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IN THIS ISSUE

Local solutions: Public Health Responses to the Urgent Dental Needs of Syrian Refugees

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The current civil war in Syria has created one of the worst humanitarian crises of any time. Millions of people have either been killed or forced to flee their homes. Soon after the Liberal government was elected, Canada opened doors to thousands of Syrian refugees on humanitarian grounds. The Government of Canada is working closely with Canadians, including private sponsors; non-governmental and charitable organizations; and provincial, territorial, and municipal governments to welcome Syrian refugees into the country and settling them successfully.

At this time, approximately 25,000 Syrian refugees have been resettled into Canada and the influx of such a large group will predictably have an impact on the health care system. In Ontario, Public Health Units (PHUs) have successfully managed the healthcare of Syrian refugees including timely care of acute and infectious illnesses, vaccinations, dental problems, and medication. Based on their resources, PHUs addressed urgent dental needs of Syrian refugees in their jurisdictions with innovative local solutions. Representatives of three PHUs shared their stories at a panel discussion, recently held at The Ontario Public Health Convention (TOPHC) in March 2017. The Ontario Association of Public Health Dentistry (OAPHD) organized the panel discussion.

The panel was moderated by Dr. Gary Aslanyan, Manager, Partnerships and Governance, World Health Organization. Panelists included:

- Ms. Nancy Kennedy: Manager, Oral Health, Ottawa Public Health (OPH)
- Dr. Michele Wong: Manager, Dental and Oral Health Services, Toronto Public Health (TPH) >

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- Dr. Sundoss Kemal: General dentist working with TPH
- Ms. Kimberly Casier: Manager, Oral Health, Windsor Essex County Health Unit (WECHU)
- Mr. Manhal AlNadr: A Syrian refugee who received dental care from TPH

Three Ontarian PHUs shared their experiences of dealing with oral health issues of Syrian refugees. In particular, they outlined the barriers they experienced in delivering care and concerns with the Interim Federal Health Program (IFHP). In addition, they shared lessons learnt during the process of addressing this health issue and success stories of partnership with individuals, community, and professional organizations, which facilitated care delivery and experimenting innovative ways of addressing barriers to access to care for Syrian refugees. Importantly, Mr. Manhal Al Nadr shared his lived experience with health care services including dental care after moving to Canada as a refugee.

Refugee experience

Manhal noted that his daughter had toothache and swelling prior to moving to Canada, but her dental problem could not be resolved because of the lack of affordability and the unavailability of a dentist to provide care. Soon after moving to Canada, his daughter received due care. She was screened on a dental bus located close to their temporary residence (hotel) and was referred to a specialist after being enrolled into the Health Smiles Ontario program. Manhal was happy that this program was available for children.

However, he also noted that it was difficult to afford any medication expenses and hoped that coverage could be extended to include medication. He also noted that dental coverage for adults under the Interim Federal Health Program (IFHP) was very limited and hoped that this benefit could be expanded to include more services. He extended his appreciation to the Canadian Government, all those working with refugees coming to Canada and the health and dental teams.

Barriers experienced in delivering care

Some common barriers in regards to communicating and coordinating services were experienced across all three health units, such as:

- Limitation in understanding the Arabic language;
- Cultural sensitivity;
- Arranging transportation from hotels to dental clinics;
- Helping refugees in navigating the health care system;
- Competing priorities for shelter, medical needs, and paper work for immigration; and
- Logistical issues, such as the need to be aware of the refugees' schedule (prayer times, meal times, etc.) prior to planning for and delivering care.

Limited coverage for IFHP is also an ongoing challenge. Although staff were able to provide services required to children (through the Healthy Smiles Ontario provincial program), adults were unable to receive care other than emergency dental services as there are no safety nets for adults in terms of dental care, at the provincial level.

Based on the context and the volume of immigrants, some specific challenges were also observed by PHUs. As per TPH's experience, the challenges were not unexpected but at times were overwhelming because of the sheer volume. They needed to address the oral health concerns of a large number of people within a limited amount of time efficiently and in a culturally sensitive manner. The logistics added to the challenge as refugees were located in different hotels with limited parking space for a dental bus. Some cases were urgent and complicated needing the attention of dental specialists. >

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It was also difficult finding specialists who were willing to accept and treat at a short notice. The staff of OPH and WEHU felt that system capacity was limited to address the needs of the large numbers.

Issues with IFHP coverage

Healthcare providers need to be registered with the IFHP to get reimbursed for services provided to refugees. Coverage of dental services under the program is limited to emergency relief of pain or infection. Complicated extractions and restorations require pre-determinations, which may take 6-8 weeks to be authorized (1). A prior approval request must be submitted to Medavie Blue Cross before treatment begins, but if treatment is time sensitive and the provider performs the procedure, the provider is at risk of not being paid given that claims may not be approved. Also, many physicians and pharmacists are unaware that prescriptions are covered under the IHFP, and end up seeking reimbursement from refugees for any prescriptions they deliver. Furthermore, IFHP does not coordinate benefits with other insurance plans/ programs; therefore, co-payments are not possible (1).

Partnership with community organizations

All three health units partnered with community agencies and shared experiences of the partnerships they developed. TPH collaborated with two community partners to identify and manage the dental needs of Syrian refugees, COSTI Immigrant Services and the Refugee Health Network (RHN). TPH built on their pre-existing relationship with COSTI. The RHN is primarily a group of health care providers providing health services to refugees in need. Importantly, RHN members had already reached out to healthcare providers in Germany, who had previously taken refugees, to better understand the health needs of this population, and oral health needs were identified as a priority. TPH engaged Arabic speaking specialists and the University of Toronto to see clients. TPH also worked closely with primary care providers to ensure that no refugees were missed.

In Ottawa, a city wide level committee was set up called Refugee 613 (613 is the area code for Ottawa). This was a high level coordinating committee led by a city councilor. Each city department (social services, public health, etc.) assigned one person to represent them on this coordinating committee. This made it easier to retrieve important information on the volume of refugees arriving and timeline of arrival to better plan services. This also supported overall communication and collaboration among different areas. OPH communicated with the Ottawa Dental Society to determine if private providers were interested in collaborating with public health to meet the dental needs of Syrian refugees.

The WECHU is a member of a community of 90 organizations helping newcomers. Being part of this community helped prepare for the influx of refugees. The WECHU also shared a close working relationship with settlement agencies.

Innovative ways of addressing barriers to access to care

All the PHUs being represented developed innovative ways of providing timely dental care to this vulnerable population.

At OPH, it was recognized that the IFHP would be a barrier from the get go and therefore decided not to register any dentists with the program. Instead, the health unit worked with volunteer dentists in the community. One time funding of $50,000 was requested to cover the cost of the initiative. Through communication with the Ottawa Dental Society, volunteers signed up to work at PHU clinics on Fridays for four hours shifts. Overall, 57 volunteer dentists, dental assistants and interpreters contributed more than 1000 volunteer hours and treated approximately 533 patients.

TPH had set up “surge” clinics within existing TPH dental clinics to treat the emergency clients. A dental bus was also brought on site to eliminate the need to transport clients. This strategy was also more efficient as staff could go into the hotel to find clients who may have had to attend other appointments. TPH staff triaged dental needs; people who had dental problems, which were causing inability to eat, speak or sleep, were prioritized. The first wave of treatment was meant for those with the highest priority, i.e., to manage emergencies.

TPH had Arabic speaking staff to support. A dental hygienist and an outreach worker who spoke Arabic identified those who needed dental treatment. Also, primary care physicians identified dental care conditions using a tool provided by TPH and made timely referrals. Front line staff built relationship with dental specialists by speaking to them over the phone and explaining clients’ situation to them. Staff also assisted specialists with paperwork for the Healthy Smiles Ontario program. >

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Acknowledging transportation as a barrier, the WECHU created maps in the Arabic language to assist refugees to navigate their way to the two dental clinics. The health unit also hired an Arabic speaking dentist and a translator on contract to assist.

Panel highlights

- Manhal had a great experience with TPH at every level, including people at the hotel, the dental screening team, the ease of access to the mobile dental clinic, and the ease in getting a quick appointment with the specialist for her daughter. He appreciated the coverage for his children under the HSO program, and hoped that more could be done for adults.

- OPH had never worked with volunteer dentists previously. It was a new and uplifting experience. Private providers worked well with public health staff. They commended the training PH staff had, and appreciated the work they did.

- All the three health units had an enriching experience of collaboration with various agencies, local dentists, settlement agencies, etc., and in creating awareness among community providers to help people in need access programs.

- TPH had to learn to deal with a large volume of clients. This required flexibility, quick decisions and being adaptable. Staff showed these qualities.

- Ironically, the IFHP, a program specifically targeting the needs of refugees was not favourably sought because of issues with provider enrollment, coverage, pre-determinations, claims refusal, and long processing time of claims.

- Dealing with refugees further highlighted the inequity in access to care based on age. This is a large number of employable adults entering Canada as refugees, and as a newcomer they would need to get a job, and without an improvement in their health, they will have less opportunity.

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1) Information Handbook for Interim Federal Health Program Health-care Professionals, https://docs.medaviebc.ca/providers/guides_info/IFHP-Information-Handbook-for-Health-care-Professionals-April-1-2016.pdf

NEW CDHA COMMUNITY WATER **FLUORIDATION RESOURCES**

The Canadian Dental Hygienists Association (CDHA) has released an updated position statement on community water fluoridation (CWF). The statement is available in both English and French on the association's website, and is supported by additional resources, including FAQs and a public awareness poster, which can assist you in educating your clients and others on this vital preventive public health initiative.

CDHA would like to thank CAPHD for its continued support and advocacy work on community water fluoridation, as it remains an important, safe, effective, and equitable means of reducing dental decay. **We all care about our communities, so let's do our part to help more Canadians benefit from access to community water fluoridation.**

President's Message

Dr. Rafael Figueiredo, BDS, MSc (DPH), FRCDC(C)

Dental Public Health is always challenged by its ability to deal with a range of problems involving specific characteristics of the host population and the environment including social, economic and political circumstances. To improve the dental health of the population or of a group of the population involves evolutionary methods and concepts that must be tailored to the recipients' needs. In addition, teamwork becomes a necessity in extending the scope of care to the targeted population using cost effective measures. With all the concepts of clinical epidemiology, risk assessment, program planning, resources allocation and equity in mind, CAPHD decided to discuss these topics during its 2017 Annual Scientific Conference.

The 2017 CAPHD Conference is entitled "**Common Risk Approach: the Role of Policy, Programs and Research**". The conference will be held in Toronto, Ontario on September 22nd and 23rd, 2017, in collaboration with the valuable partnership of the Ontario Association of Public Health Dentistry (OAPHD) and University of Toronto, Faculty of Dentistry. The 2017 CAPHD conference will focus on a rational basis for promoting oral health considering the influence of socio-environmental factors as key determinants of health. Thus, education, policy and services delivery will be part of the presentations and discussions during the meeting. For the second time, the scientific session will include poster presentations, which enables a large number of dental public health researches to be presented in an interactive way. It is very inspiring to witness the engagement of health professionals in this knowledge exchange experience.

I would like to invite and encourage all of you, CAPHD members and professionals who have interest in these issues, to participate with us in the learning, discussions and networking activities proposed by this conference. I thank you in advance for supporting the dental public health in Canada and I am looking forward to seeing you in Toronto.

Call for Submissions

Now accepting submissions for the Winter 2017 issue of the Mosaic Newsletter.

Submission guidelines can be found here:
http://www.caphd.ca/programs-and-resource/the-mosaic-newsletter

Smoking cessation interventions and quitlines

Jeff Werner, BSc., MPH

In the more than seven years that I've been working in the smoking cessation industry, I've met many oral health care professionals who are especially concerned about their patients who use commercial tobacco. One of the most frequent questions I get asked is "In the little time I spend with my clients, how can I help them quit?"

Outside of the dental office, nicotine replacement therapies (NRT), pharmaceuticals (e.g. buproprion, varenicline), and counselling are becoming increasingly accessible and affordable for people wanting to quit, and have been proven effective in helping people abstain from smoking. However, having a conversation - a Brief Intervention - with patients about cessation at a teachable moment during a dental visit, also increases their chances of quitting (1, 2, 3). One method is known as the 3 As:

- Ask about tobacco use at every visit: "Have you used any form of tobacco in the last 7 days?"
- Advise your client to quit: "Quitting smoking is the best thing you can do for your health."
- Arrange for additional cessation support by referring to the quit-line in your province.

The third A, Arrange, is an important part of keeping someone on track once they've left the dental office and throughout their journey of becoming commercial tobacco-free. Every province and territory in Canada has a quitline and most have a referral system where health care providers can arrange for the quitline to connect with their patient. Quitlines that provide counselling have demonstrated to double or triple someone's chances at staying quit, compared to quitting with no assistance (i.e. cold turkey) (6).

It has been shown that combining counselling with NRT or pharmaceuticals further increases the odds of smoking abstinence (4,5). However, because everyone's journey to being commercial tobacco-free is unique and there isn't only one way that works for everyone when it comes to quitting, it is important to let patients know about all options that are available to them. In addition to counselling, learning how to deal with cravings, and making a quit plan, quit coaches are also available to discuss quitting options.

One such quitline, Smokers' Helpline (SHL), offers this service through their Quit Connection referral form, which is available to download from their website (SHL services the Yukon, Saskatchewan, Manitoba, Ontario, New Brunswick and Prince Edward Island). Once the client referral form has been filled out and sent to SHL, your client will get a call from a Quit Coach. A recent evaluation of SHL services shows that 60% of people would not have called on their own (6).

Evidence suggests that resources, such as quitlines, are currently underutilized when it comes to smoking cessation, and it is recommended that quitline use be intensified (7,8). Encouraging your patients to get in contact their local quitline or by calling the number on their cigarette package can make a difference in their oral health and overall quality of life. Quitlines that have the quit coach initiate contact with clients through referrals or client requests, known as proactive calls, are especially effective in reducing smoking rates (7, 8). Therefore, by referring patients (arranging a proactive call) to effective, non-judgemental support, you can help to reduce smoking rates and positively impact someone's life. One way to do this is by integrating referrals for patients who smoke, as a part of intake forms.

Contact your region's quitline service to find out how they can support your practice and help your patients on their journey to being commercial tobacco-free.

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What more can be done for the oral health of Syrian refugees in Ontario?

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Text Abstract:
Canada welcomed 40,081 refugees since the start of the Syrian Civil War. These refugees are receiving special health care services and limited dental services that are time-bound to one year upon arrival. These newcomers suffer from poor oral health conditions and limited oral health literacy. The Canadian health system's direction towards focusing on emergency-type care delivery for refugees is not sufficient nor sustainable. Focus needs to shift towards improving their oral health literacy to drive increased knowledge and health-promoting behaviors. This will better assist in promoting individual and community responsibility for health care and self-management.

Commentary:
Since March 2011, eleven million Syrians have fled their homes because of the Syrian Civil War. Now, six years on, 13.5 million need humanitarian assistance within the country. The majority of Syrian citizens have sought refuge in neighboring countries or within Syria itself. According to the United Nations High Commissioner for Refugees (UNHCR), 4.8 million have fled to neighboring countries, and 6.6 million are internally displaced within Syria. Meanwhile, UNHCR reported that nearly one million Syrians have requested asylum in Europe, with Germany and Sweden receiving the largest number of these refugees (1).

In Canada, the first Syrian refugees began to arrive in November 2015 and by January 2017, 40,081 Syrian refugees had arrived and begun to settle in (Immigration, Refugees and Citizenship Canada - IRCC) (2). More refugees are expected in Canada in the coming years. Settlement patterns to date show that 95% of Syrian refugee newcomers of all categories (Privately Sponsored Refugees, Blended Visa Office-Referred and Government-Assisted Refugees) have settled in across the country, with the bulk of these in six areas of the province of Ontario: the cities of Windsor, London, Hamilton, Ottawa, the Region of Waterloo and the Greater Toronto Area (GTA), particularly the City of Toronto and Peel Region (2).

The civil war led to a collapse of the Syrian health system, including dental care (3, 4), and left the fleeing and internally displaced in dire need for oral health care (5). Most of the Syrians who arrived in Canada came from rural areas and camps in border regions (e.g., Zatari Camp) that are lacking in good oral health care resources. These populations were not like those who fled the major cities with well-established health systems such as Damascus, Homs and Aleppo. Many from the urban centres settled early on in the war in European countries like Germany and Sweden (6). As a result, it is expected that Syrian refugees who have settled in Canada have poorer oral health compared to those who settled in Europe. In addition, refugees yet to land in Canada may well be suffering from more severe health conditions than those who settled earlier, owing to the gaps in the health care delivery system that have occurred since the outbreak of the fighting (7). Trauma is usually considered the priority mental health issue among refugees, however, evidence has shown that many psychiatric disorders are strongly associated with dental disease and its management (8). Therefore, oral health of Syrian refugees should be one of the main health priorities of the Canadian health system.

Upon arrival in Canada, Syrian refugees are screened by quarantine officers. The dental assessment performed includes assessment for pain, obvious dental caries and oral disease. The newly arrived refugees receive counseling regarding oral hygiene, pain is treated with non-steroidal anti-inflammatory drugs, and urgent or routine referral to professional dental care is provided (9). Once they have settled in, the refugees are expected to seek assistance on how to navigate the health care system from settlement organizations in their communities. >

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In 2014, a scoping review showed that newcomers in general have poor oral health when compared to the general population. Treatment of dental caries and periodontal disease were the most urgent (10). Furthermore, these new immigrants may have poor oral health literacy and not be aware of the importance of routine dental visits (10). Therefore, there is no reason to believe Syrian refugees would be any different from past newcomers to Canada. News reports from dental practitioners about their concern over the oral health of new Syrian refugees have been making the headlines (11, 12). The health assessments provided upon arrival have shown that dental health is emerging as a significant health concern among Syrian refugees across all age groups. The Ontario health system action plan has recognized oral health as a predominant health concern for this population (9). Under the Interim Federal Health Program (IFHP) Syrian refugees in Ontario are automatically eligible for full health care coverage, which includes limited dental care that is comparable to emergency care. This is provided under supplemental benefits for up to 12 months after landing (13). This emergency-type service is provided through dentists registered with IFHP. Healthy Smiles Ontario, a free dental program for eligible children and youth aged 17 and under, also provides free dental care that includes regular check-ups, preventive care, and treatment for eligible children (14). Eligibility criteria for the Healthy Smiles Ontario program include refugee status, special needs and families of limited income. These programs and services, while adequately covering children, leave adult Syrians facing pricey preventive and curative private dental services. Under such conditions, individuals usually tend to approach emergency services in a hospital setting at late disease stages (10), the cost of which is high to the health care system (15).

It has been one year since the arrival of the first cohort of Syrian refugees. But it is unclear what their dental care needs will be once the 12-month dental coverage period ends. More can be done and needs to be done to address the oral health care problems facing new refugees because oral health is an integral part of overall health and wellbeing. The World Health Organization, at its 69th World Health Assembly, identified priorities in addressing the health needs of migrants and refugees. It is worth noting that priorities included 'rais[ing] awareness among migrants and refugees of their entitlements and obligations' and 'involv[ing] migrants and refugees in decisions relating to the delivery of health care and social services so as to enhance integration and self-reliance and improve public health' (16). It is essential to promote individual and community responsibility for health care and self-management, but there should also be efforts by all levels of government, dental regulatory authorities, provincial/territorial dental associations and the public towards providing comprehensive oral health care through an affordable insurance scheme for all. To achieve these ends, efforts should also be directed at improving oral health literacy to drive increased knowledge and health-promoting behaviors. Context specific and applicable evidence to support interventions that improve oral health literacy among newly arrived Canadians is much needed today.

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Policy and dental care of refugees and refugee claimants in Canada

Dr. Mark Keboa B.ChD, MSc, PhD (c)

Introduction

About 25,000 refugees and refugee claimants (humanitarian migrants) arrive in Canada yearly [1]. This population often have limited finances and are in need of healthcare upon arrival [2, 3]. In Canada, literature on the oral health of humanitarian migrants, while scant, suggest poor oral health [4, 5] and limited access to oral health care [6].

The Federal Government insures healthcare for humanitarian migrants through the Interim Federal Health Program (IFHP). Dental coverage is limited to urgent treatment to relieve acute pain from oral disease or fractures during the first 12 months in Canada [7]. However, the IFHP policy is subject to amendments that can affect the range of insured services. For example, in 2012, the Federal Government passed Bill C-31 that cut funding to the IFHP [8]. Refugee claimants, and Private-Sponsored Refugees (PSR) who make up 75% of the humanitarian migrant population, had to pay for needed dental care. Payment options included out-of-pocket, private insurance, or employment-based insurance. Only Government-Sponsored-Refugees retained their dental coverage under the IFHP following the 2012 reforms. Figure 1 shows the changes in the number of dental service users in four Canadian provinces prior to and after the 2012 IFHP-reform.

Our study

The purpose of our research project was to understand oral health and dental care experiences of humanitarian migrants in Montreal in order to inform policy and services for this population.

METHODOLOGY

Using focused ethnography [9], we used individual interviews of a purposeful sample of humanitarian migrants in Montreal, and observed dental care for underserved populations provided by the McGill Mobile Dental Clinics. We adapted the McGill Illness Narrative (MINI) guide [10], and asked participants how to improve access to dental care. The concept of illness behaviour [11] and "The public health model of the dental care process" [12] informed data analysis and interpretation.

RESULTS

We interviewed 25 participants (16 women and 9 men) from four global geographical regions. The results presented in this article detail policy-related experiences and perceived solutions to improve access to dental care as expressed by our participants. >

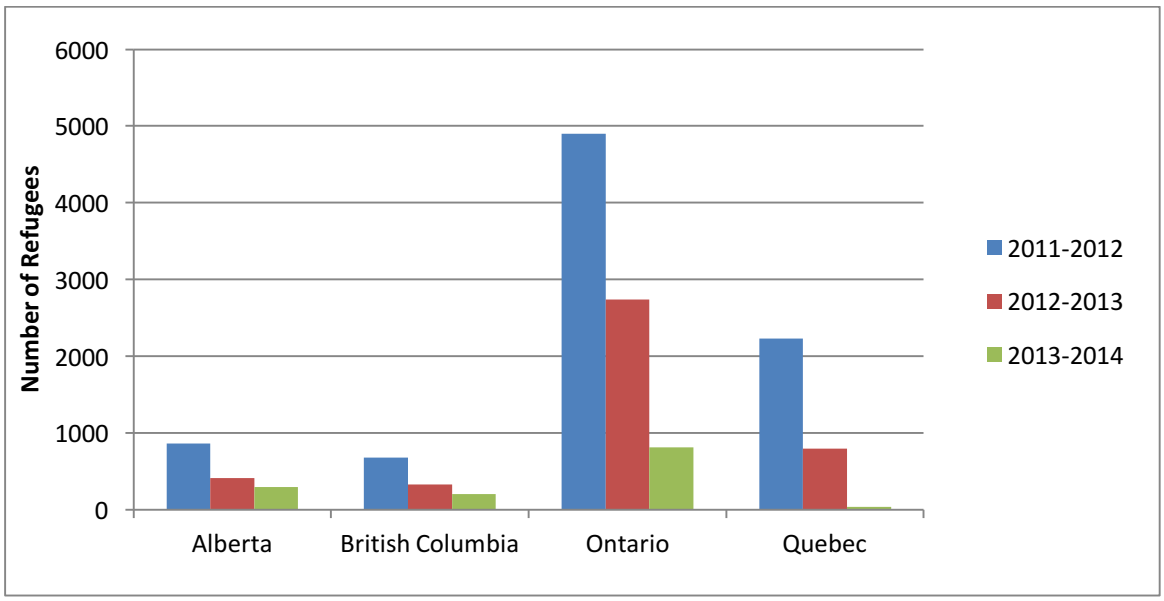

Figure 1. Number of refugee Dental Services users per province/year (Data source: Statistics Canada)

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IFH policy related experiences:

i) **Non-inclusive policy:** Participants were critical about their exclusion from dental care and considered the government's policy of selective dental coverage based on immigration status unfair.

ii) **Confusion over IFHP certificate:** Some participants did not understand the provisions of the IFHP certificate regrading dental care, which resulted in uncomfortable experiences during dental care.

iii) **Inadequate coverage:** Some participants felt that dental coverage that only targeted urgent care was inadequate. Further, they felt that the limited scope of the IFHP excludes them from receiving standard care.

iv) **Gratitude for the opportunity:** Many participants expressed gratitude to the Federal government for the dental insurance that enabled them to consult a dentist when in need.

Suggestions to improve access and oral health of humanitarian migrants:

i) **Change of policy:** All participants expressed the desire for the federal government to abandon the 2012 IFHP policy, for a more inclusive policy;

ii) **Reduction of cost:** Participants wanted the government and dentist to work towards reducing the cost for oral health care;

iii) **Harmonize dental benefits:** Participants wanted the government to make dental benefits for humanitarian migrants similar to treatment options available for social welfare beneficiaries;

iv) **Community dental clinics:** The government should establish community dental clinics that would provide less expensive oral health care;

v) **Dental examination:** Dental examination could be made mandatory for this population on entry into the country on condition that treatment will be provided for diagnosed diseases.

vi) **Research & development:** Government policies should support university research into less expensive dental materials and equipment that can eventually reduce treatment cost.

DISCUSSION AND CONCLUSIONS

Our study highlights the consequences and potential role of policy on access to oral healthcare for humanitarian migrants in Montreal, Canada. Strategies proposed by participants are similar to recommendations to improve access to care for vulnerable populations in Canada [6, 13]. For example, McNally and colleagues [13] have proposed the inclusion of oral health screening as part of the medical examination administered for this population, and developed a guideline for this purpose.

Although the federal government has restored basic emergency dental coverage for all humanitarian migrants as of April 2016 [8], providing coverage for urgent dental care is a necessary but not sufficient solution. Policymakers and other stakeholders have to explore the feasibility of alternative strategies to improve access to oral health care for this population. An evaluation of the current focus on emergency dental care is needed. This approach is probably more expensive [14] for the government and ill adapted for the beneficiary population.

Oral health policies that prioritize preventive oral health services can introduce humanitarian migrants to the Canadian oral health system early in their resettlement process. Early orientation of humanitarian migrants to the Canadian dental care system and oral health culture has the potential to curb the decline in oral health of this population [15]. Government and other stakeholders need to take into account the potential consequences of poor oral health on the general health of humanitarian migrants with already fragile health. Oral health policies that enable prompt access to oral health care, and promote good oral health of humanitarian migrants will indirectly enhance their general health.

About the author

Dr. Keboa is a doctoral candidate at the McGill University Faculty of Dentistry. His interests include knowledge translation to improve access and quality of healthcare.

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Lift the Lip with Healthy Smile Happy Child: Preventing Early Childhood Caries

Healthy Smile Happy Child's new "Lift the Lip" Video - Teaching Parents and Caregivers early intervention strategies for young children

Rates of early childhood tooth decay among vulnerable populations, such as Indigenous children, continue to surpass the rates of non-Indigenous children. Aboriginal children have three to five times the amount of tooth decay of non-Aboriginal children (First Nations Oral Health Survey, 2010) and nearly 86% of First Nations preschoolers had Early Childhood Caries (ECC).

Healthy Smile Happy Child (HSHC) is an Intersectoral, collaborative partnership that takes an upstream community development approach to engage communities in Early Childhood Caries (ECC) prevention strategies and promotion of early childhood oral health. HSHC has a well-established partnership that includes a multidisciplinary team of clinicians, Regional Health Authorities (RHAs), decision-makers, communities, health providers, and professional groups.

To help build awareness of early childhood tooth decay, HSHC has partnered with Healthy Start for Mom & Me, a Canada Prenatal Nutrition Program in Winnipeg, to produce a culturally appropriate video incorporating key oral health messages for vulnerable children 0-6 years old and their families. Funded by the Public Health Agency of Canada, and with the collaboration and technical expertise of the Office of the Chief Dental Officer, the video is being produced in English, French, Cree, Ojibwe and Inuktitut.

It demonstrates a practice called "Lift the Lip" to complete a simple assessment of tooth decay in children. This practice is recognized worldwide as an effective means to increase early intervention to prevent more advanced oral caries and disease. The screening practice promotes a family focus on oral health and preventative care.

To promote the release of the video, Nanaandawewigamig First Nations Health and Social Secretariat of Manitoba - Partners for Engagement and Knowledge Exchange (PEKE) and the Saint Elizabeth First Nations, Inuit and Métis Program hosted webinars in both French and English. Both webinars can be viewed by visiting the following:

ENGLISH WEBINAR
https://attendee.gototraining.com/r/1723632194025555458

FRENCH WEBINAR
https://attendee.gototraining.com/r/8184121726014678274

HSHC also has a printed resource, "Lift the Lip to check baby's teeth", to accompany the video. It is available, along with HSHC's many other printed resources, on the HSHC website at: **http://www.wrha.mb.ca/healthinfo/preventill/oral_child.php**

Lift the Lip to check baby's teeth brochure
Found on: http://www.wrha.mb.ca/healthinfo/preventill/oral_child.php

All versions of the video will be hosted on the HSHC website and their YouTube channel (**https://www.youtube.com/channel/UCd6ZyKUqiqnBEhQJoO-hrjg**). As well, it has also been posted on the HSHC Facebook page and Instagram. HSHC partners in the Regional Health Authorities in Manitoba are encouraged to play the video in waiting rooms and educational settings. It is hoped that the video will be widely used to help parents and caregivers to care for their babies' teeth right from the start.

FNHA Oral Health: Steering the Canoe Upstream Toward Health & Wellness with BC First Nations

John Mah, *VP Health Benefits*
Carol Yakiwchuk, *Manager, Oral Health*

The FNHA Journey

Our presentation at the 2016 Canadian Association of Public Health Dentistry (CAPHD) conference on October 1st happened to fall on the third anniversary of the creation of the First Nations Health Authority (FNHA) – the first province-wide health authority of its kind in Canada. The FNHA was created by and for First Nations in British Columbia (BC) with a dynamic mandate to elevate the health and wellness outcomes for First Nations peoples in the province.

More than 10 years of negotiation and a series of political agreements led to the formation of a new First Nations health governance structure in BC and the beginning of new relationships in health between First Nations, federal, and provincial governments. A historic journey brought together First Nations leadership in BC as a whole to reach consensus and exercise authority to create an FNHA and return self-determination over health back to First Nations peoples in BC.

In 2013, the FNHA assumed the programs, services, and administrative responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region. FNHA is responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC. We work together with federal, provincial, regional and community health partners to avoid duplication of programs and services, and to innovate, transform and redesign health service delivery for BC First Nations communities, families and individuals.

FNHA's vision is of healthy, self-determining and vibrant BC First Nations children, families and communities. It is our job to support transformation of health and wellness services in BC to better serve First Nations community members and work towards improved long-term health outcomes. Committed to embedding cultural safety and humility into health service delivery, the FNHA is working to reform the way health care is delivered to BC First Nations to one that is upstream and wellness focused - through direct services, partnership, and health systems innovation.

Taking an upstream approach to oral health

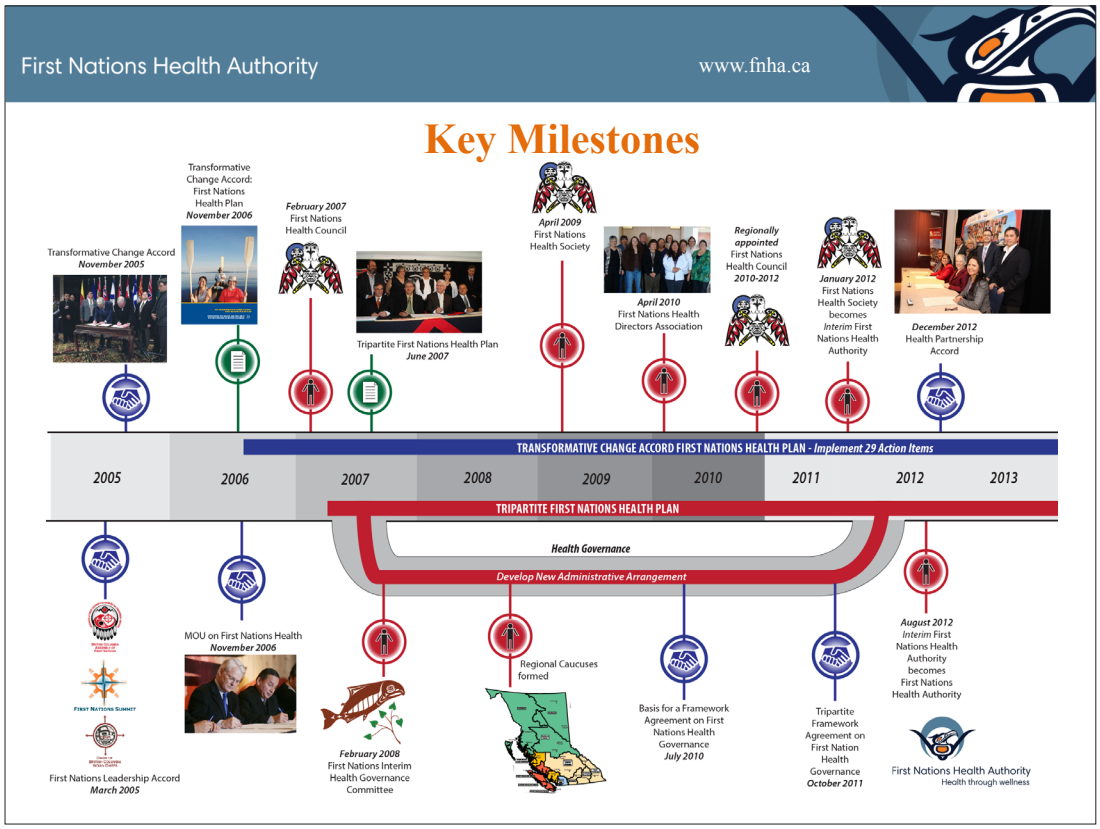
FNHA is a health and wellness partner to more than 200 First Nations communities in BC. Our clients include all status First Nations people in BC, living both at home (on-reserve) and away from home (off-reserve). Last year, FNHA Health Benefits served 141,251 clients, including 59,783 who accessed our dental benefits. Together with dental benefits, FNHA has an oral health program that takes a holistic approach to oral healthcare through our Children's Oral Health Initiative (COHI) and Dental Therapy Program (DTP), and by supporting communities to bring dental services closer to home.

Our seven dental therapists deliver a range of preventative and treatment-focused oral health services in community under the supervision of a dentist. They currently provide professional services in 53 communities, serving over 3,000 clients. Reaching clients in community can mean traveling great lengths, by logging roads, sea planes, ferries and small boats. New portable digital radiography equipment combined with portable dental equipment allows our dental therapists to extend the reach of their practice to areas without established dental clinics, reducing the need for our clients to travel for care.

Positioned as an upstream initiative that reflects a vision of wellness, FNHA's COHI program is an early childhood tooth decay prevention program for children aged 0-7, their parents, caregivers, and pregnant women. COHI currently reaches 76 communities and is delivered by 24 providers and 62 community-based aides. Public health dental hygienists (funded through our partnership with BC's regional health authorities) and our dental therapists serve as community program leads for this initiative. Each COHI aide is a vital cornerstone in their community, providing oral health education, applying fluoride varnish, and strengthening community connections when the program lead is away.

Improving access to oral health care for BC First Nations

Historically, First Nations communities have faced significant barriers to oral health care. The First Nations Oral Health Survey tells us that First Nations people are less likely to visit an oral health professional each year, and that many First Nations clients face significant travel to access professional oral healthcare services.[1] >



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As well, First Nations children have the highest rates of untreated tooth decay, possibly related to a lack of access to oral health care.

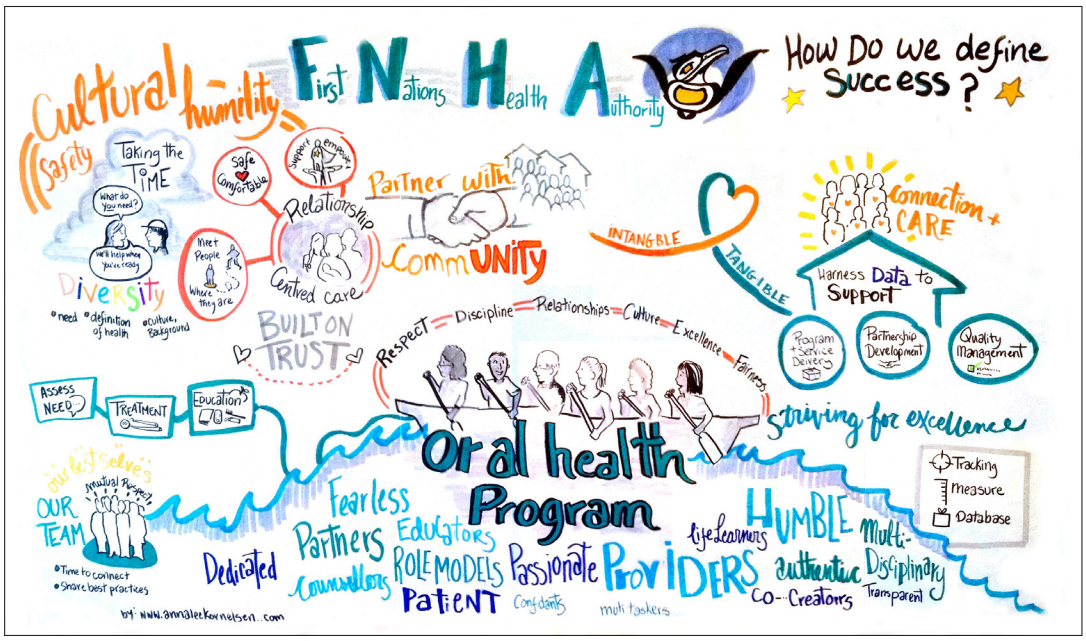
To improve access, it is essential for FNHA to deliver programs in partnership with First Nations communities and clients through a community-driven, Nation-based approach. There are a number of ways FNHA works to bring oral health care services closer to home for First Nations clients:

- Using powerful data analytics to understand and respond to community needs.
- Embracing a continuum of oral health providers: Having the right provider for the right level of service, based on local needs.
- Collaborating with health providers without dental expertise to incorporate oral health promotion and caries prevention work into their day to day practice.
- Partnering to fund and support community and regional health plans related to oral health.
- Working towards the integration of oral health care services into primary health care.
- Enabling health care providers to approach every encounter with a client as an opportunity to have a health and wellness conversation that is inclusive of oral health.

Cultural safety in oral health care

Improving cultural safety in oral health care is another critical piece of work. Cultural safety is about provider self-reflection and respectful engagement with clients that recognizes and strives to address power imbalances inherent in the healthcare system. FNHA aims to support all partners to create health care environments free of racism and discrimination where people feel safe when receiving service.

In March 2017, 23 health regulatory bodies in BC including the College of Dental Hygienists, Dental Surgeons, >



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Dental Technicians, and Denturists of BC declared their commitment to making the health system more culturally safe for First Nations and Aboriginal People. In signing the Declaration of Commitment to Cultural Safety and Humility, BC health professionals were the first in Canada to the pledge.[2] The FNHA encourages dental staff to visit www.fnha.ca/culturalhumility to find a number of background resources and practical tools around integrating cultural humility into your work. We also challenge you to make your own personal pledge of integrating cultural humility into your work through our pledge cards.

Another important step dental staff can make is to take the San'yas Indigenous Cultural Safety (ICS) training, hosted online by the Provincial Health Services Authority. To date, 22,000 health professionals in BC have completed the course. In July, FNHA welcomed dental hygienists to register as direct care providers to our Health Benefit program. With the support of the College of Dental Hygienists of BC (CDHBC) and with the intention for dental hygienists to lead the way and encourage other dental professionals to learn more about culturally safe and humble practice, FNHA requires that independent dental hygienists complete the ICS training to qualify as a FNHA Health Benefit provider.

Join our journey

Thank you for the opportunity to share the historic journey of First Nations in BC bringing about health care reform, and some of the early transformative changes FNHA has made toward an upstream approach to oral health care. We welcome CAPHD's partnership as FNHA continues to steer the canoe upstream toward health and wellness in partnership with First Nations in BC.

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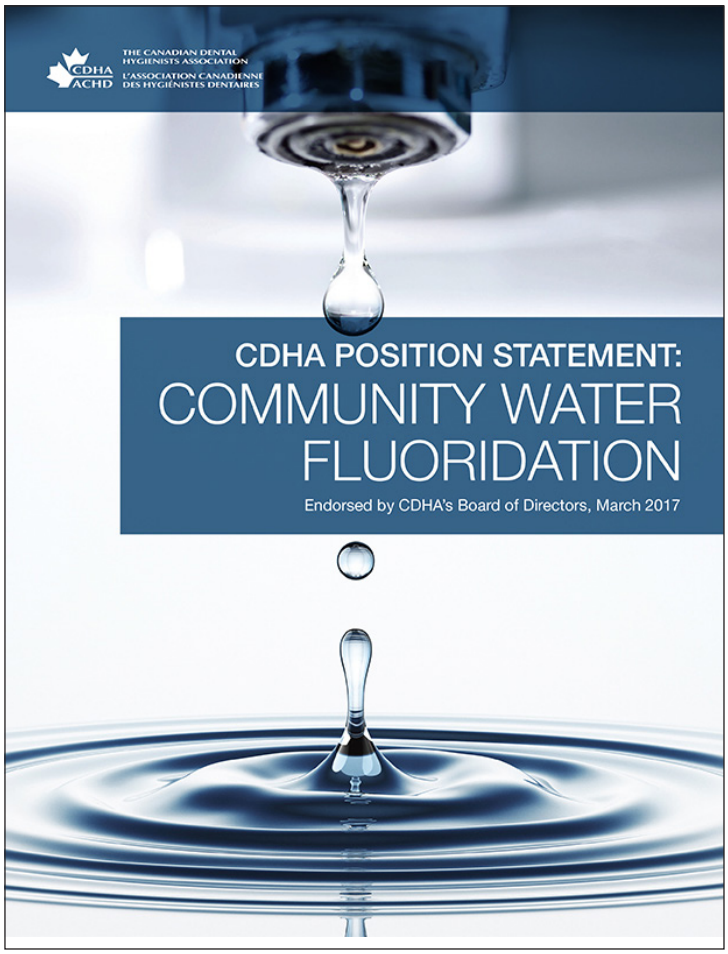
Cessation of community water fluoridation in Calgary – an update

In May 2011, the City of Calgary discontinued the practice of community water fluoridation. That created a research opportunity (natural experiment) to explore the implications of fluoridation cessation for children's dental health. We performed such a study, in which we compared grade 2 schoolchildren in Calgary (cessation in 2011, after having been in place since 1991) and Edmonton (fluoridation began in 1967 and is still in place). We used population-based data collected by former health regions in Alberta in 2004/05 ('pre-cessation data', when both Calgary and Edmonton had fluoridation in place), and we collected data specifically for this purpose in 2013/14 ('post-cessation data') – approximately 2.5-3 years post-cessation. In light of the short time frame for follow-up (which was influenced by funds available to support our research), we considered this to be a short-term evaluation, with a need for longer-term follow up.

In brief, we found that dental caries experience in primary teeth increased over the time frame of the study (2004/05 – 2013/14) in both cities, but to a greater extent in Calgary (cessation) than in Edmonton (still fluoridated). In terms of permanent teeth, caries experience actually decreased (improved) in Calgary during the time frame of the study. However, when we looked at smooth tooth surfaces (where we would most expect to see fluoridation have an effect), we saw the trend in Calgary reverse direction, such that there was an increase (worsening) that we did not see in Edmonton. However, that effect was very small and not statistically significant. Overall, and considering the other data we had (e.g., socio-demographic information from a questionnaire; fingernail clippings), we concluded that findings observed are consistent with an adverse effect of fluoridation cessation for dental caries, but that additional monitoring would be needed to confirm the effects.

The first results from our research were published in February 2016 and there was intense media interest. Between myself and co-investigator Dr. Steve Patterson, we did over 30 media interviews within less than two days. According to a media report prepared by the Cumming School of Medicine at the University of Calgary, the study generated over 200 media articles which



were shared over 33,000 times on social media. The study release also led to a number of presentations and opportunities to meet with decision-makers, including City Councilors in Calgary and in Okotoks (a municipality south of Calgary that ceased fluoridation in 2012).

The attention was definitely a mix of positive and negative, and to say that this period was stressful would be an understatement! Some of the coverage was positive and accurate, but in other cases the study findings were mis-reported and the conclusions overstated; for example, suggesting that 'cavities spiked since fluoridation was stopped'. There was no spike but rather a gradual increase, and the trend observed was not since fluoridation was stopped, but rather over a time period during which cessation occurred: 2004/05 to 2013/14 (cessation occurred in 2011).

Release of study findings also led to some strong criticism and attacks of the research. In some cases, the points of criticism were fair, and along the lines of what we >

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would expect within the realm of scientific debate. In other cases, they were very aggressive, including calling into question my integrity as a researcher and person.

Following the summer break, Calgary municipal council reconvened in the fall of 2016. Some councilors were interested in potentially revisiting the fluoridation issue. In September, a notice of motion was put forth for Council to seek information that would help them to decide whether to consider re-instating fluoridation, by consulting with the O'Brien Institute for Public Health at the University of Calgary (I am a member of this Institute but was not involved in this initiative). The O'Brien Institute was offering to draw from the expertise of its members (including scientists with expertise across the breadth of public health) to provide information about various aspects of fluoridation, including implications for dental health, safety vis-à-vis an array of adverse health outcomes (e.g., neurodevelopment) and ethics. On September 13, 2016, City Council voted against this motion, 9-5. Although I was not present at the deliberations, the media stories suggest that some councilors did not desire to wade back into the issue, which I must say I can understand on some level!

Despite the ups and downs of the research and especially the aftermath of its release, I still believe that there is considerable value in this work. Dr. Sonica Singhal and I did a systematic review of published research on cessation of community water fluoridation and dental outcomes (the review was published in the Journal of Epidemiology and Community Health earlier this year). We found a total of 15 studies ever, which are mostly not current (all except one were prior to the 2000s). This is a significant knowledge gap, considering changes over time and between countries in terms of oral health epidemiology and exposure to diverse fluoride sources, as well as the apparently increasing frequency with which communities across Canada are revisiting their fluoridation status (i.e., there is a need for this knowledge). Even if research evidence is not sufficient for informing decisions, I believe it is necessary.

There is a need and opportunity to strengthen the evidence base. In our case, it will be important to follow up our 2013/14 survey with another survey that permits assessing longer-term trends with additional data points which will make the study design stronger. I think it would be ideal to focus on the time period when we have a new cohort of the same-aged children (grade 2, approx.. age 7) who were born in the post-cessation period and had no exposure to fluoridation in Calgary, i.e., children born in 2012, who will be 7 years old in 2019. However, a follow-up survey at any time point would add value, and it will be important to align with important provincial initiatives such as the surveillance priorities of the new Oral Health Action Plan, which Dr. Rafael Figueiredo (Dental Public Health Officer, Alberta Health Services, and new CAPHD President) presented at the 2016 CAPHD conference in Edmonton.

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CALENDAR OF EVENTS

CAPHD 2017 Conference in Toronto
September 22-23, 2017
http://www.caphd.ca/professional-development/caphd-annual-conference

2017 Annual Health Promotion Ontario in Toronto November 23, 2017
http://parc.ophea.net/event/2017-annual-health-promotion-ontario-conference

CDHA Conference in Ottawa October 19-21, 2017
https://www.cdha.ca/cdha/Education/2017_National_Conference/Welcome/CDHA/Education/2017_National_Conference/2017_National_Conference_Welcome.aspx

American Association of Public Health Dentistry 2018 National Oral Health Conference Louisville Kentucky April 16-18, 2018
http://www.aaphd.org