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Aboriginal and Torres Strait Islander Peoples' Experiences With Culturally Safe Dental Research: A Qualitative Exploration

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ABSTRACT

Objectives: The engagement and retention of Indigenous participants are critical factors in the success of oral health research, particularly in longitudinal studies. However, participant experiences and perceptions of Indigenous research involvement remain underexplored. The objective of this qualitative study was to explore Indigenous participants' experiences of culturally safe oral health research.

Methods: The longitudinal intervention study involved Indigenous adults who received culturally safe dental care. The intervention included home-based dental checks, flexible appointment scheduling, regular follow-up and financial support for dental treatment at a local dental clinic. Following dental treatment, semi-structured interviews were conducted using a yarning-based approach to document participants' experiences of both the intervention and the study processes. Interviews were audio-recorded, transcribed and analysed thematically.

Results: Four themes were developed from 136 participants' experiences of culturally safe dental research: (1) research and clinical team characteristics including positive interactions with team members and personalised care; (2) participation in a research intervention that breaks down barriers to dental care including home visits, flexible scheduling and financial support; (3) research participation as a means of supporting personal and community health; and (4) a community-driven recruitment strategy that improved trust and retention.

Conclusions: Culturally safe, community-driven dental research centred on Indigenous representation, personalised care and home-based dental service delivery can effectively reduce barriers to dental care and improve engagement and retention among Indigenous participants in oral health research.

1 | Introduction

Oral health is an important aspect of overall wellbeing for Aboriginal and Torres Strait Islander (hereafter referred to as Indigenous) communities; however, Indigenous Australians experience considerably worse oral health outcomes than

non-Indigenous Australians, with higher rates of untreated dental caries, periodontal disease and tooth loss [1, 2]. This may result in poor nutrition, impaired speech, missed work and poor quality of life [3, 4]. These inequalities are not just clinical issues; they highlight the effects of colonisation, social disadvantage, racism and the ongoing absence of culturally safe healthcare

The first two authors contributed equally to this article.

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and health promotion [5–7]. Dental attendance patterns among Australians differ, with Indigenous Australians more likely to present to a dentist with pain or emergency conditions rather than for preventive care [8]. For communities in rural and remote regions, there is limited clinical infrastructure, workforce shortages and long travel distances to dental services [9]. The Australian National Oral Health Plan 2015–2024 recognises Indigenous Peoples as a priority group and highlights the need for culturally appropriate dental care and improving access to oral health services [10].

Recently, there has been growing demand from both national and international stakeholders for culturally safe dental research, necessitating shifts in research paradigms, policies and practices [11, 12]. Culturally safe care is defined by Indigenous Peoples themselves, focusing on environments and practices that respect identity, uphold traditional knowledge and actively dismantle racism [13]. Key elements include genuine partnerships with Indigenous communities, Indigenous leadership at all stages of research, recognition of historical and social context, use of Indigenous methodologies (such as yarning [Yarning is an Aboriginal and Torres Strait Islander cultural practice of informal, conversational storytelling used to build trust, share knowledge and engage in respectful dialogue]) [14] and trauma-informed, strengths-based approaches to care and data collection [11, 15]. The AIATSIS Code of Ethics and similar national frameworks (e.g., Australian Health Practitioner Regulation Agency, Australian Dental Council) set explicit standards for culturally safe research, emphasising Indigenous self-determination, leadership, culturally competent staff, mutual respect, open collaboration, responsive informed consent and ongoing Indigenous governance and benefit [16–18]. Hedges et al. [19] outlined five explicit pathways for decolonising Indigenous oral health research: (1) embedding positionality statements in all research; (2) honouring reciprocal relationships through traditional knowledges and community models; (3) developing culturally secure, strengths-based data capture tools; (4) constructing frameworks that address the intersection of multiple axes of oppression; and (5) implementing decolonising knowledge translation techniques. While the decolonisation of research is a long-term and ongoing process shaped by broader institutional structures, dental researchers have an ethical obligation to actively champion decolonising initiatives that promote equity, self-determination and justice in oral health research and care.

Despite acknowledging these challenges, the development of policy frameworks that emphasise cultural safety remains limited, and there is still limited empirical evidence on what constitutes effective, culturally safe dental research and care [17, 18]. Understanding Indigenous perspectives on research participation and culturally safe dental care is crucial for developing effective service delivery models and research approaches that can address oral health inequities [11, 15, 20, 21]. The literature provides limited qualitative evidence on how Indigenous participants perceive culturally safe dental care within research-integrated models. Hence, this study addresses the following research question: What are the experiences and perceptions of Indigenous Australian adults who participated in a culturally safe dental research study?

2 | Methods

The qualitative findings reported are part of a longitudinal quasi-interventional study and registered with the Australian New Zealand Clinical Trials Registry (registration number: ACTRN12626000046303) [13]. The study involved oral epidemiological examinations at baseline and at the 12-month follow-up (after receiving dental care). The qualitative interviews were conducted at the 12-month follow-up period from January 2024 to March 2025. This study received ethics approval from the Aboriginal Health Council of South Australia's Human Research Ethics Committee (04-22-990) and the University of Adelaide Human Research Ethics Committee. The research followed the CONSIDER statement for Indigenous health reporting guidelines (see Data S1) [22].

2.1 | Positionality Statement

The research team comprised six Indigenous and seven non-Indigenous researchers. Overall, the team was led by a Senior Aboriginal Research Officer and Director of the Indigenous Oral Health Unit with over 15 years of experience working in Indigenous oral health research (JH). Additionally, study governance was provided by an Indigenous Oral Health Unit Reference Group, which covered all aspects of the project. The team engaged in regular reflection sessions led by JH and Indigenous researchers on positionality and how our assumptions impact the research overall, further ensuring that cultural safety was centred across all project dimensions.

2.2 | Culturally Safe Research Framework

This study was guided by a generative co-design approach adapted for oral health, bringing together Indigenous participants, Elders and community leaders, Aboriginal Community Controlled Health Organisations (ACCHOs), dental practitioners, researchers and service partners to iteratively design and refine culturally safe dental care and research processes [23]. The approach centred on shared problem definition, rapid feedback cycles and joint decision-making to ensure that study priorities, procedures and outcomes reflected community-defined needs. The study adhered to national Indigenous research values (spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility) and emphasised relational accountability, benefit sharing and long-term commitments [18]. Knowledge translation was planned from the outset, and findings were returned through yarning groups, community reports, newsletters and co-presentations. Across all phases, the framework operationalised cultural safety using Indigenous methodologies to co-create actionable, locally owned solutions that improve trust, satisfaction, empowerment, self-determination and retention in oral health research and care [24].

2.3 | Study Participants and Recruitment

Inclusion criteria for participation of adults were: (i) aged 18 years and older; (ii) identified as Aboriginal or Torres Strait Islander; and (iii) resided in South Australia. Study information

was shared with local ACCHOs, Indigenous and non-Indigenous community organisations and social media. In addition to convenience sampling, snowball sampling was employed, whereby existing study participants referred eligible friends or family to join.

2.4 | Culturally Safe Research Methodologies

Before conducting the study, all field workers and researchers underwent cultural safety training. Introductions by the research and clinical team routinely involved sharing cultural background, community affiliations and connections to Country. Yarning was used to explain study details during interviews and when completing questionnaires. Yarning as a research methodology prioritises relationship-building, reciprocity and culturally safe communication between researchers and participants [14]. Researchers ensured the consent process respected the need for time and clear, responsive communication, allowing participants to fully understand the research purposes, methods and potential outcomes. Power imbalances were reduced by field staff wearing Indigenous-designed uniforms featuring Indigenous artwork, engaging in informal conversations and being attentive to language needs and preferred communication methods. The study's findings were disseminated to participants through an annual newsletter and community presentations.

Dental examinations were delivered through personalised oral health checks (such as home visits, workplace visits and community centre visits), flexible appointment scheduling and regular follow-ups. Based on ownership of an Australian Government Health Care Card (HCC; concession card), participants were referred to either a private or a public dental service. At a private urban dental clinic, participants could choose either an Indigenous or a non-Indigenous dental professional for treatment. The programme provided financial assistance with travel to the dental clinic and with preventive and therapeutic dental services [25]. Oral health education was tailored to individual and family needs, using clear language, storytelling and culturally relevant visual aids (artwork) to illustrate complex oral health concepts.

2.5 | Data Collection

With consent, interviews were audio-recorded and transcribed, and any personally identifying information was removed. Through open-ended interview questions, the research team asked participants about their experiences with the culturally safe research programme, with reflections on the positive aspects of their involvement, memorable experiences across all stages of participation, and whether they shared the details about the study with their other family and friends.

2.6 | Analysis

Template analysis was used to thematically analyse responses to specific open-ended interview questions regarding participant experiences with the research [26, 27]. The six steps of

analysis involved: (1) authors (S.N., R.A., J.G., A.P.) engaging in data familiarisation by repeatedly reading transcripts; (2) preliminary coding of the data relevant to the aims of the study, with concept themes identified in advance by the authors (e.g., 'Reduced stigma and fear', 'Relaxed environment', 'Contributions to Indigenous oral health research'); (3) organising themes into clusters and defining the connection between themes including hierarchical 'child' themes nested within broader 'parent' themes; (4) developing the coding template; (5) in an iterative process, applying the template to the data and modifying the template with themes redefined or removed where necessary to enable a rich representation of the data; (6) the template was finalised and then applied to the data, with themes collaboratively developed through discussion with the research team, whereby authors selected extracts and defined themes.

3 | Results

3.1 | Study Participant Characteristics

A total of 136 Indigenous South Australian adults ($n = 80$ female, $n = 56$ male), with a mean age of 46.23 years (Table 1), participated in an interview. Most participants had a tertiary education (53%), and about half held an HCC (51%). Participants reported poor self-rated oral health (75%) and had not attended a dental appointment in over a year (69%). Cost was the most common barrier (63%), and 71% of participants were referred to private clinics for dental treatment. These characteristics reflect the challenges Indigenous Australians experience in accessing routine dental services and underscore the relevance of the culturally safe intervention model evaluated in this study.

3.2 | Thematic Analysis

Four themes were developed and described below (Figure 1): (1) research and clinical team characteristics; (2) research intervention characteristics; (3) research participation supports personal and community health; and (4) word-of-mouth referrals as a community-driven recruitment strategy.

3.2.1 | Theme 1: Research and Clinical Team Characteristics: Recognising Contextual Factors and Providing Personalised Care

In this theme, participants described their interactions with clinicians (treating dentists) and the research team as positive and culturally safe. Participants valued the personalised communication and tailored approach to care delivered by the research team. Many felt that their experiences and beliefs were validated by the team, with one participant describing how they felt 'proud' to receive treatment from an Aboriginal dentist:

One of the best parts was going into dental clinic and receiving all your care from Aboriginal dentist...I was just like proud and I felt safe straight away.

(P69)

TABLE 1 | Study participant characteristics.

Level	<i>n</i>	%
Age (mean SD)*	136	46.23 (16.13)
Age category		
18–34 years	36	26.3
35–54 years	51	38.3
> 55 years	48	35.3
Gender		
Female	80	58.9
Male	56	41.0
Indigenous identity		
Aboriginal	125	91.8
Aboriginal and Torres Strait Islander	4	2.9
Other Indigenous groups	7	5.1
Residence location		
City	111	81.6
Regional/remote	25	18.3
Site of dental examination		
Clinical/dental clinic	57	42.2
Home visit/community centre	79	57.7
Education		
High school or less	64	47.4
Tertiary education	72	52.5
Ownership of healthcare card		
No	67	49.2
Yes	69	50.7
Last dental visit		
Less than 1 year ago	43	31.3
More than 1 year ago	93	68.6
Reason for last dental visit		
Check-up	30	21.6
Problem	106	78.3
Avoided dental visit due to cost		
No	50	37.0
Yes	86	62.9
Self-rated oral health		
Good	34	25.1
Poor	102	74.8

(Continues)

TABLE 1 | (Continued)

Level	<i>n</i>	%
Referral for dental treatment		
Public dental service	35	25.7
Private clinic	97	71.3
No treatment required	4	2.9

Abbreviations: LCI, lower confidence interval; UCI, upper confidence interval.
*The mean and standard deviation were calculated for age (continuous variable).

Participants also expressed appreciation for the relaxed home-based clinical environment:

...the way that the team interacted with us you know, it wasn't just like a really clinical approach it was a relaxed environment, you know, a bit of banter. So it was quite friendly and inviting.

(P244)

Importantly, some participants felt that the research team recognised contextual factors such as cultural and social histories that may impact oral health and access to dental care for communities. This was seen as further supporting personalised and culturally safe care and promoted confidence in caring for oral health:

A more personal level of care, more consideration of cultural and social context, easier assistance to dental care, that usually it's time constraints and usually it's fear-related if it's not time constraints, that usually impacts how frequently I go to the dentist...Just have a bit more insight and confidence in just looking after oral and physical health.

(P339)

Overall, a relaxed, personalised environment, Indigenous representation among the research and clinical team and culturally safe communication (e.g., clear explanations, taking time to yarn about participants' oral health, validating experiences) supported positive research experiences for participants.

3.2.2 | Theme 2: Research Intervention Characteristics: Breaking Down Barriers

Research intervention characteristics play an important role in positive participant experiences. For example, mobile dentistry improved participants' anxiety of dentists, the stigma associated with attending dental clinics and provided greater accessibility for large families:

Having them checked at home, keeping them comfortable...I was just saying it's quite a traumatic experience, [daughter] gets quite scared. So it's really good for them to be able to be at home (P74)



FIGURE 1 | Themes mapping the components of culturally safe dental research. The central concept is supported by four themes: (1) breaking down barriers, which includes home-based dentistry, continuity and regular check-ins, flexible scheduling, family-centred care and financial support; (2) personalised care, encompassing personalised communication, Indigenous representation in the dental care team, a relaxed and welcoming clinical environment and building trust; (3) community health and wellbeing, capturing the desire to give back to the community, build evidence and influence policy; and (4) community-centred research, driven by word-of-mouth referrals, family inclusion, community support and the fostering of trust and relationships.

Continuity of care across the study and regular check-ins with participants were key aspects of culturally safe dental research. This supported retention at follow-up and ensured participants felt that they were not forgotten:

...so I think just communication of the project guys was really helpful and constant, so I didn't feel like I'd been left to wander the streets as you might, you know, put it.

(P146)

Many participants favoured receiving subsidised dental care as part of the study, as one participant stated: 'Best part...it's free... cause dental can be costly' (P49). Additionally, the inclusion of health promotion and education alongside clinical care was another valued aspect of the research:

The best part is being aware of the condition of my teeth and how it can affect me in the future when I do get old, especially so from the kind of information given to me by the expert who looked at my teeth...So that makes me feel happy.

(P380)

This theme relates to the research project's 'practice model' being well-received by Indigenous participants. The factors that worked included home-based dental care, the inclusion of health promotion and education alongside clinical care, flexible scheduling, family-centred approaches, follow-up and continuity of care and financial support for dental treatment and travel.

3.2.3 | Theme 3: Research Participation Supports Personal and Community Health

In this study, Indigenous participants described how their participation in Indigenous oral health-related research with a holistic focus provided them with greater insight into their own personal health and oral health. Additionally, participation was described as a positive way to support the health of the broader community by promoting the 'building of evidence' in this research area, which in turn may have positive implications for healthcare delivery:

I think it was just contributing towards the building of evidence and information towards having the service be available to all Aboriginal and Torres Strait Islanders in the state, I think it's a really, really important bit of work and I was just happy to play my

part in it to contribute and just to help underline the importance of that....

(P206)

As such, participants recognised the individual impacts of receiving clinical care through research, as well as how research may influence policies leading to improvements in health for Indigenous Peoples. These discussions indicated that participants viewed oral health service delivery as generally not adequately designed for Indigenous Peoples, and that feedback and participation are essential in improving services:

I suppose to develop further information for the dental industry in regards to Aboriginal people. I like to participate to give back as well but also I received a lot of help and support myself in regards to my teeth... benefited me quite a lot.

(P196)

Overall, many participants highlighted research participation as a way to give back to their community and to learn more about their own personal health, which some described as an empowering experience. Importantly, supporting Indigenous participation in oral health research requires building trust with communities through culturally safe approaches, as described in the aforementioned theme.

3.2.4 | Theme 4: Word-of-Mouth Referrals: Community-Driven Recruitment

Another factor that supported recruitment, participation and retention of participants as part of the current study was word-of-mouth referrals about the study (i.e., snowball sampling). Participants who had positive experiences with the study described sharing study details with friends, family members, work colleagues and clients:

I was sending a lot of clients to you guys as part of the study and all the feedback I had from other clients, they really appreciated it and that because they couldn't afford to get their teeth done.

(P257)

Additionally, many favoured the subsidised and personalised dental care they received, as well as the flexibility of the research team:

That you came to us and done it in the comfort of our homes. But then we're also able to get other family members who would not go to the dentist.

(P9)

Some participants asked if this programme was available to other family members and friends during the follow-up, reflecting that trust and rapport-building with communities are beneficial approaches to supporting research participation. These reflections highlight how community-driven recruitment

increases participation while also extending the reach and impact of the intervention.

4 | Discussion

This qualitative study explored the perspectives of Indigenous Australians involved in a culturally safe dental care research intervention. Importantly, participants themselves defined what culturally safe dental care meant to them, rather than having it determined solely by practitioners or institutional guidelines. Findings demonstrate that when research is designed around Indigenous values, including personalised care, Indigenous representation, flexible and accessible service delivery and community-driven participation, it can effectively reduce long-standing barriers to dental care and foster trust, engagement and retention among Indigenous communities. This study adds to the established evidence that non-Indigenous-led dental services, which are not culturally safe, prevent utilisation by Indigenous Peoples [28].

4.1 | Strengths and Limitations

The strengths of this research include capturing lived experience perspectives of 136 Indigenous Australian adults of various ages and community groups, as well as having an Indigenous dentist provide culturally safe dental treatment. The limitations include potential selection bias with snowball sampling and variability with self-reported experiences across quantitative measures. Only a small number of perspectives from participants living in regional and remote areas were captured, warranting further exploration.

4.2 | Lessons Learned

The findings from this study generated five key lessons for researchers, clinicians and policymakers seeking to design and deliver culturally safe oral health research with Indigenous communities:

1. Culturally safe environments and personalised approaches:

The findings from this study demonstrate that the provision of culturally safe dental intervention characteristics, such as home-based dental checks, flexible appointments, regular follow-ups, and oral health education, is pivotal in breaking down long-standing barriers to care for Indigenous communities. Mobile dentistry and culturally safe environments helped to alleviate the anxiety and stigma often associated with clinic-based dental treatments, particularly for families and young children. This aligns with past research, which confirms that accessibility, comfort and service flexibility are core determinants of health-seeking behaviour and satisfaction in Indigenous oral health interventions [20, 29, 30]. The study participants also emphasised that personalised, relationship-focused care, using tailored communication approaches, created a positive experience in dental research, maintaining a relaxed, friendly clinical setting. Participants' appreciation of yarning, clear explanations and validation of their experiences further aligns with Indigenous

methodologies, which privilege Indigenous voices and reciprocal relationships in health research [16]. Understanding preferences for scheduling dental appointments was key to supporting attendance. Participants emphasised the importance of convenient clinic locations and accessible transport over drop-in clinics and suggested grouping family members' appointments to engage parents and children better.

2. Addressing financial barriers:

The provision of financial support was particularly valued, as the cost of dental care is a significant barrier to access for many Indigenous families. This highlights the need to design oral health programmes that address not only clinical needs but also financial and logistical obstacles, especially when dental care is excluded from universal healthcare coverage (i.e., Medicare) [11].

3. Workforce:

Indigenous representation among dental practitioners and research staff has been shown to reduce power imbalances and alleviate anxiety. The presence of Indigenous dental providers was identified as instrumental for culturally competent communication and continuity of care [15, 31]. These local health care providers connect non-Indigenous care providers and patients by translating communication and serve as facilitators of continuity of care, maintaining services during professional turnover [31].

4. Research participation:

Participants recognised the broader benefit of contributing to building evidence and informing policy, viewing their involvement as a meaningful way to 'give back' to the community and help shape more responsive, effective oral health systems [21]. Participants reported not only personal benefits but also altruism (acting to benefit others, despite affecting oneself), helping others and contributing to science [32].

5. Community-driven recruitment strategies:

Word-of-mouth referrals and snowball sampling were used in promoting participation and retention, and when participants had positive experiences with the research team, they became advocates for the study, sharing their experiences with family, friends and colleagues, and actively encouraging others to participate. This peer-based recruitment approach not only increased study reach but also helped to overcome entrenched barriers of mistrust, shame and affordability that can inhibit dental care access among Indigenous communities [21, 32].

4.3 | Implications for Policymakers, Clinicians and Researchers

Policymakers can improve oral health service utilisation for Indigenous Peoples by supporting Indigenous-led oral health programmes, including dental clinics within ACCHOs, and oral health promotion and education campaigns led by Aboriginal Health Workers and Practitioners. Non-Indigenous-led dental

services, such as state dental services and private dental clinics, can listen, learn and grow from feedback from Indigenous patients and clinicians to improve cultural safety. This will be further supported by increasing Indigenous workforce representation within dental services to act as a cultural bridge, foster trust and sustain continuity of care. This study's Theme 1, '...recognising contextual factors and providing personalised care,' should be a guiding ethos for Indigenous oral health service delivery. In this project, features included home visits for anxiety in the clinical environment, treatment at no cost due to financial barriers, and regular contact because of unfamiliarity with dental systems. The onus is on state health and oral health policymakers to support practice model changes and culturally safe dental treatment for Indigenous Australians [33]. Non-Indigenous-led dental programmes aiming to increase Indigenous participation should consider Theme 4, which highlights the power of word-of-mouth referrals. When services are culturally safe and meet individual and family needs, participants are keen and proud to refer new participants to the study.

Clinicians can present these findings to managers and policymakers to advocate for changes within the dental clinics and systems in which they work. Where policymakers are unable or unwilling to make changes, clinicians can take inspiration from Indigenous co-designed and led dental research projects to improve the way they practise. When designing studies, dental researchers should centre Indigenous voices using participatory, decolonising approaches such as yarning, Indigenous leadership and community-driven recruitment to improve engagement and achieve better research outcomes. Protocols should consider both financial and logistical support, and findings should always be returned to communities.

Although this study was conducted with Indigenous Australians, the core findings are likely to resonate with Indigenous communities in other colonised nations including Aotearoa New Zealand (Māori), Canada (First Nations, Inuit, and Métis) and the United States (Native Americans and Alaska Natives), all of whom experience disproportionately higher rates of untreated dental disease than their non-Indigenous counterparts. The fundamental enablers identified in this study, which include culturally safe environments, Indigenous workforce representation, accessible and flexible service delivery and community-driven participation, align with principles in international Indigenous health frameworks and have been echoed in oral health research across these nations.

5 | Conclusion

This study highlights the importance of a culturally responsive oral health research team, the impact of culturally safe research, the role of participation in supporting both personal and community health and the value of community-centred recruitment processes.

Author Contributions

S.N.: contributed to conception and design, analysis, interpretation, drafted manuscript, critically revised manuscript and gave final

approval. R.A.: contributed to conception and design, analysis, contributed to interpretation, drafted manuscript, critically revised the manuscript and gave final approval. J.G.: contributed to design, analysis, contributed to interpretation, drafted manuscript, critically revised manuscript and gave final approval. J.H.: contributed to design, contributed to analysis and interpretation, drafted manuscript, critically revised the manuscript and gave final approval. G.L.G.: contributed to conception and design, contributed to interpretation, drafted manuscript, critically revised the manuscript and gave final approval. K.K.: contributed to conception and design, contributed to interpretation, drafted manuscript, critically revised the manuscript and gave final approval. A.P.: contributed to interpretation, drafted manuscript, critically revised the manuscript and gave final approval. L.J.: contributed to conception and design, contributed to interpretation, drafted manuscript, critically revised the manuscript and gave final approval.

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Ethics Statement

Ethics approval for this study was granted by the Aboriginal Health Council of South Australia Human Research Ethics Committee (04–22–990) and the University of Adelaide Human Research Ethics Committee. Ethics approval for this study was granted by the Aboriginal Health Council of South Australia Human Research Ethics Committee (04–22–990) and the University of Adelaide Human Research Ethics Committee.

Consent

Written informed consent was obtained from all participants prior to the interviews. Participants were informed about the study procedures, their voluntary participation, and their right to withdraw at any time without consequences.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

References

1. Australian Institute of Health Welfare, *Oral Health and Dental Care in Australia* (AIHW, 2023).
2. Australian Institute of Health Welfare, National Indigenous Australians Agency, *Measure 1.11 Oral Health, Aboriginal and Torres Strait*

Islander Health Performance Framework Website (AIHW & NIAA, 2023).

3. S. Nath, B. Poirier, X. Ju, K. Kapellas, D. Haag, and L. Jamieson, "Periodontal Disease Inequities Among Indigenous Populations: A Systematic Review and Meta-Analysis," *Journal of Periodontal Research* 57, no. 1 (2022): 11–29.
4. S. Nath, B. F. Poirier, X. Ju, et al., "Dental Health Inequalities Among Indigenous Populations: A Systematic Review and Meta-Analysis," *Caries Research* 55, no. 4 (2021): 268–287.
5. L. Jamieson, X. Ju, D. Haag, P. Ribeiro, G. Soares, and J. Hedges, "An Intersectionality Approach to Indigenous Oral Health Inequities; the Super-Additive Impacts of Racism and Negative Life Events," *PLoS One* 18, no. 1 (2023): e0279614.
6. J. Hedges, D. Haag, Y. Paradies, and L. Jamieson, "Racism and Oral Health Inequities Among Indigenous Australians," *Community Dental Health* 38, no. 2 (2021): 150–155.
7. S. Nath, J. Groundwater, R. Aiyar, et al., "Psychosocial Impact of Dental Aesthetics Among Aboriginal and Torres Strait Islanders: Mixed-Methods Study Using Psychosocial Impact of a Dental Aesthetics Questionnaire," *International Dental Journal* 76, no. 1 (2026): 109339.
8. K. Jones, N. Keeler, C. Morris, D. Brennan, K. Roberts-Thompson, and L. Jamieson, "Factors Relating to Access to Dental Care for Indigenous South Australians," *Journal of Health Care for the Poor and Underserved* 27, no. 1 (2016): 148–160.
9. A. Durey, N. Naylor, and L. Slack-Smith, "Inequalities Between Aboriginal and Non-Aboriginal Australians Seen Through the Lens of Oral Health: Time to Change Focus," *Philosophical Transactions of the Royal Society, B: Biological Sciences* 378, no. 1883 (2023): 20220294.
10. Australian Institute of Health Welfare, *National Oral Health Plan 2015–2024: Performance Monitoring Report* (AIHW, 2020).
11. A. Pham, J. Hedges, E. Flanagan, T. Mastrosavas, L. Jamieson, and S. Nath, "Aboriginal and Torres Strait Islander Dental Program Evaluations: A Mixed-Methods Systematic Review," *Community Dentistry and Oral Epidemiology* 53, no. 6 (2025): 713–723.
12. J. Satur and S. D. Carrington, "Cultural Safety in Aotearoa New Zealand and Australia-Why and How for Oral Health?," *Australian and New Zealand Journal of Dental and Oral Health Therapy* 10, no. 2 (2022): 4–7.
13. L. Jamieson, J. Hedges, Z. Dodd, et al., "Provision of Dental Care to Indigenous South Australians and Impacts on Improved General Health: Study Protocol," *International Journal of Environmental Research and Public Health* 20, no. 4 (2023): 2955.
14. D. Bessarab and B. Ng'andu, "Yarning About Yarning as a Legitimate Method in Indigenous Research," *International Journal of Critical Indigenous Studies* 3, no. 1 (2010): 37–50.
15. C. Mangoyana, S. March, R. Laloo, and L. J. Walsh, "Positive Oral Health Outcomes: A Partnership Model Improves Care in a Rural Indigenous Community," *Australian Journal of Rural Health* 31, no. 3 (2023): 452–463.
16. AIATSIS, "Principles for Engagement in Projects Concerning Aboriginal and Torres Strait Islander Peoples," (2020).
17. Australian Dental Council, "Professional Competencies of the Newly Qualified Dentist: Guidance Notes on Cultural Safety," (2022).
18. Australian Health Practitioner Regulation A, Aboriginal, Torres Strait Islander Health Strategy G, *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025* (Australian Health Practitioner Regulation Agency, 2020).
19. J. Hedges, B. Poirier, G. Soares, et al., "Journeying Towards Decolonising Aboriginal and Torres Strait Islander Oral Health Research," *Community Dentistry and Oral Epidemiology* 51, no. 6 (2023): 1232–1240.

20. J. Patel, A. Durey, S. Naoum, E. Kruger, and L. Slack-Smith, “Does This Dental Mob Do Eyes Too?: Perceptions and Attitudes Toward Dental Services Among Aboriginal Australian Adults Living in Remote Kimberley Communities,” *BMC Oral Health* 21, no. 1 (2021): 662.
21. R. Sheridan, J. Martin-Kerry, J. Hudson, A. Parker, P. Bower, and P. Knapp, “Why Do Patients Take Part in Research? An Overview of Systematic Reviews of Psychosocial Barriers and Facilitators,” *Trials* 21, no. 1 (2020): 259.
22. T. Huria, S. C. Palmer, S. Pitama, et al., “Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous Peoples: The CONSIDER Statement,” *BMC Medical Research Methodology* 19, no. 1 (2019): 173.
23. M. Bird, M. McGillion, E. M. Chambers, et al., “A Generative Co-Design Framework for Healthcare Innovation: Development and Application of an End-User Engagement Framework,” *Research Involvement and Engagement* 7, no. 1 (2021): 12.
24. R. Aiyar, S. Nath, J. Hedges, et al., “Indigenous Australians’ Oral Health Care Experiences: Recommendations for Culturally Safe Dental Care,” *JDR Clinical & Translational Research* (2025): 23800844251390485.
25. G. L. Guzzo, S. Kularatna, S. Nath, et al., “Costs of Providing Culturally Safe Dental Care for Indigenous People of Australia: A Follow-Up Intervention Study,” *Community Dentistry and Oral Epidemiology* (2025): 1–9, <https://doi.org/10.1111/cdoe.70048>.
26. J. Brooks, S. McCluskey, E. Turley, and N. King, “The Utility of Template Analysis in Qualitative Psychology Research,” *Qualitative Research in Psychology* 12, no. 2 (2015): 202–222.
27. G. Symon, “Qualitative Organizational Research,” in *Doing Template Analysis*, ed. C. Cassell and N. King (Sage, 2012), 426–450.
28. N. Stormon, D. Carr, P. Drahm, and K. Phillips, “Utilizing Aboriginal Participatory Action Research-Dadirri-Ganma to Co-Design the Deadly Dental Home,” *Qualitative Health Research* (2025): 10497323251335837, <https://doi.org/10.1177/10497323251335837>.
29. A. Tynan, D. Walker, T. Tucker, B. Fisher, and T. Fisher, “Managing Oral Health Care and Prevention: The Experience of Aboriginal and Torres Strait Islanders Living in a Rural Community in Queensland, Australia,” *Australian Journal of Rural Health* 30, no. 2 (2022): 228–237.
30. J. Patel, R. Long, A. Durey, S. Naoum, E. Kruger, and L. Slack-Smith, “The Kimberley Dental Team: A Volunteer-Based Model of Care Serving Remote Aboriginal Communities,” *Rural and Remote Health* 23, no. 3 (2023): 7366.
31. M. A. Gray and F. I. Oprescu, “Role of Non-Indigenous Researchers in Indigenous Health Research in Australia: A Review of the Literature,” *Australian Health Review* 40, no. 4 (2016): 459–465.
32. A. G. Castillo, L. Jandorf, L. D. Thélémaque, S. King, and K. Duhamel, “Reported Benefits of Participation in a Research Study,” *Journal of Community Health* 37, no. 1 (2012): 59–64.
33. Commonwealth of Australia, “Australian Government Response to the Senate Select Committee Into the Provision of and Access to Dental Services in Australia Report,” (2024).

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** CONSIDER statement.