Access to oral health care for people living with HIV/AIDS attending a community-based program

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PRACTICAL IMPLICATIONS OF THIS RESEARCH

- Dental professionals need to recognize and address the influence of socioeconomic status, HIV-related stigma, and histories of trauma on the ability of people living with HIV/AIDS (PLWHA) to access oral health care.
- Dental curricula should provide comprehensive education on the history, background, and issues related to HIV and provide hands-on experience interacting with PLWHA with emphasis on a trauma-informed care approach.

ABSTRACT

Objective: People living with HIV/AIDS (PLWHA) have difficulty accessing oral health services primarily due to HIV-related stigma and discrimination. In 2011, the University of British Columbia (UBC) Dental Hygiene Degree Program implemented a preventive oral health services program at the Positive Living Society of British Columbia (PLSBC), a non-profit organization supporting PLWHA. This study aims to assess the perception of how this type of service delivery influenced access to oral health care for members of PLSBC. **Methods:** Personal interviews with 10 members and one focus group comprising 12 staff were conducted. Audiorecordings were transcribed verbatim and coded thematically. Emerging themes were identified using the interpretative phenomenology approach following Penchansky and Thomas' theory of access. **Results:** The program helped members maximize their dental coverage to receive other types of dental services. Members who were influenced by past traumatic experiences appreciated that services were delivered in a safe manner and in a stigma-free setting. Members valued the opportunity to educate future dental professionals to reduce HIV-related stigma. However, dental needs that could not be addressed by the program remained untreated for some members who continued to face barriers to care at referral clinics. **Conclusion:** This community-based preventive dental program provided affordable dental care, a stigma-free setting, care delivered in a safe manner, an educational opportunity, and accessible location, which all seemed to have a positive influence on access to oral health care for members of PLSBC. However, the limited availability of the program prevented many members from accessing comprehensive oral health care and is a factor that should be addressed.

RÉSUMÉ

Objectif : Les gens qui vivent avec le VIH/SIDA (GVAVS) ont de la difficulté à accéder à des services de santé buccodentaire, principalement en raison de la stigmatisation et de la discrimination associées au VIH. En 2011, le Programme de baccalauréat en hygiène dentaire de l'Université de la Colombie-Britannique (UBC) a mis en place un programme de services de santé buccodentaire préventifs à la Positive Living Society of British Columbia (PLSBC), un organisme sans but lucratif soutenant les GVAVS. La présente étude vise à évaluer la perception de la façon dont ce type de prestation de service a influencé l'accès aux soins de santé buccodentaire pour les membres de la PLSBC. **Méthodologie :** Des entrevues personnelles ont été menées avec 10 membres et un groupe de discussion comprenant 12 membres du personnel. Les enregistrements sonores ont été transcrits mot à mot et codés par thème. Des thèmes émergents ont été ciblés au moyen de l'approche phénoménologique et interprétative, fondée sur la théorie sur l'accès de Penchansky et Thomas. **Résultats :** Le programme a aidé les membres à maximiser leur couverture dentaire afin de pouvoir recevoir d'autres types de services dentaires. Les membres qui ont été influencés par des expériences traumatiques précédentes ont été reconnaissants que les services aient été fournis de façon sécuritaire et dans un milieu exempt de stigmatisation. Les membres ont aimé avoir l'occasion d'éduquer les futurs professionnels dentaires en vue de réduire la stigmatisation liée au VIH. Cependant, les besoins dentaires qui ne pouvaient pas être satisfaits par le programme sont demeurés non traités pour certains membres qui ont continué à faire face à des obstacles en matière de soins aux cliniques de renvois. **Conclusion :** Ce programme dentaire préventif offert en milieu communautaire fournit des soins dentaires à prix abordables, un milieu libre de stigmatisation, des soins offerts de manière sécuritaire, une occasion de formation et un emplacement accessible, qui semblent tous avoir une influence positive sur l'accès aux soins de santé buccodentaire des membres de la PLSBC. Cependant, l'accessibilité limitée du programme a empêché plusieurs membres d'avoir accès à des soins de santé buccodentaire complets et cela est un élément qui doit être abordé.

Keywords: access, community-based preventive dental program, HIV/AIDS, oral health care, people living with HIV/AIDS, stigma
CDHA Research Agenda category: access to care and unmet needs

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INTRODUCTION

The Public Health Agency of Canada estimated that approximately 63,110 Canadians were living with HIV at the end of 2016.[1] The rate of HIV diagnoses in British Columbia was 5.1 per 100,000 persons in 2016, consistent with the rate in 2015.[2]

Antiretroviral therapy (ART) offers the potential of lifelong viral suppression of HIV; people living with HIV/AIDS (PLWHA) who receive this therapy can expect to have a longer lifespan.[3] The initiation of ART has caused a dramatic decline in the prevalence of HIV-associated oral lesions.[4] Yet the prolonged use of ART and a recovered immune system put PLWHA at risk of developing oral mucosal hyperpigmentation, oral dryness, parotid gland enlargement, and human papilloma virus (HPV)-associated oral warts.[4-6] Given the increased risk of oral complications, it is important that PLWHA receive routine oral assessments and care.[7]

However, dental services to specifically address the needs of PLWHA are sparse in British Columbia[8,9] and elsewhere[10,11] despite the prevalence of unmet dental treatment needs.[8-11] This situation is in part due to HIV-related stigma that remains one of the major challenges for PLWHA when accessing needed care because of fears of disclosure, discriminating acts, and social exclusion.[12,13] Moreover, PLWHA may include marginalized intersectional groups such as racial or ethnic minorities, substance users, the precariously housed, and those living with mental illness, who often experience oral health inequities.[14] Additional barriers that PLWHA may face when accessing oral health care include disability, chronic illness, addiction, poverty, confidentiality-related issues, lack of access to support services, and limited oral health literacy.[15,16]

The Positive Living Society of British Columbia (PLSBC) is a non-profit organization that advocates the rights of their members living with HIV/AIDS.[17] In September 2011, a weekly preventive dental clinic was launched in collaboration with the University of British Columbia (UBC) Dental Hygiene Degree Program (DHDP) at PLSBC. Through this community-engaged program, 4th-year dental hygiene students delivered preventive oral health services for 6 hours each week throughout the year, including assessments, periodontal therapy, fluoride applications, sealants, temporary restorations, education, and referrals for dental treatment.

Students also undertook various activities such as working in the onsite food bank, conducting lunch-and-learn sessions, and participating in fundraising activities with organization members to gain a deeper understanding of the sociocultural background and issues related to HIV. In preparation for working with this population and organization, students were required to complete a 6-hour online trauma-informed care course, a 2-hour violence and prevention course, and six 3-hour classroom sessions on the management of vulnerable populations. Students also completed a 3-hour online module about HIV and oral health supplemented by personal testimonials from PLWHA guest lecturers. This study aims to assess the perception of how the type of service delivery provided by the students influenced access to oral health care for members of PLSBC.

METHODS

Data collection

Upon ethics approval from the UBC Behavioural Research Ethics Board (BREB H17-02457), members of PLSBC who had availed of the program were recruited to participate in personal interviews to elicit insight into their experience accessing Canada's oral health care system and this community-based program. Inclusion criteria required participants to be a past or current client of the program, an ability to communicate in English, and a commitment to a 1-hour, face-to-face interview. Recruitment posters outlining details of the study and interview were placed on bulletin boards and in visible areas at PLSBC, and a Can$25 honorarium was offered for participation. Ten individual interviews were conducted between January and May 2018 following a semistructured interview guide. Interview questions pertained to members' past dental experiences outside the program, members' experiences using the program, and members' satisfaction and suggested improvements.

The focus group comprised 12 PLSBC staff and administrative personnel, who were recruited by 2 collaborators because of their perceived insight into how the program influenced access to oral health care for members. Participants in the focus group had a different perspective, serving as staff or administrative personnel at the organization, which added richness to the data and provided broader suggestions for improving the current program. Characteristics of members and the positions of staff who participated in the study are found in Tables 1 and 2.

Analysis and theoretical framework

Following each interview and after the focus group session, the audiorecording was transcribed verbatim. Each transcript was read multiple times and coded thematically using N-Vivo® 11 software. Rigour was reached by employing reflexivity, data saturation, and member checking in order to reduce subjectivity and achieve the standards of ethics and quality in qualitative research. Coding and emerging thematic analysis were completed accordingly for each interview and the focus group using the interpretative phenomenology approach with Penchansky and Thomas' concept of access as the framework.[18] This framework defined access as 5 interlocking dimensions to the relationship between the client and health care system on individual terms (Table 3).[19]

An iterative and systematic approach was used to construct codes, categories, and themes. Three authors (IF,

Table 1. Demographic characteristics of members participating in personal interviews

Member	Gender	Age	Area of residence[a]	Year diagnosed with HIV	Number of medications	Occupation	Duration using program (years)
1	M	54	DT	2007	1	Retired	3
2	M	65	DT	1991	3	Retired	1
3	M	40	DT	2011	2	Unemployed	2
4	M	65	DT	1989	15 to 20	Retired	7
5	M	69	Surrey	2007	4	Retired	2
6	M	45	DTES	2001	2	Part-time jobs	2
7	M	56	New Westminster	1994	2	PLSBC staff	1
8	M	53	DT	1993	0	Training manager	2
9	F	48	DT	1995	3	Unemployed	5
10	M	50	DT	1997	1	Part-time jobs	6

[a]DT = Downtown Vancouver; DTES = Downtown Eastside Vancouver

MB, LD) each coded the same interview, and 2 authors (IF, LD) then coded 3 of the same interviews which were then compared and discussed until consensus was reached. The remaining 6 interviews and the focus group session were coded by the first author (IF). A total of 99 codes were assigned to statements that were relevant to the research question, then sorted into 18 categories that described an aspect of the phenomenon. Similar categories were grouped into 11 themes and structured into the 5 domains of access described ahead.

RESULTS

Affordability

Under- and unemployment

Under- and unemployment were significant barriers to dental care for some members who were struggling financially. Some members described coping with the complex medical issues related to HIV and the difficulty of working full time and earning a stable income. Some members also identified competing needs, such as for food, shelter, and clothing, which take priority over their dental care. As member 3 shared, "I have $1,100 every month to pay for my rent, food, medications, and vitamins."

While dental care was deemed important, members stated they sought dental care only when perceived as needed or under emergency circumstances. Members who were unable to afford dental care continually described how they often avoided dental care:

> *The only concern I had with dental care is that I had to pay for it, because I have been fully employed, but then I wasn't covered with the dental plan. So I had to pay for it, the things out of my own pocket, these dental services. (member 1)*

It was clear that members had difficulty obtaining oral health care due to cost, which proved to be one of the main reasons for accessing and valuing the program. The program was an opportunity for many members who were underinsured to receive some preventive dental care with little impact on other life priorities.

Limits of public benefits

Members who were unable to afford dental care directly out-of-pocket often relied on publicly funded dental benefits. The Government of British Columbia's Ministry of Social Development and Social Innovation (now the Ministry of Social Development and Poverty Reduction) offers public dental benefits up to a maximum of $1,000 over 2 calendar years for residents who are eligible for financial assistance.[20] Unfortunately this amount of dental funding was often not enough to meet the dental care needs of members, as described by member 4:

> *I've been on disability and we're limited to about one thousand every 2 years paid for by the government. When you start putting 6 cleanings over 2 years, that takes up more than half of your [dental benefits], and I was always needing fillings or bridges or a root canal.*

Given this limited dental coverage, "having [the program] augments whatever service [members] are going to get based on coverage" (staff K). Both members and staff discussed that, because the oral care was delivered free of charge, it allowed members to earmark their limited dental benefits for other dental services.

Table 2. PLSBC staff and administration who participated in the focus group

Position	Staff ID
Administrator	A B D J K L
Peer navigator	C G I
Coordinator	E F H

Table 3. Penchansky and Thomas' proposed dimensions of access[19]

Dimension	Description
Accessibility	The relationship between the location of supply resources and the client.
Accommodation	How supply resources are organized and tailored to the client's needs
Affordability	The set of prices the client is required to pay for specific services.
Availability	The type of existing services that meet the client's needs.
Acceptability	The client's attitudes towards and preference for the personal and practice characteristics of the provider, also referring to the client's social and cultural beliefs to accept aspects of the service delivered.

Acceptability

Importance of trauma-informed care

Throughout the interviews, a prominent theme was the influence of trauma in members' lives, from issues related to HIV disclosure, perceived stigma and discrimination, to traumatic dental experiences. This theme highlighted the need for dental providers to be trained in trauma-informed care (TIC), as staff G suggested, to mitigate further trauma among members:

> *Trauma-informed care teaches how some people have traumatic experiences in their lives that could easily be triggered by things we might take for granted...So things like trust, safety, communicating well with your patient, those kinds of things are really important for people who are carrying trauma around.*

Members described various traumatic experiences from their personal lives to being newly diagnosed as HIV positive. They recalled the complication in disclosing their HIV serostatus to their previous dental providers. As member 8, who struggled with his decision, explained:

> *[I felt] mad, embarrassed...You just don't want to tell anybody for the fear of not getting looked after. But it also puts everybody at risk if they don't know...because if you tell [them] you don't get the service, and if you don't tell them you put them at risk. So I never went to the dentist.*

Some members also experience trauma through perceived stigma as described by member 5:

> *It was just walking in and everybody was rosy...I fill out the form, and I checked off the HIV box. I don't know if they've ever had that box checked off before in front of them...it was like they were triple gloved. And she went into shock. I could see it in her eyes...It was almost a frightening experience.*

The multiple forms of trauma described specifically influenced the acceptability of a dental provider. The onset of dental fear seemed to be related to individual vulnerability, traumatic dental experiences or perceived threat, as with the experience of member 2 who avoided dental visits for a long time after his extraction:

> *"[The dentist] had me back in a chair, he had his knee on my chest, he had both hands on the puller, and whipped my head back and forth trying to get this tooth out."*

Members had their own way to deal with their trauma; one coping mechanism was to seek care from dental providers who exhibited specific attributes in order to prevent further trauma when receiving future dental care.

HIV knowledge and sensitivity

Members seemed to emphasize the need for dental providers to be knowledgeable in all aspects of HIV. While staff and members recognized the program provided access to preventive oral care and education, they also believed there to be a reciprocal opportunity to educate future dental providers. It was interesting that members 5, 8, and 9, in particular, identified the value of the opportunity to help students understand the impact of HIV. In fact, member 5 stated this was his primary reason for using the program:

> *This younger generation is learning...Those are my biggest reasons for coming to this program. I feel all these dental hygienists should be exposed to HIV and what the protocol is, because obviously some people don't. It's one thing to*

> *say, "Oh we learned about it in school." It's another thing to say, "Yeah I actually worked on people with HIV and it's not a big issue."*

The program was an educational opportunity for some, helping to remove the fear students may have had about PLWHA through interacting and learning cultural sensitivity early on in their practice. Both groups indicated that the more educated a dental provider was about HIV, the more likely members felt comfortable and safe, and would return to that same provider.

Non-discriminatory attitude

Comments about the way students treated members was another recurring theme, especially that students treated them "like any other normal human being" (member 8). Members believed the students and instructor displayed characteristics such as compassion, earnestness, and genuine care towards them as member 1 praised, "I was always impressed with the courtesy, the manners, the grace with all the students and coordinators." The students' education and volunteer activities may have helped them to overcome HIV-related fear, prejudice or misconceptions, thus developing empathy towards members that allowed them to have a non-discriminatory approach to care. Staff K noted:

> *the students would interact with the members in the lounge, which I thought was an amazing experience...Not only it educates the students, but the members. The young professionals are looking out for them...and are concerned about them.*

Informative and attentive

Throughout the interviews, members also commented that the care students provided was "extremely informative, nice, and made [members] feel at ease" (member 7). For instance, students took the time to inform members of the assessments and procedures they were doing as member 2 noted:

> *[The student] was thorough, she was gentle, she talked me through it, "This is what I'm going to do, that's what I'm going to do, this is why I'm going to do it."*

This approach and the personalized attention that members received appeared to build a positive relationship and trust while encouraging members to actively engage in managing their oral health.

Accessibility

Location and service convenience

The PLSBC facility was originally located in Vancouver's central business district, known as Downtown Vancouver. From 2015 to 2017, the facility was under construction and moved to the Downtown Eastside of Vancouver (DTES), a community known to struggle with issues of drug use, crime, poverty, mental illness, homelessness, and unemployment.[20] PLSBC returned to its location in Downtown Vancouver in September 2017.

Members commented on the convenience of traveling to the Downtown Vancouver location in particular because of the transit options. As member 7 said, "it's just that [the DTES], it's kind of out of the way, it's off. [Downtown Vancouver] is pretty direct with your Sky Train then you take a bus. Whereas [the DTES], Sky Trains are not that close." In addition, the Downtown Vancouver location allowed members to access a variety of health and social services conveniently because of their close proximity to each other. The Downtown Vancouver location "is more in a service corridor. Members can go to St. Paul's Hospitals, mental health, a doctor's appointment at Spectrum, and they're on the bus line. Everything is close to here" (staff B). There is also a variety of services offered at PLSBC, which enhanced the convenience of services accessible within the organization. Finally, the travel distance was also emphasized as an important consideration, with the Downtown Vancouver location being more favourable. It was not surprising to hear that the more convenient and closer the location, the more likely members were to make efforts to seek oral health care.

Accommodation

Self-disclosure of HIV status

The clinic was able to reach out to the HIV community thanks to the integration of the program at PLSBC. The location of the dental program and the requirement that members of the organization be HIV positive meant that disclosure of HIV serostatus was eliminated, which was an important factor in utilization of services from the clinic as staff K stated, "of course the whole idea is that you don't have to disclose here. It's sort of given for our members, that everyone here is HIV positive. There isn't that one last hurdle to get over." Member 10 also indicated that "I would prefer to stay [at the program] because I know I'm not going to be discriminated and be looked at as a freak." Consequently, the collaboration with PLSBC may have been one of the largest facilitators to access to the dental services provided by this program as it may have been perceived as more approachable and non-stigmatizing than other clinics.

Duration of appointment

Each appointment at the clinic can take up to 2 hours for students to complete, and it was anticipated that this 2-hour time period would be a detriment to the program. Yet, it seemed the extended appointment time permitted members to feel more at ease and relaxed as staff L commented, "A lot of our [members] like that the students

take longer because it gives them a couple of hours to lay down and relax and have someone focus on caring for them." Members further elaborated that they believed the 2-hour appointment time allowed students to dedicate more time to personal attention, interaction, and education with them, characteristics which were favoured as member 7 expressed:

> *You've got 2 hours so [the students] do a lot... they're checking your pulse...checking for bumps...She's found something on the back of my ear that could potentially be a problem, or maybe not, but alerted me to another health issue that might be happening.*

The positive feedback of a longer appointment indicated that this may be a more appropriate approach for community-based programs such as this one, considering this client pool may have experienced various life challenges and trauma, and appreciated the greater amount of time dedicated to their care and interaction.

Facility design

The program provided manual periodontal therapy on massage tables due to an inability to maintain infection control and the limited space provided at the facility. The majority of members described the experience as varying from comfortable to stiff to strange. As member 4 stated, "even now that we are in the new building, we are still on massage benches here with your head tipped over. That's okay. I don't mind that at all. In fact, it's kind of restful."

Members who did not find comfort with the massage chairs, however, came to moderate their view. As member 8 said, "it would be nice to have a couple of dental chairs instead of beds... but the space is fine and it is what it is." Similar to various responses received about the massage chairs, some members noted the benefits to having power equipment available for better comfort and ease such as member 7 who indicated, "you don't have the rinsing spit sink you know...I did have water, but I did need to spit it out into another cup. So that's just one difference, but I don't mind the little hand tools."

It appeared this type of facility and equipment set-up created a non-intimidating, quiet environment that allowed members to feel more relaxed as compared to settings with high-tech equipment that produced a "functioning noise...and made [members] more alert" (member 7). Many members were in favour of this casual setting without dental equipment because "[members] have [their] own intimidation of a sterilized dental office with all those drill sounds and all the compressors going" (staff E). Furthermore, as this client pool is more likely to have experienced trauma, removing triggers and creating a quiet comfortable setting may have been beneficial in managing PLWHA in this type of setting.

Availability

Addressing immediate dental needs

As part of the students' education, they were required to manage their community-based program. Some members found the appointment system a negative aspect of the program due to the lack of immediate contact and availability. A phone number was designated to contact the students, and members were required to leave messages on the answering machine when the program was not operating, as staff D described:

> *Some members have commented that they never get to speak directly to an individual whenever they call. So it's usually a follow-up call. It's very rare [members and the students] make first contact when dialing the dental clinic.*

In addition, the program only operated from 10 in the morning until 4 in the afternoon on Wednesdays during the school year with several appointments arranged during the summer. Due to the program's operational time and appointment system, immediate dental needs from members could often not be met. Members also had to adjust their schedule and book in advance to receive their services in a timely manner. Although Wednesday hours of operation worked well for members who were retired, unemployed or volunteered, the program was not available to those who worked on Wednesdays and needed the income.

However, the program's flexibility and the ability to drop in for appointments or to inquire about resources prior to booking an appointment was perceived as a positive aspect of the clinic. As member 4 stated, "the program has an open door. So if I need to change something, I can always come down and knock on their door." It was clear that this program was readily available to meet the dental needs of members who were active within PLSBC and willing to work with how the program was set up according to the students' curriculum. This program did not seem to have the capacity to serve members who required urgent dental care and those who were unable to commit to program operation hours and dates.

Referrals

When the need for dental treatment was identified and/or the member was in pain, completed referrals were given to regular and reduced cost dental clinics in the Vancouver area so that radiographs could be taken and restorative care provided as indicated. Personal interviews revealed that some members already had a dental office they visited regularly, while other perceived regular dental care as unnecessary; most could not afford further dental care. Before the program was implemented, members 4 and 9 indicated that they did inquire into affordable dental care at PLSBC. Staff G, one of the peer navigators who helped members search for services such as housing, employment, and government funding, commented that before the

program, "many [members] came to [the organization] asking how [staff] can look after these things. Because dental is one of the hardest things to get covered. Even with people on those benefits, it's incredibly limited." With the referrals provided by the program, staff noted it had helped to increase dental resources for the organization and helped members navigate the dental system.

DISCUSSION

The aim of this study was to assess the perceptions of how this community-based preventive dental program influenced access to dental care for members of PLSBC. Thematic analysis showed that affordable preventive dental care, stigma-free setting, care delivered in a safe manner, educational opportunity, and accessible location were positive influences while the limited availability of oral care appointment times may have caused members to become lost in comprehensive care.

The majority of the members interviewed were often under- or unemployed which caused them to struggle financially to address their dental needs under Canada's oral health care system. Members stated that they would avoid dental visits if they had competing financial priorities, similar to Jessani et al. who found that more than half of the PLWHA participants faced challenges associated with access to food, housing, transportation, clothing, and dental coverage.[13] This program addressed the members' financial challenges by offering preventive services without out-of-pocket expenses or the need to draw on their limited dental benefits. The affordability of the services offered at the clinic was one of the main reasons members initially came to the clinic and continue to do so.

Many members described how their past traumatic dental experiences affected how they accessed dental care. This came as no surprise as perceived discrimination and HIV-related stigma are often associated with lower access and usage of health and social services.[13,22,23] Due to the influence of individualized vulnerability and trauma, members required a trauma-informed care (TIC) approach to care in order to promote safety, trust, empowerment, respect, and resiliency.[24] Clients are more likely to engage actively and return for care when trust is established.[25-27] Therefore, the ongoing interaction and the personal characteristics, attitudes, and behaviour of the students and the instructor seemed to be well accepted by members, which influenced their desire to access the clinic.

The clinic setting also seemed to have complied with the standards of TIC to help members feel safe, and to have influenced the acceptability and accommodation dimensions of access. The onset of dental anxiety and trauma can be triggered through sensory experiences, such as the unpleasant sound of dental drills, sensation of high-frequency vibrations or sight of anaesthetic needles.[28] Therefore, the reduction of dental stimuli, triggers, and noise, as well as the atypical setting and design of the clinic may have established a non-threatening, quiet, and casual environment.

The collaboration with PLSBC was essential in reaching PLWHA who were registered and familiar with the organization. As the clinic was only available to members, HIV disclosure was not required, which eliminated the perception of stigma and discrimination. The location of the clinic within PLSBC also enabled emotionally safe access to preventive dental services and accommodated the unique needs of PLWHA. Multidisciplinary clinics have been described as an innovative strategy for establishing a medical home with access to multiple health services for PLWHA.[29] It seemed that PLSBC offered sufficient resources to meet the overall needs of members, non-medical and medical, to support their overall health which may have further encouraged members to utilize the clinic and enhanced the availability.

The program was described as convenient for the majority of members to travel to thanks to various transit options, the proximity to their home, and easy access to other services that were situated in the area.[19] In contrast, transportation and services were limited at the DTES and may have reduced the accessibility of the clinic for members.

Some members took the opportunity to help reduce HIV stigma among future dental hygienists. The ability to educate students and faculty about their lived experience of HIV and dental care was described as empowering. This finding is in line with other academic curricula that provide HIV education and training for medical, dental or dental hygiene students in order to improve cultural competency with an increased compassion and empathy for providing client-centred care for PLWHA.[30-32]

Lastly, previous studies have reported that roughly half of their participants who are living with HIV have unmet dental treatment needs.[8-11] The program's lack of available dental services, flexible operation times, and direct contact could not serve members who were either unable to attend on the program dates and times or required immediate dental care. Although the program provided referrals to help increase dental resources and assist members in navigating the dental system, members would be required to approach an unfamiliar dental clinic and dental professional, with the perceived possibility of experiencing discrimination. Members may have been lost during the referral care process due to lack of priority or the interrelated dimensions of access as previously discussed.

Implications and recommendations

Findings highlight some key implications for dental providers. Results indicate that there is a need to be mindful of the socioeconomic status of PLWHA and the limitations of their government funded dental benefits in order for dental providers to work effectively with their clients and their benefit providers. Additional advocacy efforts by policy makers, HIV-specific organizations, and dental

providers may encourage a more equitable reimbursement scheme for PLWHA to promote increased access to more affordable care. It is also important for dental providers to be aware of the types of trauma that PLWHA have encountered during their life, from their diagnosis to societal stigma and discrimination. The experience of trauma had a direct influence on how participants viewed oral health and their propensity to seek care. A TIC delivery approach is necessary for PLWHA to feel comfortable, safe, and respected in a dental setting. Finally, it is important that dental providers be knowledgeable about more than just the clinical manifestations of HIV. Education and training should be delivered to future dental professionals, with an emphasis on the history of HIV and HIV-related stigma. The acquired understanding appeared to have influenced the way services were delivered to the members and created desirable characteristics among the students.

It is recommended that there be increased collaboration, more active involvement, and communication with PLSBC staff to address the limited availability of the program. Peer navigators may be in a position to guide and provide resources for members when the clinic is not operating. The program needs to improve upon finding members an appropriate dental home that meets their personal needs in order to improve overall access to oral health care for members.

Limitations

The findings that describe the health and oral health status of the population at PLSBC cannot be generalized to all PLWHA living in Canada due to the small convenience sample of members who participated in the personal interviews. The experiences of PLWHA who are hard to reach, who live outside the Greater Vancouver area, are not registered with the organization, are a past user or discontinued the program were not captured. The feedback did not represent all members who utilized the clinic and may have produced biased responses from those who were satisfied and continued to use the program. While our findings may not be generalizable due to these limitations, the themes may be transferable to a similar population or organization and should be further investigated in a larger, more representative sample of PLWHA.

CONCLUSION

The ongoing free services and education delivered through this community-based preventive dental program appear to have multiple influences on access to oral health care for members of PLSBC. Embedding the program within a HIV-specific organization removed the fear of stigma and discrimination. Members felt empowered to break the societal stigma of HIV through the opportunity to interact and educate future dental professionals about issues that are important in their lives. Finally, the manner in which the services were delivered and the characteristics of the providers encouraged members to continue participating in the program. While many positive influences on access to oral health care were identified, access to comprehensive oral care appeared to need improvement.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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