Community Dental Health (2023) **40,** 16–22
Received 3 July 2022; Accepted 11 September 2022
© BASCD 2023
doi:10.1922/CDH_00146Durey07

Reciprocity in the intercultural conference space to improve Aboriginal oral health: A qualitative study

Angela Durey,[1] Nola Naylor[2] and Linda Slack-Smith[1]

[1]School of Population and Global Health, University of Western Australia, Australia; [2]Aboriginal Health Strategy, Clinical Service Planning & Population Health, Fiona Stanley Hospital, Australia

Objectives: Despite high rates of oral disease in Indigenous communities globally, progress is slow in implementing policies and practices so the depth of inequity is addressed and oral health outcomes improve. Indigenous communities are often poorly consulted in the process. This paper responds to this inequity by seeking to create a respectful intercultural space at international dental conferences where Aboriginal health practitioners and dental public health researchers can discuss ways forward for oral health in Indigenous communities. ***Methods***: Participatory action research informed by Indigenist methodologies guided this research. Two roundtable discussions between Australian Aboriginal and non-Aboriginal participants were recorded, transcribed and analysed for themes related to problems and potential solutions to dental disease in Indigenous communities. Follow-up discussions on participants' reflections engaging in this intercultural space were recorded and analysed. ***Results***: Two Aboriginal health practitioners and five non-Aboriginal international dental public health researchers identified the importance of inclusion where intercultural engagement and collaboration with Indigenous Peoples were integral to conducting research in this context and improving oral health outcomes. ***Conclusions***: Creating a safe, respectful space between Aboriginal health practitioners and non-Aboriginal dental public health researchers at an international conference fostered dialogue to better understand barriers and enablers to good oral health outcomes. Intercultural engagement and discussion is a step towards mutual understanding of oral health perspectives and experiences that can foster equity and enable more collaborative responses to improve oral health outcomes.

Keywords: *Conference, qualitative, consumer, equity, indigenous*

Introduction

The ongoing legacy of colonisation and inequitable power relations underpinning health practices have led to worse health outcomes for Indigenous compared to non-Indigenous Peoples (Gone *et al*., 2019; Huria *et al.*, 2019; Tuhiwai Smith, 1999). Health inequities faced by Indigenous communities are multi-factorial and intergenerational, ranging from the loss of culture, lands and identity to socioeconomic and geographical disadvantage (Reynolds, 2014). However, in many colonised countries, the western biomedical culture of health is privileged, and the knowledge, beliefs and values of Indigenous Peoples related to health are often ignored (Tuhiwai Smith, 1999). Tuhiwai Smith (1999) called for a more ethical and respectful approach that increased Indigenous participation and respected and included Indigenous knowledge and priorities in research within a framework of equity.

Napier and colleagues (2014) support Tuhiwai Smith's (1999) claim that when Indigenous cultural beliefs are marginalised or demeaned by the dominant culture, promoting and maintaining health can be eroded, with blame for non-compliance with western treatment regimens often projected onto those who are already disadvantaged.

Current and often costly models of dental care, frequently resulting in late-stage dental treatment rather than prevention, have not led to satisfactory improvement of oral health outcomes at a population level and fail to capitalise on upstream opportunities to prevent disease and promote and sustain oral health (Watt, 2007).

Research has identified that oral disease and access to dental services is a serious problem for Indigenous Peoples globally, including Aboriginal Australians (Durey *et al.*, 2016b; Parker *et al.*, 2010; Slack-Smith *et al.*, 2011). Aboriginal Australians experience greater rates of caries, higher levels of untreated caries, more missing teeth, and poorer periodontal health than non-Aboriginal Australians (Christian and Blinkhorn, 2012; Kapellas *et al.*, 2014). In addition, Aboriginal Australians can experience discrimination when attending health services leading to their reluctance to access care (Durey *et al.*, 2016b; Shahid *et al.*, 2009). To better meet Aboriginal Australians' oral health needs, engaging with the community and focusing on prevention, rather than just treatment of disease needs to be addressed.

The paper presents findings from a qualitative research project that explored creating an intercultural space in a conference setting. The study supported two front-line Australian Aboriginal health practitioners from Perth Western Australia, to participate in an International Association for Dental Research (IADR) conference in San Francisco in 2017 (the site of our study). A core value of the IADR (2023) is social responsibility, to 'improve health and well-being for all People, to reduce health inequalities and inequities, and proactively take actions and positions to improve health'. These values and the recognised need to address Indigenous participation prompted our exploration into considering more innovative and inclusive ways to engage Indigenous stakeholders in decisions about the oral health needs of their communities.

Correspondence to: Prof. Linda Slack-Smith Email: linda.slack-smith@uwa.edu.au

This lack of engagement of Indigenous stakeholders, in this case Aboriginal Australians, in decisions about their oral health was evident from our previous research (Durey *et al.*, 2016a; Durey *et al.*, 2017).

Our project came about following a process of professional intercultural engagement over several years between the Aboriginal and non-Aboriginal authors. Collaborating on various research projects to improve Aboriginal oral health generated a commitment to two-way learning in this intercultural space that led to mutual respect, honesty, the capacity to be reflexive and recognise limitations and a willingness to listen and learn in a mutually supportive environment that allowed trust to develop. (Wilson *et al.*, 2020) The authors collaborated to devise and develop this project this project that included discussions over time with Aboriginal colleagues and members of the project advisory group. Our intention was to create a safe intercultural space at an IADR conference.

This study aimed to explore whether working to create an equitable and respectful intercultural space at an international dental research conference can lead to productive two-way learning and understanding about how to respond to barriers and enablers to oral health in Indigenous communities. We worked with Aboriginal Australian colleagues as one group of Indigenous Peoples in this study. The purpose was to bring international dental public health researchers and front-line Aboriginal health practitioners together in an intercultural space to share their respective knowledge and expertise of Aboriginal health and oral health in ways that were respectful and equitable. Aboriginal knowledge was valued as integral to understanding oral health in a colonised context (Dudgeon and Fielder, 2006; Nakata *et al.*, 2012).

Methods

The principles of participatory action-research (PAR) guided the research and included 'reflection, data collection, and action that aims to improve health and reduce health inequities' (Baum *et al.*, 2006). Funding was obtained to support two Aboriginal community frontline health practitioners to participate in the 2017 IADR Congress. A key activity was to participate in two roundtable discussions with international dental public health researchers in this intercultural space to discuss challenges and potential solutions to the problem of poor oral health in the Aboriginal community. Both Aboriginal participants were invited to participate having worked in senior roles in the Aboriginal health sector for many years. Non-Aboriginal international senior dental public health researchers with backgrounds in oral health in under-served communities, were identified and invited to participate.

Ethics approval to conduct the research was granted from [removed for review as potentially identifying]. Following participants providing informed written consent, two roundtable discussions were organised over lunch at a local restaurant, facilitated, recorded and transcribed by two authors (AD and LS) and imported into NVivo12 to help organise and manage the data for analysis.

We were guided by Nakata et al.'s (2012) research on the 'cultural interface' and Homi Bhaba on 'the third space' (Rutherford, 1990) on how to better engage in this intercultural space when working with Indigenous Peoples in a colonised country. It is the space where different cultures meet, a liminal space between cultures, often contested and uncomfortable yet with the potential for participants from different cultures to come together, listen and share knowledge and experience. Avoiding binary positioning, where each defends their world view and opposes the other, can assist this and prevent shutting down inquiry. Instead, creating a space where neither culture is dominant and participants from each culture listen to, acknowledge and respond to the other so two-way learning can develop as they share the space together in ways that are respectful and equitable. (Nakata *et al.*, 2012; Rutherford, 1990).

However, sharing this space can be confronting, risky and unsettling as participants may be resistant and experience tension communicating cross-culturally. Learning how to be together differently in ways that are not restrictive but inclusive and expansive can open up the potential for new understandings, identities and positions to emerge (Nakata *et al.*, 2012; Rutherford, 1990). This is particularly pertinent in colonised countries where inequitable power relations have systematically devalued and marginalised Aboriginal knowledge and continue to negatively impact on health outcomes for Aboriginal Peoples (Moreton Robinson, 2000; Pease, 2010). Adopting a de-colonisation approach recognises and re-values Aboriginal knowledge and culture in ways that can positively impact on Aboriginal health and wellbeing (Chandler and Lalonde, 1998; Moreton Robinson, 2000).

We adopted a Yarning approach, a method used to gather data in Indigenist research. Yarning is an 'informal and relaxed discussion through which both the researcher and participant journey together visiting places and topics of interest relevant to the research study' (Bessarab and Ng'andu, 2010). Each participant introduced themselves and their professional background at the start of the discussion to help build rapport in this intercultural space and explore what Aboriginal participants wanted to learn from the dental public health researchers, as advised by their community members, and what international dental researchers wanted to learn about the Aboriginal context in relation to oral health.

Non-Aboriginal participants were then followed up via email for their reflections on engaging in the discussions and sharing knowledge about Aboriginal oral health. Questions included key areas of importance from the discussion and whether they had learnt anything new. Both Aboriginal participants agreed to take part in a joint interview about their reflections on the discussions which were recorded and transcribed following informed written consent.

A line-by-line analysis of the transcripts of the discussions and reflections identified key themes and noted similarities and differences in responses. Data were reviewed and discussed between the researchers and any sub-themes noted under the key themes. This iterative process permitted review and revision of findings and interpretations to ensure consistency and quality until consensus was reached (Bazeley, 2009). Findings from the reflections also indicated whether shared learning in the intercultural space was experienced as equitable and cultural differences respected. Participants were de-identified where quotes referred to Aboriginal participants as AP 1-2 and International Dental Researcher - IDR 1-5.

Results

Two roundtable discussions/Yarning sessions lasting around 60 minutes each were held over lunch at a location adjacent to the conference venue with five international dental public health researchers – two from the UK, one from New Zealand, one from the US and one from Canada. An additional brief discussion was held with another senior dental researcher from the US studying Latino oral health. Three of the non-Aboriginal participants (US, New Zealand and Canada) had conducted research in Indigenous oral health contexts.

The overall response from international participants for the initiative was positive – '*an amazing start – but we needed more time'*. The discussion provided a unique opportunity to meet and share knowledge and experience from different international perspectives that revealed similarities in key barriers and enablers to improving, not just oral health in Aboriginal communities, but also in other communities disadvantaged socioeconomically. There were also frustrations that dental research and practice often focused on the minutiae of treatment rather than big picture social determinants such as poverty that negatively impact oral health outcomes of Indigenous communities. Participants considered that ideas for how to resolve some of these issues required lateral thinking that, in the case of children's oral health, could focus more on parent issues and locus of control rather than specifically oral health.

The results are organised into categories of barriers and ideas for improving oral health in the Aboriginal community followed by a summary of participants' reflections on participating in this initiative. This will include the overall outcome of working in the intercultural space.

Barriers

Structural and organisational barriers

Key barriers identified in the discussion related to the limited recognition given by the dental profession to structural issues such as poverty negatively affecting oral health outcomes in Aboriginal communities.

> *For me when I have seen the problems with affording good food is an issue, you might want to have fresh fruit and veg to feed the family, but a packet of biscuits or chips is cheaper, quicker, easier to keep someone quiet.* (IDR2)

One participant highlighted that some Indigenous Peoples in the US experience high levels of unemployment, alcohol abuse, violence, limited access to healthy diet and low incomes, factors not dissimilar to those in some Indigenous communities in Australia and Canada. Access to education about prevention was frequently non-existent and attending dental services was often difficult when appointments were mandatory and lacked flexibility despite attendance challenges for community members due to distance, transport and cost.

> *If they have to travel 50 miles to get to the Indian health service office what I was observing that drives me mad is that you have to have an appointment, you can't just drop in, and if you don't have a car and you have to travel there and you have to borrow a car and then something happens and you can't get the car, well, you go to the bottom of the list again so it might* be *months before you can get another appointment*. (IDR5)

Another participant commented that despite large amounts of money being poured into oral health in Indigenous communities:

> *…all that investment, planning and consultation and still the disease process gets worse.* (IDR4)

High rates of dental caries associated with sugar consumption are presented as risk factors yet sugary food and drinks are heavily promoted in advertising, raising ethical questions about their detrimental effect on health outcomes. In some countries there has been a push to remove vending machines containing sugary drinks from schools, but challenges persist.

> *The schools were so reluctant, you could see the health benefits of water for the children. But to buy the gym equipment to keep their bodies healthy with exercise, they need the income from the vending machines.* (IDR2)

The response to whether dental public health researchers had a role in advocating for policies to reduce sugar consumption was met with the reality they confronted with a multi-million dollar '*sugar industry [as] a huge lobby*'. Discussion instead considered that:

> *…public policy is essential, but we can't sit around and wait for it to change.* (IDR3)

While government policy documents are often replete with good intentions to improve oral health in Aboriginal communities, (Centre for Oral Health Strategy, 2014; WA Department of Health, 2016) progress in implementing practice is slow and risk factors persist (Butten *et al.*, 2018). Empowering Indigenous communities to have more agency in how to address the problem is important and shifts the narrative from a top-down process with little or no consultation with the community.

> *I think it is still really important to help empower the people who are being affected by this to resist it and come up with their own strategy. I come back to the whole strategy that we need to listen to what the communities are saying.* (IDR3)

Yet, in the context of a conference, this was challenging given the overall focus of research in presentations:

> *I have been walking up and down and most of these people have been doing very intensive, micro level stuff. They don't quite see the bigger picture. And if you look on the street, you see the reality of poverty, drugs, mental illness and most of the researchers don't get that in terms of the work.* (IDR4)

There was also frustration at the short-term rather than longer term focus on sustainable interventions. Another participant suggested that the problem might also lie in the lack of rigorous assessment and '*iterative participatory evaluation'* of current interventions:

> *People are publishing a 'show and tell – this is what we did in our community' but there is very little evaluative data that you can then use to move it forward.* (IDR3)

This raised the issue of accountability about whether a program or intervention was successful in achieving its aims, in the short or long-term. This was considered important in terms of local reach and broader application to other contexts. One Aboriginal participant noted the lack of coordination between agencies and programs often resulted in duplication of programs that suggests

a structural and organisational problem adding to the oppression rather than addressing closing the gap in dental health.

> *I think we have a lot of programs in the Aboriginal community. A lot of times there is [duplication]and funding is given to different agencies or organisations, and they are doing the same thing. It is a matter of making it work a little bit smarter. So, looking at where the programs are and how to work with other people to get the most out of them for our community.* (AP1)

Another key barrier raised was the lack of culturally respectful care of Aboriginal Australians, which was a common theme across nations represented in the discussion.

Culturally safe care

Some participants discussed the inter-generational effects of trauma as an ongoing legacy of colonisation and discrimination leading some Indigenous Peoples' reluctance to attend dental services that are not welcoming nor felt culturally safe. The Aboriginal participants offered some context about these effects that often led to mistrust of mainstream health services:

> *We also have the Stolen Generation in Australia where a lot of children were taken away from their families to missions. A lot of the now grandmothers who were taken away were sexually abused so do not trust the white person and the stories go down from daughter to daughter to granddaughter. And that keeps the stories going, so they think going to see a GP or a dentist and especially if it is a male practitioner, they won't go. So, a lot of them will look around to see where there is a female GP or dentist or allied health practitioner. There is a lot of trust that needs to be brought back.* (AP2)

This suggests that some dental services were not culturally safe and failed to understand this and other factors preventing access. These included expectations for community members to make appointments to attend the service rather than the service having a more flexible approach to appointments. This seemed particularly relevant given the lived experience of some Aboriginal community members with competing demands on limited funds and unreliable access to transport, often leading to non-attendance.

While Aotearoa/New Zealand's embedding of cultural safety into their dental curriculum had positive outcomes where students engaged early with Māori communities and health services, other countries have limited or non-existent opportunities or material in their curricula to learn about what constitutes culturally safe and respectful care of their Indigenous Peoples.

Enablers

Key enablers to improving oral heath in Aboriginal contexts included the importance of consulting with, and listening to Aboriginal communities and adapting policy and practice interventions to the local context; involving consumers in an iterative evaluation of oral health programs so they can be modified along the way to ensure they are effective in different settings. Other enablers included minimising poverty as a risk factor to oral health, a focus on prevention, including success stories about effective ways to engage Indigenous Peoples and thinking creatively about solutions to improving oral health.

Community engagement and participation in promoting oral health

Participants expressed their frustration and discouragement at the slow progress in improving oral health in Indigenous communities, despite extensive efforts. Participants noted that the current one size fits all approach had not been effective, whereas actively involving marginalised local communities in decisions related to their oral health, including around education, was effective.

> *…community workers from within the areas where there was the worst poverty and the highest level of oral disease. It was they who were delivering the messages, bottom up and it was very successful, and it reduced a lot of inequalities.* (IDR2)

This approach not only recognised the strengths within local communities but also built their capacity in oral health and preventing disease in the long-term. It also targeted efforts towards the needs of the local community, including around cultural appropriateness, rather than a one-size-fits-all model. This more tailored approach respected the lived experience and agency of such communities and in ways that understood:

> *… their fear, and the resistance and what do they think we should do about it.* (IDR3)

This community centred, participatory approach to evaluating the project at various stages of implementation identified what is and is not working with opportunities to *'tweak it'* along the way to be more effective.

While participants did highlight the need to address structural issues such as poverty and families being able to afford a healthy diet and dental care, addressing the problem from other perspectives was also important.

Prevention and lateral thinking

One participant considered a strengths-based approach, with a focus on prevention and factors that facilitated success and offset the usual deficit approach where the focus was always on problems.

> *I've often thought it would be great to go to high schools and start at that level with people before they have even started thinking about becoming parents, about educating them and how they would look after a child's teeth and hygiene in general so bringing the mouth back into the body.* (IDR2)

Rather than focus on the problem, one participant had interrogated their research results where a minority of children in an Indigenous community had no cavities. While no differences in income or education of parents were detected as to why they were cavity free, variations were found in locus of control. Those parents with more sense of control in their parenting:

> *… tended to say that oral health was more important than the parents of the kids who did have caries.* (IDR5)

This raises questions about the role of broader social and psychological issues of Indigenous parents' responses to their children's oral health, factors influencing their choices and how to facilitate that sense of coherence and locus of control. Participants discussed that focusing on building self-esteem and parenting skills that includes oral health care, might empower parents and would-be parents to access dental care and:

...understand that they are valued and have as much right as anyone else to access services. (AP1)

Reflections and the intercultural space

Four of six non-Aboriginal participants and both Aboriginal participants offered their reflections on the roundtable discussions in the intercultural space. Key themes emerging in all responses were that discussions were engaging, informative and worthwhile, an initiative that '*planted a seed*' opening the door to '*future opportunities'*. The value of this approach and the process of coming together was noted:

A few of the things we spoke about might be difficult to find in any written format such as publications or on the web such as the initial barriers to projects that had to be overcome. (IDR2)

An opportunity to share 'campfire stories' where we all talk, listen and learn. (IDR1)

And the discussions with the dental experts, I really liked how it was done, like a Yarning session. (AP2)

Despite only '*touching the surface'* and '*needing more time'* to explore issues, all participants appreciated the opportunity to listen and learn about each other's contexts and experiences, noting similarities and differences between Aboriginal and other cultural groups across nations. Both Aboriginal participants found the discussions and the overall conference a positive experience, expanding their understanding of the importance of oral health in primary health care and positioning Aboriginal oral health within a broader global perspective. One participant noted that in other colonised countries:

... consulting with the community needs to happen more. It is good to hear other countries that are doing that. (AP2)

Even though one Aboriginal participant was initially apprehensive about the discussions, both appreciated the interactions and felt respected:

It was comfortable but at the same time I knew there was a little bit of pressure to talk. (AP1)

It made me feel comfortable anyway just sitting down and Yarning with them. ... And knowing they wanted to come and have lunch with us made me feel more relaxed as well, not us chasing after them for when they are ready. They come to lunch with us. (AP2)

Instead of Aboriginal knowledge being devalued and marginalised, it was acknowledged and respected, leaving Aboriginal participants with a sense of:

... going back to our community feeling empowered and knowledgeable ... and more directed in a way about what can be done. (AP1)

Discussion

All participants valued the opportunity to come together in this intercultural conference space to discuss oral health in Indigenous communities, with a focus on Aboriginal Australians. The discussion gave international dental researchers first-hand knowledge of the lived experience of Aboriginal Australians and the barriers they can face accessing education and treatment for dental disease and hearing their suggestions for potential solutions. It also gave the Aboriginal participants the opportunity to engage in a safe and respectful space where their knowledge and experiences were heard and valued. Their responses reflected the value of Yarning in creating an informal atmosphere where Aboriginal voices are validated and participants felt safe to express their ideas and experiences, share their knowledge and learn from each other. (Bessarab and Ng'andu, 2010).

Structural and organisational issues featured strongly in the findings and included issues such as poverty, unemployment, violence and limited availability of oral health education that impacted, not just on oral health but also on access to services for Indigenous Peoples. Organisational barriers included dental services in some colonised countries responding insensitively to the socioeconomic and cultural context of Indigenous Peoples and their often-reduced capacity to access care. This included limited if any flexibility around appointment times of services, a focus on expensive treatment, generally out of reach for many, rather than on prevention, and a lack of awareness that many Indigenous People wanting care may not have access to transport. Services' failure to recognise the intersection of culture and socioeconomic context with structural and organisational factors can undermine and compound poor health outcomes (Napier *et al.*, 2014).

Findings raised ethical questions about the negative effect on health outcomes, including oral health, of the sugar industry often targeting children when advertising sugar sweetened beverages and food (Ju *et al.*, 2019; Moynihan and Miller, 2020). This was concerning when schools were reluctant to remove vending machines selling sugar sweetened beverages because the income was used to buy sports equipment. As noted by one participant, despite substantial financial investment into Aboriginal oral health, outcomes have not improved overall. According to participants, a top-down process and one-size-fits-all approach has been the norm with limited if any consultation with local Aboriginal communities about how to address the issue more effectively. Little if any education and training for dental practitioners in delivering services in culturally safe ways in some countries is an issue. According to one participant, the conference seemed not to address these issues with a focus more on treatment and '*intensive micro level stuff'*.

Suggestions to improve oral health centred around consulting with, including, and empowering Indigenous communities in decisions about their oral health. Fostering a sense of agency for the person seeking care reflects the concept of patient centre care, defined as: 'Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions' (Scambler *et al.*, 2016). This approach disrupts the narrative of a top-down, standardised model where patients are expected to adapt to the needs of the organisation by, for example adhering to a rigid appointment system. Instead, it offers a flexible and targeted approach that meets the needs of the local context and community.

The discussion gave international dental researchers first-hand knowledge of the lived experience of Aboriginal Australians and the barriers they face accessing education and treatment for dental disease and hearing their suggestions for potential solutions. Dental practitioners with knowledge of the local Aboriginal context and lived experience who include patients in decisions about their oral health not only reflected the principles of patient

centred care but were more likely to build relationships and promote oral health in ways that are non-judgemental, respectful and likely to increase Aboriginal Australians' trust and future access to services. This patient-centred approach also offered opportunities for the dental and Aboriginal community sectors not just to work together to build local oral health capacity, but also to think creatively about broader issues such as parenting skills and self-efficacy as a strategy to promote better oral health outcomes.

Conferences have traditionally provided a communal space for academics and other stakeholders including policymakers and practitioners (generally the privileged) to share knowledge, present their findings, build relationships and augment their status. (Nicolson, 2017) However, findings may take years to reach Indigenous (and in this case Aboriginal) communities and for policies and practices to be implemented so health outcomes improve. Hence a potential location for this intercultural engagement is at an oral health conference. The likely beneficiaries of research, in this case Indigenous Peoples, are often not included despite the potential for intercultural discussions to increase understanding of what is needed to improve oral health outcomes in this context. The lack of inclusion can inadvertently reinforce the health inequities that such conferences often seek to address (Durey *et al.*, 2016b; Nicolson, 2017).

Some have argued that conferences are elitist and benefit the privileged rather than the disadvantaged groups they research (Urry, 2007). However, guided by theory of the intercultural space, this project has demonstrated that creating a safe and non-judgemental space between Indigenous and non-Indigenous cultures at an international conference fostered dialogue in a spirit of shared inquiry. Thus, there may be thoughtful ways to assist in creating an intercultural space at conferences such as facilitated small group engagement. This discussion led to increased awareness about what works and the barriers to oral health in Indigenous communities at systemic and clinical levels, including the idea of conducting iterative evaluations of interventions with the community to ensure they were achieving their aims to improve oral health outcomes (Nakata *et al.*, 2012; Rutherford, 1990). As a result of these activities, we went on to host two of the participants for three visits to Perth during which we held informal roundtables with Aboriginal colleagues to continue discussions, inform practice and build relationships.

The study has limitations. The context specific and time-limited design and the targeted yet small number of participants indicate that findings may not be generalised to other settings. However, the study did reflect the advantages of bringing Indigenous and non-Indigenous participants together to engage in a reciprocal exchange at an international conference on issues related to oral health in an intercultural space.

This project benefited from the extensive experience and knowledge of a select group of participants in their respective cultures and professions who were prepared to contribute to a discussion about the barriers and enablers to oral health in Indigenous communities at an international conference. While the findings reflect participants' individual perceptions, experiences and interpretations of oral health in Indigenous communities, they raise important ongoing questions for researchers, dental practitioners and policy makers to consider at conferences and beyond. These include how best to respond to a) systemic barriers and enablers to improving oral health in Indigenous communities and b) providing appropriate opportunities at international conferences to engage Indigenous Peoples in discussions and decisions about improving their oral health. Collaborating with Indigenous Peoples to incorporate their perspectives and experience related to oral health is essential if problems are to be addressed within a framework of health equity.

Acknowledgement

The authors acknowledge funding from the University of Western Australia Research Impact Grant and support from International Association of Dental Research Regional Development Program. We extend sincere thanks to the participants who gave their time willingly to participate in the project and our project advisory group for valued advice.

References

Adelson, N. (2005): The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health* **96**, S45-S61.

Albino, J.E. and Orlando, V.A. (2010): Promising directions for caries prevention with American Indian and Alaska Native children. *International Dental Journal* **60**, 216-222.

Anderson, P. (2021): *How respecting rights, respecting the evidence and respecting each other can make change happen*. Congress Lowitja, Melbourne.

Ashcroft, R. (2010): Health inequities: Evaluation of two paradigms. *Health and Social Work* **35**, 249-256.

Baum, F., MacDougall, C. and Smith, D. (2006): Participatory action research. *Journal of Epidemiology and Community Health* **60**, 854-857.

Bazeley, P. (2009): Analysing qualitative data: More than 'identiying themes'. *The Malaysian Journal of Qualitative Research* **2**, 6-22.

Bessarab, D. and Ng'andu, B. (2010): Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies* **3**, 37-50.

Broughton, J. (2010): An oral health intervention for the Māori indigenous population of New Zealand: Oranga niho Māori (Māori oral health) as a component of the undergraduate dental curriculum in New Zealand. *International Dental Journal* **60**, 223-228.

Butten, K., Johnson, N., Hall, K., Anderson, J., Toombs, M., King, N. and O'Grady, K. (2018): Risk factors for oral health in young, urban, Aboriginal and Torres Strait Islander children. *Australian Dental Journal* **64**, 72-81.

Chandler, M. and Lalonde, C. (1998): Cultural continuity as a hedge against suicide in Canada's Indigenouss. *Transcultural Psychiatry* **35**, 191-219.

Christian, B. and Blinkhorn, A. (2012): A review of dental caries in Australian Aboriginal children: The health inequalities perspective. *Rural Remote Health* **12**, 2032.

Delbridge, R., Garvey, L., Mackelprang, J., Cassar, N., Ward-Pahl, E., Egan, M. and Williams, A. (2021): Working at a cultural interface: Co-creating Aboriginal health curriculum for health professions. *Higher Education Research & Development* **9**, 1-16.

Dudgeon, P. and Fielder, J. (2006): Third spaces within tertiary spaces: Indigenous Australian studies. *Journal of Community & Applied Social Psychology* **16**, 396-409.

Durey, A. (2010): Reducing racism in Indigenous health care in Australia: Where does cultural education fit? *Australian and New Zealand Journal of Public Health* **34**, S87-92.

Durey, A., McAullay, D., Gibson, B.J. and Slack-Smith, L. (2016a): Aboriginal health worker perceptions of oral health: A qualitative study in Perth, Western Australia. *International Journal for Equity in Health* **15**, 4.

Durey, A., McAullay, D., Gibson, B.J. and Slack-Smith, L. (2017): Oral health in young Australian Aboriginal children: Qualitative research on parents' perspective. *Journal Dental Research: Clinical and Translational Research* **2**, 38-47.

Durey, A., McEvoy, S., Swift-Otero, V., Taylor, K., Katzenellenbogen, J. and Bessarab, D. (2016b): Improving healthcare for Aboriginal Australians through effective engagement between community and health services. *BMC Health Services Research* **16**.

Gone, J.P., Hartmann, W.E., Pomerville, A., Wendt, D.C., Klem, S.H., & Burrage, R.L. (2019): The impact of historical trauma on health outcomes for indigenous populations in the USA and Canada: A systematic review. *American Psychologist* **74**, 20.

Huria, T., Palmer, S., Pitama, S., Beckert, L., Lacey, C., Ewen, S. and Tuhiwai Smith, L. (2019): Consolidated criteria for strengthening reporting of health research involving indigenous poeples: The CONSIDER statement. *BMC Medical Research Methodology* **19**, 173.

International Association for Dental Research (2023): *Who we are.* IADR, Georgia. https://www.iadr.org/about/who-we-are-0

Jamieson, L., Haag, D., Schuch, H., Kapellas, K., Arantes, R. and Thomson, W.M. (2020): Indigenous oral health inequalities at an international level: A commentary. *International Journal of Environmental Research and Public Health* **17**, 3958.

Ju, X., Do, L., Ha, D. and Jamieson, L. (2019): Association of modifiable risk factors with dental caries among Indigenous and nonindigenous children in Australia. *JAMA Network Open.* **2**, e193466.

Kapellas, K., Skilton, M., Maple-Brown, L., Do, L., Bartold, P., O'Dea, K., Brown, A., Celermajer, D. and Jamieson, L. (2014): Periodontal disease and dental caries among Indigenous Australians living in the Northern Territory, Australia. *Australian Dental Journal* **59**, 93-99.

Moreton Robinson, A. (2000): *Talkin' up to the white woman: Indigenous women and feminism*. Brisbane, University of Queensland Press.

Moynihan, P. and Miller, C. (2020): Beyond the chair: Public health and governmental measures to tackle sugar. *Journal of Dental Research* **99**, 871-876.

Nakata, M., Nakata, V., Keech, S. and Bolt, R. (2012): Decolonial goals and pedagogies for Indigenous studies. *Decolonization: Indigeneity, Education & Society* **1**, 120-140.

Napier, A., Ancarno, C., Butler, B. Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., Jadhav, S., Macdonald, A., Neuendorf, U., Parkhurst, A., Reynolds, R., Scambler, G., Shamdasani, S., Zafer, S., Stougaard-Nielsen, J., Thomson, L., Tyler, N., Volkmann, A-M., Walker, T., Watson, J., de C Williams, A., Willott, C., Wilson, J. and Woolf, K. (2014): Culture and health. *Lancet* **384**, 1607-1639.

Nicolson, D. (2017): *Academic conferences as neoliberal commodities* Basingstoke UK: Palgrave Macmillan

Parker, E., Jamieson, L., Broughton, J., Albino, J., Lawrence, H. and Roberts-Thomson, K. (2010): The oral health of Indigenous children: A review of four nations. *Journal of Paediatrics and Child Health* **46**, 483-486.

Parker, M. and Weik, E. (2014): Free spirits? The academic on the aeroplane. *Management Learning* **45**, 167-181.

Pease, B. (2010): *Undoing privilege: Unearned advantage in a divided world. London*. London: Zed Books.

Petti, S. (2010): Why guidelines for early childhood caries prevention could be ineffective amongst children at high risk. *Journal of Dentistry* **38**, 946-955.

Reynolds, H. (2014): Action and anxiety: The long history of settler protest about the nature of Australian colonization. *Settler Colonial Studies* **4**, 334-339

Rutherford, J. (1990): The third space. Interview with Homi Bhabha. In, *Identity: Community, Culture, Difference*. ed. Rutherford, J. London: Lawrence and Wishart.

Scambler, S., Delgado, M. and Asimakopoulou, K. (2016): Defining patient-centred care in dentistry? A systematic review of the dental literature. *British Dental Journal* **8**, 477-484.

Shahid, S., Finn, L. and Thompson, S. (2009): Barriers to participation of Aboriginal people in cancer care: Communication in the hospital setting. *Medical Journal of Australia* **190**, 574-579.

Sischo, L. and Broder, H. (2011): Oral health-related quality of life: What, why, how, and future implications. *Journal of Dental Research* **90**, 1264-1270.

Slack-Smith, L., Read, A., Colvin, L., Leonard, H., Kilpatrick, N., McAullay, D. and Messer, L. (2011): Total population investigation of dental hospitalizations in Indigenous children under five years in Western Australia using linked data. *Australian Dental Journal* **56**, 358-364.

The Centre for Oral Health Strategy (2014). NSW Aboriginal oral health plan 2014–2020. Sydney, NSW Ministry of Health.

Tudor Hart, J. (1971): Inverse care law. *Lancet* February, 405-412.

Tuhiwai Smith, L. (1999): *Decolonising methodologies: Research and indigenous PeoplesPeoples.* London: Zed Books.

Urry, J. (2007): *Mobilities*. Cambridge: Polity Press.

WA Department of Health (2016). State oral health plan 2016–2020. Perth, WA, Office of the Chief Dental Officer, Clinical Services and Research, Department of Health.

Watt, R.G. (2007): From victim blaming to upstream action: Tackling the social determinants of oral health inequalities. *Community Dentistry and Oral Epidemiology* **35**, 1-11.

Wilson, A., Kelly, J., Jones, M., O'Donnell, K., Wilson, S., Tonkin, W. and Margarey, A. (2020): Working together in Aboriginal health: A framework to guide health professional practice. *BMC Health Services Research* **20**, 601.