ISSUE NUMBER 6- IMMIGRANT AND REFUGEE ORAL HEALTH IN CANADA WINTER 2014

# Mosaic

Canadian Association of Public Health Dentistry

## IN THIS ISSUE



## Dental Disease: Creation of Primary-Care Clinical Guidelines for Newly Arriving Immigrants and Refugees to Canada

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The health needs of newly arriving immigrants and refugees to Canada are known to differ from men, women and children who are Canadian-born. There are many reasons for these differences including previous exposure to disease, migration trajectories, living conditions and genetic predispositions as well as barriers to accessing care due to language and cultural differences.[1] The Canadian Collaboration for Immigrant and Refugee Health (CCIRH) (University of Ottawa, http://www.ccirh.uottawa.ca) recognized the pressing need to better understand the management of health inequities specific to this population. They embarked on a process to identify priority health needs and to address those needs by linking clinical preventive approaches to primary care practitioner (i.e., physician and nurse) delivered primary care in Canada. The aim was to improve uptake and health outcomes using existing high quality evidence-based clinical preventive recommendations, (such as those produced by the Canadian Task Force on Preventive Health Care and the US Preventive Services Task Force) to develop guidelines tailored specifically for newly arriving immigrants and refugees to Canada.

Developing the Guidelines: In 2007, The CCIRH began the process of selecting guideline topics through literature review, stakeholder engagement and a modified Delphi process involving 40 Canadian primary care practitioners who care for immigrants and refugees.[2] Primary care practitioners were identified as having experience working with migrant populations and came from 14 Canadian urban centers. Through three survey rounds (80% consensus cut-off), they selected the 20 most pressing health conditions facing new immigrants and refugees using defined criteria that included: importance (most prevalent health issues), usefulness (conditions for which guidelines could be implemented and evaluated) and disparity (conditions that are poorly addressed through existing public health and illness-prevention measures within the general public). Dental disease (including dental caries and periodontal diseases) was among the top eleven conditions identified in the first round. Dental Disease was selected for guideline review along with three additional chronic and non-communicable diseases, nine infectious diseases, four mental health conditions and three conditions specific to women's health.[1]

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Through consensus, experts in immigrant and refugee health developed a systematic process for transparent, reproducible, evidence-based reviews for the 20 identified conditions. A guideline committee selected review leaders from across Canada on the basis of their clinical and evaluation expertise.a Methodology for all conditions followed the fourteen-step process for evidence reviews developed by the CCIRH1 based on the internationally recognized Appraisal of Guidelines for Research and Evaluation (AGREE; www.agreetrust.org). Quality of evidence to assess the magnitude of effect on benefits and harms and clinical preventive recommendations were developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE).[3,4]
Dental Disease Guidelines: The Dental Disease Team worked closely with CCIRH over the course of 2 years to complete the evidence review and guideline development.[5]
While navigating the 14 step methodology, there were three notable and practical challenges in developing Dental Disease guidelines focused on primary care physicians and nurse practitioners. The first relates to the delivery of dental services. Most dental services in Canada are delivered by the private sector on a fee-for-service basis and are not covered under public medical care programs; this is a system that physicians and nurses generally do not have to consider when doing assessments and planning care. However, during the settlement period, Convention refugees, refugee claimants, and other protected people are eligible to apply for the Interim Federal Health Program to cover some costs associated with dental care. The eligibility period varies depending on refugee status. Dental screening as early as possible in the settlement period could allow refugees to take full advantage of the federal health program. Newly arriving immigrants to Canada also undergo an immigration medical examination that includes a single assessment of whether throat, mouth and teeth are normal or abnormal. If problems are identified, there is no referral mechanism. Because primary care practitioners are likely the first and only point of contact with the Canadian health care system for new immigrants and refugees, oral health should be included in early assessments.
Although the Delphi process identified Dental Disease as important to primary care physicians and nurse practitioners who care for newly arriving immigrants and refugees, a second challenge arose with the recognition that these clinicians typically do not have training in dental disease diagnosis. How could we focus our inquiry on practical approaches and information that would be most useful to them? To address both of these challenges, we decided through consensus with CCIHR to focus our assessment of evidence and guidelines on primary care oral screening, on dental health education, and on referral and management of acute pain and infection.

Our third challenge was similar to one faced for many of the guideline conditions. There was a dearth of data to support evidence-based primary care guidelines related to prevention or management of common oral conditions specific to immigrant and refugee populations. With a lack of direct evidence from immigrant and refugee populations, we expanded our search to include indirect evidence from other populations and downgraded the quality of evidence for indirectness when there was concern that the evidence might not be applicable to immigrant and refugee populations. These determinations were again the result of discussion and consensus amongst the Dental Disease team and CCIHR leads.

Details of the Dental Disease guideline development, the evidence-base for the recommendations, quality of evidence and clinical considerations in implementing guidelines are provided in McNally et al[5]. There was evidence to support health benefits when primary care physicians and nurse practitioners: 1) Screen for dental pain (asking, "Do you have any problems or pain with your mouth, teeth or dentures"), 2) Treat dental pain with nonsteroidal anti-inflammatory drugs and refer patients to a dentist and [3]. Screen for obvious dental caries and oral disease in children and adults (examine mouth with penlight and tongue depressor) and refer patients with obvious dental disease to a dentist or oral health specialist.

While these recommendations may seem obvious to dental professionals, oral screening and referral in early physician/nurse health assessments to determine dental needs of immigrants and refugees was not known to be integrated into existing routine screening practice. Rather, its inclusion in these comprehensive guidelines for physicians and nurses is meant to promote the uptake of explicit and evidence-based practices in response to identified dental care needs. A growing body of evidence suggests that physicians are willing to include oral health within their range of care6 and that they are increasingly being called upon to do so.[7,8] Therefore, our guidelines also include evidence-based (moderate -to high- quality evidence) secondary preventive interventions for primary care physicians and nurses that include recommendations for the application of fluoride varnish to the teeth of children at high risk for caries and that teeth be brushed twice daily with toothpaste containing 1000 ppm fluoride.[9,10]

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* The Dental Disease guideline review team consisted interdisciplinary researchers who were supported through funding from the Office of the Chief Dental Officer, Health Canada. Team members and affiliations at the completion of guideline development: Mary McNally, Debora Matthews, Faculty of Dentistry, Dalhousie University; Kevin Pottie, Departments of Family Medicine and Epidemiology and Community Medicine, University of Ottawa; Barry Maze, Director, Dental Public Health, Prince Edward Island (retired); Shafik Dharamsi, Department of Family Practice, Faculty of Medicine, University of British Columbia; Helena Swinkels, Department of Family Practice, University of British Columbia, and Medical Health Officer, Fraser Health Authority; Khairun Jivani, Researcher, Population and Public Health, British Columbia Children's Hospital; Vivian Welch, Research Associate, Centre for Global Health, Institute of Population Health, University of Ottawa; Ahsan Ullah, Canadian Institutes of Health Research Post-Doctoral FellowInstitute of Population Health, University of Ottawa.

**References:**


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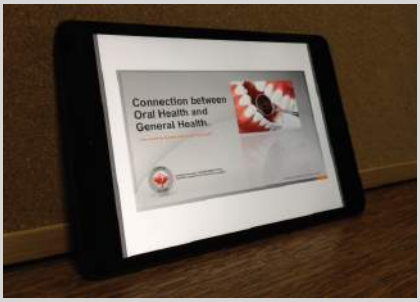
## Advocacy- Dental Health Matters!




As dental public health professionals, we know that oral health is more important than many people might realize. We are often asked to get the facts about how the health of the mouth can affect general health. To help CAPHD members to communicate these messages in the most effective and credible manner, the Policy and Advocacy Committee (PAC), developed a short presentation that can be used widely at various situations. "This is a first advocacy product based on current evidence that we are pleased to make available to the members", says Dr Garry Aslanyan, Chair of PAC. Available at: http://www.caphd.ca/programs-and-resources/resources-for-professionals#advocacy. Members can request the .ppt version from info@caphd.ca; in all cases of use, CAPHD logo, sources used and acknowledgements must be referenced. Please let us know how you used the presentation and if there is anything we can do to make it even more effective.

# President's Message

Dr. Carlos Quiñonez,DMD, MSc, PhD, FRCDC

It is with great pleasure and appreciation that I will be acting as your President for the upcoming year. I have been involved with CAPHD since the early 2000s, and have always enjoyed the collegiality and the ability to keep in touch and learn from the diversity of colleagues involved in dental public health. From those in public health units and in government, to those in universities and in professional bodies, we are an excellent group of service providers, policy makers, researchers, and advocates.

As I'm sure every President's message says, we have lots to do! We just came out of a very successful annual scientific and general meeting in Saskatchewan, and are now planning next year's conference in Ontario. With the hard work of your board of directors, staff, committee chairs, volunteers, and you, we will continue to grow our organization's reach and influence. Every year, we are becoming more prominent than ever. Indeed, governments and non-governmental organizations, dental public health professionals, the media and the public increasingly look to CAPHD for information and support on dental public health-related matters.

To continue to support our growth and reach, my goals for this year are threefold: 1. Improve our governance; 2. Increase our membership and 3. Improve our presence on the web. The first grows out of the unforeseen demands that our new governance model has created for us. Over the last two years, it has become clear to the Board that process has been getting in the way of our continued success. Indeed, as said best by one of the Board members: "relevance before governance." As a result, we will be exploring ways to adjust our current governance model to one that is more streamlined and that supports our volunteerism as opposed to bogging us down in minutiae. The second goal is one that is necessary in order for us to continue the success that we have recently seen. We are exploring ways to increase membership through our Membership Committee and by promoting CAPHD through our provincial and university contacts. The third goal is to make us as contemporary as possible. Most people now seek out knowledge and information on the internet, and we should try to meet this need with as much rich content as is possible. We are now reviewing our website -- which is already great -- to see what we can tweak to make it that much better!

So what can you do to help us? You can continue to be an active member and a promoter of CAPHD and its activities. You can contact us and tell us about issues of relevance in your local environment. And you can provide us with ideas on how and what we can improve. We are always willing to listen, so let us know!

# Message du Président

Dr. Carlos Quiñonez, DMD, MSc, PhD, FRCDC

C'est avec grand plaisir et satisfaction que je vais agir à titre de votre président pour la prochaine année. J'ai été impliqué avec l'ACSDP depuis le début des années 2000. J'ai toujours apprécié la camaraderie entre les divers collègues en santé publique, ainsi que d'apprendre de leurs expériences. Provenant des centres de santé publics, du gouvernement, du milieu académique ou d'organismes professionnels, nous formons un excellent groupe de fournisseurs de services, de décideurs, de chercheurs et de défenseurs des intérêts.

Comme je suis bien certain que tous les présidents le disent, nous avons beaucoup à faire! Après une grande réussite de la conférence scientifique annuelle ainsi que l'assemblée générale en Saskatchewan, nous planifions maintenant la conférence de l'an prochain qui aura lieu en Ontario. Grâce au travail acharné de votre conseil d'administration, du personnel, des présidents de comités, des bénévoles et vous, nous continuerons à développer notre portée et l'influence de l'organisation. Chaque année, nous prenons de l'importance. En effet, les gouvernements, les organismes non-gouvernementaux, les professionnels dentaires de la santé publique, les médias, ainsi que le publique se tournent de plus en plus vers l'ACSDP pour de l'information et du soutien sur les questions relatives à la santé dentaire publique.

Afin de soutenir notre croissance et notre portée, mes objectifs pour cette année sont de trois ordres: 1. Améliorer notre gouvernance; 2. Augmenter le nombre de membres; 3. Augmenter notre présence sur le web. Le premier objectif dérive de demandes imprévues que notre nouveau modèle de gouvernance a créés. Au cours des deux dernières années, il est devenu clair au Conseil que les processus sont devenus lourds face à notre succès. En effet, comme mieux dit par l'un des membres du Conseil: «pertinence avant gouvernance». Par conséquent, nous allons explorer différents moyens d'ajuster le modèle de notre gouvernance actuelle pour la simplifier ainsi que d'assurer un soutient à nos bénévoles plutôt que de nous embourber dans les détails. Le second objectif est nécessaire afin de poursuivre le succès que nous avons vu récemment. Nous étudions les moyens d'accroître le nombre de membres par le biais de notre comité d'adhésion et en promouvant l'ACSDP grâce à nos contacts avec les provinces et les universités. Le troisième objectif est de nous faire aussi actuel que possible. La plupart des gens cherchent maintenant leurs informations sur Internet. Nous devons donc essayer de répondre à ce besoin avec un contenu aussi riche que possible. Nous examinons maintenant le contenu de notre site web, qui est déjà bien, afin de le rendre encore plus intéressant!

Alors, que pouvez-vous faire pour nous aider? Vous pouvez continuer à être un membre actif et d'être un promoteur de l'ACSDP et de ses activités. Vous pouvez nous contacter et nous parler de questions d'intérêt dans votre emplacement. Vous êtes également les bienvenus à nous fournir des idées et suggestions sur comment nous pouvons nous améliorer. Nous sommes toujours à l'écoute, alors laissez nous savoir !

# Improving Oral Health of Preschoolers among Newcomers in Edmonton Using a Community-Based Participatory Research

**Dr. Maryam Amin, DMD, MSc, PhD**

*Associate Professor and Division Head of Pediatric Dentistry*
*Oral Clinical and Population Health Sciences Graduate Program Director*
*University of Alberta*

Oral health is a serious public health concern in young children of newcomers to Canada. While ethnicity and newcomer status are considered as risk factors for early childhood caries (ECC), many children of newcomer families may not have received needed dental care in their original country before their arrival in the host country. Canadian surveys have shown that children of recent immigrants and refugees have higher rates of caries and lower rates of dental visits than Canadian-born children and tend to seek dental care for treatment reasons primarily. Therefore, there is a critical need to better understand the psychosocial factors influencing dental health of newcomers and their access to dental services in Canada. [1-3] There may be a unique range of psychosocial barriers impeding access to the uptake of oral health in these families that need to be identified and characterized before successful interventions can be developed.

ECC is a multifactorial disease with a number of biological, behavioral, and social risk factors that disproportionally affects marginalized populations. It has been recognized that traditional research approaches have had limited success in solving a complex health disparity. Therefore, there is a need for a new research method to not only find answers to a complex health issue with multiple psychosocial determinants, but also to have those results provide information that can be used by the communities to develop their own solutions. Community-based participatory research (CBPR) is a relatively new approach in oral health that intends to alter the relationship between researchers and communities, from researchers that act upon a community to researchers that work side by side with community members. They work together to identify problems, define questions and design projects. They also collaborate in implementing the project, disseminating the knowledge, and apply the findings. Therefore, community members become part of the research team and researchers become engaged in the activities of the community. This approach will increase greater trust and respect between researchers and communities. [4]

With this aim, a collegial collaboration was established with several community organizations serving newcomers in Edmonton including Multicultural Health Brokers Coop, Edmonton Multi cultural Coalition, Mennonite Centre, Catholic Social Services, Africa Centre, and Millwoods Welcome Centre. A CBPR project was designed and conducted in four phases. Phase I included a series of focus groups with community leaders who had an affiliation with one of the above organizations. In total, 22 community workers representing 13 communities participated in the focus groups. The primary objective of this phase was to explore the feasibility of conducting community-based participatory research that would eventually result in an oral health promotion program tailored to the needs of each community. Focus groups shed light on what community health workers knew about oral health of their community in general and their children in particular including their dental needs and barriers to access to dental services within the communities they serve. Information gathered from phase I helped us to identify some areas that required further exploration among the newcomer families who experience, first-hand, the challenge of providing an optimal oral health for their young children.

In Phase II, a group of community leaders who had access to newcomer families with young children were trained to conduct focus groups with parents of their community in their original languages. In total, 99 parents from African, South Asian, and Chinese communities were participated in 15 focus groups. Two dimensions were identified in our qualitative analysis: barrier-related and individual-related dimensions.[5] Barriers to prevention of ECC were associated with home-based prevention, early detection, and access to professional care. Barriers to parental prevention were related to health beliefs, knowledge, oral health approach, and skills. Barriers to early detection included perceived role of caregivers and dentists, perceived identity of ECC, ways of detecting cavities, and parental self-efficacy. Access barriers were related to parental knowledge of preventive services, attitudes toward dentists and dental services, English skills, and external constraints concerned dental insurance, social support, time, and transportation. Overall, the study revealed visible differences among the participating communities and confirmed the necessity of customizing preventive strategies to meet the needs of each community.[6]

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In phase III, about 300 African and South Asian children received a free dental examination in different community locations. A quantitative questionnaire was also completed by their newcomer parents. The primary objectives of this phase were to explore the prevalence of dental caries among the children and to measure parental awareness of their child's dental status as well as their cultural beliefs regarding oral health of young children and prevention of ECC. In total, 56% of the children had dental caries and 52% never had a dental visit before. It was concluded that children of newcomers are at high risk for developing severe dental decay because of low parental awareness and lack of regular dental visits. [7] The knowledge produced through phase I, II, and III was translated to an oral health educational package and disseminated in several community-based workshops for newcomer parents of young children from African and South Asian communities in phase IV. The impact of the workshop was then evaluated using a pre- and a post-intervention questionnaire in 105 newcomer families.[8] The study concluded that a one-time, hands-on training of newcomer parents could be effective in changing their knowledge about, and attitudes toward preventive dental care and their intention to take action in a foreseeable future.[8]

Upon completion of phase IV, a CIHR funded symposium was hosted at the University of Alberta. An impressive group of researchers across Canada, Alberta government, and community representatives were brought together to reflect on what have learned from the CBPR project and to define and prioritize deliverables and next steps to achieve a broader, multicentre and multidisciplinary research agenda. The workshop served as a catalyst to evoke the changes necessary to overcome identified barriers to oral health care among newcomer families, particularly parental behaviors and cultural beliefs about oral health care of young children. In addition, it proposed changes to existing services and programs for newcomer families offered by stakeholders (government, health care system, and community-based) and identified priorities.[9]

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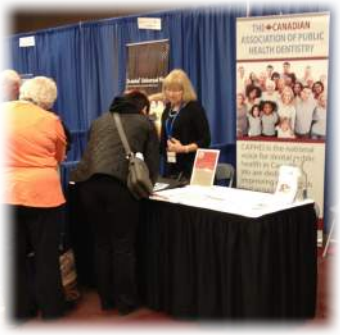
SAVE THE DATE for the next CAPHD Conference

SEPTEMBER 25 & 26, 2015

At the Toronto Reference Library

## Learning on the banks of the Saskatoon River, September 2014

This fall, CAPHD collaborated with the Saskatoon Oral Health Professions Association and the College of Dental Surgeons of Saskatchewan to host our scientific conference and annual general meeting. This collaboration provided an opportunity for delegates to learn about a variety of topics including public health dentistry.



CAPHD volunteers had the opportunity to promote the association to over 1000 delegates. Visitors at our exhibitor booth picked up copies of the Mosaic, the position statement on community water fluoridation and information about the association.

Dr. Carlos Quiñonez was a keynote speaker and provided a dynamic session titled "Dental Care in Canada: The Role of Saskatchewan in Leading Innovation and Change".

CAPHD helped to organize a press release, where the Canadian Academy of Health Sciences report, "Improving Access to Oral Health Care for Vulnerable People Living in Canada" was released. Several CAPHD members were on the panel for this release including: Dr. Paul Allison, Dr. Carlos Quinonez, Dr. Gerry Uswak, Dr. Alyssa Hayes, Ms. Janet Gray and Ms. Mary Bertone.

Annual Conferences also provide an opportunity to network with colleagues during social events. CAPHD hosted a reception at the James Hotel where delegates had the chance to network with colleagues from the Canadian Dental Association, Canadian Dental Hygienists Association, Canadian Dental Therapy Association and students from the University of Saskatchewan. Members thanked the association for providing an event with the best view of the Saskatchewan River. Simply breathtaking!

The conference ended with CAPHD's annual general meeting, where the CAPHD welcomed new board member Dr. Garry Aslanyan and thanked Dr. Gerry Uswak for his contribution on the board of directors as his past president term expired. Dr. Carlos Quiñonez assumed the President role and subsequent to the meeting, the board of directors elected Dr. Alyssa Hayes to assume the president-elect position.

The CAPHD Board of Directors and Conference Committee extend a huge thank you to the Saskatchewan Oral Health Professions Group, who were so enthusiastic about including dental public health into their conference and provided such support to our organization!

We hope you'll join us on September 25th and 26th, 2015 when we head back to the Toronto Reference Library. Book your calendar to attend a national event dedicated to providing continuing education to Canadian dental public health professionals!

# An Overview of the 2014 Environmental Scan of Publicly Financed Dental Care in Canada

**Dr. Jodi Shaw, Ms. Julie Farmer**

The Dental Public Health graduate program at the University of Toronto offers students national and international opportunities to work with dental public health professionals during their compulsory practicum placement. The Office of the Chief Dental Officer (OCDO) employed two practicum students this year whose priority project was to update the Environmental Scan of Publicly Financed Dental Care.

At present, the report is in its final stages and will describe the current state of affairs of Canada's public dental health care system as well as developments since the completion of the original environmental scan in 2005. Similar to the previous report, the current report will describe provincial and territorial public dental programs, and will detail on associated legislation and financing trends.

Enumeration and remuneration of dental public health human resources across Canada, as well as reimbursement rates of publicly financed dental programs within provinces, will also be included in the report. Of note, the report will not describe an exhaustive list of dental care efforts from charitable organizations, university programs, and private sector involvement. The ultimate aim of the report is to foster interest in public health dentistry and to improve access to dental care, especially to socially marginalized groups.

Information was collected through cooperation with provincial/territorial and federal government dental representatives. Supplementary information was obtained through publicly available resources.

Preliminary findings show most oral health initiatives at the provincial/territorial level since 2005 continue to focus on children, primarily those who are socially disadvantaged. There have been both increases and decreases in expenditures and service coverage for dental programming across the nation. Overall expenditures appear to have increased since 2005, with slight fluctuations over time. Despite the increase in the elderly population, few jurisdictions have programs for these populations. Some provinces and territories have received investments and renewed focus directed towards dental public health efforts with expansions to their preventive programs. Reimbursement rates of dental programs vary across provinces with the average percent reimbursement rate ranging from 70 to 80 percent of provincial fee guide rates. The number of dental professionals in Canada has risen steadily over the last decade; however, efforts for improving leadership in dental public health have not been consistent across provinces and territories. New Brunswick and Nova Scotia remain without dental public health leadership at the provincial level, and other provinces/territories hold part-time positions for these roles.

We can presume that due to the challenging financial climate in Canada over the past decade, it has been difficult for key stakeholders to move forward with initiatives aimed at improving the oral health of Canadians. Through creative collaboration, strong determination, and sufficient resources to support evidence-based approaches, key stakeholders will be better equipped to reduce oral health disparities nationwide.

It is understood that dental public health programming and human resources in Canada are constantly evolving. As such, the report will serve as a descriptor of public dental care activities at the time of the scan (Summer 2014), as well as changes that have occurred since the previous scan. The final report will be made publicly available in the summer of 2015 in both official languages through the Federal Provincial Territorial Dental Working Group website www.fptdwg.ca.

Author Biography:

**Dr. Jodi Shaw** is a dentist and a member of the Canadian Armed Forces enrolled in the MSc Dental Public Health program at the University of Toronto.

**Ms. Julie Farmer** is a Registered Dental Hygienist enrolled in the MSc Dental Public Health program at the University of Toronto.

# Congratulations! Félicitations!

***2014 Dr. James Leake Student Bursary (CAPHD) / Bourse étudiante Dr. James Leake 2014***

Dr. Sojung Lee (second from right - deuxième de la droite)

Dr. Ziadeddin Al-Baghdadi (middle - au centre)
http://www.caphd.ca/dr-leake-student-bursary

***2014 CAPHD Life Membership Award / Prix de membre à vie ACSDP 2014:***

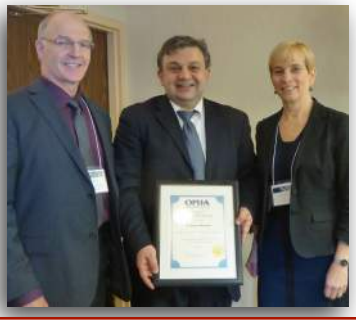
Ms. Holly Heard-Lucas
http://www.caphd.ca/about-us/honourary-life-members

***2014 CAPHD Honourary Membership Award /Prix de membre honoraire ACSDP 2014:***

Dr. Daniel Pierre Kandelman
http://www.caphd.ca/about-us/honourary-life-members

***2014 Ontario Public Health Association Lifetime Membership Award / Prix de membre à vie de l'Association de santé publique de l'Ontario***

Dr. Garry Aslanyan (shown in middle - au centre)



# Oral Health Literacy in Refugee and Immigrant Populations in Canada

**Editorial by Kamini Kaura, HBSc, RDH**
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In 2012, an approximate 260,000 immigrants were accepted by Canada; with a large two-thirds of Canada's growing population coming from international migration, the oral health status of these individuals is a rising issue of interest[1]. An evidence based review by the Canadian Collaboration for Immigrant and Refugee Health, carried out by McNally et al., in 2011, found a higher prevalence of oral disease and limited awareness or use of professional and preventive dental care among newcomers[2]. As access to prevention and early treatment is limited, oral disease has the potential to contribute to many serious systemic conditions such as diabetes, respiratory diseases, heart disease and women delivering pre-term, low birth rate babies, impacting the overall health status of Canadians[2, 3].

Importantly, the Oral Health Component of the Canadian Health Measures Survey (CHMS) of 2007-2009, stated that the majority of adults report a good to excellent oral health status. However, the CHMS also reported disparities in oral health and access to dental care, as related to the following: age, insurance coverage, income, level of education and immigration status[4, 5]. A recently published report, by the Canadian Academy of Health Sciences, analyzes the CHMS stating the evidence and data show that there is an issue of access to oral health care for vulnerable populations in Canada[5, 6].

Inequalities in access to dental care are contributing to inequalities in oral health and therefore general health, both of which have the same social, economic and behavioural determinants. With 94% of dental care being provided in the private sector however, a sound model of health care provisions has not been developed for vulnerable groups suffering with the highest levels of oral health problems[7]. Recent changes to the Interim Federal Health Program have also limited provisions of dental care for refugees and immigrants[7, 8]. With the minimal amount of publicly funded oral health care services in Canada, it is critical that we focus on creating programs aimed at those carrying the greatest burden of oral disease.

Improving access to oral health care for vulnerable populations in Canada requires the need for sensitization among oral healthcare professionals as well as the public. A greater recognition of both systemic, literacy and cultural barriers among care providers will assist in expanding access to oral health care for immigrants and refugees. These new Canadians face barriers in accessing oral health care such as: limited income, poor language skills, a fear of dentists, history of inadequate care, potential embarrassment about their current oral condition, and differences in cultural approaches and concepts for dental prevention and treatment.

There is a greater than ever understanding, that to improve one's chances of receiving preventative care, health literacy must increase[9]. Low health literacy can be described as a silent epidemic, where the limited capacity to access, understand and use health information can hinder the chances of improved health outcomes, especially in vulnerable populations. The Intersectoral Approach to Improving Health Literacy for Canadians describes a health literate individual as having the ability to: "1) understand and carry out instructions for self-care, 2) plan and achieve the lifestyle adjustments necessary for improving health, 3) make informed positive health related decisions, 4) know how and when to access health care, 5) share health promoting activities and 6) address health issues in the community and society"[9, 10]. Oral health literacy is no different, consisting primarily of hygiene instruction, oral cancer self-exams and the importance of regular visits to your oral healthcare provider.

Improving the chances of greater oral health outcomes in immigrant and refugee populations in Canada means more than the transmitting of information and developing the skills to be able to read pamphlets and follow through with appointments. Improving health literacy among Canadians means simplifying the message, where an ethical approach to alleviating low health literacy would be to educate and empower people, giving them the skill set enabling them for functional health literacy[11, 12]. The focus is then shifted to the content and method of communication, where personal forms of communication and community based outreach programs are emphasized to allow for greater access and maintaining oral health.

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There are many examples of health literacy in practice across Canada, all creating and testing programs to address health literacy issues and minimize the barriers of access. The initiative of these programs emphasizes communication, information development and dissemination, peer navigation, prevention and treatment and education[12, 13]. However, these programs are aimed at larger groups and must increase initiatives in health promotions and minimizing barriers of access for priority groups such as Aboriginal Peoples, seniors, people with disabilities and recent immigrants and refugees.

Interventions to increase oral health literacy among Canadians could be facilitated as a multidimensional oral health literacy project, where the combined efforts of organized dentistry and oral hygiene at the federal, provincial and municipal levels of government could be directed at those most vulnerable. With a consideration to cultural barriers and other economic determinants, educators on the secondary and post secondary level, ESL in Canada, children's programs and services for the elderly would be able to provide a greater understanding of oral health.

The Canadian Oral Health Framework (COHF) 2013-2018 has a vision of creating programs addressing the needs of Canadians through public and community based programs[8, 12]. As we recognize those facing the greatest barrier to access and the greatest burden of oral disease, we can create goals and strategies promoting greater oral health literacy. Monitoring the progress of these programs will ensure steady improvement in the oral and systemic health of all Canadians. Health professionals at all levels must do their part now in creating an oral health literate Canada for a health literate future.

**Citations:**


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## The Oral Health of Preschool Children from Newcomer Families to Manitoba

**Mohamed El Azrak, Mary Bertone, Khalida Hai-Santiago, Robert Schroth**

Today, early childhood caries (ECC) remains a significant public health problem that can have both immediate and long-term consequences for children. Poverty, unemployment, limited parental education, and lack of dental benefits are recognized to contribute to increased caries risk. Therefore, newcomers, especially refugees, are considered a moderately high risk group for ECC.

The objective of this study is to determine the prevalence of ECC in preschool children from the newcomer community in Winnipeg, Manitoba. This cross-sectional study was approved by the Health Research Ethics Board at the University of Manitoba. Team members are visiting newcomer settlement agency sites (Welcome Place, Immigrant and Refugee Community Organization of Manitoba, and Hospitality House), community clinics (Mount Carmel Clinic), and the Healthy Start for Mom & Me program. Newcomers with preschool children are invited to participate. Children undergo a dental screening and parents complete a short questionnaire with the assistance of a team member. The questionnaire poses simple questions related to the child and parent (e.g. country of origin, language spoken, type of dental insurance, whether their child has received dental care in Winnipeg, and oral hygiene habits).

After the first 8 weeks, 88 children were recruited from five different sites. Participants come from 20 different countries, with most being from Africa and Asia.

Preliminary results suggest that ECC does affect newcomer preschool children as nearly 40% had ECC. Further, the majority (approximately 87%) had never been to the dentist before in Winnipeg. Children without established dental homes are connected with dental clinics in the community.

The team has encountered some unique challenges so far. The biggest challenges have been language barriers and connecting with the various programs providing settlement services to newcomer families. However, the excitement for this project has been incredible. Some of the agencies and programs have provided interpreters for us, while a couple of members and students with the team spoke the same language as some participants. The large influx of refugees at the different refugee settlement sites does increase our ability to recruit children, but at the same time staff at these settlement agencies is often overwhelmed with the immediate needs of trying to help refugee families settle in Winnipeg.

While there are several barriers that we must address, we believe that this is important research that can benefit newcomers to Winnipeg. Oral health is an important aspect of the overall health of children, and by doing the screening and connecting the newcomer children with dental clinics we aim to help raise awareness amongst this vulnerable group about the importance of oral health and maintaining good oral hygiene. We are amazed and encouraged with the number of parents who are eager and willing to have their children undergo dental screening. This team has started to build important relationships with families that can connect them with needed oral health information and services in the community.

# Member Profiles

*CAPHD is proud of it's interdisciplinary membership and what members do to contribute to improving the oral health of Canadians!*

## Ms. Holly Heard-Lucas
BA, RDH

Ms. Holly Heard-Lucas is a Registered Dental Hygienist who has been working in public health since 1976. In 2008, she earned a BA with a major in Sociology from UWO. She is a committed member of the Ontario Oral Health Alliance advocacy group, co-chair of the Oxford Oral Health Coalition and a volunteer on CAPHD's membership committee. She is the recipient of the 2014 CAPHD lifetime membership award.

Holly has been a mentor for many other dental hygienists who have come to Public Health over the years. She has knowledge and experience in all areas of dental public health and has spent many years working in the school programs teaching dental health education, screening school children, collecting dental indices surveys and developing health promotion initiatives.

In 1986, she was the first hygienist to be hired to work at the dental clinic for the Middlesex-London Health Unit. From 1986-1996, Holly continued to work in both schools and homes for the aged across Oxford County. From organizing mouthguard clinics to developing oral health communication campaigns, Holly has been a champion for oral health promotion.

In the 1980's Holly was a founding member of the Ontario Society of Supervisors in Public Health Dentistry from 1985 until the group merged with the Ontario Society of Public Health Dentists in 1987. This merge formed the new group, the Ontario Association of Public Health Dentistry (OAPHD). She participated on the Health Promotion Committee for the province and was the Co-Chair of the 2 for 2 provincial campaign for Dental Health Month.

In 1995, Holly joined the CAPHD and attended annual conferences across the country. Following the 2005 conference in Edmonton, she was inspired by the Fluoride Varnish research presentations and returned to Ontario to develop a pilot study using Fluoride Varnish applications for high-risk preschoolers in their own homes. The 2 year study was used as a best practice guideline for Health Canada.

In 2009, she received a grant from the Oxford Community Partnership Fund to develop a dental care program for low-income adults living on Social Assistance. Many people received essential dental care and dentures through this program and some were able to secure employment as a result.

At this time, Holly is working with the local archivist to chronicle all of the Dental Program information that she has collected over the years from 1986 to 2014. The first of its kind. Holly is planning to retire at the end of this year but plans to continue to advocate on behalf of the people who have no access to oral health care.

## Dr. Rafael Figueiredo
BDS, MSc, FRCD(C)

Dr. Rafael Figueiredo assumed the position of Provincial Dental Public Health Officer with Alberta Health Services in Edmonton, Alberta in September 2014. For the last 13 years, he has been working as a Researcher with the Community Dental Health Services Research Unit at the Faculty of Dentistry, University of Toronto. Further to his research activity and teaching at the Faculty of Dentistry, University of Toronto, he received a Master of Science Degree, M.Sc. in 2011, and a Dental Public Health Specialty Degree in 2014. He has certification in Dental Public Health with the Royal College of Dentists of Canada.

Dr. Figueiredo's involvement with Dental Public Health and his interest for the vulnerable population started right after his graduation as a dentist. The beginning of his career was dedicated to the provision of dental care to patients with special needs, children and adults. Subsequently, he got involved with dental care with Aboriginal communities in the extreme north of Canada and with oral health prevention to First Nations children in Ontario. More recently he conducted an important research concerning the adult homeless population in Toronto, investigating their oral health status and utilization of hospital emergency departments for dental problems.

**-CAPHD congratulates Dr. Rafael on his new position!**

## CAPHD Mosaic Newsletter Submission Guidelines

The goal of the Mosaic newsletter is to provide twice yearly useful and current information to members about what's happening across Canada in community and population oral health, and to educate the members on dental public health topics.

**Topic:**
We welcome any news or information that you would like to share, including research studies, outreach projects, new initiatives, event information, or advertisements for employment within the public health field. Please include a title (if applicable) in your submission.

**Due Dates:**
Please submit by March 1st for the April newsletter and October 1st for the November newsletter.

**Length:**
There is no minimum length, but a maximum length of 800-1000 words is recommended.

**Format:**
Submissions should be in DOC or DOCX format.

**Images:**
Images should be submitted as separate JPG or GIF files, in high quality (at least 300 dpi for pictures and 600 dpi for graphics). Please include descriptive captions as required, and ensure that you reference any images that do not belong to you. Copyright rules require written permission from the owner to publish any image. Simply referencing is not sufficient. Consent must be acquired from all people/clients in photos and the CAPHD photo consent must be completed.

**Author Information:**
Please include your name and credentials, along with a short biography (approximately 25 words) and an optional photo of yourself. Also let us know if you would like your contact information such as email address or website included in the newsletter.

**References:**
Please include an organized list of references, if applicable.

Please email submissions or questions to the Communication Committee at info@caphd.ca for consideration. To view the newsletter, please visit the CAPHD website at www.caphd.ca/mosaic.

Also, keep in mind that these are guidelines only, and exceptions may be made at the discretion of the Communication Committee.

The CAPHD reserves the right to edit/alter articles for length or clarity. Authors will be notified of any such changes prior to publishing the newsletter. Opinions contained in this newsletter are of the authors and may not reflect the opinions of the Canadian Association of Public Health Dentistry.

## CALENDAR *of events*

**APRIL**
•Mosaic Newsletter Issue 7
•Dental Health Month

**JUNE**
•Deadline for Dr. James Leake Bursary applications & abstract submissions for 2015 CAPHD Scientific Session

**SEPTEMBER**
•25-26 CAPHD Scientific Conference & AGM

**OCTOBER**
•1st- Deadline for Mosaic Submissions

**NOVEMBER**
•Mosaic Newsletter Issue 8

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MOSAIC NEWSLETTER COMMITTEE:

Andrea Richard (Communication Committee Chair), Mary Bertone, Dr. Michelle Budd, Julie Farmer, Dr. Sojung Lee, Dr. Martin Chartier (Communication Committee Members)