The Children's Oral Health Initiative: An intervention to address the challenges of dental caries in early childhood in Canada's First Nation and Inuit communities

Kavita R. Mathu-Muju, DMD, MPH,[1] James McLeod, RDT,[2] Mary Lou Walker, RDH,[3] Martin Chartier, DMD,[4] Rosamund L. Harrison, DMD, MSc[5]

ABSTRACT

OBJECTIVE: The objective of the Children's Oral Health Initiative (COHI) is to increase access to preventive oral health services provided to First Nations and Inuit (FN/I) children living on federal reserves and in remote communities.

PARTICIPANTS: COHI targets preschool children; 5–7-year-olds; pregnant women; and parents/caregivers in FN/I communities.

SETTING: The program was piloted in 2004 by Health Canada and is potentially available to all FN/I communities. However, the community must consent to the program's implementation and agree to support a community member to be trained as a COHI aide.

INTERVENTION: Dental therapists and hygienists screen eligible children, apply fluoride varnish and sealants to children's teeth, and stabilize active dental caries with glass ionomer. An innovation was the development of a community oral health worker, the COHI Aide. The COHI Aide is a community member who serves as an advocate for preventive oral health in the community and provides instruction to children, parent/caregivers and expectant mothers in preventing dental caries.

RESULTS: COHI was piloted in 41 communities in 2004. By 2014, the program had expanded to 320 FN/I communities, which represents 55% of all eligible FN/I communities. In 2012, 23,085 children had received COHI preventive oral health services.

CONCLUSION: The results demonstrate COHI's success as a preventive oral health care delivery model in remote communities. Implementation and delivery of preventive oral health services has been enhanced by the sustained presence of a community-based COHI Aide.

KEY WORDS: Indigenous health services; pediatric dentistry; oral health; dental caries; community health worker

La traduction du résumé se trouve à la fin de l'article.

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Approximately 4% (1.4 million people) of the Canadian population self-identify as being of Aboriginal descent. Of these individuals, over 314,000 live in 636 communities, also referred to as federal reserves, located on lands held in trust for bands by the Crown.[1] Aboriginal people living in these small, geographically isolated communities do not have equitable access to the full range of health services enjoyed by individuals living in southern Canada.[2,3] Geographic and political obstacles coupled with workforce constraints perpetuate these inequities and make oral health care delivery particularly challenging.[2] As a consequence, Aboriginal children bear a disproportionately higher burden of dental disease than other Canadian children, despite the availability of federally funded reimbursement for dental care.

Both the 2009 Inuit Oral Health Survey[3] and the 2010 First Nations Oral Health Survey[4] demonstrated that significant oral health disparities exist between indigenous and non-indigenous Canadians. First Nations and Inuit (FN/I) children were more likely to experience a greater prevalence of dental caries (tooth decay) as well as higher levels of untreated dental caries than other Canadians. Of 3–5-year-old children, 85% had experienced dental decay. The average number of decayed, missing and filled (dmft) primary teeth in this age group was 8.22, with nearly half (49%) of decayed teeth untreated. Among 6–11-year-old children, 80% of First Nations children and 71% of Inuit children had experienced dental caries in their primary dentition compared with 48% of other Canadian children.

In 2004, through the joint effort of Health Canada and FN/I communities, an innovative community-based preventive program – the Children's Oral Health Initiative (COHI) – was started in an effort to reduce the prevalence of dental caries in early childhood.[5,6] The objective of this paper is to describe the COHI intervention and its implementation, and to present evidence that it has improved access

Author Affiliations

1. Assistant Professor, Division of Pediatric Dentistry, University of British Columbia, Vancouver, BC
2. Dental Program Manager, First Nations and Inuit Health Branch, Manitoba Region, Winnipeg, MB
3. COHI Coordinator, B.C. First Nations Health Authority (now retired), Vancouver, BC
4. Acting Chief Dental Officer, Health Promotion and Chronic Diseases Prevention, Public Health Agency of Canada, Ottawa, ON
5. Professor, Division of Pediatric Dentistry, University of British Columbia, Vancouver, BC

Correspondence: Prof. Kavita R. Mathu-Muju, Division of Pediatric Dentistry, University of British Columbia, 2199 Wesbrook Mall, Vancouver, BC V6T 1Z4, Tel: 604-822-3316, E-mail: kmmuju@dentistry.ubc.ca

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to preventive dental services for FN/I children living on federal reserves and in remote Northern communities.

THE INTERVENTION: THE CHILDREN'S ORAL HEALTH INITIATIVE

Description

COHI specifically aims to shift the emphasis from a primarily restorative/surgical treatment-based approach in managing dental caries (i.e., restorations and extractions) to a more balanced approached with a community-based focus on prevention and non-surgical care.[7] COHI was integrated with the existing Health Canada dental public health infra-structure operated by dental therapists and dental hygienists. Therefore, COHI has been implemented primarily in communities located on federal reserves and the Northern Region (Northwest Territories, Yukon, Nunavut). The program is directed at four target groups: 1) pre-school children, birth to 4 years of age; 2) school children, 5–7 years of age; 3) parents/primary caregivers; and 4) pregnant women. Dental caries has a multifactorial etiology, which includes social determinants of health (nutrition, oral self-care), as well as biological determinants of health (cariogenic bacteria). Therefore, a combination of preventive dental services has been applied for a population-level approach to controlling dental caries in children. COHI utilizes preventive approaches that are supported by scientific evidence and represent recognized standards of care in controlling dental caries. They include fluoride varnish, fissure sealants, oral health counselling and atraumatic restorative therapy (ART), which uses a glass ionomer biomaterial to stabilize active dental caries.

Generally, the services of the program are linked to the school year. Either the dental therapist or dental hygienist completes the screening of COHI-eligible children in the fall and performs the first fluoride varnish application. Over the course of the programmatic year, further preventive services are delivered, including additional fluoride varnishes, sealant application and treatment of carious lesions, as necessary, with ART. There is a focus on oral health education of both children and parents or caregivers. Depending on the type of service and the age of the child, care may take place in either the school dental clinic or in community settings, including children's homes.

Implementation

Introduction of COHI in a community is predicated on an individual community's determination that they are ready for the program. Emphasis is on community ownership of the program. The typical process includes 1) confirming federal program funding availability; 2) confirming community dental therapist/hygienist availability; 3) completing/reviewing baseline oral health surveillance data; and 4) meeting with the community to determine readiness and commitment. Implementation of COHI cannot proceed without the collective community being engaged; the community assumes control over decisions influencing the oral health of its members.

Community meetings are held to 1) introduce the concept and objectives of COHI; 2) encourage the community to consider its readiness for ownership of the program; and 3) emphasize that the program will be community-based. These community meetings acknowledge the right of First Nations to self-governance in health and the desire to respect the community as the entity making an informed decision whether or not to participate in the program. As a goal of the program is to develop community capacity and to provide employment in COHI communities, there is the expectation that the community employ and retain a "lay" community oral health worker, a COHI Aide. The COHI Aide supports the oral health professional delivering services within the community.

COHI Aide

The development, training and utilization of a community health worker to promote and support oral health activities in the community is a significant innovation of the COHI initiative. A "community health worker" is a community member delivering a small number of focused interventions addressing a particular health issue, and who has been trained in the context of the intervention but does not have any formal professional certification.[8–10] As COHI was being developed it was recognized that dental therapists and hygienists would need community-based support in identifying children and caregivers, in engaging with the community and in providing the clinical services included in the initiative. The COHI Aide was introduced as the community health worker who helps the oral health professional deliver services in the community. A training program delineating five areas of competence for the aides was developed and implemented by Health Canada.[6] COHI aides provide a sustained dental presence and become the oral health knowledge keepers within the communities. The aides participate in community events and engage with children, expectant mothers and parents outside of clinical settings to help align conventional dental public health messages with traditional models of wellness.

The COHI Aide works collaboratively with the dental therapist/dental hygienist, helping create more effective linkages between community members and the oral health care system. During home visits, the Aide explains the purpose of COHI and obtains an informed consent from parents permitting their children to participate in the program. Oral health education is a focus of the visit. Once children have received their initial oral health screening from the COHI dental therapist or hygienist, the COHI Aide schedules dental appointments for children requiring ART to ensure that care is received to stabilize the progression of dental caries. In addition to other health promotion/disease prevention responsibilities, the COHI Aide provides regular fluoride varnish applications, thus helping extend the reach of the program's clinical prevention efforts. The COHI aides' ability to effectively perform these duties can be partially attributed to the attributes they share with the community members they serve: ethnicity, language, socio-economic status and life experiences.[11]

OUTCOMES

Evaluation of COHI requires an understanding of both its short and long-term objectives. The immediate goal of COHI is to increase access to preventive oral health care services for FN/I children. The desired long-term outcome is decreased levels of dental disease. As this is a dental public health intervention for a population with historically limited access to oral health care, the initial assessment of COHI's success in meeting its objectives is obtained by measuring the target population's level of participation in the

Table 1. Number of COHI communities per fiscal year

Region	2004–2005	2005–2006	2006–2007	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012	2012–2013	2013–2014	2014–2015
Atlantic (n = 34)	10	6	19	25	25	28	28	29	33	32	32 (94%)
Québec (n = 40)	4	9	10	10	14	14	15	15	15	16	19 (48%)
Ontario (n = 139)	11	25	28	34	53	60	60	62	62	70	69 (50%)
Manitoba (n = 63)	3	28	27	27	27	27	27	27	27	27	27 (43%)
Saskatchewan (n = 70)	6	24	29	28	34	40	40	40	40	40	42 (60%)
Alberta (n = 48)*	4	4	11	19	28	28	28	16	55	49	47 (98%)
British Columbia (n = 198)	3	30	27	29	49	56	61	62	62	79 (40%)	N/A†
Northern Region (n = 44)	0	3	3	7	6	8	7	8	6	7	6 (14%)
TOTAL FN/I communities (n = 636)‡	41 (6%)	129 (20%)	154 (24%)	179 (28%)	236 (37%)	261 (41%)	266 (42%)	259 (42%)	300 (47%)	320 (50%)	242 (55%)§

Note: The data were provided by the Oral Health Promotion Office, Office of Primary Health Care in Ottawa, ON.

* A discrepancy noted was that Aboriginal Affairs and Northern Development Canada (AANDC) lists Alberta as having 48 First Nations communities, but national data show that up to 55 communities had implemented COHI. For the purpose of this document, the working number of communities is defined as 636 across Canada and 48 in the province of Alberta, and the data are managed accordingly.

† The First Nations Health Authority assumed responsibility for the delivery of health services in British Columbia.

‡ The federal government reports both 617 and 636 as being the total number of First Nations communities in Canada. However, data available at AANDC, updated as of 2015, indicate that 636 represents the current number of communities. These 636 communities have census and National Household Survey data based on the total population enumerated within the communities affiliated to this First Nation.

§ As of 2014, the number of communities from British Columbia are excluded, as health care delivery was transferred to the BC First Nations Health Authority; the working number of communities for the 2014–2015 year is 438.

program. Improvement in access to care can be evaluated by quantifying the number of eligible First Nations communities enrolled in COHI and assessing changes in the number of communities participating in the program over time. Measures of improved access to care can also be evaluated with descriptive statistics giving counts and percentages of the preventive procedures performed for the eligible population. Success in reducing dental disease can be evaluated using standard epidemiological measures (dmft/DMFT: primary teeth/permanent teeth) for caries prevalence and treatment. However, the long-term objective of a reduction of dental disease levels is beyond the scope of this investigation. The focus of this manuscript is to assess COHI's success in the first steps of the program – improving access to preventive oral health care.

COHI is overseen nationally by the Oral Health Promotion Officer and National Dental Therapy Advisor, both based in the Office of Primary Health Care, Ottawa, ON. Longitudinal data on the number of eligible First Nations communities enrolled in COHI as well as the total number of individuals receiving specific COHI services by region were provided by the Oral Health Promotion Office. Dental screening, fluoride varnish application, sealant placement and ART, which are identified by national numerical codes, are reported annually from all federal regions.

Community enrollment

COHI was piloted in 41 communities in 2004 in seven regions across Canada: 10 in Atlantic Canada; 4 in Quebec; 11 in Ontario; 3 in Manitoba; 6 in Saskatchewan; 4 in Alberta; and 3 in British Columbia. By the third year of the program, 24% of all FN/I communities had adopted COHI. By the sixth year of the program, it was present in 41% of all communities. As of 2014, COHI had been established in 320 communities. There is variance in the national penetrance of the program, between 14% (Northern Region) and 98% (Alberta) of communities having established COHI. Nationally, 55% of all eligible FN/I communities now benefit from the COHI intervention (see Table 1).

Service delivery

Federal data available from 2006 to 2013 demonstrate a steadily increasing trend in the total number of individual children participating in the program (see Figure 1). During the 2012 programmatic year, 23,585 children had received at least one COHI service; 21,085 had been screened; 22,245 had received at least one fluoride varnish; 2,853 had received at least one sealant; and 1,071 had been treated with ART. The slight decline in numbers in 2013 is attributable to the transition of health care delivery in British Columbia to the First Nations Health Authority, thus reducing the overall number of children registered in the Health Canada-funded program. Census data do not provide statistics on the specific number of 0–7-year-old children living on federal reserves. However, the results of the 2011 National Household Survey indicated that 0–4-year-olds make up 10.7% of the FN/I population and 5–9-year-olds make up 9.8%.[12] From these data, it can be estimated that between 46,000 and 47,000 (15%) of 0–7-year-old children live in First Nations communities, suggesting that approximately 50% of children, nationally, living on reserves have participated in COHI, This conforms with the knowledge that half (320) of all First Nations communities participate in COHI,

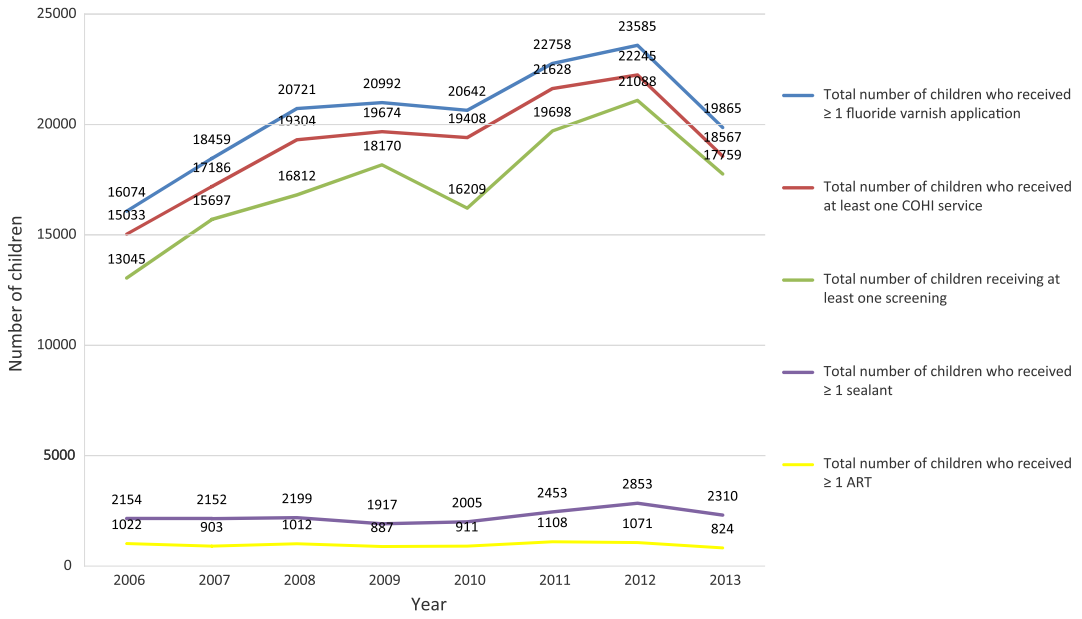

Figure 1. National Children's Oral Health Initiative Preventive Dental Service Totals 2006–2014 (data provided by the Oral Health Promotion Office, Office of Primary Health Care in Ottawa, ON)

which suggests high utilization of COHI services by individuals once the program has been introduced.

Workforce

The sustainability of the program depends upon its ongoing ability to recruit and maintain dental public health workers in communities. As of 2013, the national COHI workforce consisted of 115 dental therapists, 70 dental hygienists and 222 COHI aides. The majority of federal dental therapists work in Saskatchewan (n = 60) and Manitoba (n = 22). The majority of COHI dental hygienists providing care are in Ontario (n = 31), Quebec (n = 12) and British Columbia (n = 19). Historically, both the provincial and federal dental therapy training programs were located in Saskatchewan, resulting in a proportionally greater number of dental therapists in the Prairie Provinces, thus contributing to this workforce distribution. Because of provincial regulation restrictions, there are no dental therapists practising in Ontario or Quebec; therefore, dental hygienists administer COHI in these provinces. Currently, there are no training programs for dental therapists in Canada.

DISCUSSION

Around the world, indigenous people with a history of colonization have experienced similar challenges to receiving equitable health care.[13,14] Indigenous people have perceived that they have had little power over their oral health or oral health care-related decisions.[15] Historically, Canadian federal policies have limited the autonomy of FN/I communities in determining and addressing their own health needs.[16,17] In contrast, COHI's continued expansion to over half of the country's 636 Aboriginal communities during the past decade is an example of effective collaboration between FN/I communities and the federal health regions. COHI has avoided the usual fate of a program with limited or short-term funding. Typically, this minimalistic approach does not favor the creation and development of a sustainable program.[18] However, the data demonstrate that once a community implements COHI, it maintains the program over time. Further, there are high participation rates in the program within COHI communities. There is rich cultural, historical and language diversity among FN/I people, thus it is unrealistic to assume a "pan Aboriginal" solution exists to oral health care access. Explaining the success of this collaboration, demonstrating COHI as a viable preventive oral health care delivery model, requires understanding the definition of "community" in Aboriginal culture as well as the concept of "community capacity building."[19]

In Canada, "a First Nations community refers to a relatively small group of Aboriginal people residing in a single locality."[20] The majority of communities in this study are located on federal reserves. Those living on reserves generally share common values, traditions and practices rooted in their ancestral heritage. In Aboriginal cultures, engaging the collective community is essential for decisions that affect the community as a whole.[21] COHI's successful national expansion may partly be attributed to its evolution into a community-centred partnership with the federal government from its origins within the federal dental therapy program. The COHI program was designed to ultimately empower communities by using a participatory planning approach.[19] Participatory community programs are characterized by 1) ownership of the program; 2) community-based identification of the problem; and 3) community-facilitated action and change.[20] The concepts and objectives of COHI are introduced during an initial community meeting at which it is acknowledged that the community is the entity making the informed decision to introduce the program (community ownership). The community must consider its oral health needs and readiness for the program (community identification of the

problem), as well as commit itself to providing structural support for the program in the form of employing and retaining a COHI Aide (community action and change).[22]

An authentic reciprocal relationship evolved between the regional health authorities and the FN/I communities – a top-down commitment from the government to commit the federal funding and workforce support necessary for the goal of improving the oral health of FN/I children, as well as a bottom-up involvement from the communities to achieve and support that objective. The success of COHI's implementation can be attributed to the community assuming control over decisions influencing the oral health of the community. The federal government funds the program, but it is the community that provides the social capital to implement and sustain it.

Community capacity building is the "interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems, and improve or maintain the well-being of that community."[18] A significant component of developing community capacity includes a commitment to employing Aboriginal staff to assist in overcoming the dental issues identified by the community.[23] The COHI aides extended the reach of the program beyond the abilities of externally contracted dental hygienists/therapists. Further, they provided a sustained dental presence in the community. Canada has frequently used dental service providers in FN/I communities who are neither Aboriginal nor from the community in which they are employed.[24] Non-indigenous dental service providers conveying information about oral health are not always easily related to by the indigenous patients using their services.[25] However, the COHI aides can effectively deliver oral health messages because they share a culture and background with the community. This use of community oral health workers to facilitate improvements in the oral health of marginalized populations has been demonstrated in other indigenous populations.[26,27] However, this approach has infrequently been used in addressing oral health issues within Canada's Aboriginal communities. Training COHI aides as community health workers broadens the scope of people who can provide oral health education in the future and builds community capacity.[28]

A limitation of this investigation is that data alone cannot explain the regional variations in the number of communities participating in COHI. However, it can be speculated that the relatively few numbers of COHI communities in the Northern Region may be related to differing health governance processes in the territories versus the provinces. Across Canada, there are inadequate numbers of dental therapists and dental hygienists available to work in remote and isolated communities. This workforce shortage, especially with regard to dental therapists, could have a detrimental effect on the number of communities able to support the implementation of COHI. Budget constraints limit the number of days funded for individual communities to receive visits from an oral health professional. It would be difficult to effectively implement the program in small communities eligible for only 2 or 3 days of dental services per month. Regions may prioritize implementing COHI in remote "fly-in" communities with no other access to preventive dental care or in communities with historically high rates of referral of children for dental treatment with general anesthesia. Dental surgery related to dental caries in early childhood is the most common surgical outpatient procedure in most pediatric and community hospitals in Canada.[29] To date, there has been no examination of the variables that influence a particular community's "readiness" to take ownership of the program. Therefore, because of the diversity of FN/I cultures, regional health authorities may lack clarity about the influences on the process of community empowerment and how to address these barriers in the context of introducing COHI to the community.

The community enrolment and service delivery data demonstrate the success of COHI in improving access to preventive dental care. However, further research is needed to assess the program's impact on reducing levels of dental disease in communities. An investigation using standard epidemiological dental disease indices is in progress. These further outcomes assessments are required to evaluate the comprehensive effectiveness of COHI. Should the intervention prove successful in decreasing dental disease levels as well as improving accessing to preventive dental care, future implications include expanding the program to include more age groups as well as more communities.

CONCLUSION

First Nations and Inuit have historically petitioned for autonomy in managing health services delivery for their communities.[30] The native self-determination movement has resulted in First Nations and Inuit people assuming increasing control over which public health programs to integrate into their communities, as well as respecting the choice of individuals to participate or not. As FN/I organizations increasingly assume responsibility for health services delivery, it is important to support this process by identifying health promotion-disease prevention activities that can be easily and cost-effectively integrated into the new governance system. Oral health care delivery models used in urban regions will not suffice in overcoming the health care challenges of delivering dental care to isolated FN/I communities. The Children's Oral Health Initiative has been shown to be a delivery model that has improved access to preventive oral health services to children.

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RÉSUMÉ

OBJECTIF : L'Initiative en santé buccodentaire des enfants (ISBE) vise à élargir l'accès aux services de santé buccodentaire préventifs offerts aux enfants inuits et des Premières Nations (IPN) vivant dans les réserves fédérales et les communautés éloignées.

PARTICIPANTS : L'ISBE cible les enfants d'âge préscolaire, les enfants de 5 à 7 ans, les femmes enceintes, et les parents et aidants vivant dans les communautés IPN.

LIEU : Mis à l'essai par Santé Canada en 2004, le programme est potentiellement disponible dans toutes les communautés IPN. Toutefois, la communauté doit consentir à la mise en œuvre du programme et accepter de soutenir la formation d'un membre de la communauté comme représentant ou représentante en santé dentaire pour l'ISBE.

INTERVENTION : Des thérapeutes et des hygiénistes dentaires filtrent les enfants admissibles, appliquent un vernis fluoré et un scellant sur les dents des enfants et stabilisent les caries dentaires actives avec du verre ionomère. L'une des innovations du programme a été la création du poste de représentant ou représentante en santé dentaire pour l'ISBE. Cette personne plaide en faveur de la santé buccodentaire préventive dans la communauté et donne des instructions aux enfants, aux parents ou aidants et aux femmes enceintes sur la prévention de la carie dentaire.

RÉSULTATS : L'ISBE a été mise à l'essai dans 41 communautés en 2004. Dix ans plus tard, l'initiative était présente dans 320 communautés IPN, soit 55 % des communautés IPN admissibles. En 2012, 23 085 enfants avaient reçu des services de santé buccodentaire préventifs de l'ISBE.

CONCLUSION : Ces résultats indiquent que l'ISBE est un modèle efficace de prestation de soins buccodentaires préventifs dans les communautés éloignées. La mise en œuvre et la prestation des services de santé buccodentaire préventifs sont rehaussées par la présence continue d'un représentant ou d'une représentante en santé dentaire pour l'ISBE.

MOTS CLÉS : services de santé autochtones; dentisterie pédiatrique; santé buccodentaire; caries dentaires; auxiliaires de santé communautaire