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Decolonising child oral health: a racial justice framework for transforming pediatric dental care

Abstract

Background: The persistent oral health disparities affecting children of colour represent a manifestation of colonial structures embedded within healthcare systems.

Objective: This perspective examines how decolonisation theory provides a framework for understanding and addressing racial inequities in paediatric oral health. Specifically, it analyses how colonial legacies and structural racism influence oral health outcomes among children from Indigenous and Black populations, and proposes a racial justice framework to guide more equitable and culturally responsive paediatric dental care.

Methods: By analysing colonial legacies that shape contemporary dental care delivery, we explore how Western biomedical models have marginalised Indigenous and traditional healing practices while perpetuating systemic barriers to care.

This perspective paper draws on existing scholarship on oral health inequalities, structural racism in healthcare systems, and decolonisation theory to examine how historical and contemporary power structures influence paediatric dental care. The discussion integrates evidence and concepts presented throughout the paper, including research on oral health disparities among Indigenous populations, institutional racism frameworks such as those articulated in the Stephen Lawrence Inquiry, and insights from racial justice movements. These perspectives are used to analyse how current paediatric dental care systems reproduce inequities and to identify community-centred and culturally responsive approaches that may contribute to more equitable child oral health outcomes.

Results: Through a racial justice lens informed by the Stephen Lawrence Inquiry and Black Lives Matter movement, we propose transformative approaches that centre community knowledge, cultural practices, and self-determination in child oral health promotion.

Conclusion: This framework calls for fundamental restructuring of paediatric dental services to honour diverse healing traditions, address institutional racism, and empower communities to lead their own oral health initiatives. Achieving oral health equity requires not merely addressing access barriers but fundamentally transforming the epistemological foundations of paediatric dental care to challenge existing power structures and create more equitable, culturally responsive systems of care.

Keywords: oral health inequalities, pediatric dentistry, decolonization, racial justice, indigenous health, social determinants, structural racism, health equity

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Introduction

Oral health inequalities among children remain a significant global public health concern. Substantial evidence demonstrates that children from racial and ethnic minority groups experience disproportionately higher rates of dental caries, untreated dental disease, and limited access to preventive dental services compared with children from majority populations.[1] These disparities are particularly pronounced among Indigenous, Native, and Black communities in many countries. Such inequalities cannot be explained solely by individual behaviours or clinical factors; rather, they reflect broader structural determinants shaped by historical processes including colonisation, social exclusion, and systemic racism.

The concept of decolonisation, initially developed in the context of political liberation from colonial rule, has increasingly been applied to healthcare systems to understand how colonial logics continue to shape medical practice and health outcomes. In the realm of child oral health, decolonisation offers a critical framework for examining how Western dental paradigms have marginalised Indigenous and traditional healing practices while perpetuating barriers to culturally responsive care.

This paper explores the intersection of decolonisation theory and racial justice in child oral health, arguing that achieving oral health equity requires not only addressing access barriers but fundamentally transforming the epistemological foundations of pediatric dental care. By centering community knowledge, cultural practices, and self-determination, a decolonised approach to child oral health can challenge existing power structures and create more equitable, culturally responsive systems of care.

Indigenous, Native, and Black communities have long maintained culturally grounded practices and community-based health strategies that support oral health, including traditional hygiene practices, plant-based remedies, and collective approaches to health promotion. However, these contributions have often been marginalised within dominant biomedical dental systems. Recognising and integrating these knowledge systems is essential for developing more equitable and culturally responsive approaches to child oral health.

Theoretical framework: decolonization and health

Decolonisation theory provides a lens for understanding how colonial structures continue to operate within contemporary

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institutions, including healthcare systems. Decolonisation involves recognising how colonial histories have shaped medical knowledge production, institutional practices, and patient-provider relationships. This includes acknowledging how Western biomedicine has been positioned as superior to Indigenous and traditional healing systems, often leading to the systematic devaluation and suppression of alternative approaches to health and wellness.

For child oral health, decolonisation requires examining how Western dental paradigms have been universalised while Indigenous oral health practices have been marginalised or dismissed. This process involves not only critiquing existing structures but also creating space for alternative ways of understanding and promoting oral health that are grounded in community knowledge and cultural practices.

The social determinants framework provides essential context for understanding oral health inequalities. As Watt demonstrates, the persistent and universal nature of oral health inequalities mirrors those in general health, highlighting the underlying influence of psychosocial, economic, environmental and political determinants. The dominant preventive approach in dentistry, narrowly focusing on changing behaviours of high-risk individuals, has failed to reduce oral health inequalities effectively and may indeed have increased the oral health equity gap.[1]

Colonial legacies in child oral health

The historical context of colonialism profoundly shapes contemporary oral health disparities. Colonial processes disrupted Indigenous food systems, introducing processed foods high in sugar and refined carbohydrates that contributed to increased rates of dental caries among Indigenous populations. Simultaneously, traditional oral health practices, including the use of medicinal plants and culturally specific hygiene practices, were often discouraged or prohibited.

The establishment of Western dental education and practice further entrenched colonial logics within oral healthcare. Dental schools, predominantly located in urban centres and serving affluent populations, developed curricula that emphasised technical proficiency while largely ignoring the social, cultural, and political determinants of oral health. This biomedical focus obscured how structural factors, including poverty, racism, and geographic isolation, contributed to oral health disparities.

Research on Indigenous populations clearly demonstrates these patterns. Jamieson and colleagues found significant oral health inequalities among Indigenous and non-Indigenous children in Australia,[2] while studies from Brazil show that Indigenous people had different patterns of oral disease and access to care compared to their non-Indigenous counterparts.[3] These disparities reflect differences in historical, socioeconomic, cultural, environmental and political determinants that different groups have experienced over time.

Manifestations of structural racism in pediatric dental care

Structural racism operates within pediatric dental care systems through multiple interconnected mechanisms that perpetuate disparities in access, quality, and outcomes. These manifestations extend beyond individual prejudice to encompass institutional policies, practices, and norms that systematically disadvantage children of colour. The concept of institutional racism, crystallised in the Stephen Lawrence Inquiry Report, provides a crucial framework for understanding how healthcare systems can perpetuate racial inequalities through "processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping".[4]

The Lawrence Inquiry's identification of institutional racism as the "collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin"[4] resonates powerfully within pediatric dental care. This framework helps explain how well-intentioned healthcare policies and practices can nonetheless produce racially disparate outcomes through systemic biases embedded in organizational structures and professional cultures.

Geographic maldistribution of dental providers represents a significant structural barrier, with rural and predominantly minority communities experiencing severe shortages of pediatric dentists. This maldistribution reflects historical investment patterns that have concentrated dental education and practice in affluent, predominantly white communities while neglecting areas with high concentrations of racial and ethnic minorities.

Payment systems within dental care further entrench racial disparities. Medicaid reimbursement rates for dental services often fall below the cost of providing care, leading many dental practices to limit or exclude Medicaid patients. Since children of color are disproportionately enrolled in Medicaid, these policies effectively create barriers to care based on race and socioeconomic status.

Racial justice movements and health equity

The Black Lives Matter movement, emerging from grassroots organising and gaining global prominence following high-profile police killings, has fundamentally reshaped discourse around racial justice in healthcare. The movement's analysis of state violence extends beyond policing to encompass systematic shortening of life through institutional neglect and structural violence. This framework provides crucial insights for understanding oral health disparities as manifestations of structural violence against Black and brown children.

The movement's emphasis on intersectionality illuminates how race intersects with class, gender, immigration status, and other identities to create compound vulnerabilities in oral health outcomes. For example, Black girls face unique risks related to adultification bias that leads to harsher school disciplinary actions, potentially interrupting access to school-based dental services.

Fleming and colleagues argue for moving beyond simply documenting disparities to understanding structural oppression manifested in policies and practices across the lifespan.[5] Their framework emphasises how major sociohistorical processes have profound effects on oral health, with impacts experienced through structural oppression that creates cumulative disadvantage over the life course.

Indigenous knowledge systems and oral health

Indigenous communities around the world have developed sophisticated knowledge systems related to oral health that predate Western dental medicine by millennia. These systems encompass not only specific practices and remedies but also holistic understandings of health that integrate physical, spiritual, and social dimensions of wellbeing.

Traditional oral health practices include using medicinal plants such as sage, cedar, and sweetgrass for oral hygiene and the treatment

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of dental conditions. The chew stick, derived from various tree species, has been used across Africa, Asia, and the Americas for cleaning teeth and maintaining oral health. Archaeological evidence suggests that these practices were highly effective in preventing dental disease before the introduction of processed foods and Western diets.

Research by Tsai and colleagues provides valuable insights into Indigenous oral health programs worldwide.[6] Their systematic review identifies lessons learned from the field, emphasising the importance of community ownership, cultural appropriateness, and integration of traditional knowledge with contemporary approaches. The marginalisation of Indigenous knowledge within contemporary healthcare systems represents a significant loss of potentially valuable approaches to oral health promotion.

Studies of Australian Aboriginal children demonstrate both the challenges and opportunities in this area. Slade and colleagues conducted a community-randomised controlled trial examining the effect of health promotion and fluoride varnish on dental caries among Aboriginal children.[7] While clinically efficacious interventions showed some benefit, the research highlighted how Western approaches alone may not be sufficient for lasting improvement in contexts where socioeconomic status, access to services, and cultural factors act as barriers.

Community-centered approaches to oral health

Decolonising child oral health necessitates shifting from provider-centered to community-centered models of care that recognise communities as experts in their own health needs and solutions. This approach involves transferring decision-making authority from external professionals to community members and organisations while providing necessary resources and support.

Community health worker models have shown promise in addressing oral health disparities by training residents to provide education, prevention services, and care coordination. These programs build on existing social networks and cultural knowledge while addressing barriers such as transportation, language, and unfamiliarity with culture. Programs that integrate oral health education with artistic practices and community values have demonstrated greater effectiveness than standardised approaches.

Participatory research approaches that involve community members as co-investigators and decision-makers can help ensure that oral health interventions are culturally appropriate and responsive to community priorities. These approaches challenge traditional research hierarchies that position academic researchers as experts while treating community members as subjects or informants.

Recent work emphasises the importance of structural determinants in oral health outcomes. Broomhead and Baker argue for moving beyond downstream interventions focused on individual behaviour change to address upstream determinants, including macroeconomic policies, governance structures, and welfare regimes.[8] This aligns with community-centred approaches that recognise the need to address root causes rather than merely symptoms of oral health inequities.

Policy implications and system transformation

Achieving decolonised child oral health requires comprehensive policy reforms that address structural barriers while supporting community self-determination. This includes reforming payment systems to ensure adequate reimbursement for preventive and culturally responsive care, expanding the dental workforce to include community-based providers, and investing in community-controlled oral health programs.

Regulatory reforms are needed to recognise and integrate traditional healing practices within formal healthcare systems. This may involve developing new categories of oral health providers who combine traditional knowledge with contemporary training, creating pathways for conventional healers to practice within healthcare institutions, and establishing protocols for integrating plant-based and other traditional remedies into clinical care.

Educational reforms within dental schools and public health programs are essential for preparing future providers to work effectively within decolonised models of care. This includes incorporating Indigenous knowledge systems into curricula, providing cultural competency training that goes beyond superficial awareness to challenge structural racism, and creating pathways for students from underrepresented communities to enter dental professions.

The work by Abbas and colleagues on science communication and academic health advocacy provides essential insights into how researchers and practitioners can better engage with policy processes to improve population oral health.[9] They argue that oral health professionals have a responsibility to communicate evidence effectively and advocate for policies that address the root causes of oral health inequalities.

Challenges and opportunities

Implementing decolonised approaches to child oral health faces significant challenges, including resistance from established professional organisations, regulatory barriers, and limited funding for community-based initiatives. The dominance of biomedical paradigms within healthcare systems creates institutional inertia that may resist fundamental changes to care delivery models.

Professional boundary disputes may arise as traditional healers and community health workers take on expanded roles in oral health care. Addressing these challenges requires developing new frameworks for interprofessional collaboration that respect different forms of expertise while ensuring patient safety and quality care.

Resource constraints pose another significant challenge, as community-based programs often require sustained funding to build capacity and achieve long-term impact. Traditional funding mechanisms that prioritise short-term outcomes may not align with the longer-term community development approach necessary for decolonisation.

Despite these challenges, significant opportunities exist for advancing decolonised child oral health. Growing recognition of health equity as a priority has created political openings to address structural barriers and invest in community-based solutions. Advances in telemedicine and mobile health technologies can support community-based care delivery while maintaining connections to specialised services when needed.

Faulks' work on oral health inequalities and disability provides insights into how marginalised communities can be centred in oral health research and policy.[10] Emphasising common ground between groups experiencing health inequalities and considering multiple forms of marginalisation as primary variables can improve outcomes for all children.

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Future directions and research priorities

Research priorities for decolonised child oral health should centre on community-defined outcomes and employ participatory methodologies that involve communities as partners in knowledge production. This includes developing culturally specific measures of oral health and wellbeing that go beyond clinical indicators to encompass community values and priorities.

Intervention research should focus on community-controlled programs that integrate traditional knowledge with contemporary approaches. Rigorous evaluation of these programs can provide evidence for their effectiveness while respecting community autonomy in defining success measures.

Policy research should examine the impact of structural reforms on oral health equity, including changes in payment systems, workforce models, and regulatory frameworks. Longitudinal studies that track the implementation of decolonised approaches can provide insights into practical strategies for system transformation.

Conclusion

Decolonising child oral health represents both a moral imperative and a practical necessity for achieving oral health equity. The persistent disparities affecting children of colour reflect colonial legacies and ongoing structural racism that cannot be addressed through technical solutions alone. A fundamental transformation of pediatric dental care systems is required, centring on community knowledge, cultural practices, and self-determination.

This transformation requires challenging Western biomedical hegemony while creating space for Indigenous and traditional knowledge systems. It demands addressing structural barriers while supporting community-controlled health programs. Most importantly, it requires transferring power from professional institutions to communities themselves, recognising that those most affected by oral health disparities are best positioned to develop culturally appropriate solutions.

The path toward decolonised child oral health will not be without challenges, but the potential benefits extend far beyond improved clinical outcomes. By honouring diverse ways of knowing and being, supporting community self-determination, and addressing structural inequities, decolonised approaches can contribute to broader processes of healing and justice that benefit all children and communities.

The urgency of this work cannot be overstated. Every day that systemic barriers remain in place, children of colour continue to experience preventable oral health problems that affect their educational outcomes, social development, and overall well-being. Decolonising child oral health is not merely an academic exercise but a critical component of the broader struggle for racial justice and health equity.

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Authors' contributions

Ester Okorodudu: Led the background research, editing and approved the final submission.

Raman Bedi: Led the conception, drafting and final submission.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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