providers were not satisfied with the administration of services and (ii) Indigenous people were not involved in managing their services or sharing decisions with their service providers. Traditional healing seemed important to participants: they preferred the traditional healing services found in their communities even when the services existed in the city and even though transportation to their communities was difficult. Mental health was a major concern and one of the most frequently sought services. Having a good social network was also important for people's health and well-being. Although overall mainstream services appeared to meet the needs of the community, the cultural appropriateness and accessibility of these services seemed to be major problems. The barriers to access included language and social class discrimination, difficulty finding doctors and nurses, long waiting lists, and a lack of identification papers for Inuit people. In summary, access to health services was a clear problem, and incorporating traditional healing, Indigenous spirituality, and cultural sensitivity was still lacking in the Québec health care system.

How Indigenous people's general health may impact their oral health

Indigenous people in Canada experience higher rates of chronic diseases and health problems than non-Indigenous people, such as diabetes, heart problems, obesity, and mood disorders. They also

experience higher rates of risk factors such as smoking and stress. This information about their health status and risk factors is relevant to their oral health. Oral health problems have risk factors in common with many chronic diseases (FDI World Dental Federation., 2020). Indigenous people's high rates of smoking may lead to general chronic diseases, and the dryness of the oral cavity created when smoking may also increase the risk of dental caries (Jiang et al., 2019), periodontal disease, and oral cancer (Zhang et al., 2019). In addition to heart problems, the elevated level of stress among Indigenous people has been associated with chronic musculoskeletal pain that can affect the temporomandibular joint (First Nations Information Governance Centre, 2012). Moreover, the high rates of obesity and diabetes among Indigenous people are related to poor diet, which is in turn associated with dental caries and periodontal diseases. The intricate link between general health and oral health underpins the common risk factor approach to oral health promotion (Sheiham & Watt, 2000).

Oral health status of urban Indigenous people in Canada

Although information about the oral health of urban Indigenous populations in Canada is scarce, the OHC project, conducted by Well Living House in Toronto (2018) is notable, given its important baseline data. Whereas 85% of non-Indigenous adults in Toronto rated their oral health as good, very good, or excellent, the proportion was 54% of Indigenous adults. This represents a huge gap even if no statistical test was conducted to verify the significance of the difference (Well Living House, 2018).

In terms of access to dental services, around 50% of the Indigenous participants reported that they had consulted a dentist in the past 12 months. Among these individuals, 28% had sought emergency dental care. This compares unfavourably to the 75% of non-Indigenous adults who reported consulting a dentist during the same period. For the Indigenous participants, reasons for

not visiting a dentist regularly included the cost, lack of time, and low importance attributed to oral health. Lawrence et al. (2016) also found that racism, either perceived or experienced, was an important determinant that negatively affected access to oral health services and dental care for urban Indigenous people in Manitoba and Ontario (Lawrence et al., 2016).

The OHC is the most recent comprehensive survey to provide health information for urban Indigenous populations in Canada. Although this project was conducted in six different cities in Ontario, data about oral health was only included in the Toronto study. The result clearly demonstrates oral health inequalities between Indigenous people in Toronto and their non-Indigenous counterparts.

The Montreal Urban Aboriginal Health Needs Assessment is more relevant to my study given that both took place in Montreal and examined oral health services, although using different methods. The health needs assessment allowed Indigenous organizations in Montreal to reflect on health service delivery to Indigenous people and suggest strategies to reduce gaps and inequalities in the continuum of health care (Montreal Urban Aboriginal Health Committee, 2012). In particular, dental professionals and Indigenous people were asked to rate on a scale of 0 (very bad) to 10 (very good) the dental services available to Indigenous people. The study found that dental care was a highly sought health service, with 54 out of the 89 participants (60%) reporting going to the dentist. Indigenous participants rated the appropriateness of oral health care services highly, whereas dentists rated the services as fairly good. However, the study did not provide insights into participant assessments of dental services as such.

Existing oral health initiatives targeting rural vs urban Indigenous people

The Canadian Government has implemented two interventions in Indigenous communities to improve oral health: FNIB and COHI. The objective of the COHI was to reduce and prevent oral

disease through education, prevention, and oral health promotion and to increase access to oral health care (Mathu-Muju et al., 2016). By 2014, the program had served 320 First Nations and Inuit communities, representing 55% of all eligible First Nations and Inuit communities. More specifically, this initiative reduced decay rates in children and increased awareness of the importance of oral health (Auditor General, 2017; Mathu-Muju et al., 2016). Although these interventions did not include urban Indigenous communities, they were significant because, as seen among my participants, many urban Indigenous people had previously lived in rural Indigenous communities; their oral health had been shaped before moving to the city.

In urban contexts, information about oral health initiatives targeting Indigenous communities is scarce in the published Canadian Indigenous literature. Based on the results of this study, some oral health promotion programs and outreach services have been conducted by the NFCM and other Indigenous organizations. However, no studies have evaluated the effectiveness and accessibility of such initiatives and whether they were inclusive and responsive to the oral health needs of this diverse community.

2.14. Montreal's Indigenous community

I will now describe the Montreal Indigenous community, focusing on aspects I considered relevant for my study. Although this community has much in common with other urban Indigenous communities in Canada, it has unique local characteristics. Knowledge of the community was the first step towards understanding the study population, which guided my recruitment strategy and partnership-building and helped me understand the urban context in which I explored the oral health experiences of participants.

Demographics and composition

According to the 2016 census, 182,890 Indigenous people lived in the province of Québec, representing 11% of the national Indigenous population and 2.3% of Québec's total population (Statistics Canada, 2016). Montreal is the second most populated urban centre in Canada after Toronto. It is home to the largest Indigenous population in Québec, totalling 34,745 people (Statistics Canada, 2017). The population of Indigenous people in the city increased from 26,280 in 2011 to 17,865 in 2006 (Statistics Canada, 2013b). These figures show that the Indigenous population in Montreal almost doubled between 2006 and 2016. In 2016, First Nations people accounted for 60% of the Indigenous population, Métis made up 34%, and Inuit people made up 3% (Statistics Canada, 2016). Notably, these counts did not include Kahnawake or Kahnesatake, two Indigenous communities located in the Montreal Census Metropolitan Area (CMA), which were incompletely enumerated because their Band councils refused to give permission (Statistics Canada, 2013b). The CMA covers a land area of 4, 258.31 square kilometres (1, 644.14 sq mi). The size of a city is said to affect the Indigenous community's sense of cohesion (Royal Commission on Aboriginal Peoples, 1996).

Macdonald (2008) suggested that "urban Indigeneity" and commonalities in their "city living" are possible ways to improve connectivity and cohesion among the vastly heterogeneous population (Macdonald, 2009). However, the Montreal Indigenous population is highly diverse.

In 2011, the median age of Indigenous people in Montreal was 37 years, compared to 39 years for the non-Indigenous population. Additionally, 40% of Indigenous people were aged under 25 years, an increase from 33% in 2006 (Statistics Canada, 2013b).

A community of diverse Nations

The Montreal Indigenous population comprises several First Nations that are in turn organized into

many Indigenous communities (NETWORK, 2019a). The city has the second-largest Inuit population (900 people among census metropolitan areas in Canada, after Edmonton; 1,115 people; Statistics Canada, 2013b). The population is less heterogeneous compared to First Nations that include many different communities: Mohawk, Atikamekw, Cree, Naskapi, Montagnais, Micmac, Huron, Malecite, and Algonquin (Native Friendship Centre of Montreal Inc., 2019). These communities are also culturally diverse even within the same major Indigenous group. For example, cultural differences exist among Inuit from the northern part of Canada, Inuit from Nunavik (the northern third of Québec), and Inuit from Kuujjuaq (the largest village in Nunavik). However, these groups fall under federal jurisdictions and are legally and culturally different from Indians (Voyageur & Calliou, 2001).

Montreal's Indigenous population is multilingual, communicating in French, English, and Indigenous languages (NETWORK, 2019b). Language or the ability to communicate between service providers and service users is a known social determinant of health, which is especially important for this population given that traditional healing and finding a 'home' are central in maintaining the health and well-being of Montreal's Indigenous community.

The government-attributed status of Indigenous people constitutes another element of diversity in the population. For example, around 60% of Montreal's First Nations people are non-status Indians and therefore are not covered under the NIHB program (Statistics Canada, 2016).

A community with undefined boundaries

In most Canadian cities with Indigenous people, the population is concentrated in specific locations with poor living conditions that have been described as "Aboriginal ghettos" (Rae, 2012). Montreal appears to be an exception, with a more dispersed Indigenous population. The Indigenous population in Montreal can be best described as a network of multicultural individuals who view

themselves as a mixture of Indigenous and non-Indigenous ancestry, living throughout the Island of Montreal (Macdonald, 2009). They are often mobile, moving in and out of the city between rural and urban communities (NETWORK, 2019a; Place, 2012). This high mobility is one of the reasons the Federal Government reduced funding allocations for programs and initiatives targeting the population. For the same reason, the provincial and municipal governments have described Montreal's urban Indigenous population as insignificant compared to the city's population (MacDonald et al., 2010).

Social and cultural services for Montreal's Indigenous community

Montreal has several organizations that offer social and cultural services for all Indigenous people, such as McGill University First People's House, the NFCM, the Native Women's Shelter of Montreal (NWSM), Projets Autochtones Du Québec (PAQ), and Montreal Urban Aboriginal Strategy Network (known as NETWORK).

The McGill University First Peoples' House provides Indigenous students attending McGill with a 'home away from home' where they can find support to succeed in their studies and stay connected to their culture. The NFCM is a non-profit organization committed to supporting the entire Indigenous population of Montreal, with the goal to "promote, develop, and enhance the quality of life in the urban Aboriginal community of Montreal" (Native Friendship Centre of Montreal Inc., 2022). The NWSM provides shelter and support to Indigenous women and their children to help them overcome the different challenges of urban living (NWSM, 2022). PAQ is an Indigenous organization that offers shelter, housing options and services that promote well-being and healing, and strengthen the urban Indigenous community (PAQ, 2022).

NETWORK, which includes all these organizations, is composed of Indigenous service providers; local urban Indigenous people; representatives from the municipal, provincial, federal, First

Nations, and Inuit governments; and the general population who wish to provide opportunities for organizations serving Indigenous people in the greater Montreal area (NETWORK, 2019b). Among its organizational structure is the health committee MUAHC, whose vision is to empower the Indigenous community by working together toward healing. Its mission is to achieve a culturally competent, holistic health service delivery model that is accessible to all Indigenous people within Montreal and surrounding areas, with a focus on quality and continuity of care (NETWORK, 2019b).

2.15. Summary of the literature review

As seen from the literature, oral health surveys have found that Indigenous populations have almost double the prevalence of dental disease and more unmet oral health needs in comparison to non-Indigenous Canadians (Canadian Dental Association, 2017; Well Living House, 2018). This oral health inequality is linked to factors such as fewer regular dental visits by Indigenous people (CAHS, 2014). Despite attempts by Health Canada to improve the oral health of Indigenous people by providing dental services such as the NIHB and the COIH, oral health inequalities continue to exist between Indigenous and non-Indigenous Canadians. The provision of free dental services seemingly does not resolve the complicated problems of poor oral health and persistent oral health inequalities affecting Indigenous Canadians. To curb health inequalities for the population, stakeholders must consider the historical, political, social, and economic conditions that have shaped Indigenous health (Pan-Canadian Public Health Network, 2018).

More than half of Indigenous people today live in urban areas (Statistics Canada, 2016), and researchers increasingly recognize the health challenges that these Indigenous people face (Lawrence et al., 2016; Well Living House, 2018). However, we know very little regarding the oral health care challenges faced by this population. For example, many Indigenous people in

urban areas are not eligible under the NIHB program (e.g., non-status Indians, Métis). We do not understand the factors that facilitate or impede access to dental services for the population, given that extant research does not clearly explain how urban Indigenous people access dental services. Although urban Indigenous people have been documented to experience racism, discrimination, and social exclusion when moving to urban areas (Lawrence et al., 2016; Well Living House, 2018), researchers know little about the experiences associated with access to dental services. Furthermore, we found no study that has examined the oral health perceptions of urban Indigenous people. A study that fills these research and information gaps will provide useful data to guide programs and policies that respond to the oral health care needs of urban Indigenous populations (Beaudet, 2016; Canadian Institutes of Health Research, 2016).

CHAPTER 3. PURPOSE AND OBJECTIVES

3.1. Purpose of the study

Our purpose was to understand urban Indigenous people's views about oral health and how their culture as well as their urban environment shape their oral health–related practices. We also wanted to learn about their oral health care experiences and perspectives about access to oral healthcare. This knowledge will help us better serve this population and may guide the design and implementation of programs to respond to their specific needs and ultimately improve their health and well-being.

3.2. Research question and objectives

The study was designed to answer the following broad research question: how do Indigenous people in Montreal perceive oral health and experience access to oral health services?

The specific objectives were:

(i) to understand how urban Indigenous people in Montreal perceived and experienced oral health

(ii) to describe the oral healthcare pathway of urban Indigenous people in Montreal, including their experiences with dental professionals.

I approached the research question with the premise that to understand the oral health experiences and needs of Indigenous people in Canada, it is integral to contextualize their experiences within the historical, political, social, and economic conditions that have influenced their health. For this purpose, I developed a conceptual framework that drew on the conceptual model for oral health inequalities (Watt & Sheiham, 2012). My conceptual framework describes structural and intermediate determinants that help us gain insights relevant to the study objectives. In the framework, key structural determinants include colonization, Indigenous culture, and

urbanization, while intermediate determinants include socioeconomic and cultural influences, oral health policies, and traditional beliefs of Indigenous people. I will describe the details of the conceptual framework in the next chapter.

CHAPTER 4. METHODOLOGY

The first part of this chapter presents a synopsis of theoretical and conceptual frameworks relevant to my study. I will then describe my study design, sampling, data collection, and analysis and highlight the measures undertaken to ensure rigour.

4.1. Theory and theoretical frameworks

The theory of social production of disease

This social theoretical framework, otherwise known as the social production of health, attributes health to the absence or presence of disease. It posits that characteristics of human society, especially social and economic conditions, are the fundamental causes of health inequalities (Amzat & Razum, 2014). Underscoring the important role of societal characteristics in health and disease, Krieger (2001) noted that "we literally incorporate biological influences from the material and social world" and "no aspect of our biology can be understood divorced from knowledge of history and individual and societal ways of living." Congruent with Krieger, to understand the oral health experiences of urban Indigenous people, I needed to contextualize them within (i) the colonization and urbanization history, (ii) the traditional individual oral health perceptions that they may hold, and (iii) the urban ways of living and social influences in urban settings.

The psychosocial theory

A psychosocial approach helps us understand how the perceptions of urban Indigenous people may influence their oral health. For example, Raphael (2006) suggested that the "perception and experience of personal status in unequal societies lead to stress and poor health." Similarly, Wilkinson (1999) sought to link altered neuroendocrine patterns and compromised health capability to people's perception and experience of their place in social hierarchies. When Indigenous people migrate to urban areas, which for some are their traditional lands, this is

expected to impact their sense of ownership and social position in society. Therefore, considering urban Indigenous people's perceived social position is important when attempting to understand their oral health experiences.

Model for the mechanisms of oral health inequality

Diderichsen (2012) provided a model for "the mechanisms of health inequality." It explains that health inequities flow from patterns of social stratification; that is, from the systematically unequal distribution of power, prestige, and resources among groups in society, creating unequal socioeconomic positions on the social hierarchy (Diderichsen et al., 2012). Oral diseases are socially patterned across the entire social hierarchy: the most advantaged have a better oral health status than the less advantaged. Available data supports this theory; urban Indigenous people have lower socioeconomic positions (i.e., lower employment and education) than non-Indigenous people, and their oral health status is poorer. Therefore, the oral health experiences of urban Indigenous people need to be understood in the context of their socioeconomic positions, which have been historically impacted by colonial powers.

In addition, cultural beliefs should be recognized as an important social determinant of health that may shape the oral health of disadvantaged populations. Culture is an organizing framework through which peoples' norms of family life, birth, childrearing, aging, and death, as well as their recognition of illness and care-seeking practices around health, take shape (Strauss, 1990). Sometimes cultural beliefs and practices can influence health and facilitate or act as barriers to accessing health care services (Nelson & Wilson, 2018). Since health care is a cultural construct arising from beliefs about the nature of disease and the human body, cultural issues are central to the delivery of health service treatment and preventive interventions (Nelson & Wilson, 2018). Therefore, understanding the traditional beliefs that may impact urban Indigenous people's oral

health and access to oral health services is important.

4.2. Conceptual model for oral health inequalities

Watt and Sheiham developed the social determinants of oral health model based on the World Health Organization model for SDH (World Health Organization, 2013). The model draws from theories such as the social production of disease theory, psychosocial theory, and the model for mechanisms of health inequality. According to the model (Figure 4.1), factors contributing to oral health inequalities can be grouped under two broad categories: structural determinants (political and economic drivers) and intermediate determinants (circumstances and risk of oral disease).

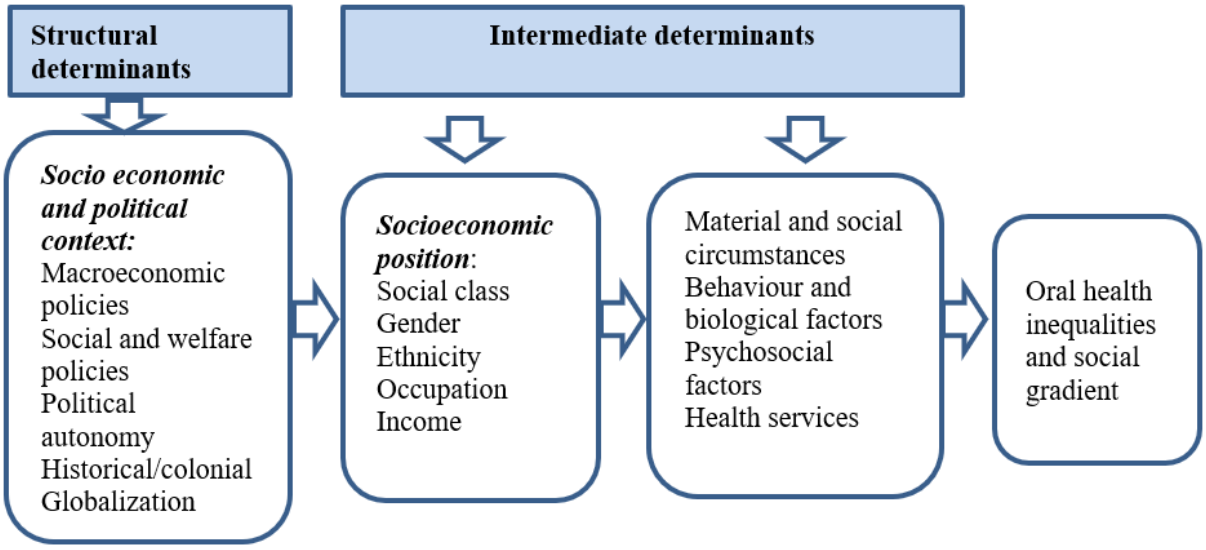

Figure 4.1. Conceptual model for oral health inequalities adapted from Watt and Sheiham (2012).

The model explains that interactions between the overarching structural determinants shape the socioeconomic characteristics of individuals (gender, income occupation, ethnicity) that in turn interact with intermediate determinants to cause oral health inequalities. For example, social hierarchy, which is an outcome of interactions between structural determinants, can contribute to oral health inequalities through several routes. Furthermore, the social determinants model widens the range of factors that fall under circumstances and risk for oral disease and contribute to oral

health inequalities.

4.3. My conceptual framework

My conceptual framework (Figure 4.2) is an adaptation of the conceptual model for oral health inequalities (Watt & Sheiham, 2012) given the oral health inequalities that exist between Indigenous and non-Indigenous Canadians.

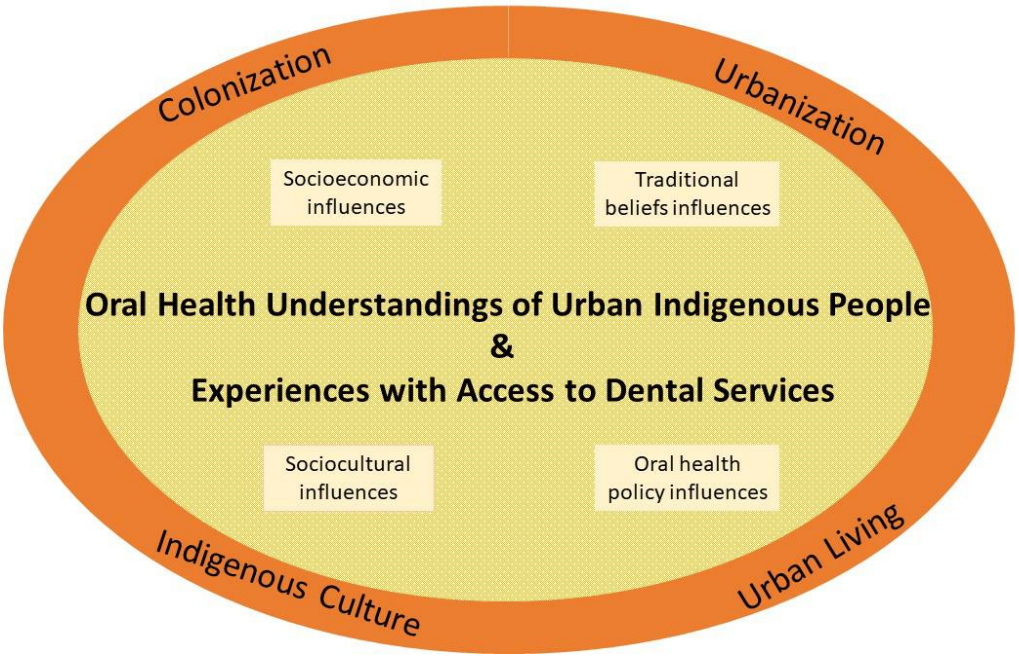

Figure 4.2. Study conceptual framework: adapted from the model for oral health inequalities.

In developing the conceptual framework, I assumed that the key structural determinants relevant to urban Indigenous people were colonization, Indigenous culture, and urbanization.

Colonization occupies an important position in my conceptual framework, based on its impacts on the health of Indigenous people. Drawing on Watt and Sheiham's model, I assumed that colonization could influence the oral health practices and experiences of Indigenous people through various complex routes. For example, colonization led to the loss of their lands, which in turn significantly reduced their power, prestige, and access to resources. The resultant low

socioeconomic position of Indigenous people is associated with intermediary determinants (e.g., poor living conditions, damaging oral health behaviours, stress) that contribute to oral health inequalities. Furthermore, sociocultural impacts of colonization, such as discrimination, breakdown of family ties, loss of culture, and mobility patterns, contribute to societal hierarchies that influence the intermediary determinants.

Indigenous culture encompasses traditional beliefs and Indigeneity. Indigenous culture recognizes the influence of traditional cultural beliefs on urban Indigenous people's oral health understandings and their experiences in accessing dental services. Traditional cultural beliefs may affect oral health through beliefs about basic concepts of health and illness, use of folk remedies, teeth and the oral cavity, oral hygiene practices, help-seeking and preventive care, and diet (Butani et al., 2008; Carteret, 2013; Smith et al., 2013).

Intermediate determinants of the conceptual framework include socioeconomic influences, sociocultural influences, oral health policies, and traditional beliefs. This category of determinants is closely linked to structural determinants and through a series of complex interactions may influence oral health and access to care.

My conceptual framework helped us organize our thoughts and interpretations of the study findings as they related to the study objectives, although the focus of the parent model is to explain oral health inequalities. Our research team gained better insights into the study data by contextualizing the narratives of participants within the historical, political, social, cultural, and economic lenses provided in the framework.

4.4. Study design: focused ethnography

Several researchers have highlighted the pertinence of qualitative approaches in dental public health (Bower & Scambler, 2007; Chai et al., 2021). Qualitative researchers study phenomena in

their daily context and try to make sense of them by understanding the meanings that research participants bring to them (Denzin & Licoln, 1994; Savage, 2005). Of the different qualitative research methodologies, I adopted ethnography, and more specifically focused ethnography. According to Fetterman (2010), ethnography is an effort by a researcher to generate a rigorous and authentic account of people's perspectives of their culture or a specific aspect of it. All ethnography is holistic and contextual, with the physical context in which participants live, work, and interact integral to the research (Boyle, 1994). Health-oriented ethnographies can be highly focused; they are 'mini ethnographies' in that they only examine a narrow aspect of the social or cultural spectrum of local worlds (Kleinman, 1992). Focused ethnography emerged in health research to focus on a distinct issue or shared experience in a discrete community and within a specific context (Higginbottom et al., 2013). My study focuses on a specific aspect of the urban Indigenous context, their oral health and access to oral health services, which legitimates my choice of conducting a focused ethnography.

One main purpose of focused ethnography is to discover how people from certain cultures integrate health beliefs and practices into their lives (Higginbottom et al., 2013; Roper & Shapira, 2000). In addition, focused ethnography helps researchers understand the interrelationship between people and their environments in the society in which they live. It offers the participants an opportunity to share their perspectives on societal events and issues that may affect different areas of practice (Cruz & Higginbottom, 2013).

In summary, focused ethnography is versatile in exploring a problem in a specific context (Roper & Shapira, 2000). It was appropriate for the purpose of this study, which was to explore the perspectives and experiences about oral health and access to care of Indigenous people in Montreal.

Community participation in this study

The participation of Aboriginal communities and individuals at various stages of the research assumed that knowledge that originates with people best informs strategies for resolving their problems (Canadian Institutes of Health Research, 2016). Adapting the community approach, rather than an expert-driven or top-down approach, brought together partners with different expertise, knowledge, and sensitivity needed to improve health care services and promote the health of Indigenous people. For example, working with the MUAHC as partners was a strategy to increase our research rigour and credibility, given the comprehensive knowledge and research expertise of the organization regarding Aboriginal health (MUAHC, 2016). Moreover, a growing body of literature shows that public health programs based on community participation reduce health inequities and promote social justice (Thompson et al., 2016).

Engaging with the Indigenous community and building partnership

To better prepare for the research study, I spent the first 2 years of my PhD learning about Canadian Indigenous people's health and the history of colonization. I attended conferences about Indigenous health and established rapport and trust with Indigenous communities in Montreal, particularly via the NFCM, the MUAHC, and McGill University's First People's House. Through my engagement with these urban Indigenous community, I learned about their history, culture, and social lives, and how these could influence their life and more specifically their health.

The MUAHC is part of NETWORK and is interested in improving the community's health by creating culturally sensitive health care models that are well-respected by the community.

I conducted a 1-hour oral presentation of my research proposal to the MUAHC. Fifteen members attended the session and shared their thoughts. The MUAHC helped reformulate my research question, facilitated recruitment of research participants, and will assist in disseminating my

findings and recommendations. The MUAHC also issued a letter to my research supervisors, confirming their support of my study and its significance (Appendix II).

The NETWORK distributes a monthly newsletter to its extensive group of Indigenous organizations and stakeholders in Montreal. In addition, it includes federal, provincial, and municipal government representatives in its organizational structure (Appendix I). As such, the organization will be a useful platform for dissemination of my study findings and potentially influence the oral health–related actions of various levels of government.

4.5. Population, sampling, and recruitment

The MUAHC representative provided valuable guidance in recruiting members of Montreal's Indigenous community through publicity in the NETWORK newsletter. I used a maximum-variation sampling strategy (Palinkas et al., 2015), considering various criteria: age, gender, Indigenous status, area of residence, edentulous level, and socioeconomic status. I chose these criteria based on my knowledge of Montreal's Indigenous community's diverse composition. I also adopted a snowball sampling strategy (Font & Méndez, 2013) to ensure enough participants were recruited.

To take part in the study, participants had to meet the inclusion criteria: (i) be an Indigenous individual aged 18 years or older, (ii) be able to communicate in English, and (iii) have lived in Montreal for more than 6 months; we chose this cut-off time to exclude transient populations, based on the assumption that people who had lived for less than 6 months in Montreal would not contribute well to my study's objectives. I recruited my first participant through word-of-mouth during a field visit to the NFCM. The individual then referred me to two other potential participants, and the snowballing approach continued. Other potential participants contacted me by email after reading about the study in the NETWORK newsletter. I verified that the individuals

met the inclusion criteria, explained the purpose of the study, and answered any questions they had via email. I then prepared a timetable for the interviews based on participant availability.

I embarked on the recruitment without a pre-determined sample size, congruent with my qualitative methodology. The number of participants was informed at a point where additional data would not add to the content and the quality of available data and themes would be repeated (Higginbottom et al., 2013). In ethnography, this point of data saturation is attained whenever the phenomenon under study has been uncovered and the research question answered. However, sample sizes of similar studies using focused ethnography to explore health care experiences have ranged from 11 (Wilson & Cardwell, 2012) to 25 (Keboa et al., 2019). The MUAHC also approved the proposed $20.00 compensation to each participant of the study.

4.6. Data collection

Data collection in ethnographic research involves various strategies to ensure an in-depth understanding of the phenomena and triangulation for validation (Denzin & Licoln, 1994; Savage, 2005).

Participant observation

Traditional ethnography requires intense immersion of the researcher in the field for long periods. In focused ethnography, intermittent and purposeful field visits to specific sites are sufficient for data collection (Higginbottom et al., 2013). Based on this criterion, I participated in cultural events organized at the NFCM and the First People's House at McGill. Moreover, I attended two conferences on Indigenous health, and two informative events on Indigenous history led by Indigenous speakers. I also visited the Native Women's Shelter of Montreal, PAQ shelter, and was invited to a participant's home. In total, I observed 34 sessions that lasted approximately 2 hours each. During the sessions, I observed Indigenous traditional and spiritual practices and learned

about the social values and life challenges of the people. Importantly, I had informal discussions with urban Indigenous people about their lives, oral health issues, and use of dental services. For most of the field visits, I was accompanied by an Indigenous facilitator who helped explain the context and meaning of some of the cultural practices. At the end of each visit, I made notes of the day's events, key observations, and lessons learned. I then reflected on these notes and prepared a summary that I later used in my data analysis.

Semi-structured interviews

I conducted semi-structured interviews that complemented my observations and provided directions for future observations. Specifically, I conducted approximately 1-hour-long interviews with each participant in a place we had agreed on. Most of the interviews took place in an Indigenous community centre, three at the McGill Faculty of Dentistry, one at the home of a participant, and one in a public building. I used an interview guide (Appendix III) that began with a general background section. The goal of this section was to obtain information about participants' Indigenous identity, government status, and pathways over the years, including their places of residence, social life, education, and employment. I was interested in the participants' lives before moving to Montreal (e.g., previous job, social life, residential school attendance for them or their parents). Collecting this data was important given that the literature indicates that previous socioeconomic status and the intergenerational trauma of residential schools may impact the oral health of Indigenous people (Wilk et al., 2017).

The second section of my interview guide focused on exploring participants' meanings of oral health and illness. My goal was to understand participants' perceptions under the six domains that fall under Indigenous culture in my conceptual framework: basic concepts of health and illness, use of folk remedies, benefits of teeth and the oral cavity, oral hygiene practices, help-seeking and

preventive care, and diet.

I then explored the oral health care processes of participants to uncover illness experiences and facilitators and barriers to access. I avoided using leading questions to ensure trustworthiness and neutrality in the data. For example, I did not ask questions such as: “Do you face discrimination when you visit the dentist?” Instead, I asked: “Tell me about your experience when you visited the dentist.” The aim was to understand how their oral health and access to oral health services could be improved. I audio-recorded all interviews for verbatim transcription.

4.7. Data analysis

Iterative data analysis occurred simultaneously with informal and formal data collection. I reflected on my field notes and made short summaries that aligned with the study objectives. After each interview, I completed an interview report form, which required me to systematically record information about the arrival time of the participant and interviewee, the interview setting, and the interview process, including the composure of the participant and any interruptions during the interview. Another section of the report form required me to reflect on the data collection method and specific use of the interview guide. I also recorded any new leads to be explored in subsequent interviews and relevant information provided after the interview had officially ended. Completing the interview report helped me summarize and reduce the data, codify verbatim accounts, and reflect on the data for a preliminary assessment of important themes. This stage also revealed concepts that needed further exploration and guided the recruitment of subsequent participants.

I then transcribed verbatim the audio-recorded interviews and imported the text into QDA MINER LITE software v.2.0.5 to assist the analysis, which was based on a deductive–inductive approach. I first read the interview transcripts twice to immerse myself in the data and gain a broader sense of the narratives. During the third reading, I assigned deductive codes to phrases,

sentences, or entire paragraphs of the transcribed text. I started with a short list of deductive codes based on my conceptual framework. I had two broad categories of codes: one on the understanding and relevance of oral health and the second on access to oral health care, which drew upon the Patient-centred access to health care model (Levesque et al., 2013).

The 'parent' or trunk codes for the oral health categories included socioeconomic influences, sociocultural influences, Indigenous cultural influences, uses of dentition, and relevance of good oral health. For access to oral healthcare, the codes included availability of dental clinics, accessibility, affordability, acceptability, and accommodation. I created secondary codes related to each of these primary codes. For example, secondary codes for the sociocultural influences included mobility patterns, family ties, and discrimination.

Further, I created inductive codes that emerged from the data. The new codes enabled me to expand and refine my coding scheme in the process. I then brought together texts with similar codes from the different interviews and recoded the aggregated data as necessary, making notes that captured my thought process and reasons for the new codes where applicable. I applied the same coding scheme to my summarized field notes, then referred to my field notes and interview report form to match similar findings and note any contradictions. Further, I brought together the secondary codes to form themes that better addressed the study objectives. The aim was to produce a thick description by building a rich narrative that was faithful to cultural, historical, social, and contextual complexity (Higginbottom et al., 2013). The conceptual framework of the study and underlying theories, field notes, and reflexivity after completing the interview report forms guided my interpretation of the data, with validation from MUAHC.

4.8. Methodological rigour

Scientific rigour in qualitative research is maintained through confirmability, auditability,

credibility, and trustworthiness (Gunawan, 2015). I ensured credibility with my learned interviewing skills and rigorous review of the transcripts and field notes. To ensure confirmability and dependability, I kept an audit trail (a record of decisions and steps in the analysis) so that others could follow the decisions, deliberations, and approaches I used. In presenting my findings, I used direct participant quotations, where appropriate, to help maintain neutrality. Further, during data collection, I was conscious of how my role as a foreign-trained dentist could influence my interaction with participants, the information they disclosed, and my interaction with the data. Spending time with Indigenous people in Montreal helped me navigate and make sense of my data. As a foreign-trained dentist in an advanced economy, I could readily understand participants' need for holistic care and effective communication with their dentists. However, exploring what oral health meant to the participants and their sociocultural influences would have been difficult to comprehend had I not familiarized myself with the Indigenous people in Montreal. This process of reflecting on my interactions with Indigenous people and the data I had collected and analyzed (reflexivity) also enhanced the rigour of my study (Barrett et al., 2020). Further, I submitted my findings and interpretation of the data to two members of MUAHC for review and feedback.

4.9. Ethics

According to the Canadian Institutes of Health Research (CIHR, 2013), working with Indigenous people in all phases of research can foster trust between the researchers and Indigenous communities and enable the study to proceed in a manner that is culturally sensitive, relevant, and reciprocal. In line with this recommendation, I obtained an approval letter from the MUAHC attesting that my study proposal met their requirements for Indigenous research and that the research project was relevant to the population. I attached the approval letter to my ethics application to the McGill Institutional Review Board (IRB), and I have obtained the IRB's approval (Appendix IV). At the participant level, I obtained signed written consent (Appendix V) while giving participants the freedom to opt for verbal consent, given that Indigenous people may consider requesting written rather than verbal consent distrustful (CIHR, 2013).

The consent standard required for participant observation was based on the balance of risks and benefits expected for my study. In situations where the risks are judged to be minimal, verbal consent may be sufficient, and this is one of the various approaches used in research involving Indigenous people (Fitzpatrick et al., 2016). For my participant observation at NFCM for example, I obtained verbal informed consent from the managers of the centres because requesting consent from everyone was impractical. Further, I wore a badge that identified me as a researcher to reassure participants of my affiliation.

To ensure the anonymity of participants, I used pseudonyms for interviewees during data analysis and reporting and stored the data as password-protected files on my password-protected computer. All data will be destroyed 7 years after the publication of the results.

5. RESULTS

5.1. Description of the sample

I will begin by describing the sociocultural and economic characteristics of participants, including their age, Indigenous origin, Indian status, place of residence, and employment status. Table 5.1 details some of the characteristics at the individual level, and Table 5.2 presents a summary.

Age and Indigenous origin

The sample included 20 participants (10 males and 10 females) aged between 19 and 55 years. The youngest was a 19-year-old woman from the Ojibwe Nation, and the eldest was a 65-year-old Inuit woman. The sample was diverse in terms of Indigenous origin, but most belonged to a First Nation (n=16), including four Miqmaks, two Mohawks, two Ojibwes, four Crees, one Algonquin, and one Iroquois. Two participants identified themselves as members of a First Nation but did not specify which. The sample also included two participants who identified themselves as Inuits and two others who were Métis (Table 5.1).

Socioeconomic status

Seven participants, five women and two men, were employed full-time. Six of them were staff in Indigenous organizations, and the other was a customer service representative in a non-Indigenous organization. For reasons of confidentiality, I cannot provide details regarding their jobs.

Besides these full-time employed participants, one was a casual worker and two were post-secondary students (one at university and the other enrolled in a collegial vocational training program). The remaining 10 participants were unemployed at the time of the study and had been unemployed or sporadically employed for periods ranging from 1 to 20 years. Unlike the employed participants, who had post-secondary education (e.g., university or college), the unemployed participants had left school before university.

Indian status

The sample included 16 registered (Indian status) and four non-registered participants (Table 5.2). Two of the four non-registered participants (Gabriel and Andrew) were ineligible to obtain Indian status because they could not provide proof of their Indigenous ancestry, and the other two (Don and Sam) did not apply for Indian status although they were eligible. Gabriel was adopted by the age of 12 and did not know his biological parents or nation of origin, and Andrew indicated that he had Indigenous roots although he was raised by French Canadian parents. He further explained that according to family oral history, his paternal great-grandmother was Métis. Don's father was part Inuit and Métis from Labrador and registered as a recognized Inuit, while his mother was a non-Indigenous Canadian. Although Don was eligible to be registered as an Inuit, he mentioned that he did not apply for the status because he was unaware of the health benefits associated. Don only obtained a Métis card via the Métis association in Labrador.

Similarly, Sam, who had a French mother and an Indigenous father, was eligible to receive his Indian status card but had not applied for it because he was unaware of its health benefits. Sam's father only received his status eight years prior, when he learned from his mother that he had Indigenous roots and started searching for documented proof. Sam also mentioned that applying for the status card requires time and money and that he was busy searching for employment.

Residence and migration pathways

The participants had been living in Montreal for periods ranging from 6 months to 35 years, except for two who had lived in Montreal all their lives (Gabriel and Sally, due to their adoption; Table 5.2). The others had migrated from other parts of Canada or the United States. Before their migration, they were living in different Indigenous communities: seven on reserves, including one in the United States; five on rural northern Cree and Inuit villages and lands; and six in rural non-

Indigenous-specific towns. These participants had migrated to Montreal mainly in search of employment or educational opportunities or to flee domestic violence, as two participants reported. Many maintained the bond with their Indigenous communities through occasional visits to family members, participation in Indigenous events, or providing volunteer services where the opportunity arose. Some participants visited their Indigenous communities when tracing their Indigenous origins or to consult a dentist.

Table 5.1: Detailed sociodemographic characteristics of participants (n=20).

Participant	Age	Employment	Gender	Duration in Montreal (years)	Indigenous origin	Registered
Lolly 1	52	No	Woman	4	Mikmaq	Yes
Rock 2	39	Yes	Man	6	Mohawk	Yes
Alex 3	32	Yes	Man	12	Mikmaq	Yes
Lucy 4	32	No	Woman	10	Ojibwe	Yes
Angelie 5	19	Post-secondary student	Woman	10	Ojibwe	Yes
Sally 6	50	Yes	Woman	50	Mohawk	Yes
Emily 7	40	Yes	Woman	20	Mikmaq	Yes
Ashley 8	39	Yes	Woman	12	Mikmaq	Yes
Dolly 9	37	Yes	Woman	19	Algonquin	yes
Adam 10	38	No	Man	1	Cree	Yes
Mark 11	32	No	Man	5	Cree	Yes
Claire 12	52	No	Woman	20	Inuit	Yes
Sam 13	40	No	Man	35	Métis	No
Molly 14	22	University student	Woman	1	Iroquois	Yes
Don 15	45	No	Man	0.5	Inuit and Métis	No
Richard 16	27	No	Man	5	Cree	Yes
Nathan 17	47	Casual	Man	4	Cree	Yes
Gabriel 18	49	No	Man	49	Non-identified First Nation	No
Andrew 19	48	No	Man	2	Non-identified First Nation	No
Rona 20	55	Yes	Woman	27	Inuit	Yes

Table 5.2: Summary of sociodemographic characteristics of participants (n=20).

Characteristic	Category	Number of participants
Age (years)	18–30	3
	30–40	10
	>40	7
Employment	Yes	8
	No	12
Gender	Man	10
	Woman	10
Indigenous origin	First Nations	16
	Inuit	2
	Métis	2
Duration of stay in Montreal (years)	0.5–5	9
	6–15	5
	>15	6

Table 5.3. Summary of participant perceptions of oral health.

	Aspects related to traditional Indigenous culture	Aspects related to Western culture
Perception of oral health	● Holism and balance ● Eating traditional foods	● Aesthetics ● Function
Ways to improve oral health	● Balance and moderation in diet ● Herbs for pain control in case of illness	● Oral hygiene ● Healthy diet ● Regular dental visits (check-ups) ● Western medicine in case of oral illness (pain)
Challenges to improving oral health	Unemployment and poverty leading to stress and unhealthy behaviours, including: - lack of concern for oral health - poor access to healthy food	

5.2. Perceptions of oral health

Participants' perception of oral health was influenced by both Western and Indigenous cultures, although the former seemed to be dominant in their discourse. I will thus present their perspectives on oral health through this bicultural lens and show some areas of overlap or convergence between the two influences. Table 5.3 summarizes the perceptions of oral health.

5.2.1. Aspects related to Indigenous culture

Two interrelated concepts emerged from the analyses: holism and moderation to achieve balance. Regarding holism, participants emphasized the connection between oral health and general health. In their view, general health was related to an equilibrium between the mental, physical, spiritual, and emotional aspects of life. For them, these four key components of health and well-being were intertwined and applied to oral health. Lolly, a participant living in Montreal for 4 years, explained this holistic vision of oral health:

> *"Some of my views on health care have become more entrenched in the spiritual side of things… because physical, mental, emotional, spirituality is interconnected. So, I think it [oral health] does combine all of that and think it is [oral health] extremely important."*

Participants stressed the importance of achieving an equilibrium between the physical and non-physical components of health and provided various ways to attain such balance: prayers, caring for the sick, and eating and drinking in moderation. For example, they saw prayers as a key component of sustaining the spiritual aspect of health and well-being. To some participants, offering prayers was a routine practice, but their frequency and intensity increased when they encountered challenges or faced difficult moments in life. During these traditional prayers, they used tobacco smoke to create an appropriate environment for communication with the ancestral spirits.

Participants suggested that caring for the sick was another way to achieve positive physical and mental well-being, not only for the sick person, who received emotional comfort important for the healing process, but also for the carer. In their view, it was important to show empathy and provide care to anyone with an illness, including oral illness. As one participant put it: *"I believe that when people are sick, if you nurture them and give them some love care, that that will help improve their condition."* They argued that people who cared for the sick experienced inner satisfaction and happiness that would contribute to their mental health.

Regarding the physical aspects of health, participants discussed the need for humans to ensure moderation in what they ate and drank, mentioning that excess eating or drinking was likely to disrupt the equilibrium needed for good health. Speaking specifically about moderation and oral health, participants considered that limiting the amount of "junk food," such as "McDonald's, Pepsi, and Coca-Cola," was important to maintaining good teeth. This belief encouraged them to limit the number of candies and sweetened drinks that their children consumed. Some also explained how they encouraged their children to eat more vegetables and fruits and less food that they deemed unhealthy. Speaking about healthy traditional diets, Sally, a 50-year-old participant born in Montreal, described a typical Mohawk soup as follows: "*The traditional Mohawk corn soup is all vegetables and includes turnips, cabbage, carrots, hominy corn, and kidney beans. The base of the soup is made with pig's feet, steak, and cornbread.*" In line with the concept of interconnectedness and holism, some participants suggested that people who drank too much alcohol were emotionally or mentally unstable and unhappy, which influenced how they would take care of their teeth, for instance.

Participants also discussed the importance of dentition to a traditional diet. The narratives illustrated how Indigenous people needed good teeth to eat meat from a range of animals including

goose, rabbit, moose, porcupine, caribou, beaver, bear, deer, lobster, and salmon. Some participants considered that the traditional food was healthy and possibly explained why, as one person mentioned, their ancestors had "strong yellow teeth but never complained about toothache." The participants' narratives implicitly established a reciprocal relationship between a healthy diet and good dentition. Explaining the usefulness of natural dentition over dentures, Rona, a 55-year participant who had lived in Montreal for 27 years, said:

> *"I have top dentures. The lower ones I have, but I have not been able to wear them because my gums are hurting me. I cannot really eat food that's hard, but I always manage to find something to eat. I love my own native food, which is fish, caribou, shrimps."*

For some participants, traditional diets were the staple while living in the Indigenous community, and they indicated that these foods were served during cultural events and other celebrations. Even after moving to Montreal, they visited their Indigenous communities during cultural events just to participate in and enjoy these special meals. In Montreal, they also visited Indigenous community centres, which served traditional foods to visitors and the public on specific days or occasions.

In brief, participants' perspectives on oral health emphasized the need for an equilibrium between the mental, physical, spiritual, and emotional aspects of health and the importance of teeth to eating Indigenous diets. In their view, oral illness, such as toothache, limited one's ability to chew and disrupted the equilibrium required for health and well-being.

5.2.2. Aspects related to Western culture

For most participants, their views about oral health were also influenced by mainstream Western culture. They described how good oral health was important for physical appearance, particularly smiling, and self-esteem. They also referred to their ability to eat, especially traditional food, showing some overlap between the Indigenous and Western cultures. Another example of this

bicultural overlap emerged when participants indicated that they consulted a dentist to have "nice teeth," an outcome that made them feel "good and happy". One participant stated: *"If you have really bad teeth and you're always in pain, you're not going to be able to sit there and eat or, you know, concentrate or anything like that..."*

Participants explained how they acquired their Western views about oral health, mentioning the influence of the Western schools they attended but also of their parents and communities. For example, some explained that their parents trained them to brush their teeth at least twice a day, in the morning and at night before going to bed. They also received regular oral health talks as part of morning routines when attending Western primary schools: *"I have been taught in school the kind of foods to eat, what you do about your oral health, how you brush your teeth, flossing, etc., as long as you aren't eating sugary foods and greasy foods before going to bed."*

Others mentioned how attending oral health promotion sessions in Montreal had positively impacted their oral health care. These sessions, according to them, had reinforced their attitudes and practices related to tooth brushing, flossing, and the use of mouth rinses. Furthermore, using the information obtained from dental professionals, they encouraged their children to eat more vegetables and fruits and less of what was deemed unhealthy. For instance, they advised their children to brush their teeth after consuming candies or sweetened drinks. The extent to which some participants had adopted Western oral health care practices was expressed by Alex, a 32-year-old participant living in Montreal for 12 years: "*He [referring to his child] has been to the dentist like four times already, you know. My wife is even better at making sure he does a really good job of brushing his teeth and he's into it. I mean, I feel like we're doing good."* To further illustrate the level of Western oral health acculturation of some participants, Dolly, a 30- year-old participant living in Montreal for 19 years, added: *"My family, honestly, are not all traditional. It*

is conventional medicine in my family, whether it's health or oral health." Our interviews revealed the extent to which participants were acculturated to Western culture and how this had shaped their perspectives of oral health.

5.2.3. Promoting oral health

Concerning Western culture, participants indicated that dental professionals had guided and informed them; some referred to personalized information received during individual dental consultations, whereas others mentioned receiving information from dental and dental hygiene students during events hosted at the NFCM. These sessions covered a variety of oral health–related topics, including the importance of good oral health, diet, and oral health, and participants received hands-on training on toothbrushing techniques. The sessions appeared to have some positive effects on participants' oral hygiene practices. Describing his experience of an oral health promotion session, Adam, a 38-year-old participant living in Montreal for 1 year, shared his knowledge about the effect of some chewing gums to prevent dental diseases:

> *"I was told that if you want to take care of your teeth you are going to have to change the gum that you chew… I forget the name of the gum that the dental students showed him, but I know the picture. When I go to shop, I say, okay, this is the one that's going to help. It's like flossing at the same time. When you're finished eating something and you chew the gum, it's like brushing your teeth."*

Some participants wondered why similar oral health promotion sessions were not carried out in the rural Indigenous communities, suggesting it could help improve the oral health status of the population. Reflecting on ways to promote the oral and general health of Indigenous people, Nathan, a 47-year-old participant living in Montreal for 4 years, suggested that the oral, mental, and general health care needs of the Indigenous people were the effect of colonization. Further, a

deeper examination of participants' narratives indicated that oral health beliefs held by a small proportion of Indigenous people could explain why some did not bother to seek professional dental care. For example, some of the participants considered that any decayed tooth needed to be extracted and that it was normal for an individual to lose their teeth at a certain age.

Participants reflected on the use of folk remedies in the prevention and treatment of oral disease. They explained that, when appropriate, Indigenous people used herbal tea to treat toothache and throat inflammation. For instance, one participant reported gaining relief from a toothache after placing a specific quantity of herbal tea in his mouth, holding it in place for at least a minute, gargling, and spitting it out. Although the mixture of herbs varied based on the specific condition to be treated, participants mentioned four important herbs with medicinal value: tobacco, sweetgrass, sage, and cedar.

The narratives on folk remedies complemented insights I gained in the field. While observing an Indigenous event in Montreal, my Indigenous facilitator explained to me how Indigenous people prepared concoctions with plants for healing during special ceremonies. According to him, the elders organized traditional treatment sessions that provided services to people of all ages. Members of the community sought traditional treatment as a first line of care or, in some cases, as an alternative to Western medicine. They received individual or group therapy for a duration determined by the type and severity of their health issue. In some of the therapies, the smoke that emerged from applying herbs onto a flame was said to help connect Indigenous people spiritually and purify their environment. Emily corroborated the narrative on folk medicine as she explained how she turned to traditional folk medicine in Montreal to treat her cough:

> *"I was having a cough, and it wouldn't go away. I tried everything that I could think of, and Western medicine did not help. I went to the lodge, and an elderly man made some*

kind of drink I used for a couple days. I don't even know what it was."

Participants had either used or heard about the Indigenous healing system. In their view, the principles and skills of folk medicine were preserved and passed from one generation to another, with traditional practitioners usually selecting and training their successors.

Challenges in improving oral health

For some participants, living in Montreal presented social and economic challenges that limited their ability to take appropriate care of their oral health. One such challenge was unemployment, which participants attributed to their lack of Western education. Overall, participants with limited formal education found it difficult to pursue Western education after moving to Montreal. According to them, it limited their chances of getting a job, which negatively impacted their oral health. In particular, the participants who were on social assistance described how being unemployed and living in poverty made taking care of their teeth difficult and sometimes led them to engage in unhealthy behaviours, such as excessive alcohol drinking. Some participants, experiencing deep poverty, even reported that they could not afford a toothbrush. They further explained that they were preoccupied with the search for a job and did not have the time to take care of their health, such as with routine dental visits.

Speaking about underscholarization as a major challenge for Indigenous people in Montreal, Rock, a 39-year-old participant living in Montreal for 6 years, described their reticence towards the Western educational system and the long-term community consequences of the residential schools:

"Education is not valued in [a name of an Indigenous community], unfortunately. You have all these other generations of people who are reticent to having their youth be sent away to school. There is a big problem even finishing high school… I mean, I have been to a Cree

community for a career fair and the principal was telling me… you know we haven't had a single graduate for the last 3 years. This is like one hundred per cent drop-out rate in high school! … We are still reeling from this residential school experience."

According to participants, living in Montreal introduced additional sociocultural challenges that impacted their employability. These included perceived or experienced racism, language barriers, and a lack of social networks. These barriers are further reported in the results section (5.3.1) that focuses on access to oral health care. Our data suggested that Indigenous community organizations in Montreal recognized these challenges and directed most of their services towards helping Indigenous people overcome the experienced or perceived societal challenges. Specifically, participants highlighted the need to motivate Indigenous youths to acquire Western education or pursue vocational training, considering that acquiring knowledge and skills would improve their integration into the city and their general quality of life.

Another challenge to promoting oral health concerned the dietary options available to Indigenous people. Given the affordability of meals and that a healthy diet was a challenge to some participants since moving to Montreal, to them, eating fast food was the easier choice. For some, living in poverty forced them to frequent food banks, which, in their view, did not always serve healthy foods. Overall, participants indicated that dependence on fast food was a Western culture that Indigenous people were quickly adopting.

To overcome people's perceived dependence on fast food, some Indigenous community organizations had implemented programs to help their members afford healthy food items. The data suggested that these programs did not always meet the expected objectives, given the difficulties involved to change behaviours. Sally, a 50-year-old participant born in Montreal, explained the role of her community organization in influencing healthy diets among Indigenous

people. She described her challenges and failures when providing members of the community with money to purchase healthy food:

> *"In my program, I used to give them [her clients] $100, or $50, and I would take them shopping. I would say to them, 'Okay, you need to buy your basics; no junk food.' However, it's like the first thing they went for was soft drinks, chips, cookies, you know. And I am like, no, I can't permit you to buy those items with this budget. You need to go to get your meat, your potatoes, your vegetables, apples, you know."*

5.3. The oral healthcare pathway

To structure the narratives regarding participants' oral healthcare process, the themes are described under three chronological phases of the oral healthcare pathway: Phase I: Before going to the dentist, Phase II: Finding a dentist, and Phase III: At the dentist. Although some factors influenced more than one phase of the oral healthcare process, they are only described once. For example, while I describe discrimination and negative stereotypes under the first phase of the oral healthcare process, the experiences can negatively influence the entire oral healthcare process (Figure 5.1). Further, factors associated with health care policy acted as facilitators and barriers to oral healthcare.

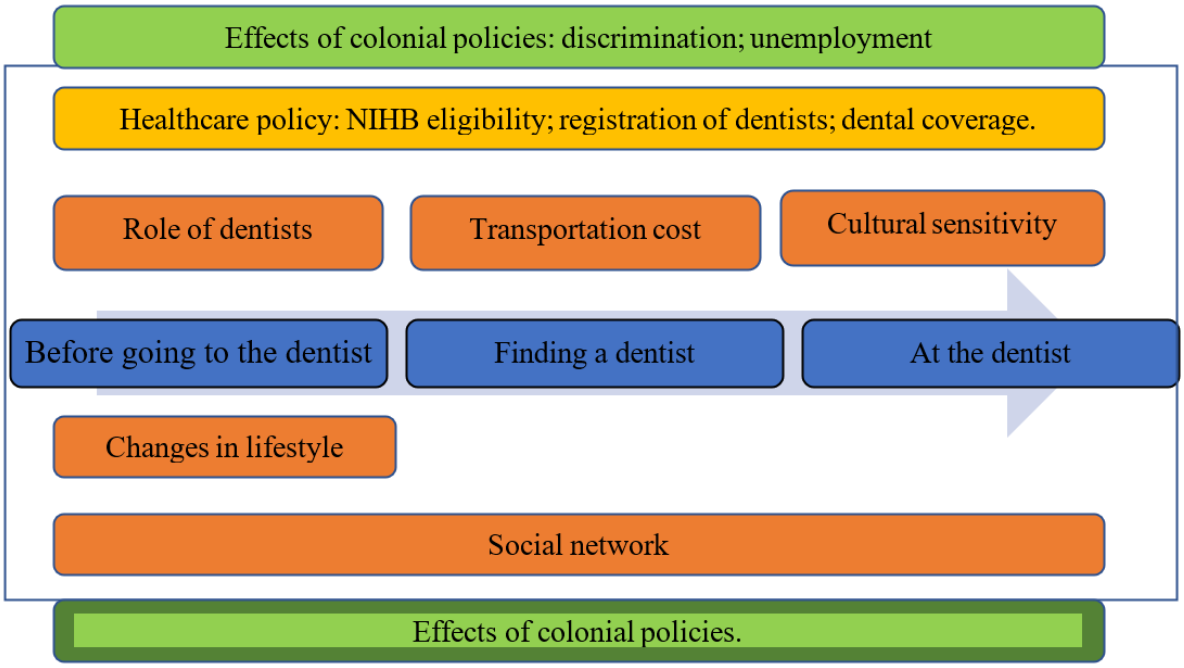

Figure 5.1. Themes associated with the oral healthcare process of Indigenous people in Montreal.

5.3.1. Phase I: Before going to the dentist

5.3.1.1. Motivations to consult a dentist

Some participants mentioned that they were motivated to visit the dentist because they wanted to achieve or maintain holism and balance, given that the health of their teeth and mouth was important for smiling, self-esteem, and eating. Those who had positive experiences at the dentist described how they felt "good and happy" following the care episode, which also boosted their mental well-being. Some of the participants started going to the dentist when they were children and maintained the practice as adults. These individuals now encouraged their children to develop healthy personal oral hygiene habits and consult dental services. Reflecting on the positive impact of professional dental care on her well-being, Emily, a 40-year-old participant living in Montreal for 20 years, said:

"... if you look at your life in a balanced way, you're more likely to live a happy, comfortable

life… In this regard, our whole family was always at the dentist when it was their time. This also works vice versa: I care for my teeth and visit the dentist because I am a happy person due to the balance I maintain in my life."

Ultimately, the positive experiences and anticipated dental care benefits encouraged individuals to consult the dentist regularly, although toothache was a major reason for consultation.

5.3.1.2. Unemployment as a barrier to access

Despite the motivation to consult a dentist, participants who were jobless described how being unemployed negatively influenced their decision to seek professional dental care. Some only went to the dentist when in absolute need, given that they were busy trying to secure the necessities of life (food, housing, and employment). In their view, finding a job in the city was difficult since they lacked the necessary education or skills or could not meet the language requirement of employers. One participant indicated that his criminal record meant he was almost always denied a job. Although this served as a barrier to finding a job, he remained resilient and determined: *"It's kind of hard to find a job with a criminal record like mine. Yeah, but it still doesn't stop me from continuing my search for employment."*

Being unemployed, according to the participants, was stressful and lowered their self-esteem. The stress that characterized their daily living reduced their motivation to consult a dental professional or even care about their health and oral hygiene. They drew a contrast between their situation and that of the employed, whom they considered lived a more stable life and were more likely to make oral health care a priority. Overall, although some of the participants had dental coverage, competing daily challenges due to employment limited their willingness and ability to consult a dentist.

The interview data corroborated what I learned during my field trip about employment

opportunities for Indigenous people. Potential employers required Indigenous people to speak and understand basic French for most jobs in Montreal. Further, they needed to speak one of the two official languages to facilitate their movement from one part of the city to another during job searches.

5.3.1.3. Chaotic lives leading to substance use as a barrier to access

Some participants reported having chaotic lives or chaotic periods in their life while unemployed. During these periods, they were engaged in unhealthy behaviours, such as substance use. In these difficult times, they did not consider consulting a dentist even if they felt they needed dental treatment. To some of the individuals, there was no need to visit a dentist to 'fix' a broken tooth, given that the tooth would again be broken in their next physical fight. According to one participant: *"I used to get into a fight almost every night, which means I would be going back almost every day to get my teeth repaired."* Participants attributed their unhealthy lives to the lack of a job, which left them with "free time" to drink with friends "to keep life going." When drunk, they explained, they were prone to poor judgement that often led to inter-personal violence and resulted in damage to their teeth, lips, and tongue: *"...most of the time I'm drunk, but when I'm sober, I don't I don't get into fights..."* Participants also reported losing their dentures or health insurance card when drunk. Overall, our data show how the substance use that characterized their chaotic lives limited their willingness and ability to seek professional dental care and, in some cases, directly affected their oral health.

5.3.1.4. Stereotypes and discrimination

In addition to unemployment and chaotic lives, participants had experienced discrimination and negative stereotypes at various stages of their lives, which could negatively influence their decision to consult a dentist. These experiences occurred in different settings, including Western

educational institutions, the medical care system, and the justice system. For example, a participant who attended a post-secondary educational institution in Montreal felt that Indigenous students were put on the spot when issues of culture and race were discussed during lectures. In describing "unfair" practices, Molly, a 22-year-old university student in Montreal, explained how racism was prevalent in society, even among people who were educated and should be respectful of all cultures:

> *"There are racist students in anthropology. You would think that they're not racist because they're in anthropology, but a lot of them are European, and they would say things like, yeah, everybody has an equal culture just below the European."*

Further, Emily, a 40-year-old participant living in Montreal for 20 years, summed up the embarrassment that some participants felt when they first moved to Montreal and experienced racism:

> "*I was kind of embarrassed to be Native because I didn't want people to call me a savage. I gained more weight, and people will look and me and ask are you Native? And I'm like, yes, that is not an insult. I got that a lot."*

As a precautionary measure against anticipated discriminatory practices and negative stereotypes, some parents discouraged their children from revealing their Indigenous identity to the public, although being proud of their cultural background. When describing their negative experiences, participants often referred to colonial policies, which they considered the root cause of many problems faced by Indigenous people. Specifically, participants suggested that unemployment, low education rates, and oral health challenges that Indigenous people faced were direct consequences of colonial policies. One participant summarized the general impression: *"There is so much to restore right now due to colonization."*

Discrimination and stereotypes, unemployment, and chaotic lifestyles are intricately connected outcomes of colonial policies that are potential barriers to the oral healthcare process.

Although participants who visited the dentist before did not specifically mention they were discriminated against in the dental clinic, such negative feelings have the potential to discourage the utilization of health services in general.

5.3.1.5. Stringent NIHB eligibility criteria as a barrier to access

To some participants, their decision to consult with a dentist was closely related to their eligibility for the NIHB program. They indicated that qualifying for and maintaining their eligibility under this program was an important challenge and influenced their decision. Providing official proof of Indian status was a complex and lengthy procedure even for those with Indigenous biological parents. Participants adopted by non-Indigenous parents explained how they had to carry out private investigations to acquire the government-required Indian status document. In this complicated process, they had to make several visits to the reserve and Indigenous community centres in Montreal and hold conversations with individuals who could provide information about their biological parents. These laborious private investigations were sometimes unsuccessful, meaning that the participants could not be covered by the NIHB. Overall, the data suggests that being born to Indigenous parents was a necessary but insufficient condition to benefit from health care coverage designed for Indigenous people. The administrative requirements to ascertain Indian status, in some instances, actually closed the door to available health care benefits for the population. To this albeit small proportion of Indigenous people, failure to prove their Indian status was a barrier to the first phase of their oral healthcare pathway. In addition, the inability of an Indigenous person to show proof of Indian status meant that they could only receive dental care under the Québec provincial dental program, which one participant indicated could lead to

significant delays in necessary care.

5.3.2. Phase II: Finding a dentist

5.3.2.1. Shortage of NIHB dentists and solutions

Finding a dentist who accepted NIHB beneficiaries was a challenge to some participants seeking their first appointment. They explained they had to contact several dental clinics to find one that would accept their oral health plan. This difficulty in finding a dentist resulted in delayed appointments and increased anxiety. To these individuals, navigating the dental care system in Montreal was exhausting and frustrating. In expressing her dissatisfaction over the insufficient number of dentists accepting the NIHB card, Lucy, a 32-year-old participant living in Montreal for 10 years, also highlighted the importance of being covered, considering the costs of dental services:

> "*I haven't been to the dentist in 2 years, which is very bad. I used to go every year, but now I get frustrated with trying to find a place that will take my card. It would be easier if I found a place here that would take it because going to the dentist is pretty fricking expensive.*"

In their dental care process, participants thus devised various strategies to deal with the shortage of NIHB dentists and dental clinics. They first asked in their social networks whether people knew a dentist accepting NIHB beneficiaries. Their networks included family members, friends, colleagues, and members of the Indigenous community in Montreal. These people, who in some cases had previously helped them obtain Indian status, enrol into the NIHB, and obtain the beneficiary card, advised them in their search for a dentist and even accompanied them to the dental clinic. Having a social network was thus positive in terms of access and supported them during the three stages of their oral healthcare pathway.

Their social networks also introduced some participants to the McGill mobile dental clinic

program, a charity program that participants described as a rich source of oral health information and basic dental care. At the mobile clinics, McGill University dental students provided oral health information and basic care within the NFCM. Participants who attended these mobile clinics appreciated their "friendly" interaction with dental students and the non-urgent care they received, such as teeth cleaning. One participant explained: "*They asked me how I brushed my teeth, and I showed them, and they said, 'Yeah, very good. You are taking care of your teeth. Now, give me a smile.' And I smiled."*

Some participants, who could not find a private clinic or felt uncomfortable receiving treatment from a 'new dentist' at the McGill mobile dental clinic, reported travelling back to their Indigenous community to receive dental care there. To these individuals, maintaining the existing trustworthy relationship with the dentist in their community was worthwhile. One participant stated: *"I think it was a lot easier that I didn't have to explain a lot of stuff..."* However, the round trip from Montreal to the community came at a cost. Some participants considered the transportation cost significant, although they did not mention a dollar amount: "*I always have to hire a car to go to the reserve to see my doctor and my dentist..."* For these individuals, although travelling to the Indigenous community was a potential solution to the short supply of NIHB dentists, the associated cost could represent a barrier. As well as the transportation cost, individuals needed to make additional plans when travelling out of the city, such as pet care.

5.3.3. Phase III: At the dental office

5.3.3.1. Cultural competency of dental providers

At the clinic, participants were concerned about the cultural values of the dentist and their interpersonal relationship. Ideally, participants would prefer to be treated by an Indigenous dentist or at least one who understood Indigenous cultures. They felt that such a dentist would be more

likely to respect their spiritual beliefs and consider their cultural values when planning and implementing dental treatment. More specifically, participants indicated that a dentist who understood their values would spend enough time to communicate with them and build trust. They considered that effective communication was important in establishing a strong and trustworthy care relationship. Expressing how such interpersonal interaction enriched the dental care experience, one participant stated "*... he is always great as he brings in Jewish elements, he talks about his history and I'm there listening to him. So, he is great!"*

Participants further suggested that although all dentists had the required training and clinical skills to provide standard care, the interpersonal relationship with Indigenous people made the difference between a good and an excellent dentist. Speaking on this issue, Alex, a 32-year-old participant living in Montreal for 12 years, explained why he had to change dentist: *"I thought she [his previous dentist] was cold… I think she is just really like in and out and you don't have that kind of personal interaction. Honestly, I think she is a good dentist, but I think it is just more of her personality."*

Trust and respect toward Indigenous cultural values were thus important determinants of the dental care process, to the extent that some participants preferred returning to their dentist in the Indigenous community or reserve.

5.3.3.2. Benefits and limits of NIHB dental coverage

All participants who had used the NIHB dental coverage indicated that it allowed them to receive dental care that they would otherwise be unable to afford. To them, they usually received standard care and did not have to settle for a 'second-best' treatment". The insurance coverage enabled participants to receive various treatments, including but not limited to teeth cleaning, extractions, root canal treatment, filling of carious teeth, and orthodontic treatment. Participants also explained

that they could accompany their children for dental care without much thought about the financial implications. They expected that, by consulting the dentist early in life, their children would maintain this practice over their lives. Participants who utilized dental services appreciated the usefulness of the dental coverage and the positive experience of not having to worry about dental fees.

However, some participants reported frustrations when at the dentist because they could not access the treatment they had expected. For example, one complained that a dentist asked him to pay 50% of the orthodontic treatment cost, which amounted to $2,000 and seemed excessive and unacceptable to him. In this regard, the individual described NIHB coverage as "limited and selective" because they claimed the full cost of the same procedure was covered in other provinces and territories. Reflecting on orthodontic treatment and NIHB coverage, Molly, a 22-year-old living in Montreal for 1 year, stated: *"If you're going to make dental free, why not all of it? Or make it less expensive. I think my braces are the same price as anybody else."*

Another participant suggested a lack of accommodation from the dentist who required him to pay upfront for treatment. The dentist had indicated that the client could subsequently apply for reimbursement from the government. Having no other option and in need of urgent care, this participant had to ask family members for money to pay for the treatment.

The data indicated that although NIHB coverage facilitated access to dental care for most participants, a few had mixed experiences because of co-payments or upfront payment. Individuals without NIHB coverage or who had to incur personal costs had additional financial hurdles.

CHAPTER 6. DISCUSSION

To my knowledge, this is the first empirical study in Canada to provide an understanding of urban Indigenous people's oral health perceptions and oral healthcare process. The main additions to the literature on Indigenous oral health include the fact that Indigenous and Western cultures influence the oral health perception of this population as well as their diet and that urban Indigenous people still experience barriers to accessing oral healthcare despite having coverage under the NIHB. The dissertation presents insights into the oral health perceptions and oral healthcare process experience of Indigenous people residing in Montreal, a metropolitan area in Canada with close to 35,000 Indigenous people (Statistics Canada, 2016). In the following sections, I will draw on my field experience to discuss the findings in relation to available literature and identify opportunities for various stakeholders, including policymakers, dental public health practitioners, dental services providers, and community organizations. The thesis includes further research priorities, has the potential to inform policy, and can guide the actions of service providers aiming to improve the oral health of Indigenous people in similar contexts.

6.1. Perceptions of oral health

Participants had a bicultural perception of oral health, although the Western perspective seemed to dominate the Indigenous culture. The two views on oral health overlap in certain aspects, especially regarding the functional and aesthetic importance of the mouth. The fact that our sample mainly comprised Indigenous people who initially lived in communities before migrating to Montreal contributes to the bicultural lens. Through the Indigenous lens, participants tended to define or understand oral health around the concepts of holism and balance, popular principles in Indigenous health literature (Hunter et al., 2006). Few studies on the oral health of Indigenous people have referred to the Indigenous holistic model of well-being, which is central to the

Medicine Wheel (NETWORK, 2019b; Well Living House, 2018). According to the Indigenous Medicine Wheel, an individual experiences health and well-being when an equilibrium exists between the physical, emotional, mental, and spiritual aspects of self. For Indigenous people, such balance between the human activities and the environment is required to maintain good general and oral health of the population (Mathu-Muju et al., 2017a; Wilk et al., 2018). The Indigenous perception of oral health is similar to the Western biomedical definition of health as "not merely the absence of disease, but a complete state of physical, mental, and social well-being" (World Health Organization, 2022).

Dong et al. (2007) described a similar bicultural perception of oral health among Chinese immigrants in Montreal, where participants referred to the concept of 'fire' in Chinese traditional medicine. The internal fire flares up when an individual experiences chronic anxiety or does not eat appropriate food or drink adequate liquids. Outside Canada, researchers found the cultural background of Indigenous people in Australia was a major factor influencing how the population perceived oral health and accessed professional dental care (Krichauff et al., 2020).

Overall, the empirical literature highlights that cultural groups have certain understandings and beliefs that influence how they maintain oral health, deal with oral illness, and access dental services (Butani et al., 2008; NETWORK, 2019a; Well Living House, 2018). Therefore, the cultures of sub-groups of a population must be taken into accountwhen designing health-related programs (Ghanbarzadegan et al., 2021). For example, dental public health professionals must find ways to align oral health messages to the holistic health concept of Indigenous people to render the messaging culturally appropriate and acceptable.

For our study participants, praying, caring for the sick, and eating in moderation constituted ways to achieve and maintain the equilibrium necessary for oral health and general well-being. This

perception of oral health fits one of the lay dimensions of health, in which individuals define health as “equilibrium, balance, harmony contingent upon events in life, a state often under attack in modern society” (Hughner, 2004). In contrast, dental pain or oral disease can disrupt the equilibrium, resulting in undesirable or negative functional, physical, and emotional impacts on the individuals affected. Available evidence indicates the oral health impacts of a disrupted equilibrium are higher among Indigenous people compared to non-Indigenous people in the same country and globally (Tiwari et al., 2018a).

In addition to maintaining equilibrium, participants described the usefulness of the teeth and mouth for eating and aesthetics, which aligns with the definition of “health as a function” and “health as a ‘psychological well-being’” (Hughner, 2004). In addition to the main function of eating, our findings indicate that having good dentition added to physical appearance, contributed to a beautiful smile, boosted self-confidence, and thereby positively influenced psychological well-being. In contrast, individuals with poor dentition can be withdrawn and have low self-esteem (Pazos et al., 2019).

In describing the importance of the mouth for eating, participants spoke extensively about the healthy nature of traditional Indigenous diets. This view supports the available literature on Indigenous food systems (Carmen, 2016; Kuhnlein, 2015). According to Kuhnlein (2015), precolonial Indigenous food systems were ecologically sustainable and provided healthy, varied diets that protected the health of the population. For Indigenous people, food is not just a source of nutrients and energy but a means to intimately connect to their land, family, history, and culture. Colonialism and colonial practices have disrupted the harmonious relationship between Indigenous people and their food systems, forcing the population to migrate from their habitual communities (Soares et al., 2019). After moving to Montreal, our participants had limited access

to healthy foods, including traditional Indigenous foods. A typical grocery bill in Canada has increased by over 70% between 2000 and 2020. Due to the level of inflation experienced since 2021, the cost of food items is currently at a 20-year high (Music, 2022) The escalating prices of healthy food could make these items unaffordable to low-income Canadians, including people receiving financial support from the government. Our study found that the high cost of healthy foods led some participants to turn to unhealthy foods, which although affordable, often include added sugars. Added sugars are an important risk factor for dental caries and other non-communicable diseases (Hujoel & Lingström, 2017). The acculturation process of Indigenous people in the city includes adaption to new feeding habits (Eni et al., 2021), which our findings indicate often resulted in the consumption of less-healthy diets. Further, the shift in dietary habits that occurs following the migration of Indigenous people to the city can create food insecurity for this population. Therefore, individuals unsurprisingly rely on food banks, which often do not provide healthy food choices (Roncarolo et al., 2015). Our findings support empirical literature that describes colonization as a key structural social determinant of health for Indigenous people (Ashworth, 2017) and underscores the need to improve access to healthy foods among urban Indigenous people. For example, urban Indigenous people could be offered community gardens, which would provide them with a more sustainable source of healthy food (Pan-Canadian Public Health Network, 2018; Roncarolo et al., 2015). In addition, strategies aimed at making healthy foods available and affordable for urban Indigenous people should include a nutrition knowledge component, which would help the population better appreciate the benefits of healthy eating.

In addition to narratives regarding the usefulness of the mouth, participants underscored the need for tooth brushing and regular visits to the dentist to maintain good oral health. The notion that personal oral hygiene and regular dental check-ups are important to prevent oral diseases draws

on the Western cultural background. Effective tooth brushing can reduce or eliminate mouth odour, improve self-confidence, help keep the mouth in good health for chewing, and improve self-confidence (Pazos et al., 2019). Our finding corroborates biomedical evidence on the correlation between effective tooth brushing and the prevention of dental caries and periodontal diseases (Janakiram et al., 2018). Further, dental professionals recommend a visit to the dentist at a frequency based on the patient's individual need for routine oral tissue care and the prompt diagnosis and treatment of oral disease. Our participants did not seem to have issues with the affordability of toothbrushes and toothpaste, even though they were mostly unemployed or low-income earners. In contrast, Bedos et al. found that social welfare recipients in Montreal, another vulnerable group depending on financial support from the government, could sometimes not afford products for their oral hygiene (Bedos et al., 2014).

Overall, our findings suggest that dental public health programs should consider the traditional and holistic model of wellness and health of Indigenous people and their Western cultural perceptions and practices regarding oral health (Mathu-Muju et al., 2017b; Tsai et al., 2017).

6.2. The oral healthcare pathways

The experiences of urban Indigenous participants highlighted various factors that facilitated or limited their access to oral healthcare. Previous studies in Montreal have described a similar complex and tortious oral healthcare pathway among social assistance recipients (Bedos & Levine, 2009), Chinese immigrants (Dong et al., 2011), and recent immigrants (Keboa et al., 2019).

To elaborate on this discussion, I will draw on the conceptual framework of access to health care developed by Lévesque et al. (2013). The framework describes five dimensions of access that capture the supply- and demand-side determinants: (i) approachability and the ability to perceive, (ii) acceptability and ability to seek, (iii) availability and accommodation and the ability to reach,

(iv) affordability and the ability to pay, and (v) appropriateness and ability to engage.

Approachability and ability to perceive

Approachability relates to the fact that people facing health needs can identify that some form of services exist, can be reached, and have an impact on their health. This supply dimension of access is described in conjunction with the ability of the individual to perceive the need for care (Levesque et al., 2013). Data from the interviews and my interaction with Indigenous people in Montreal indicate that the population appreciates the need to visit a dental professional for preventive and curative services. Living in Montreal offered participants the opportunity to attend oral health promotion sessions that enriched their oral health knowledge. Specifically, participants who had a dentist in Montreal had completed a higher level of formal education. The finding is in accordance with studies that found a positive correlation between the use of dental services and the education level of Indigenous people (Tiwari et al., 2018b) and aligns with the social determinant of oral health conceptual framework (Watt, 2012).

Parents and guardians represented another important source of oral health information for the participants. They helped their children and dependents identify the need for dental care and find a service provider and accompanied them to dental appointments. The ability of an Indigenous parent or guardian to support the oral health practices of their dependents is influenced by the importance the adult attributes to oral health, their oral health knowledge, and their oral health behaviour (Naidu et al., 2014). In our study, participants who had received oral health support during childhood seemed to have retained healthy behaviours and passed these on to the next generation. In contrast, Indigenous parents or guardians with poor oral health literacy are less equipped to support the oral health needs of their dependents (Naidu et al., 2014).

Some participants could not utilize NIHB dental benefits due to inadequate knowledge about the

program. Similarly, in a multi-national study, Tiwari et al. (2018a) found that Indigenous communities in Canada, the United States, Brazil, Australia, and New Zealand had limited or incomplete oral health information. They proposed interventions to enhance oral health knowledge and behaviours in these communities (Tiwari et al., 2018a).

Gaps in knowledge regarding available dental services are not limited to the beneficiary population. According to the 2017 report of the Auditor General of Canada, Health Canada, the government body responsible for implementing the NIHB, had failed to demonstrate the extent to which NIHB dental coverage helped Indigenous people maintain and improve oral health (Auditor General, 2017). Our findings on approachability suggest that knowledge gaps exist among beneficiaries and potentially program implementers, which need to be addressed.

Opportunities for action

Our findings suggest the need for stakeholders to continue exploring appropriate strategies to address gaps in oral health knowledge among Indigenous people and curb oral health inequalities in the population. Dental public health professionals should collaborate with Indigenous community organizations in developing and implementing oral health promotion programs aimed at enhancing the oral health of Indigenous people (Tiwari et al., 2018a). The programs or interventions should provide Indigenous people with appropriate knowledge, tools, and resources to help translate oral health knowledge into healthier oral behaviours.

Living in an urban centre appears to provide Indigenous people with more opportunities to access oral health information and personal oral hygiene skills training offered by academic and training institutions. These services can contribute to making dental services more approachable to urban Indigenous people. However, we do not know the proportion of the population that utilizes such outreach programs. Perhaps of greater importance is the role participants' social networks play in

providing useful information about dental services. This supports the literature that suggests social networks can positively impact access to oral health care and minimize oral health inequality (Salehyar et al., 2015).

Acceptability and ability to seek

Acceptability relates to cultural and social factors determining the possibility for people to accept aspects of the service and is associated with the ability of people to engage.

Given the opportunity, participants would prefer receiving dental care from an Indigenous dentist or one who understands and respects Indigenous cultural values. Specifically, individuals prefer dental professionals who spend time to connect with the patient and develop a relationship of trust (Ashworth, 2017). Our study found that Indigenous people feel more confident, accepted, and comfortable when receiving dental care in an environment of mutual respect and when their views are considered. This aligns with the concept of patient-centred care (Mills et al., 2014) and contrasts with the dominant prescriptive and time-bound model of dental practice in Canada. The dental practice model focuses on the number of procedures completed and is not flexible enough to accommodate the expectations of Indigenous people. Vulnerable populations are sensitive to the power relationship in the dental business model and may perceive the dental professional as more concerned about making money than the health and well-being of the patient (Bedos C, Levine A, 2009).

Our study underscores the need for oral health professionals to understand the cultural values of Indigenous people. This would help them to reflect on their practices and eliminate some unconscious prejudices towards Indigenous people. According to Breault et al. (2021), unconscious bias against Indigenous people results when professionals fail to customize treatment guidelines that have been developed for use in the general population. Dental professional bodies

in Canada appreciate the need for dentists to be culturally competent when providing services to clients from diverse cultural backgrounds and are taking appropriate measures to address this. For example, the Association of Canadian Faculties of Dentistry and its 10 dental faculties strongly condemn any form of anti-racial or discriminatory practices against people of various racial backgrounds, including Indigenous people, and are actively exploring ways to eliminate any form of systematic racism through education, research, and advocacy (Association of Canadian Faculties of Dentistry, 2018).

Another measure likely to increase the acceptability of dental services by Indigenous people in Canada is the recently announced Bachelor of Science in Dental Therapy program offered by the University of Saskatchewan. The program, scheduled to commence in fall 2023, will focus on recruiting Indigenous students (University of Saskatchewan, 2022). It aligns with guidelines developed by various organizations to help employers create inclusive and culturally sensitive workplaces. This program is expected to increase the number of Indigenous dental professionals and indirectly contribute to the acceptability of dental services among Indigenous people. Outside of Canada, Krichauf et al. (2020) identified that empathy and cultural friendliness of dental staff towards Indigenous people facilitated the utilization and acceptability of dental services among the Australian Indigenous population. To ensure that future dentists have the appropriate cultural knowledge and feel comfortable working with Indigenous people, Australian education and accreditation institutions have been exploring various options for incorporating Indigenous culture into dentistry curricula (Forsyth et al., 2019).

Even when Indigenous people appreciate the need to use dental services, the long-term effects of colonization, including racism, discrimination, unemployment, and poverty, may limit their ability to seek and accept available dental services (Nguyen et al., 2020). To Indigenous people, racism

and discrimination against them in the Canadian health care setting is a systemic problem (The National Association of Friendship Centres (NAFC), 2021). The case of Joyce Echaquan, an Indigenous woman who died in a Quebec hospital after filming staff insulting her, drew media attention to the systematic racism many Indigenous people face when accessing health care in Canada (Lowrie and Malone, 2020). In 2020, the National Association of Friendship Centres NAFC, a network of the over 100riendship Centres across Canada, launched a campaign against discrimination faced by urban Indigenous people in health care settings. The ongoing campaign includes an online forum on education and prevention of racism (The National Association of Friendship Centres (NAFC), 2021). Racist actions towards Indigenous people in health care or other sectors of society can negatively influence their decision to seek dental care (Ashworth, 2017) and limit their ability to engage with service providers. As an example, Lawrence et al. (2016) found that up to a third of Indigenous participants had experienced some form of discrimination when accessing dental care in Canada. Overall, the political and economic inequalities resulting from colonization underpin the high unemployment levels and poverty among Indigenous people that individually or collectively hinder access to healthcare (NAFC, 2021).

Reflecting on his personal experience as an Indigenous Canadian dentist, McKinstry (2017) noted that oral health professionals may unintentionally discriminate against Indigenous people when they adhere to the principles of equality for all their patients. In his view, providing the same treatment to Indigenous and non-indigenous Canadians fails to consider the cultural values and needs of Indigenous people and rather promotes inequality.

In addition, Indigenous people may feel bullied, intimidated, or discriminated against when navigating the health care system. These negative feelings could result from the health

professionals' inadequate understanding of Indigenous culture (Cameron et al., 2014). To address racism against Indigenous people in the Canadian health system, Browne et al. (2022) recommended a multi-tiered approach, including the adoption of anti-racism as a sixth pillar of the Canada Health Act. Vulnerable populations in Canada continue to experience stigma and discrimination in health and dental care settings (Donnelly et al., 2016; Jessani et al., 2020), and adopting the proposed anti-racism aspect of the Act could help curb negative patient experiences. In Australia, perceived discrimination by health providers was found to hinder the ability of Indigenous parents to make healthy choices for the oral health of their children, including the utilization of free dental services (Durey et al., 2017).

The long-term effects of colonial policies include unemployment and poverty, and half of the study participants were unemployed. Competing needs sometimes caused them to neglect their oral health. One Canadian study found that poverty was the main reason that Indigenous communities in remote Manitoba did not utilize NIHB-insured dental services (Schroth et al., 2015). Poverty was again identified as a major determinant of oral health in a review of interventions to reduce oral health inequalities among Indigenous populations of the United States, Canada, Brazil, Australia, and New Zealand (Tiwari et al., 2018a). Poverty is associated with unemployment, and the unemployed have a high burden of dental disease, partly due to limited dentist access (Al-Sudani et al., 2015; Quinn et al., 2009). Our study findings suggest that unemployed individuals were preoccupied with meeting their daily needs, which often meant making non-urgent oral health concerns a lower priority. The social ramifications of unemployment can have an even greater impact on oral health and dental care for individuals without dental insurance (Quinn et al., 2009). Associated with unemployment and poverty is the feeling of stress, which can contribute to neglecting personal oral hygiene and the need to seek professional dental care (Priyanka, 2017).

Stress is associated with teeth grinding, sores in the oral cavity, and overall poor oral health status (Nova Scotia Dental Association, 2019). Almost half of our study participants described a stressful life and had experienced depression or excessive alcohol use at some point. These individuals resorted to excessive alcohol consumption as a coping mechanism, a practice that can impair personal judgement, with an increased risk of self-harm, including oral trauma. Overall, socioeconomic challenges faced by urban Indigenous people not only result in an increased burden of oral disease but limit their ability to seek and accept appropriate care (Priyanka, 2017).

Availability, accommodation, and the ability to reach care

Availability and accommodation refer to the existence of health resources and the ability of the population to physically access the services promptly. Although more than half of the over 5,300 registered dentists in Québec are found in Montreal and dental clinics can be found at most shopping centres and business centres, our participants suggested a shortage of available dentists. This finding is understandable, given that not all dental clinics or dentists are registered with the NIHB. Some dentists have reservations about registering with and providing services to beneficiaries of dental public programs. For example, in February 2020, 1,400 dentists temporarily withdrew from the Québec public dental care plan due to a conflict with the government following negotiations to renew the previous contract that

study in Montreal, dentists cited the bureaucratic registration procedure, delays in reimbursement, and sometimes non-payment of invoices as reasons for not accepting patients insured under the public program (Keboa et al., 2019). The artificial shortage of dental professionals contrasts with the actual shortage of dentists in the rural areas of Québec (Emami et al., 2016). Shortages of dental professionals, whether artificial or real, are associated with long wait times, invariably resulting in adverse oral health consequences for Indigenous people in need of care. During the waiting period,

individuals may resort to various coping mechanisms including prolonged use of non-prescription analgesics to alleviate dental pain and avoidance of certain types of foods (Keboa et al. 2019). Skye et al. (2019) described long waiting times as a barrier to dental care access among Indigenous people (Krichauff et al., 2020). To overcome the 'shortage' of dentists in Montreal, urban Indigenous people may travel to their home community to receive treatment from a dentist with whom they already established a trusted working relationship. When this happens, the direction of movement tends to contrast with the typical travel of Indigenous people from rural areas to the city for general and dental health care.

Opportunities for action

Our results highlight the need to raise awareness and commitment among dental professionals regarding the NIHB. The program administrators should continuously seek ways to motivate the subscription and retention of dental professionals to increase the available pool of providers. Frequent monitoring and analysis of factors that motivate or hinder the participation of dentists in the NIHB should inform appropriate actions aimed at improving the availability and accommodation of dental services for urban Indigenous people.

Affordability and the ability to pay

Affordability refers to the economic capacity of people to pay for appropriate health care services. Available literature indicates that cost is a key determinant and barrier to accessing oral health care even for working Canadians (McClymont, 2015; B. Thompson et al., 2014), and up to a third of Canadians cannot visit the dentist due to the high cost of dental services. Affordability is therefore the single most important determinant of access to professional dental care in Canada. In contrast, the NIHB provides extensive dental care coverage for eligible Indigenous people at no individual cost to the beneficiary (Government of Canada, 2019c). The NIHB dental coverage enabled some

participants to visit the dentist for regular check-up, preventive, and curative care in the community and the city.

The fact that the NIHB covers the direct cost of dental care does not eliminate other barriers or obstacles among Indigenous people. For some individuals, failure to meet the NIHB eligibility meant they could not receive NIHB dental benefits although they were convinced of their Indigenous origins. The need to establish proof of Indian status later in life is linked to the non-establishment of birth certificates at birth, which remains a real problem in some Indigenous communities and is rooted in their history and colonial policies (Sanders & Burnett, 2019). Even for eligible individuals, our study identified issues with co-payment and upfront payment requested by some providers. For individuals with limited financial resources, paying for dental services can pose a serious financial challenge even if the insurance program will eventually reimburse the expense. In addition, transportation to the dental clinic constitutes an indirect cost and a significant financial barrier to accessing dental care (McKernan et al., 2018).

Another challenge regarding affordability concerns the non-coverage of certain dental procedures under the NIHB. The benefits grid includes eligible services and usually identifies procedures not covered. Public dental programs commonly exclude certain services, and some participants unsurprisingly touched on the issue. As per the NIHB dental benefit grid, orthodontic coverage is limited to the treatment of severe and functionally handicapping malocclusion (Government of Canada, 2019c). Therefore, orthodontic treatment needs that do not fit the criteria are not reimbursed by the program. Parents and children who need orthodontic treatment that does not fit the coverage criteria can experience emotional and psychological stress, given the high cost of the procedures. Research has even found less severe malocclusion, such as anterior spacing, crowding, and overjet, is associated with very low self-esteem among children (Taibah, 2017).

Opportunities for action

Our findings on the affordability of dental care suggest the need for further research to examine indirect costs that may act as barriers to dental care access among urban Indigenous people. These include co-payments, upfront payment, and transportation costs. The results will inform measures to address identified gaps in coverage. Furthermore, policymakers and program implementers should frequently review the scope of the benefits and sensitize dental professionals regarding the program and billing guidelines.

Appropriateness and ability to engage

Appropriateness refers to the extent to which a health care service fits the client's needs, as well as the quality of the service and health care facility (Levesque et al., 2013). The appropriateness and acceptability dimensions of access provide insights into how patients assess the quality of dental care they receive. Our findings indicate that participants who used dental services were generally satisfied with the quality of services they received and expressed confidence in the quality of training and clinical skills of dentists. The clinical competency of dentists and the quality of care they provided did not seem to be priority considerations influencing participants' choice of dentist. Rather, participants were more concerned with dentists' interpersonal skills and cultural sensitivity. Our findings corroborate the results of a study that analyzed patient reviews of dental services in Québec. The study found that over 80 percent of patients were satisfied with the dental care they received (Macdonald ME, Beaudin A, 2015). In contrast, people living in poverty (Bedos C, Levine A, 2009) and humanitarian migrants (Keboa et al., 2019) in Montreal criticized dentists for the type of care they received. Specifically, some participants of these vulnerable populations indicated that dentists decided to extract a tooth that, in their opinion, should have been root-treated (Bedos C, Levine A, 2009; Keboa et al., 2019). Notably, although the service does not meet the

expectation of the individual in such instances, the limited treatment options are imposed by the beneficiary's dental insurance and not the decision of the dentist. Our findings suggest that for Indigenous people, the appropriateness of dental care is synonymous with the provision of patient-centred care, which is defined as "care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Mills et al., 2014).

6.3. Strengths and limitations of the study

Collaborating with an Indigenous research partner

During this study, I established a partnership with the MUAHC, which added to the rigour and credibility of my research. This community organization understands the oral health needs and challenges of urban Indigenous people, and my interaction with the staff helped guide the research questions and interpretation of the results. Specifically, this partnership facilitated the interpretation of the findings with the perspective of urban Indigenous people, while being respectful and sensitive to Indigenous culture. Moving forward, the partnership will be useful during the knowledge translation phase.

Strength of focused ethnography

My study illustrates the usefulness of focused ethnography in health services research (Wall, 2015). Using focused ethnography contributes to the limited oral health research using qualitative designs. Specifically, although ethnography draws from the disciplines of anthropology and the social sciences, the field of oral health research is dominated by research based on the biomedical model (Stewart, 2001). The methodology allowed urban Indigenous people to express their perceptions of oral health and reflect on the dental care process in the community and the city. Combining qualitative data with measurable data from biomedical study designs provides

stakeholders with robust evidence to guide or support appropriate decisions and programs (Richards et al., 2019). Exley (2009) argued that the use of social science models and approaches in health services research better engages the policymakers responsible for formulating solutions to research findings.

During my study, I held informal interviews and observations in the field that enabled me to appreciate, in real time, urban Indigenous people's daily priorities, culture, and challenges and how these factors could influence access to dental care. Using focused ethnography facilitated our understanding of urban Indigenous peoples' perception of oral health and the oral healthcare process, highlighting areas for improvement.

Transferability

I recruited urban Indigenous participants of diverse origins, ages, and socioeconomic backgrounds that reflect the nature of Indigenous people in Montreal and Canada. Further, I obtained observational data from Indigenous health conferences and Indigenous community organizations. Attending various field events helped me understand the oral health perspectives and oral healthcare process of Indigenous people from different parts of society: school students, health professionals, and the unemployed. Participant observation at multiple field sites contributed to the uniqueness and richness of the data and provided a robust understanding of the phenomenon under investigation. Further, I triangulated the data obtained from various sources and participants from diverse walks of life. Therefore, our data and findings are not generalizable but transferable. Transferability is a form of external validity and refers to the degree to which the results of qualitative research can be transferred to other contexts or settings (Gunawan, 2015).

Limitations

A potential limitation of our study is that interviews constituted the main data source, given that I could not observe dental care episodes. In conventional ethnography, participant observation provides the main data. Conventional ethnographers may see my approach as a deviation from traditional ethnography, which requires the researcher to spend several months in the field for immersion in the culture of the population being studied (Brink & Edgecombe, 2003). However, my adaptation of the methodology is congruent with focused ethnography, where spending limited time in the field is acceptable when the researcher has good background knowledge of the population or phenomenon under study (Knoblauch, 2005). In addition, Roper and Shapira (2000) postulated that no 'right' duration exists for the observation component of ethnographic studies. Millen (2000) further expressed the possibility of obtaining rich data from less time-intensive field observation. The unavailability of a specific dental clinic for Indigenous clients in Montreal precluded the type of observation expected from a hospital ward or school setting.

CHAPTER 7. CONCLUSIONS, RECOMMENDATIONS, AND FUTURE DIRECTIONS

7.1. Conclusions

The following conclusions draw on the data collected through individual interviews with urban Indigenous adults and participant observation of Indigenous events.

i. Participants had a bicultural perception of oral health, influenced by Western and Indigenous cultures. The Indigenous cultural perception of oral health focuses on the concepts of holism and balance. Maintaining a balance between the physical, emotional, social, and mental aspects of self, the community, and the environment is required to maintain good general and oral health. The Western cultural influence of oral health stresses the need for personal oral hygiene and regular dentist visits.

   For urban Indigenous participants, maintaining good oral health was relevant for function and aesthetics, and they emphasized the important relationship between good dentition and traditional Indigenous foods and diets. Colonialism and colonial practices have disrupted the special bond between Indigenous individuals and their traditional food systems. Having migrated from their habitual communities to the city, accessing healthy foods, including traditional Indigenous foods, now posed an important challenge for the participants. This may explain why some urban Indigenous people turned to processed and less-healthy foods, which seem to be more accessible and affordable.

ii. Living in the city appears to provide Indigenous people with greater access to the oral health information necessary to inform healthier personal oral hygiene practices and seeking professional dental care in a timely manner.

iii. Colonialism had various negative direct and indirect effects on the oral healthcare process of urban Indigenous people. Firstly, some participants had difficulties obtaining the official

documents to prove their Indigenous origins, which disqualified them from the NIHB. Further, colonial effects including discrimination, unemployment, poverty, and racism experienced in various settings, before and after moving to Montreal, may erode the trust of participants in dental professionals. Further, unemployment had social and economic ramifications that could prevent people from taking care of their oral health and visiting the dentist.

iv. Given the opportunity, participants would prefer receiving dental care from a dentist who understood Indigenous culture, respected Indigenous values, and had a strong and trustworthy interpersonal relationship with the patient.

v. Participants experienced an artificial shortage of dentists because their enrolment into the NIHB was optional.

vi. The NIHB dental coverage facilitated access to dental care for participants. However, the coverage does not include certain dental procedures, and participants sometimes incurred indirect costs due to transportation.

7.2. Recommendations

The following recommendations draw on our results and are directed at various stakeholders: the Federal Government, dental faculties, dental professionals, Indigenous community organizations, and urban Indigenous people.

7.2.1. Federal Government recommendations

i. Reinforce the truth and reconciliation process with Indigenous people in Canada. This measure would help to curb discrimination against Indigenous people in various settings, increase enrolment in schools, create employment opportunities, and reduce poverty for Indigenous people and particularly Indigenous urban dwellers. Specifically, the

government could incentivize employers to create training and employment opportunities for Indigenous people migrating to the city and establish admission quotas for Indigenous people in vocational and other higher educational institutions. These measures could improve the oral health of Indigenous people and reduce the oral health inequalities between Indigenous and non-Indigenous Canadians. Overall, improving the standard of living of Indigenous people could have a positive effect on their general health and well-being.

ii. Continue funding Indigenous organizations that provide support services to Indigenous people who immigrate to the city, especially during the transitioning and settlement stages of migration. Special funding should be allocated to support measures aimed at improving access to healthy foods. This could include funding to the organization to prepare healthy meals or encourage collective ownership by Indigenous people of gardens where they could grow healthy food. Ownership of community gardens and kitchens may also provide more sustainable sources of healthy foods. These measures could also include a nutrition knowledge enhancement component to help the population eat better.

iii. Dental public health professionals should consider the traditional and holistic model of wellness and health of Indigenous people in the design, implementation, and evaluation of oral health prevention and promotion programs targeting them. Integrating traditional concepts of health in dental education and oral health promotion programs could make the programs more acceptable to the population.

iv. Train all service providers, especially dentists and Indigenous community organizations, regarding the NIHB program. For example, appropriate government units could organize or sponsor seminars, conferences, and workshops for dentists and organizations providing

services to Indigenous people in the city. The sessions could cover issues including NIHB policy; eligibility criteria; services covered; becoming a service provider; claim submission, processing, and reimbursement; and common challenges and solutions. In addition to the NIHB information on the Health Canada website, the program administrators should consider setting up an electronic system that periodically reminds key stakeholders about the program benefits, eligibility criteria, and other frequently asked questions and answers.

v. Review NIHB policy to ensure it best meets the needs of the target population. For example, policymakers could consider revising the eligibility regulations to include non-status Indians and Métis. Under the current policy, only First Nations and Inuit people recognized under the Indian Act are covered (Government of Canada, 2019). A more inclusive policy would be appropriate given that new federal laws now acknowledge Métis and non-status Indians as Indigenous groups (Government of Canada, 2020). Further, the program should consider covering orthodontic treatment for aesthetic purposes. Aesthetics plays a role in restoring people's self-esteem and could be especially important for this vulnerable population, some of whom are struggling with identity issues.

7.2.2. Dental faculty recommendations

i. Continue to conduct research on various aspects of Indigenous oral health and evaluate the long-term impacts of measures to improve it. Empirical data from such studies could help strengthen existing policies on the oral health of Indigenous people in rural and urban settings.

ii. Systematically include courses on Indigenous culture and oral health in the dental undergraduate curriculum, where this has not already been implemented. The objective is

to train and graduate culturally competent dentists who feel comfortable providing dental care to Indigenous people and people from diverse cultural backgrounds.

iii. Encourage dental students to provide oral health education and orientation sessions to Indigenous people in the city. The faculties should create an enabling environment for collaboration with Indigenous organizations, where staff could facilitate the initiation and implementation of oral health promotional projects for urban Indigenous people.

iv. Initiate or sustain initiatives that provide basic dental care to vulnerable populations without dental health insurance. An example is the McGill Mobile Dental Outreach program, which is mainly funded through donations from private organizations and individuals (Faculty of Dental Medicine and Oral Health Sciences, 2022). This and similar initiatives would improve access to dental care for urban Indigenous people who do not meet the NIHB eligibility criteria.

v. Continue providing services to inspire and support Indigenous students interested in becoming dentists. For example, UBC has an Indigenous Mentorship Program, while others, such as McGill University Faculty of dental medicine and oral health sciences and Schulich Medicine & Dentistry, have a distinct application pathway and reserve a specific number of seats for Indigenous students.

7.2.3. Dental professional recommendations

i. Encourage more dentists to register with the NIHB and increase the availability of dentists for beneficiaries. In the 2020–21 fiscal year, NIHB dental utilization rates were highest in Alberta (36%) and Québec (34%) ;(Government of Canada, 2022), confirming the need for NIHB dental services in Québec.

ii. Be conscious of the potential differences between the oral health culture of Indigenous people and non-Indigenous Canadians. Staff should strive for effective communication and show empathy towards Indigenous people. Treatment decisions or plans should be based on needs assessment, not coverage provided by the NIHB, and should consider the informed views of the client. Based on our study, Indigenous people appreciate such a positive attitude because it indicates that they are valued. It also contributes to restoring lost confidence in the health system brought about by previous negative experiences.

iii. Initiate projects or make their skills available to Indigenous-based initiatives that aim to reduce oral health inequalities. For example, dentists can contribute their time to work in a not-for-profit community dental clinic that focuses on treating Indigenous clients who are not covered by the NIHB.

iv. The dental regulatory bodies could collaborate with various stakeholders to ensure the entire population in their jurisdiction, including Indigenous people, have access to oral healthcare. Specifically, regulators could work with Indigenous organizations, researchers, and various governmental levels to design and implement programs aimed at curbing barriers and improving access to oral health care for Indigenous people.

Besides, dental regulators should include in the entry-to-practice profile of new oral health professionals the Truth and Reconciliation recommendations, which have the potential of making oral healthcare safe and inclusive for Indigenous peoples.

7.2.4. Indigenous organization recommendations

i. Continue to guide and empower Indigenous people regarding education, vocational training, and employment opportunities.

ii. Contribute to improving access to healthy foods for urban Indigenous people and provide additional services to support their acculturation and settlement.

iii. Advocate for more dentists to be registered with the NIHB, thereby increasing the pool of available dentists for beneficiaries.

iv. Work with professional dental organizations, such as the Ordre des dentistes du Québec, to establish a directory of dental clinics in Montreal that accept Indigenous people. The list will help NIHB beneficiaries easily book an appointment for dental care.

v. Explore the possibility of partnerships with dental faculties and colleges that train dental hygienists. The partnership will provide an opportunity for dental students to collaboratively develop and implement customized oral health promotion activities.

7.2.5. Indigenous people recommendations

i. Seek oral health–related information, attend oral health capacity-building, and inform themselves about the NIHB to help them make appropriate use of the available coverage.

ii. Aspire for leadership positions in Indigenous organizations and help these organizations see the need to carry out services to enhance the general and oral health of urban Indigenous people.

iii. Work with Indigenous organizations to advocate for their oral health.

7.3. Future directions

I present future directions informed by this study in two categories: (i) expanding empirical literature on the oral health of urban Indigenous people and (ii) moving knowledge into action.

Expanding empirical literature on the oral health of urban Indigenous people

Further research is needed to complement and expand what we know about the oral health of urban Indigenous people in Canada.

i. A survey of a representative sample of urban Indigenous people could provide a more comprehensive description of the oral health of urban Indigenous people, as well as their perceptions of oral health and how to promote it. The survey could address concepts that emerged from my study related to Indigenous culture, such as holism, traditional diet, and oral health.

ii. Additional qualitative studies could provide deeper insights into the oral health of urban Indigenous people and how they could be better supported during their settlement in urban areas.

Moving knowledge into action

During my PhD studies, I participated in an oral health video contest in Canada, where I produced a video that raised public awareness of oral health inequalities impacting urban Indigenous people. This video has been used to introduce undergraduate dental students to the oral health challenges of urban Indigenous people. The video and my research project have inspired undergraduate students of McGill Faculty of Dentistry to work with community organizations providing services to Indigenous people. In the early stages of the project, students accompanied me during some interview sessions at the NFCM and eventually collaborated with the centre to provide a customized oral health promotion session to the population.

Moving forward, I anticipate organizing an expanded workshop that will bring together various stakeholders: Indigenous community leaders; current and future oral health care professionals; researchers; dental faculties; NIHB officials; federal, provincial, and territorial policymakers; and employment and vocational training officers from the government and private sectors. The multi-sectorial and collaborative workshop will discuss the findings of my study and prioritize strategies to improve the oral health of urban Indigenous people.

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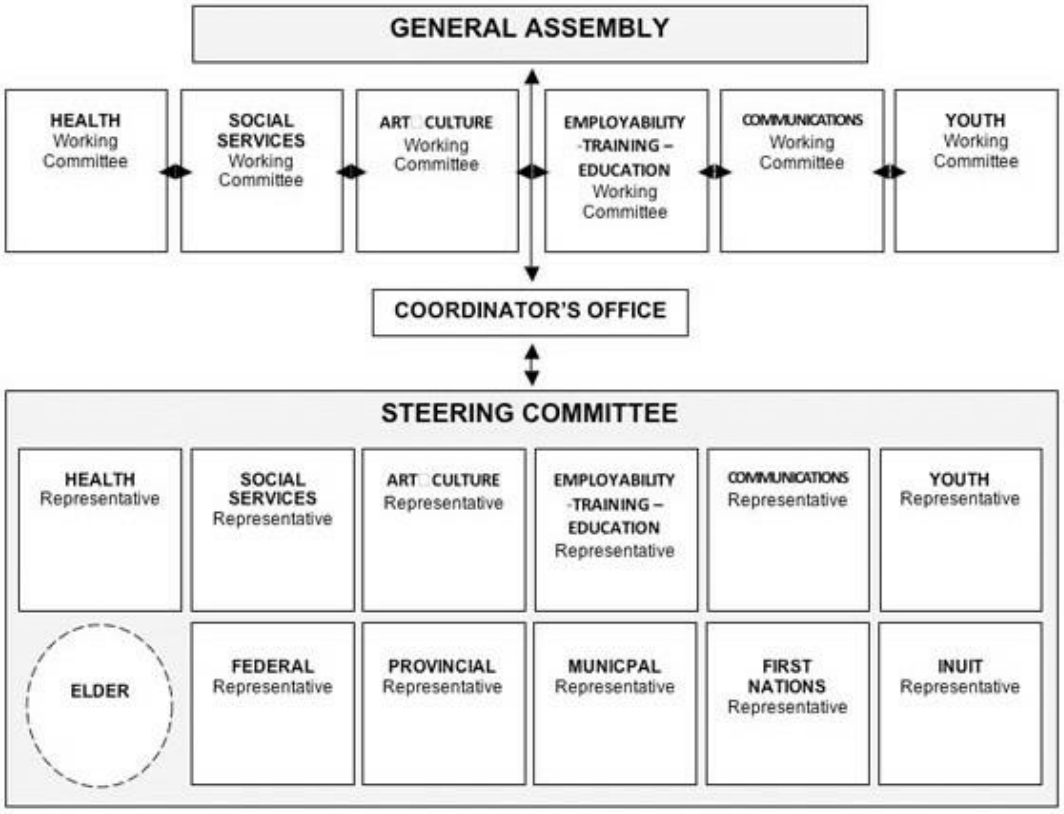
APPENDICES

Appendix I: Organization structure of Montreal Urban Aboriginal Network Strategy (NETWORK, 2012).



Appendix II: Collaboration agreement with NETWORK.

pour la stratégie urbaine
de la communauté
autochtone à Montréal

Montreal
Urban
Aboriginal
Community
Strategy
NETWORK

RÉSEAU

Montreal, September 16, 2013

Basem Danish
Faculty of Dentistry, McGill University
3550 University Avenue
Montreal, Québec,
Canada H3A 2A7

Subject: Montreal's Aboriginal Community's Experiences and Perceptions of Oral Health and Oral Health Care Service – A Qualitative Participatory Study

Dear Basem,

This letter is to confirm that we have agreed to participate in your study based on the lay description of your project which you have provided us with on July 10, 2013. At this stage, we do believe that your proposed research topic is highly relevant, and we do approve your proposed research question as presented.

Sincerely,

Carrie Martin, B.A. B.S.W.
Health Committee Coordinator

Cc: Montreal Urban Aboriginal Health Committee Members

Faculty of Dentistry
McGill University
3550 University Avenue
Montreal, QC, CANADA
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Carrie Martin, Health Representative

Chantal Robillard, Health Working Committee

Montreal Urban Aboriginal Community Strategy NETWORK (MUACSN) Pavillon

Duke Nord

5th floor, # 5151.04 801 rue Brennan Montreal QC H3C

0G4

July 10, 2013

Re: Montreal's Aboriginal community's experiences and perceptions of oral health and oral health care services: A qualitative participatory study

Researcher

Basem Danish (Dentist – PhD student – Division of Oral Health and Society).

Research Supervisors

Dr. Mary Ellen Macdonald (Assistant Professor, Division of Oral Health and Society).

Dr. Christophe Bedos (Associate Professor, Division of Oral Health and Society).

Dear Ms. Martin and Ms. Robillard,

It was a pleasure meeting you to discuss a potential partnership for conducting our research project. As per your request, following is a short lay description of our proposed study.

Our overarching research questions are, tentatively: How do Aboriginal people in Montreal access and perceive oral health and oral health care services? As well, how do dentists in Montreal experience and

perceive Aboriginal people as patients?

In asking these questions, we are interested in understanding the following issues: What do urban Aboriginal people do when they have a dental problem? Do they wait until they experience pain, and if so, how do they manage that pain? How easy is it to find a dentist in Montreal? Are there many dentists that welcome Aboriginal clients or are there only a few clinics that have become references for the "community"? Are people well-treated when they consult? How satisfied are urban Aboriginal people with their relationship with their dentists?

We are also interested in understanding the dentists' perspectives on these issues: Which dentists choose to register for the NIHB insurance program and why/why not? Is there a reticence to register? If so, is this related to a lack of demand from urban Aboriginal people, a lack of interest from clinicians, a fear of treating Aboriginal clients? What is the experience of those dentists who welcome Aboriginal clients and why do they accept to do so?

To answer these questions, we intend to use a qualitative participatory methodology and conduct interviews with urban Aboriginal people and dentists. The study is expected to be completed in 2 years during my doctoral program. We hope that our findings will help us better understand the perspectives of urban Aboriginal people in order to provide new insights that stimulate dialogue between them and local dentists. We hope this can lead to viable solutions to overcome existing challenges to improve Aboriginal people's access to oral health and services in Montreal.

Our study will align with the CIHR guidelines for research with Aboriginal people to ensure that it is culturally sensitive and respectful. This includes establishing a Research Agreement between you and us that describes in detail all research aspects prior to the commencement of the study. It also includes using a participatory framework. We believe that building a partnership with you and community dentists will increase the quality and usefulness of our research results. Thus, we would like to invite you to participate as you see fit – currently, we are especially seeking feedback regarding our research questions; however, we welcome your input in any manner you feel comfortable and interested throughout the entire study, including knowledge translation activities.

Should you require any further information, please feel free to contact me at the coordinates below. Thank you for your interest in our work!

Sincerely yours,

Dr. Basem Danish

Tel. # (438) 998-4292

Basem.Danish@mail.mcgill.ca

Appendix III: Semi-structured interview guide

Name of participant **Date** **Code** **Time**

Section 1. General background (socioeconomic and sociocultural aspects)

This includes questions about employment, income, Aboriginal identity, date moving to Montreal, residential school attendance, social life, education.

Note: answers should include information about the situation even before moving to Montreal (previous job, social life, etc.) since previous socio-economic status and intergenerational trauma may impact their current health and oral health.

Before proceeding to the next section, ask this following opening question:

What do oral health and oral illness mean to you?

Section 2. Traditional cultural beliefs

Ask if they hold any traditional Aboriginal cultural beliefs about the following:

1. Concepts of health and illness.

2. Benefits about teeth and oral cavity.

3. Oral hygiene practices.

4. Health-seeking and preventive care.

5. Use of folk remedies.

6. Diet.

Section 3. Oral health needs and priorities

Ask the following open-ended questions:

Is there is anything specific that you would consider important about your or your children's (if was a parent) oral health?

How do you think your or your children's oral health can be improved?

Section 4. Promoting oral health and dealing with oral illness

Ask the following open-ended questions:

How do you find your teeth? Gums?

Do you take care of your oral health? If yes, how? If not, why?

Do you think oral health and general health are linked?

How often do you visit the dentist?

Why do you go to the dentist?

What do you do when you have toothache or pain in your mouth?

Did you anyone advise you to visit the dentist? Who (in person)? (Through media)?

Section 5. Experience with oral health services in Montreal

Explain to me the process when you attempted to see a dentist?

Tell me about your experience when you visited the dentist?

How did you know about the NIHB?

Note: Avoid 'leading questions' to maintain the truth, trustworthiness, and neutrality in the data. For example, do not ask questions such as: "Do you face discrimination from dentists?" Instead, you should ask: "Tell me about your experience when you visited the dentist."

Appendix IV: McGill's IRB approval

McGill

Faculty of Medicine
3655 Promenade Sir William Osler #633
Montreal, QC H3G 1Y6

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June 13, 2017

Dr. Christophe Bedos
Division of Oral Health and Society
Faculty of Dentistry
2001, ave McGill College, Suite 500
Montreal QC H3A 1G1

RE: IRB Review Number A01-B04-16A
An ethnographic study to better understand oral health of aboriginal people in Montreal

Dear Dr. Bedos,

Thank you for submitting an application for Continuing Review for the above-referenced study.

The study progress report was reviewed and full Board re-approval was provided on June 12, 2017. The ethics certification renewal is valid from **January 4, 2017 to January 3, 2018**.

The Investigator is reminded of the requirement to report all IRB approved protocol and consent form modifications to the Research Ethics Offices (REOs) for the participating hospital sites. Please contact the individual hospital REOs for instructions on how to proceed. Research funds may be withheld and / or the study's data may be revoked for failing to comply with this requirement.

Should any modification or unanticipated development occur prior to the next review, please notify the IRB promptly.

Sincerely,

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Dr. Mary Ellen Macdonald
Dr. Bassem Danish
A01-B04-16A

Appendix V: Informed consent form

Title: An Ethnographic Study to Better Understand Oral Health of Aboriginal People Residing in Montreal.

Student Investigator: Basem Danish PhD (c)
Supervisors: Christophe Bedos (PhD) & Mary E. Macdonald (PhD).
Division of Oral Health & Society, Faculty of Dentistry, McGill University. 2001, McGill College, Montreal, Québec, H3A 1G1.

This document is to provide you with information about this research project and your role as a participant. Please take a few minutes to read through so you understand the content and feel free to ask any questions you may have concerning the project. If you prefer, I can read it out loud for you.

Introduction

Existing literature indicates that Aboriginal Canadians have more oral health disease (e.g., teeth or gum disease), and visit the dentist less often, when compared to non-Aboriginal Canadians. This is despite the fact that free dental insurance exists for Aboriginal people in Canada, provided by the Non-insured Health Benefits program. Although 54% of Aboriginal Canadians today live in urban centers, oral health research has focused on understanding and improving oral health of Aboriginal people living in Aboriginal-specific communities (e.g., on-reserve or in rural areas). Very little is yet known about the oral health issues of urban Aboriginal people. Poor oral health can lead to pain, difficulty in chewing and social exclusion. It can also increase the risk for other diseases. In this study, we want to find out what you think about your teeth and gums, how you take care of them, and what you do when have pain in your teeth, or gums, or inside your mouth in general. We would also like to learn about your experience accessing dental services while in Montreal. We will use this information to make recommendations that can bring about improved oral health for your population.

Voluntary participation and/ or withdrawal

Your participation in this research project is a voluntary decision and we do appreciate it. However, you can decide not to answer any question you are not comfortable with or withdraw from the study at any time without any negative consequences on you. In the case of withdrawal, you can choose to have the information collected to this point destroyed.

Confidentiality

We will ensure that any information you provide be used strictly for the purpose of this study. No personal information or that which could be used to identify you will be provided to any person not directly involved in the conduct of this research project. In the course of data analysis and scientific publication of results, codes will be employed to ensure no personal information you provide is released to the public.

Potential risks

There is no known risk for participating in this study. All information you share will be kept confidential. Audio-recorded interviews will be converted to text and stored in locked drawer in

the Division of Oral Health and Society. It will be destroyed seven years after publication.

Potential benefits
The immediate benefits for participating in the study may not be obvious. However, participants may find it beneficial to know that taking part in his study could contribute to improving access to oral health care for people in similar situation.

Compensation
You will be given 20.00CAD$ to compensate for your transport fare and time in this study.

Contact

If in the course of this research project, you find it necessary to get in contact with any member of the research team, do feel free to contact Basem Danish (438-998-4292) or Dr. Christophe Bedos (514-398-0129) from 9:00-16:00, Monday to Friday. For information or questions regarding your rights as a research participant, you may contact the ethics officer at McGill University through 514-398-8302.

Declaration of Consent

I have read this consent form and have received the following information:

- My participation in this project is voluntary. I am free to withdraw my consent and to discontinue my participation in the project at any time without explanation.
- My decision regarding whether or not to participate will have no effect on my status. Refusal to participate would involve no penalty or loss of benefits.
- The results of this study may be used in research publications and meetings.
- Confidentiality of any verbal and/or written feedback I provide will be respected. All identifying information will be removed from interview transcripts. My name and identity will not appear in any published documents.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
- I have been given sufficient time to consider the information and seek advice should I choose to do so.

By signing this consent form, I:

- Do not give up any of my legal rights,
- Acknowledge that the study has been explained to me and my questions have been answered to my satisfaction, and
- Agree to participate in this study.

Signature
Name:
Date:

NB. Verbal consent will be obtained if a participant does not feel comfortable to provide a written consent. This will be documented.