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SYSTEMATIC REVIEW

Dental care in Indigenous communities: performance and experiences of oral health professionals

Atención odontológica en comunidades indígenas: desempeño y experiencias del personal de salud bucal

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ABSTRACT

Objective: To analyze recent scientific literature on the performance, training, and experiences of oral health professionals providing care to Indigenous communities, with an emphasis on facilitating factors, structural barriers, and implemented intercultural strategies. Methods: The systematic review was conducted through searches in scientific databases (Google Scholar, Scopus, SciELO, LILACS, PubMed), using MeSH and DeCS descriptors combined with Boolean operators. Qualitative, quantitative and mixed-methods studies published between 2018 and 2025 were included. Systematic reviewsNon-traditional publications, and studies without direct participation of health professionals were excluded. After screening, 11 articles were selected.Results: The studies included experiences from Canada, the United States, Chile, Venezuela, El Salvador, Brazil, and Australia. Findings were grouped into six categories: professional experiences, structural barriers, intercultural competencies, job satisfaction, community participation, and improvement proposals. The main barriers identified were limited training in cultural competencies, high staff turnover, geographic and linguistic difficulties, and weak institutional coordination. Good practices were also highlighted, such as collaboration with Indigenous health promoters and the cultural adaptation of interventions. Conclusion: It is imperative to redesign dental care models by integrating an approach centered on rights, equity, and the full participation of Indigenous peoples.
Keywords: Oral Health. Indigenous Peoples. Health Professionals. Cultural Competency.

RESUMEN

Objetivo: Analizar la literatura científica reciente sobre el desempeño, formación y experiencias del personal de salud bucal que brinda atención a comunidades indígenas con énfasis en los factores facilitadores, barreras estructurales y estrategias interculturales implementadas. Métodos: La revisión sistemática se realizó mediante búsqueda en base de datos científicas (Google Scholar, Scopus, SciELO, LILACS, PubMed), utilizando descriptores MeSH y DeCS combinados con operadores booleanos. Se incluyeron estudios cualitativos, cuantitativos y mixtos, publicados entre 2018 y 2025. Se excluyeron revisiones sistemáticas, literatura gris y estudios sin participación directa del personal de salud. Tras la depuración, se seleccionaron 11 artículos. Resultados: Los estudios incluyeron experiencias en Canadá, Estados Unidos, Chile, Venezuela, El Salvador, Brasil y Australia. Se agruparon los hallazgos en seis categorías: experiencias profesionales, barreras estructurales, competencias interculturales, satisfacción laboral, participación comunitaria y propuestas de mejora. Las principales barreras identificadas fueron: escasa formación en competencias culturales, alta rotación del recurso humano, dificultades geográficas y

lingüísticas, y débil articulación institucional. También se destacaron buenas prácticas como la colaboración con promotores indígenas y la adaptación cultural de intervenciones. Conclusión: Resulta imperativo rediseñar los modelos de atención odontológica integrando un enfoque centrado en los derechos, la equidad y la participación plena de los pueblos indígenas.
Palabras clave: Salud bucal, poblaciones indígenas, personal de salud, competencia cultural.

INTRODUCTION

Oral health is a key part of overall well-being. Good oral health lets people eat, speak, and socialize without pain, discomfort, or stigma, directly affecting their quality of life (1). Yet, Indigenous populations worldwide face stark inequalities in dental care access, quality, and outcomes (1). These gaps result from colonization, social exclusion, lasting structural barriers, and the lack of culturally appropriate policies. Indigenous peoples—distinct groups with their own social, cultural, and historical identities—face shared challenges such as health inequities, territorial dispossession, and exclusion, even though they have diverse cultures and languages [2–4].

It is essential to recognize that, for many Indigenous communities, health is conceived from a holistic perspective that integrates body, mind, spirit, community, and territory, in contrast to conventional biomedical models [4]. This comprehensive worldview directly influences community understandings of oral health and the adoption of traditional care practices, which are deeply linked to cosmovision, spirituality, and collective bonds. Nevertheless, factors such as poverty, institutional discrimination, and the lack of integration of these perspectives into formal health systems contribute to the persistence of significant gaps in oral health indicators within this population group [5].

In this context, the role of the oral health workforce becomes decisive in promoting sustainable improvements in Indigenous communities. Evidence shows that training in cultural competencies, adaptation of services to sociocultural realities, and the active participation of community health promoters are key elements for achieving effective and culturally safe interventions [6,7]. Programs such as the Children's Oral Health Initiative (COHI), implemented in remote First Nations communities in Canada, demonstrate that considering cultural and regional contexts can significantly strengthen children's oral health [6].

Similarly, studies conducted in Indigenous Australian communities have identified facilitators at the family, community, and institutional levels that contribute to culturally appropriate and safe oral health care practices [7].

In this regard, differences exist globally among countries. In the Venezuelan Amazon and in various Indigenous peoples across the American continent, efforts have mainly focused on prevention projects and community-based strategies grounded in traditional narratives [8,9]. In the United States and Canada, lack of continuity in services and socioeconomic barriers continue to affect program effectiveness [10,11]. In contrast, countries such as Australia and New Zealand have made progress toward integrating Indigenous content into professional training curricula and implementing innovative clinical interventions, such as the use of silver fluoride for caries prevention in Aboriginal populations [12,13]. Additionally, Australia has promoted transformative frameworks to decolonize oral health and advance a human right–based approach [12].

These differences respond not only to historical and political particularities, but also to the level of recognition of Indigenous peoples' right to receive culturally safe care [1,4]. In Latin America, studies conducted in Chile, Venezuela, and El Salvador show that significant inequalities persist in access to and quality of dental services [5,9,14].
Despite certain advances, relevant gaps remain in the literature, particularly regarding the longitudinal follow-up of programs, systematic evaluation of service quality, and the effective incorporation of Indigenous knowledge into daily clinical practice [3,13,15]. Likewise, the limited inclusion of communities in decision-making processes restricts the sustainability of implemented initiatives [15].

Within this framework, the present systematic review aims to analyze recent literature on the performance and training of the oral health workforce serving Indigenous communities in the American continent, identifying implemented intercultural strategies, persistent challenges, and opportunities to advance toward more equitable, relevant, and culturally safe models of dental care.

MATERIALS AND METHODS

Between April and May 2025, a detailed exploration of scientific literature was conducted across multiple bibliographic sources—PubMed, SciELO, ScienceDirect, Scopus, and Google Scholar—to identify studies addressing the experiences and performance of the oral health workforce serving Indigenous populations. The guidelines of the PRISMA statement were followed [16]. Controlled terms from the MeSH and DeCS thesauri were used, combined with Boolean operators.

In English: ("oral health" OR "dental health") AND ("indigenous populations" OR "native communities" OR "ethnic groups") AND ("community health workers" OR "health providers" OR "dental professionals"). In Spanish: ("salud bucal" OR "salud dental") AND

("poblaciones indígenas" OR "comunidades nativas") AND ("trabajadores comunitarios de salud" OR "odontólogos" OR "promotores de salud bucal")

Articles published in English and Spanish between 2018 and 2025 were considered. Eligible studies included qualitative, quantitative, or mixed methods designs involving dentists, promoters, technicians, or assistants that examined performance, perceptions, experiences, training, knowledge, competencies, strategies, barriers, and/or challenges related to dental care for Indigenous communities. Non-traditional publications—such as institutional reports, letters to the editor, technical reports, reviews, conference proceedings or abstracts, and theses—was excluded.

Following the bibliographic search, a preliminary review of titles and abstracts was conducted based on the selection criteria. Studies were excluded if, despite involving Indigenous communities, they focused exclusively on clinical aspects of the population served without considering the active role of health professionals, as well as publications without access to the full text. Studies reflecting direct participation of oral health human resources—whether in community interventions, intercultural training processes, or the implementation of educational and preventive strategies—were selected.

This process resulted in 11 studies with significant evidence. Methodological quality was assessed using the Critical Appraisal Skills Programme (CASP) checklist, consisting of 10 questions for qualitative studies. In this review, each item was scored as follows: affirmative answers ("Yes") received 1-point, uncertain answers ("Not sure") 0.5 points, and negative answers ("No") 0 points. Studies were considered high quality when at least two-thirds of the responses were "Yes," moderate quality when four to six affirmative responses were recorded, and low quality when more than two-thirds of the responses corresponded to "No" [17] (Figure 1) (Table 1).

Figure 1. Flow diagram of the systematic literature review

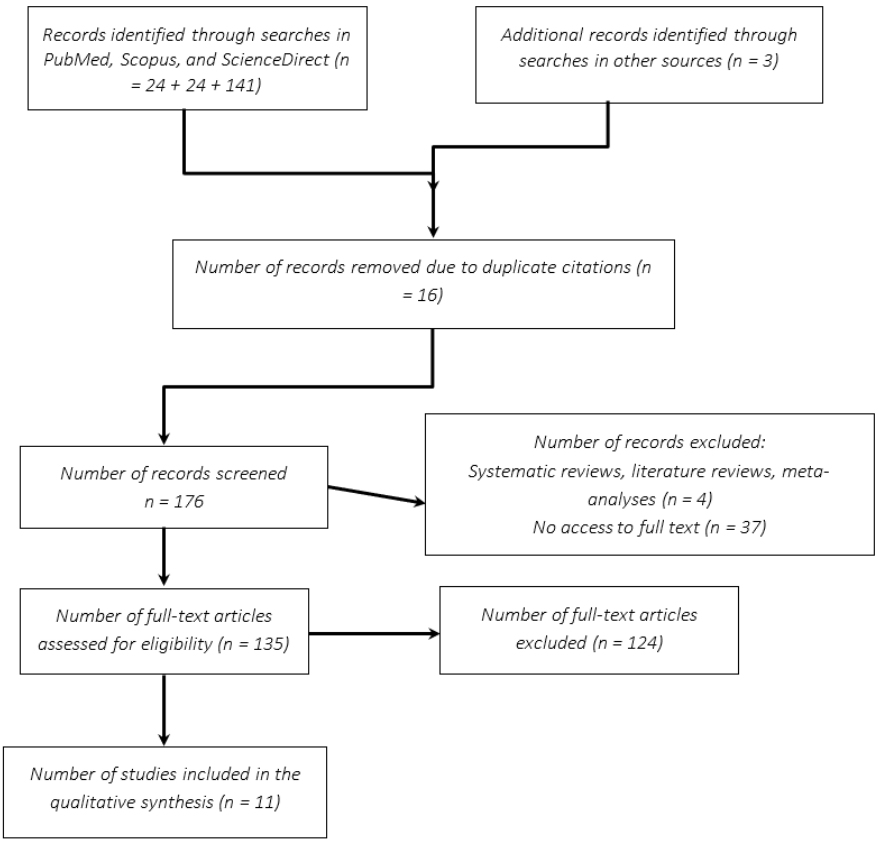

Table 1. Results of the main selected articles

Author, year and country / city	Objective	Training	Performance	Design	Conclusions	CASP	Quality rating
Cantarutti C, et al. (5) 2025. Chile / Antofagasta	Analyze social determinants affecting oral health in an Indigenous community	Local dentists, researchers with experience in community oral health	Aymara- and Quechua-speaking adults. Semi-structured interviews, surveys, and ethnographic analysis were conducted	Qualitative and quantitative (mixed-methods study)	Socioeconomic and historical factors significantly influence oral health conditions	9	High
Llaneza AJ, et al. (3) 2023. United States / Southern Plains	Identify Native communities' perceptions of access to oral health care	Dental workers, Indigenous health administrators	Indigenous adults. Surveys with open-ended questions and thematic analysis were conducted	Qualitative (interviews and focus groups)	Cultural, geographic, and economic barriers to accessing dental services were identified	9	High
Montilla G, et al. (9) 2021. Venezuela / Amazon region	Describe cultural perceptions of oral health in the Guahibo community	Researchers with local interpreters; specific professional training not detailed	Members of the Guahibo community. Open interviews and participant observation were conducted	Qualitative (interviews and participant observation)	Oral health is understood from the perspective of Guahibo community members in Amazonas State	9	High
Schroth RJ, et al. (6) 2023. Canada / Manitoba	Understand health workers' experiences with the COHI program	COHI promoters, dental assistants, community oral health workers	Focus groups with workers; field-based experiences	Qualitative (focus groups and semi-structured interviews)	The Children's Oral Health Initiative improved the promotion of children's oral health, although it faced staffing and continuity challenges	9	High
Shokouhi P, et al. (13) 2025. Australia / Queensland	Identify local strategies to improve oral health in rural Aboriginal communities	Dental educators, Indigenous leaders, oral health curriculum designers	Educators, students, and curriculum designers. Documentary analysis of dental education studies was conducted	Qualitative (phenomenological)	Community participation facilitates sustainable and relevant cultural solutions	9	High
Poirier BF, et al. (7) 2022. Australia / South Australia	Analyze facilitating factors in promoting oral health practices among Indigenous children	Indigenous health promoters or community health workers	Caregivers of Indigenous children. Motivational interviews were conducted	Qualitative (motivational interviews and thematic analysis)	Family support, motivation, and the community environment are essential to improving oral health habits	10	High
Kyoon-Achan G, et al. (10) 2021. Canada / Manitoba	Identify perceptions of access and equity in early childhood oral health care	Indigenous health promoters, community child development workers	Mothers, fathers, and grandparents of children <6 years. Sharing circles and focus groups were conducted	Qualitative (focus groups and sharing circles)	Lack of culturally safe services and socioeconomic barriers limit access to oral health care	9	High
Achalu P, et al. (15) 2019. El Salvador / Santa Ana	Analyze nutritional and child oral health practices	Community health workers (health promoters) from the local NGO ASAPROSAR (Salvadoran Association for Rural Pro-Health)	Mothers of rural children. Semi-structured focus groups and open dialogue	Qualitative (in-depth interviews)	Poor nutrition and limited access to oral health services are critical factors in child health	9	High
Shrivastava R, et al. (17) 2019. Canada / Quebec	Explore participants' perspectives on barriers and facilitators of relational continuity in dental care	Community dentists, dental hygienists, dental technicians, dental assistants	Indigenous patients, oral health workers, administrators. Interviews and focus groups on continuity of care experiences	Qualitative (multiple case study)	Staff retention improves trust and continuity in oral health care	9	High
Wilson et al. (8) 2018. United States / Alaska	Evaluate the use of traditional narratives to improve oral health knowledge	Dentists and Indigenous oral storytellers	Pregnant AI/AN mothers or those with children <6 years. Traditional oral storytelling, focus groups, and interviews were conducted	Qualitative (narrative-based intervention)	The use of traditional narratives strengthened knowledge and ownership of oral care practices	9	High

Poirier B, et al. (16) 2023. Australia, Canada, New Zealand, and the United States	Synthesize qualitative evidence on facilitators and challenges faced by Indigenous communities worldwide in maintaining oral health	Indigenous health workers, community dentists, dental assistants, oral educators, and community health promoters	Members of rural or remote communities, oral health professionals working in Indigenous contexts	Qualitative	Developing culturally safe interventions that integrate self-determination and Indigenous traditional knowledge is essential	10	High

ANALYSIS AND DISCUSSION OF RESULTS

The reviewed publications covered diverse regions of the American continent—Canada, the United States, Venezuela, Chile, Brazil, and El Salvador as well as Australia and one multinational study incorporating data from Canada, the United States, New Zealand, and Australia. Most studies were conducted in rural, remote areas, or predominantly Indigenous communities, allowing exploration of the performance of health professionals in social contexts and territorial vulnerability.

From a methodological perspective, qualitative approaches predominate, focusing on interviews, focus groups, thematic analysis, and participatory methods such as sharing circles. Three studies adopted mixed methods designs, combining surveys with ethnographic or documentary analysis, while others examined professional training and performance through phenomenological perspectives or multiple case study approaches. Methodological quality assessed using the CASP scale was high across all articles (scores 9–10), supporting the the findings.

Motivation, commitment, and barriers

The literature shows that the experience of oral health professionals in Indigenous contexts is characterized by a constant tension between community commitment and multiple occupational challenges. Studies such as those by Schroth et al. [6] and Shrivastava et al. [19] highlight that dentists, hygienists, assistants, and community promoters deeply value close interaction with Indigenous families, which strengthens trust and supports continuity of care. However, this work takes place in settings marked by logistical constraints, workload overload, and the need to adapt communication to contexts where language, cultural meanings, and traditional practices play a decisive role in the care experience.

Consistently, research identifies that the main barriers to access and effectiveness of oral health services have structural, historical, and sociocultural roots. These include long geographic distances—documented in regions such as Alaska, the Amazon, and rural Australian communities—economic constraints, limited-service availability, lack of staff continuity, and the absence of culturally safe services [3,15,19]. Institutional weaknesses related to bureaucracy and inadequate infrastructure are also reported [10]. These barriers not only affect quality of care but also erode Indigenous communities' trust in formal health systems.

These findings align with international reviews indicating that historical inequalities and institutional discrimination continue to significantly influence oral health indicators among Indigenous peoples [2,3,16]. Nevertheless, this review highlights the strategic role of community participation, the indigenization of training curricula, and the strengthening of health promoters as key axes for transforming services.

Professional training and cultural competencies

Several studies emphasize that socioeconomic and historical factors strongly condition oral health in Indigenous communities, requiring professionals to incorporate cultural competencies into their practice [5]. The importance of community participation in curriculum design and the indigenization of dental education is underscored, as is the development of educational models based on self-determination and Indigenous traditional knowledge [13]. In this framework, the value of bicultural health teams and effective communication that consider the social determinants of health is highlighted [18].

From a comparative perspective, significant regional differences are observed. Countries such as Australia, Canada, and New Zealand have advanced in implementing regulatory frameworks oriented toward cultural safety, mandatory intercultural training, and the incorporation of Indigenous knowledge into professional education [4,7,12,13,16]. In contrast, in Latin America progress is more fragmented and largely dependent on local initiatives or non-governmental organizations, with less structural and financial support [5,8,9,14,15]. This disparity reflects the absence of consolidated state policies that sustainably ensure training and support for oral health professionals in Indigenous contexts.

Job satisfaction and working conditions

Job satisfaction among personnel is closely linked to working conditions. Studies conducted in Canada and the United States report frustration due to limited infrastructure and resources, as well as high staff turnover, which hinders continuity of care and the development

of trusting relationships [3,6,9]. Nevertheless, many professionals express pride and satisfaction in contributing to children's health and engaging closely with communities, particularly when participating in culturally adapted approaches or community-based activities. These findings suggest that improving working conditions and strengthening institutional support may positively impact staff motivation and retention.

Community participation as a key facilitator

Community participation consistently emerges as a central facilitator of successful oral health interventions. Experiences documented in Australia [7], Canada [6], and Alaska [8] show that collaborative work with Indigenous promoters and leaders facilitates the adoption of healthy practices, especially in childhood. The use of traditional narratives and participatory approaches increases community empowerment and ownership of oral care practices, strengthening trust in services [8].

Overall, the findings reinforce the notion that the performance of oral health professionals cannot be understood from a clinical perspective, but also from their ability to establish horizontal, respectful, and culturally sensitive relationships with communities [6–8,18,19].

Strengths, limitations, and implications

Methodologically, this review presents notable strengths, including searches across multiple international databases, inclusion of diverse study designs, and application of PRISMA guidelines in the selection process [16]. Quality assessment using CASP indicated that most studies exhibit good methodological quality, reinforcing the consistency of the findings [17]. However, important limitations exist, including heterogeneity of designs and contexts, exclusion of grey literature, and predominance of qualitative studies, which limits generalizability. Additionally, conceptual variability is identified around the terms "performance" and "training" of oral health professionals, which in many studies are addressed implicitly or subordinated to broader public health approaches. This lack of analytical delimitation complicates systematic comparison and highlights the need for clearer theoretical frameworks [20].

The implications of these results are relevant for clinical practice, public health, and policy formulation. The importance of ongoing training in intercultural competencies, strengthening communication skills, and recognizing traditional knowledge is emphasized. Likewise, the need for participatory programs, policies that ensure staff retention in territories, and the indigenization of dental curricula is underscored. Finally, evidence gaps are identified that guide future research, particularly longitudinal and comparative studies evaluating the impact of intercultural approaches on staff performance and oral health outcomes.

CONCLUSION

This systematic review shows that oral health professionals serving Indigenous communities face structural, educational, and contextual limitations, particularly insufficient intercultural training, geographic and linguistic barriers, staff turnover, and the lack of culturally relevant institutional policies. While successful experiences based on participatory approaches and cultural adaptation of interventions were identified, progress in Latin America remains incipient compared to countries such as Australia, Canada, and New Zealand. In this context, strengthening intercultural training, continuing education, and inclusive public policies is a priority to advance toward culturally safe, equitable, and human rights–based models of dental care.

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AUTHOR CONTRIBUTION STATEMENT

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CONFLICTS OF INTEREST

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