Indigenous oral health equity: The path forward

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ABSTRACT

Objective: This narrative review explores current research on Indigenous oral health equity (OHE) and proposes a framework and strategies to guide registered dental hygienists in addressing OHE and health disparities experienced by Indigenous Peoples. **Methods:** An electronic literature search was performed using PubMed and Google Scholar. Full-text, peer-reviewed articles, written in English, and published in Canada within the last 10 years were selected for the review. The relevant grey literature was also included to ensure Indigenous perspectives relating to oral health inequity in Canada were considered and to increase the utility of the proposed strategies. Included articles were analyzed for themes. **Results:** Ten articles and 6 publications from the grey literature met the inclusion criteria. **Discussion:** The framework has 4 elements: policy driven changes to dental hygiene regulation, relationship building and allyship, workforce development, and research and education. Strategies within the framework can assist dental hygienists in adapting their approaches to oral health care delivery with Indigenous Peoples and promote OHE by providing inclusive and culturally safer care. **Conclusion:** Indigenous people throughout Canada have the right to safe oral health care, and dental hygienists can use this framework and these recommendations to promote Indigenous OHE.

PRACTICAL IMPLICATIONS OF THIS RESEARCH

- Improving Indigenous oral health requires an understanding of the structures, social processes, and root causes associated with oral health disparities.
- Dental hygienists, with their focus on oral health promotion and disease prevention, are ideally situated within the health care system to advance oral health equity.
- Four key elements identified by this review provide a framework for strategies that can be implemented by dental hygienists to advance oral health equity for Canada's Indigenous Peoples.

RÉSUMÉ

Objectifs : Cet examen narratif explore la recherche actuelle sur l'équité en santé buccodentaire (ESB) autochtone et propose un cadre et des stratégies pour guider les hygiénistes dentaires autorisés à traiter l'ESB et les disparités en matière de santé auxquelles font face les Autochtones. **Méthodes :** Une recherche documentaire électronique a été effectuée à l'aide de PubMed et de Google Scholar. On a sélectionné des articles en texte intégral, évalués par des pairs, rédigés en anglais et publiés au Canada au cours des 10 dernières années. La littérature grise pertinente a aussi été retenue pour veiller à ce que les perspectives autochtones relatives à l'iniquité en matière de santé buccodentaire au Canada soient prises en compte et pour accroître l'utilité des stratégies proposées. Une analyse thématique des articles retenus a été effectuée. **Résultats :** Dix articles et six publications de la littérature grise répondaient aux critères d'inclusion. **Discussion :** Le cadre comporte 4 éléments : les changements politiques dans la réglementation de l'hygiène dentaire, le renforcement des relations et des alliances, le perfectionnement de la main-d'œuvre, et la recherche et l'éducation. Les stratégies du cadre peuvent aider les hygiénistes dentaires à adapter leurs approches de la prestation de soins buccodentaires chez les peuples autochtones et à promouvoir l'ESB en fournissant des soins inclusifs et plus adaptés à la réalité culturelle. **Conclusion :** Les peuples autochtones du Canada ont droit à des soins buccodentaires sécuritaires, et les hygiénistes dentaires peuvent utiliser ce cadre et ces recommandations pour promouvoir l'ESB autochtone.

Keywords: cultural safety; dental hygiene; health equity; Indigenous Peoples; oral health equity; primary care
CDHA Research Agenda category: access to care and unmet needs

The term Indigenous describes First Nations, Inuit, and Métis peoples/Nations/communities in Canada, each of which is culturally diverse and distinct. The term Indigenous will be used throughout the article unless the literature cited is specific to one of these Peoples. All efforts have been made to capture the perspectives of each of these diverse and distinct peoples/Nations/communities in the article.

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BACKGROUND

Interrupting historical and ongoing colonial structures that perpetuate health disparities such as lower life expectancy, higher infant mortality, diabetes and cancer rates, and poorer oral health for Indigenous Peoples in Canada requires collective action by all health care providers.[1–7] Registered dental hygienists are ideally situated within the health system to advance oral health equity (OHE) as they are cost-effective oral health professionals who focus on oral health promotion and disease prevention.[8] However, policies and concerted strategies are needed to advance this idea. Given the importance of oral health to physical and psychosocial well-being and the longstanding inequalities experienced by Indigenous Peoples related to accessing oral health care and correlated negative health outcomes, accelerating the integration of these strategies is crucial. Strategies that address structural barriers to oral care services, improve clinical interventions,[9,10] and prepare the dental hygiene workforce to deliver culturally safer care can promote Indigenous OHE[11–14]. This review was undertaken to develop a framework and recommendations for dental hygienists that could optimize their scope of practice, influence practices across the continuum of care, promote health, and address health inequities. In alignment with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), Article 23, which outlines Indigenous peoples' right to optimal health including the self-determination of health initiatives, and the *Truth and Reconciliation Commission of Canada: Calls to Action*, implementation of any strategies requires consultation with Indigenous peoples and the communities for whom these strategies are intended.[6,15] As such, the framework and recommendations provide a starting point for action.

The World Health Organization (WHO) defines oral health as "the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment."[16 p1] OHE refers to the right of every individual to have access to safe oral health care services to achieve the healthiest mouth possible, free from pain and disease.[17] UNDRIP Article 24 affirms that health equity is a right for all Indigenous peoples[15]—a principle reaffirmed by the calls to action made by Canada's Truth and Reconciliation Commission (TRC)[6].

Recognition that some people must overcome more obstacles and have fewer resources when trying to be healthy must underpin any initiative aimed at rectifying gaps in health care.[5,17] As such, prior to embarking on any strategy with Indigenous Peoples, it is important to acknowledge the ongoing contemporary policies that perpetuate oral health inequity and the cruel and inadequate oral health care that was provided to Indigenous Peoples in the past. This historical fact continues to impact survivors and their descendants, inducing patterns of avoidance and fear which perpetuate oral health inequities.[9–14,18,19] Achieving OHE for Indigenous Peoples in Canada requires improvements in social situations with a focus on self-determination, Indigenization of research and education, and social justice.[1,3,16,20–22]

The intergenerational impact of colonialism and the ongoing legacy of residential schools are significant social determinants of health affecting Indigenous Peoples.[5,23] This should be considered in all encounters with Indigenous people. Further, health care providers must recognize that each Nation defined within the term Indigenous will experience the variable intricacies of historical and ongoing colonialism differently. For example, the Métis Peoples of Canada have traditionally been excluded from federal health benefits,[24] while the extraordinary inflated cost of living in the high north makes it virtually impossible for Inuit Peoples residing in that region to consistently access nutritious foods such as fruits and vegetables.[3] Therefore, recognizing the social and structural determinants of health and rectifying the damages created by both historical and contemporary colonial processes and policies are crucial to any equity strategy.[6,21]

Worldwide, the burden of oral disease weighs heavily on Indigenous populations.[16] There are links between oral health inequities experienced by Indigenous Peoples and the growing gaps in their life expectancy when compared to all other Canadians.[25–27] Many First Nations' cultures recognize 4 phases of life—child, youth, adult, and elder—and that oral health impacts individuals in each of these phases of life. For example, a person's ability to eat and speak, and their level of self-confidence and joy are affected by their oral health status.[1,28] In Canada, Indigenous children have rates of early childhood caries as high as 90% compared to the national average rate of less than 5%.[29,30] These oral health inequities present early in life and impact Indigenous Peoples' health throughout their entire lives.[16] This situation can potentially exacerbate existing health disparities through intersections with nutritional deficits, decreased quality of life, and increased isolation in the elderly phase of life.[1,31]

There are more than 30,000 registered dental hygienists in Canada working in private practice, public health, hospitals, long-term care, education, research, and dental industries.[8] All of these dental hygienists received education from accredited programs and are licensed by their provincial or territorial regulatory body.[32] These regulatory bodies protect the public by ensuring that all dental hygienists meet the practice standards for safe and competent oral health care, and provide practice support through education and policy. Recognizing oral health inequity, some provincial regulatory bodies have mandated cultural safety training for dental hygienists, yet the standardization of these programs and the efficacy of the training have not been adequately studied.

Additionally, the clinical integration of this education to ensure sustainable knowledge transfer and practice change requires further attention.

The Government of Canada invests over $200 million annually in oral health care for First Nations and Inuit Peoples through the Non-Insured Health Benefit program (NIHB) and the Children's Oral Health Initiative (COHI).[9] Yet the success of these programs in improving oral health is questionable and the government's strategic plan to reduce oral health inequities has yet to be finalized.[9] To ensure that these resources achieve their desired outcomes, the oral health professional workforce and strategies that specifically address OHE must be developed. OHE can be effectively guided through a framework that acknowledges colonialism and structural determinants of health. Additionally, deficit-based discourses that dominate health research and equity strategies[7,14,33] must be countered and replaced with data from Indigenous research methods and discourses on successful implementation of services that promote culturally safe health care, including oral health programming.[1,3,11,34]

METHODS

An electronic search of the literature was conducted using PubMed and Google Scholar to locate articles that would provide evidence to inform the development of a framework and recommendations that could be used by dental hygienists to promote OHE. The following terms were used to search for relevant literature: Indigenous, Aboriginal, First Nations, dental hygiene, nursing, public health, primary care, oral health, reconciliation, calls to action, health equity, oral health equity, and cultural safety. Reference lists were scanned to find additional relevant articles. For this narrative review, all types of journal articles were reviewed, and only full-text, peer-reviewed literature was included. To keep the focus on current Canadian health equity approaches and shifts in research methods with Indigenous groups, research performed outside of Canada and prior to 2015 was excluded from the results. Articles were also excluded if they discussed health equity in built environments, health equity economics or did not relate to the review topic. Additionally, grey literature was included to add breadth to the writing and ensure inclusion of Indigenous perspectives. A narrative review format was chosen for its practical application to health education and research. Narrative review methods permit the inclusion of a wide variety of studies and are suitable for topics such as OHE that are under-researched. This method permits a range of interpretations and critiques to yield a summary and thus the proposed framework.[35]

RESULTS

A total of 35 articles were found and 10[11,21,36–43] were included based on their relevance to oral health care settings, such as primary and public health settings, and their introduction of a health equity framework or model. There is a paucity of Canadian research on Indigenous OHE, therefore OHE literature that considered the general population was also included. Grey literature[1,3,5,9,22,44] from Canadian sources was included. All 3 authors were involved in synthesizing the 10 included articles and the grey literature for recurrent structures and processes that address OHE. Through discussion and an iterative process, 4 themes were identified, which became the 4 elements of a framework for strategies that can be implemented by dental hygienists to promote OHE (Figure 1).

DISCUSSION

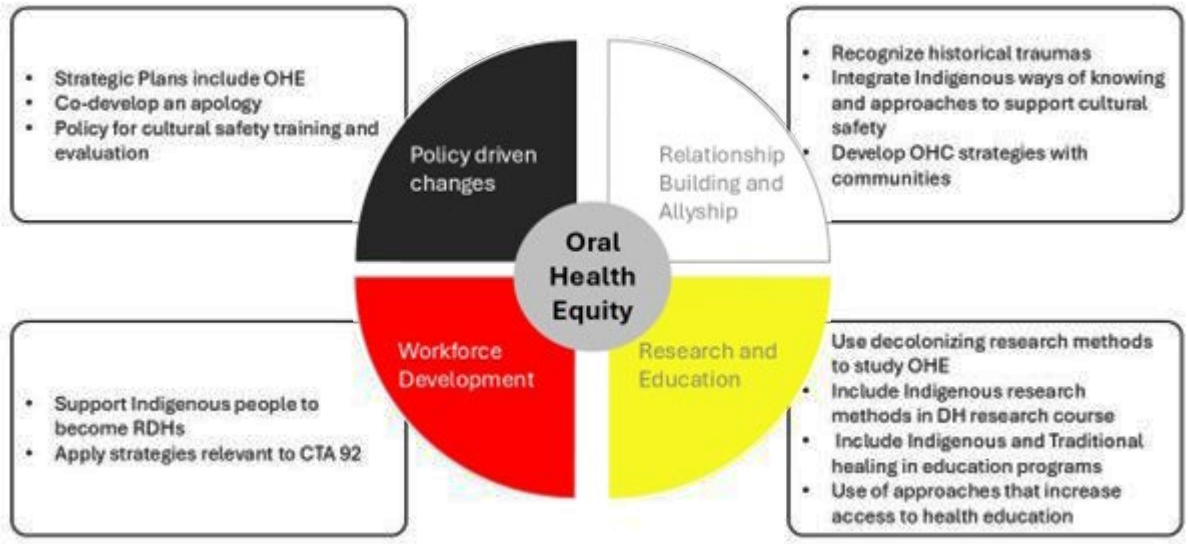
Improving Indigenous oral health requires an understanding of the structures, social processes, and root causes associated with oral health disparities. From synthesizing the 10 included articles and the grey literature for recurrent structures and processes that address OHE, 4 elements were identified and used to create a framework for strategies that can be implemented by dental hygienists to promote OHE. The 4 elements to the framework are as follows: 1) policy driven changes to dental hygiene regulation; 2) relationship building and allyship; 3) workforce development; and 4) oral health research. Specific strategies associated with each of the elements of the framework are proposed to accelerate health system transformation and promote OHE (Figure 1). This discussion supports the important work outlined by the Canadian Dental Hygienists Association related to advocacy for policy to address health equity[45] and provides pragmatic strategies that can be implemented by individual dental hygienists and those leading dental hygiene education, health systems, and professional bodies.

Policy-driven changes to dental hygiene regulation

The causes of inequities in oral health for Indigenous Peoples are complex and require policy that not only recognizes the historical and ongoing structural determinants of health, but also promotes health system transformation.[5,37,38,40,46] Improving structural and systemic issues can increase access to safe and effective oral health care. Dental hygiene regulatory bodies, professional organizations, and policy makers must ensure that their strategic plans and policies include OHE and that actions to improve OHE are informed by Indigenous Peoples.[40] Explicitly naming health equity as a goal in strategic plans and evaluating equity outcomes must be a priority.[37]

Health care workers can take it upon themselves to champion the implementation of health equity policy initiatives within their organizations.[37] Being an advocate for improvements in health equity can induce a wave of change within an organization and can prompt those in formal leadership positions to prioritize health equity initiatives.[37,43] For example, dental hygienists can encourage their workplace settings to find solutions to allow for direct billing to NIHB and to participate in the Canadian Dental Care Plan (CDCP) to ensure dental health coverage for all eligible individuals.

Figure 1. Framework and strategies to achieve Indigenous oral health equity



The TRC[6] is clear that the truth must be told before reconciliation can be achieved. Dental hygienists and their regulatory bodies can advocate and collaborate with other oral health professionals and organizations, such as the Canadian Dental Association, on the development of a position statement that acknowledges and apologizes to Canada's Indigenous Peoples for inadequate and cruel oral health practices. This action will lay the groundwork required for new pathways, while demonstrating humility and a commitment to change. The British Columbia College of Oral Health Professionals has set an example for other oral health regulators in Canada by releasing a joint statement of apology and commitment to action as they work towards reconciliation and healing.[47]

To align with TRC Call to Action 23iii, which calls upon all levels of government to provide cultural competency training for all health care professionals,[6] all dental hygiene regulatory bodies should have a policy requiring dental hygienists to take Indigenous cultural safety training. The effectiveness of this training should also be evaluated.[6] Calls to provide cultural competence training for dental hygienists predate the TRC[48] and were reinforced again in 2018[49]. Approaches to health equity training that promote cultural safety rather than cultural competency have been challenged, and researchers recommend cultural safety training that critiques the implicit power structures present at both individual and organizational levels.[12] Cultural competence involves having knowledge, skills, and attitudes to reduce the number of assumptions and biases to effectively and respectfully work with people from diverse backgrounds[50] but it fails to address structural barriers that result in differential access to care. Cultural safety, in contrast, is an outcome of care, and the recipient of care is the sole evaluator as to whether cultural safety was achieved. Cultural safety is achieved by the application of relevant approaches, including equity-oriented strategies, in therapeutic interactions with Indigenous Peoples.[51]

Given the persistent equity issues experienced by Indigenous Peoples, there is an urgent need for policy and action to systematically implement cultural safety education for dental hygiene students and practicing clinicians. A scan of dental hygiene regulatory body policies across Canada shows varying degrees of cultural safety requirements for registrants. Many of the regulatory colleges are in the early stages of Indigenous cultural safety training, with Manitoba and British Columbia leading this movement. Dental hygienists who wish to promote cultural safety training in their workplace can draw on their professional code of ethics[52] to gain traction and support from administrators. The code, which states, "Dental hygienists provide services to clients in a caring manner with respect for their individual needs, values, culture, safety and life circumstances, and in recognition of their inherent dignity,"[52 p5] can be leveraged. Effective Indigenous cultural safety training will strengthen a dental hygienist's ability to advocate by building awareness and spur the transformative change required to advance Indigenous OHE. Farmer et al. noted, when exploring the role of dental hygienists in reducing oral health disparities, that "a unified voice and a cohesive action plan is needed for the profession to fully embrace their role."[40 p1]

Relationship building and allyship

Integrating Indigenous ways of knowing with self-

determination and culturally safer care can guide relationship building and allyship. Allyship refers to non-Indigenous people's recognizing their privileges, taking intentional steps towards educating themselves and self-reflecting, and using strategies that support health equity in their organizations.[21,37] Non-Indigenous dental hygienists can become allies in their oral health practice settings and strive to create an inclusive environment for Indigenous people who access care.[39] Dental hygienists must be aware of privileges, professional power, and biases that shape their perceptions of Indigenous Peoples and be mindful of cognitive processes that influence therapeutic encounters which can inadvertently reinforce barriers to care.

Recognizing and acknowledging that, historically, oral healthcare for Canada's Indigenous Peoples was inadequate and cruel is a crucial step towards building positive relationships.[18] Dental extractions were performed without proper instruments and with no regard for pain management. For the survivors and their descendants, this type of treatment has led to physical and psychological trauma and has contributed to fear and the avoidance of any form of oral healthcare.[18] Systemic racism that sustains health inequities must be dismantled, and there must be an ideological shift from a biomedical model towards one that acts on the SDoH.[3,5,24,38] Oral health care that addresses the harms of systemic and structural racism and colonial processes will help improve OHE for Indigenous Peoples.[6] Dental hygienists implementing health equity initiatives within their practice settings must have the courage to challenge organizational norms.[38] They can critically appraise their actions and practice reflexivity to ensure that their good intentions have their desired impact.[20,41,46]

Improving OHE also requires trust.[43] Relationships that are built through integrative community-based primary care enhance overall health care within the community and can assist in building trust. An example of efforts to implement these collaborations is found in Cree communities in Northern Quebec, where wellness centres integrate general medicine, home care, oral health care, and social services under one roof.[53] Dental hygienists in these programs provide services in the wellness centre and at the community's schools and daycares.[53]

Concrete strategies such as those proposed by the Inuit Tapiriit Kanatami[44] can also be used by dental hygienists. For example, including the family in oral health education and disease prevention and considering Traditional food sources (e.g., wild/game meats, fish) can help build connections between healthy food choices and better oral health. Reasons for oral health challenges and the content of health education must be considered through trusting relationships between dental hygienists and Indigenous people, and with consideration for the intergenerational trauma stemming from colonization and the residential school system. Relationship building and trust are enhanced by consistently seeing the same oral health care provider and by improving the availability of in-community oral health care services, instead of travelling to see a provider from another community.[43] To support interconnectedness, dental hygienists should build relationships that extend beyond the individual seeking care. They should recognize that community members are not mere recipients of oral health care services, but rather integral contributors to the promotion of oral health and wellness in their community. Additionally, dental hygienists can ensure that their treatment plans are individually tailored and based on collaboration with the person accessing care to meet the needs of the individual, families, and the community in which they work.[43,46]

The trust that improves OHE does not grow quickly and must be built at many levels. Due to decades of unethical treatment and colonization, Indigenous Peoples may not trust oral health care providers in their community, and a progression towards understanding and relationship building is one step towards improving OHE.[43] The Educating for Equity (E4E) Care Framework offers guidelines for deeper engagement and relationship building, making amends for past encounters, and ultimately improving health equity and the safety that a person feels when seeking medical or oral health care.[39] The E4E Care Framework emphasizes that health care providers need to understand the context in which Indigenous Peoples experience their health and/or illness.[43,46]

Interprofessional collaboration, where doctors, nurses, dental hygienists, and dentists work together with communities to make oral health care more accessible, can foster productive and sustainable strategies. These types of interprofessional collaborations can address gaps in services and access given the remote and rural locations of many Indigenous communities.[40,44] All health services and programs delivered in Indigenous communities should be evaluated for their impact on the community.[9,19,20,43] They should be assessed for the level of cultural relevance, and critical reflection needs to occur to ensure that inequities are not perpetuated.[46] Additionally, program evaluations must include indicators that measure cultural safety and make efforts to ensure that dominant voices are not exclusively heard.[46]

Workforce development

Increasing the number of Indigenous health care professionals is a critical component of TRC Call to Action 23i and 23ii.[6,24,41,44] Supporting Indigenous Peoples who wish become dental hygienists can help diversify the workforce and ensure that there are role models and clinicians who can intuitively provide culturally safe care. Indigenous dental hygienists can help build relationships when they are part of the community rather than when they are part of a transient or contingent workforce. There is also a financial burden that comes from not having dental hygienists reside in Indigenous communities. The NIHB program spends over $400 million annually on

medical transportation to facilitate access to health care services.[54] Dental hygienists can help to mitigate some of these costs by providing early, preventive oral health care in rural, remote, and isolated communities. Ultimately, these situations improve continuity of care, help build relationships and trust, and have the potential to improve Indigenous OHE.

Within their workplaces, dental hygienists can draw attention to TRC's Call to Action 92, which offers the corporate sector specific strategies to promote reconciliation with Indigenous Peoples. The case study by Monkman and Limoges[41] demonstrates how organizational integration of Call to Action 92 supported the recruitment and retention of Indigenous nurses and can be applied to oral healthcare settings. Implementing Call to Action 92 created conditions that strengthened the ability of the organization to advance Indigenous health equity and promote reconciliation.[41] Because health care settings often function as businesses, Call to Action 92 is applicable to the oral health care sector with its private and publicly funded clinics. Enacting reconciliation in all sectors of health care is a collective responsibility of all Canadian health care professionals. The Monkman and Limoges case study provides several strategies to enhance recruitment and retention of Indigenous health care providers who can bolster Indigenous representation in the dental hygiene workforce.

Oral health research and education

Health research that integrates Indigenous ways of knowing and knowledge can help improve health equity.[5,41,46] Historically, researchers used Indigenous Peoples as test subjects and performed unethical research on community members, which led to a mistrust of Western-informed science and medicine among many Indigenous people.[55] Health research needs to be decolonized, unbiased, and reflect a desire for community improvement. Indigenous oral health research should include Indigenous people in the study design and recognize power differences between researchers and research participants.[21,38,42] This type of research can provide the evidence to inform education and clinical practice guidelines. Furthermore, Indigenous research methods should be included in introductory research courses in dental hygiene curricula.

Space must be created for Indigenous knowledge and Traditional healing approaches in health professionals education.[21] TRC Calls to Action 22 and 24 reflect this view.[6] University education programs that emphasize OHE can prepare dental hygienists to examine longstanding oral health policies and procedures that retraumatize clients or contribute to oral health inequities. This education can provide dental hygienists with the necessary skills to interrupt these practices and to deliver culturally safer care that promotes OHE. Curricula that focus on the social determinants of health and equity can assist dental hygienists in challenging biases and assumptions to consider why Indigenous people may not seek out professional oral care or why they may have trouble attending appointments at their scheduled time.[46] Dental hygienists should be taught to reflect on differences, respect diversity, recognize structural barriers, and acknowledge power differentials to help address the historical and ongoing implicit and explicit racism that perpetuates these health inequities.[41] Education can help dental hygienists learn how to balance the competing priorities of clinical efficiency (production and staying on time) and attention to health equity.[37]

Downey's model[21] and the Educating for Equity (E4E) Care Framework[39] provide a structure for dental hygiene education and clinical care through attention to self-determination, consideration of traditional healing, interconnectedness, and balance. To advance OHE, universities with dental hygiene education programs can decolonize their curricula to better attract and retain Indigenous learners. Inviting Indigenous Peoples to take the lead on Indigenizing health education helps to create an inclusive learning environment for Indigenous students and helps the students feel a sense of belonging, especially if they are far away from their homes. Finally, universities should consider offering courses using alternate delivery formats including synchronous and asynchronous online learning combined with in-person learning as a methods to improve access.[41]

Limitations

There are few Canadian studies specifically on dental hygienists and OHE. Oral health research related to dental hygiene care is also limited. This paucity of research may be due to the slow progress of efforts to have dental hygienists recognized as autonomous oral health professionals rather than oral health auxiliaries.[56] Additionally, the terms Métis and Inuit were not used in the literature search, which may have limited the scope of the review. Finally, it is possible that narrative methods are susceptible to the perspectives of the review team. Therefore, it is possible that the interpretation of the literature and creation of the framework for this article reflect the unique perspectives of the writing team.

CONCLUSION

Prior to implementing any of these strategies for Indigenous OHE, the first step is to consult with Indigenous Peoples. This will ensure that their perspectives and needs are heard, their priorities are recognized, and that distinction-based approaches in health care delivery are implemented. Improvements in OHE are essential and just, and Indigenous Peoples throughout Canada have the right to receive safe oral health care. Dental hygienists are ideally positioned to contribute to these goals. This review highlighted a framework with 4 elements and concrete actions that can be taken by dental hygienists to positively impact OHE. Dental hygienists in practice, administration, education,

and research can use the framework and strategies to engage with Indigenous communities to help address health gaps and create new pathways for improving Indigenous OHE.

This review also highlights the urgent need for further research on Indigenous OHE in areas such as ways to increase the number of Indigenous dental hygienists, evaluation of the effectiveness of cultural safety training, and strategies that integrate Traditional approaches in oral health education and practice. Using Indigenous research methods can generate the evidence needed to transform education, practice, and policy that support OHE.

ABOUT THE AUTHORS

The first author is a First Nations woman who is the daughter of a Sixties Scoop Survivor and has been a registered dental hygienist since 2002. The author has spent her career serving Indigenous peoples in both private and public dental clinics in Winnipeg, Manitoba. Through her graduate studies and onward she strives to increase her knowledge of Indigenous ways of knowing and being, and work to uncover some of the stories that were stripped from her family.

The second author is a First Nations woman from Kinosao Sipi Cree Nation and has been a registered nurse since 2004. She has focused her career on improving Indigenous health across Canada, both in First Nations communities and urban healthcare systems. Currently, she serves in executive healthcare leadership, advancing transformative initiatives to enhance health outcomes for First Nations in Manitoba.

The third author is Professor at Athabasca University and an academic ally who provided guidance in writing this paper.

CONFLICTS OF INTEREST

The authors have declared no conflicts of interest.

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