Oral Health Matters - Episode 4

A question of policy?

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SPEAKERS
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Richard Watt 00:05
Welcome to Oral Health Matters, a podcast that shines a spotlight on oral health and calls for it to be embraced as a key part of the global public health agenda. I'm Richard Watts, Professor Dental Public Health at University College London. In this first series of our podcast, I've been in conversation with international colleagues and members of the core research programme, a team of researchers and activists from around the world who are working to tackle the problem of oral diseases in Kenya, Colombia, India, and Brazil. In episode four, we're asking how we can best develop and nurture the next generation of oral health researchers. To discuss this topic, I'm delighted to be joined by Professor Lisa Jamieson, from the University of Adelaide in Australia, and Professor David Conway from University of Glasgow in Scotland. Lisa has an international reputation for her work on indigenous or health research and health inequalities. And David is an expert in dental public health research with a particular focus on oral cancer and child oral health. So welcome to both of you to our podcast interview. And my first question really is what are the main challenges to developing the next generation of oral health researchers working in dental public health or global health research? Lisa, what would your summary be of the challenges that we're facing?

Lisa Jamieson 01:32
Well, if I had to give a summary, I could start with two words, job security. We find in Australia that we are increasingly finding it difficult to get funding to do research in then dental public health space. And that means that the contracts that we give out to our emerging oral health superstar researchers often can't be more than 12 months at a time, and so for folks who are hoping to you know, often they've come through the Bachelor, Masters PhD system, they're starting off with postdocs, they tended to travel overseas and gain more experience, which is

always fabulous. But we are quite keen to keep them to develop, that we want to make sure that we can harness their fabulous intellect. So we've tried to keep them going, but when we can only offer a 12 month contract at a time, it's difficult to keep them sometimes.

Richard Watt 02:21
Okay, so that, that issue of funding and stability and job security. David, from your perspective, what would you think are the main challenges?

David Conway 02:30
Yeah, I mean, I completely agree with that. Funding is absolutely key to trying to take forward a lot of the research. And just to build on that a little bit, the funding landscape is really tight, it's hard, it's really hard to advocate or make the case for oral health research in amongst a few of other huge global health priorities. So that's a challenge. It then becomes also a challenge to take a public health approach to developing research in amongst, again, a competitive environment, which is dominated by biomedical model of research and clinical research to try to make that case. And then there thirdly, trying to go into that area of inequalities in health becomes challenging. But I think that's the direction we have to go and work with colleagues around the world and that. So I think this funding is key. And I think I think also is trying to find the opportunities to work globally, funding has to, in some ways help open that window. But I think we have to have our doors open to seeking opportunities and working with colleagues across the world.

Richard Watt 03:42
Okay well, I mean, that's some really big important issues you've both identified there. Maybe if we just focus on this issue of priority setting and funding. If we're trying to be more optimistic. Are there global developments from WHO and other places that might help us argue that oral health research from a population perspective can be a priority? I mean, I'm just trying to think of the linkage between the sort of priority setting at policy level to influencing research agencies at either national or international level. Lisa, what's your view on? Is there any traction? Is oral health more recognised now than before or not? What's your view?

Lisa Jamieson 04:27
So absolutely, WHO is a wonderful international partner to be working with? They often don't have a huge amount of money to be sharing around the collaborators, but they certainly have the interest in the wherewithal and often the connections too. Because I work a reasonable amount and the indigenous space, the United Nations have a standing committee on Indigenous Health affairs and so oral health has certainly been promoted in the last decade or so, has been a concern intentionally because of all the many issues that indigenous communities face in terms of similarities for colonisation, and racism, and all that sort of thing. So I found that through the UN, there's certainly pathways sometimes for funding at an

international level. And also we have quite a lot of engagement by, and with indigenous communities and selves who are taking leadership roles. So I find more and more, you know, as a white person working in an indigenous space, I can certainly help in the background provide scaffolding, but it's not really my place anymore to be the leader. So in my own unit in Australia, we have a team of 25, pretty much young researchers, probably in the 25 to 35 to 40 year range. And they are all international, we have probably about eight or nine indigenous scholars too. And my job basically is to write the grants and to make sure that they've got funding arming, they've got salaries coming through, so that they can develop their own research agendas. And often what we find is that we have to play the game, we have to find targeted cause of research that might be in areas such as the microbiome, and whilst we might not think upfront microbiome is anything necessarily important to dental public health, we find avenues and ways in which we can write a convincing grant application around the microbiome or a microbiome, and the ways that dental service utilisation may or may not benefit changes in the oral microbiome following comprehensive dental care, just as one example. One of the great privileges we have working with this young team is that they're so innovative, they know how to use social media, which I do not. And they are game changers in terms of optimism, really, the older I get, the more cynical I become, but I I get buoyed by their energy and enthusiasm. And, you know, we get knocked down, we come back up again.

Richard Watt 06:51
Okay, Lisa, thank you. Now, we'll come back to some of these issues you mentioned, because some of them are definitely fundamentally important. David, anything to add from your side in terms of that search for funding opportunities, the link between this agenda International and oral health is not helping at all or not really? Great, David, some really seminal issues there in terms of the sort of priority placed on oral health and under sort of broader impacts seem to be some do an important way forward. Slightly moving the focus on and thinking particularly around the issue of the inequities in accessing research, training, and development opportunities. Lisa, I'm really interested in your point you raised about your experience of working with indigenous communities, and the sort of shared partnership working in and the role in which the communities themselves lead that research and the training associated with that. Do you want to say a little bit more about how that experience has gone?

David Conway 07:10
You know, absolutely. And what Lisa said there around finding the links, I mean, that's critical to this endeavour and echo what Lisa also said about your advocacy role, and the role you've done with the Lancet Commission work that's ongoing and the work that WHO are leading in raising the profile of oral health with Benoit Varenne, and the oral health office there. And I think the approach that has been taken has been one where it's making these links with NCDs, with the non-communicable disease agenda, emphasising the common risks that oral health has with other conditions, emphasising with the global burden of disease that it's the most

common, most prevalent condition on the planet, oral disease is both in children and adults, and there's huge inequalities, both within and between countries, and like raising that profile has been really important. And then also, when you're thinking in high income country context, that the costs for care are huge, maybe within the top three for all health care conditions. There's a lot of issues in there that you can hang to make the case for delivering in oral health and not least actually, if you get back to how oral health can impact on the individual and families, on life, have that wider social impact on. We've seen in our research recently, the time lost from school related to poor oral health, and tried to explore that are you able to mitigate that through child oral health preventive activities.

Lisa Jamieson 09:33
Yes, so I have probably spent the last 15 years or so working closely with around 18 Aboriginal Community Controlled Health Organisations in Australia, we call them ACCHOs for short. And there's a lot of extremely smart CEOs, or these ACCHOs. But they are working in an industry if you like, because I think research funding has become increasingly an industry, certainly hasn't Australia. And so you've got to be able to play that game, you've got to be able to navigate these horrendous funding online platforms in terms of submitting grant applications, you've got to have a pretty impressive CV that includes publications that, you know, you really need to have an understanding of how academia works before you can publish papers. You need to be able to talk the talk when you go to meetings at universities, as well as communities. So you have to sort of be able to step one foot in both worlds, if you like. It can be so daunting, because at the end of the day, we are working in a colonial system that was introduced by Europeans and there's a lot of tokenism, certainly in Australia, around decolonizing university education courses, decolonizing health funding models, but the system very much is still geared around supporting those who have an understanding of western education systems, western banking systems, western financial systems. It's a very, very hard thing to disentangle. Just today, as an example, I've been working with three CEOs, Aboriginal people, Aboriginal leaders of these Community Controlled Health Organisations, we are trying to submit a grant around the oral microbiome, which is what I was saying before. I have pretty much written the grant with a lot of input from their side around what is and isn't going to work in the communities. But in order for them to be involved as chief investigators, because they're leading the grant, they have to navigate the system in Australia around the health research funding model, the application system, which is online, and then they get into the system and they have to have a one time password, which requires Google authentication through their mobile phones. And it's just next level, it's just so ridiculously impossible sometimes for people to navigate that. This is just one example of a funding application so at a broader level, multiply this by 1000, it's exhausting when you're also working with communities who are facing, oh, just so many major life events in a given week. Many, what they call cybers, so many deaths in a community, chronic diseases which are making a massive impact on their health services. So this kind of research around oral health and equities, really doesn't become a priority.

Unless there's someone like me, who was able to do most of the work for them. And at the end of the day, they can push the submission button,

Richard Watt 12:17
I can sense your sort of frustration in your voice and I can share that. David, thinking about in the UK, the challenges of engaging with marginalised communities, as future researchers, are we as in a bad position as they're down south in Australia, do you think?

David Conway 12:38
I mean, I don't think we've cracked it by any means. But I think there's certainly a shift, I mean, across the research agenda to engage from the start on public and patient engagement involvement in research and priority settings, but I think there's a long way to go. One of the projects we're involved with here in Glasgow is evaluating and monitoring the Childsmile, child oral health improvement programme for Scotland, which has been long running and has actually had quite a number of successes. And it does take that principle really at its heart from the outset of trying to work with communities rather than do things to them, to avoid approach that is just one on messaging or instruction or education to working with and trying to do community engagement, community development, working with communities to solve problems, to get out the dental or health service bubble and work in education settings in schools and kindergartens and nurseries, working with health visitors and other teams. So yeah, trying to take that approach, I mean, I suppose that's an example we have of trying to do that engaging work. More broadly, I think, still some way to go to have that genuine participatory involvement. I'd like that there's a model called Arnstein's Ladder of Participation and at the bottom, you placate a community or you do things to them. And as you go up, you start to engage with them more. I think we're probably halfway up that that ladder of engagement, which it goes beyond consultation to working with communities but at the top I mean, you genuinely are handing over power to communities, you're devolving power, you're devolving budgets, you're devolving leadership, and I think we've still got some way to go in that.

Richard Watt 14:21
Well, again, some really interesting points there on that sort of power dynamics, power differentials. In our other episodes in the series, those issues have certainly come up time and time again. And Lisa, reflecting on your points about the sort of colonisation agenda legacy historical long term effects of our history. Again, an interesting point that repeatedly comes up in our discussion. So some real sort of synergies of themes here.

David Conway 14:50
Yeah Richard, I think I mean just to build on that. I think as well as the local examples we've given that mean, I think there are global examples of that colonisation that Lisa talked about.

And if we're thinking of global health research agenda, it's still often driven by the high-income countries and our research institutions and what our priorities are, rather than properly reflecting the priorities and the needs of the health systems of low and middle income countries. And I think it's still some way to go for us to properly go up that ladder in a global sense as well, to really, really engage with colleagues across low- and middle-income countries in the Global South particularly.

Richard Watt 15:30
Good point David, I think just that links nicely into my next point to highlight with both of you, and naturally I suppose the role of international professional organisations, for example, IADR or others, what role could those international groups have to play to nurture the next generation of dental public health researchers? Is there anything these groups globally could do to help? Lisa, what's your thought?

Lisa Jamieson 15:59
Wow, I agree 100%, and I have to take my hat off to IADR. I believe that they have come such a long, long way, in terms of really diversifying their leadership groups, really diversifying the priority areas that have taken, you know, huge steps just even, One example is the LGBTQI+ community. So there's a leadership group around that now, I'm involved in one that's working with vulnerable populations globally with a specific focus on indigenous but also any other groups. I'm also quite involved in the Woman and Science Network. And we have incredible support throughout the whole IADR at a global level, you know, credit to the IADR leadership really for taking hold of the juggernaut around what is really important at a societal level. Because I think that we have a social licence with the work that we do, our leadership groups that we are involved with, with all international organisations need to embrace societies who are changing. And it's interesting at a global level, because some countries are not embracing LGBTQI+ communities, for example. So I think that the IADR walks a tricky line sometimes when they are embracing values and mission statements that some countries may reject wholeheartedly. But I think that in terms of a leadership sense, and for the rest of the world to see that the data has taken a stand. This is an example of an oral health research group. It's the only way that we're really gonna have change moving forward, I think.

Richard Watt 17:31
Lisa I vaguely remember you and me having a conversation probably years ago, about IADR. And I think you've really have challenged them and you have been a spearhead for a lot of that inclusion work, so I think you should take credit for a lot of that that's been achieved, because I think things have changed radically over the years.

Lisa Jamieson 17:32

Yes, they sure have, they sure have. I do remember starting and just having so much resistance and just being so frustrated because it just felt like working with the concrete wall. But there has been change, and you know, credit to the leaders who have just, you know, become part of the journey with us I feel like now, is it's a really fun environment. And it's so useful for the younger folks who are coming through because they see that and they see this as an organisation where they can belong these people there that look like them with the same colour skin, with the same different orientations for certain things. So I think that they had to do that otherwise, I think that they would have been losing the battle.

Richard Watt 18:30
David what's your thoughts on organisations like IADR, not just IADR, but any other sort of professional groups?

David Conway 18:37
During my career going to IADR, I see the shift and the research that orbit has moved very much into the space of public health and oral health and inequalities. And in the Global Oral Health Group there, away from very heavily biomedical material focused research. I would say in the last 10-15 years I've been going to IADRs its definitely shifted the conference in Latin America and Colombia and Bogota the other year was a brilliant example of like a really diverse agenda in that space. I think that's a really welcome shift. I think there's still an issue for students, postdocs, researchers, colleagues from the lower- and middle-income countries accessing IADR. I mean, I think we have to still be honest there is still some work to do to really genuinely open up, and it is through these networking opportunities that some of that research sparked. That's actually why the value of coming together in conferences. I mean, we could do a lot of these webinars online, but actually the value is that the meeting the networking, the conversations that you can get around these conferences. So I think opening that up even further is worthwhile doing. I mean maybe at this point, also worth saying an organisation, it's a funder organisation like The Borrow Foundation has been, again gone on a journey to really embrace global oral health and they provide some of that funding that we're talking about as being like hard to reach, but a lot of that and the recent calls are focused around global oral health challenges, and really embracing funding equitable partnerships with low and middle income country colleagues.

Richard Watt 20:12
Very good point, David. And, and just because Lisa, you may not know about The Borrow Foundation is a UK based charity, originally focused on milk fluoridation, but they broaden their focus much more on to inequalities, on to global health. And they fund a variety of sort of international projects now and also very important, as you say, David, supporting researchers in different countries. So for example, in Europe, supporting colleagues from Eastern European countries to attend conferences. So that's another example where were they as an

organisation have certainly move forward in the direction of what you were discussing? Just continuing that point? And thinking particularly of a sort of global north versus global south and the inequities, in terms of resources, structures, organisations, what can senior researchers like us do in the global north to support our colleagues in the global south to really move forward in terms of training and development? Lisa, what's your view on that?

Lisa Jamieson 21:20
I think that there's probably a lot that we could be doing in terms of knowledge sharing. 100% agree with what David was saying around the face-to-face benefits of conferences and networking. So certainly supporting travel scholarships and that sort of thing, so that emerging researchers from the low income countries that may struggle, I think that that would be useful. But I think also, it's about us, giving up some of our power back to the power, you know, building capacity so that the leaders in these countries and situations and groups can lead it themselves have the agency to change the agenda sometimes. It may not be done in ways that are traditional to the ways that we've been taught and believe in that sort of thing. I think that the commercial determinants of health, again, come back to a lot of this colonial western power base that often leads to oral health inequities. And frankly, I think that the way a lot of our dental institutions are run, the power lies with the powerful and it's no one really wants to give that up. So I think that in some ways, when we look at the power that we hold, as leaders, I mean, we're all right. We've all been trained and pretty solid institutions, we've all reached very high levels of degrees in education, we've all published widely. And that is something that we can help give back by submitting grant applications with folks who are from the south as you read it, then. The publication's that's always going to be useful for those who are working in a dental institution. And I think just being prepared to be in the scenes and helping behind and providing the scaffolding but having none of the glory.

Richard Watt 23:02
Good point. None of the glory. That's an interesting one. David, what what's your thoughts on that point?

David Conway 23:08
I strongly agree with Lisa on all of that. And I think people don't really understand what we're talking about, but trying to take, endeavouring to take a de-colonisation approach to working. And that is really recognising that colonisation has been exploited. That can be with within our countries, and we've talked about that in communities but also globally, particularly. And really acknowledging that privileged point of view and place that we start from in high income country, in the institutions, with an often white privilege, male privilege for me and many, many researchers as well, to start with that, and then to genuinely try and create an equitable partnership. And I do recommend listeners, and they get out an article on BMG Global Health by Bain and colleagues. It's about global health mentorship, and it talks about challenges and

opportunities for equitable partnership and equity. It talks about a lot of the things we've been discussing here, around acknowledging that, but a couple of just highlights that I thought were worth sharing. One was, it's not really one of our capacity in low and middle income countries, it's there, it's about strengthening that, not building it from scratch. It is there and working with it and taking that kind of backseat role. And I think recognising that that work is a two-way learning street and for example, colleagues in low income countries will know that the context, the challenges, the needs of that country will actually know how to do research in that context. Way more than us in high income countries, a lot of learning for us to do and that learning that can be done is actually can come right back and improve health and research in our countries. One example in Childsmile is we've adopted these community link workers in Scotland in dental support working roles, but also across health. And that has come from a strong tradition in the global south of community workers working across any areas whether on health services.

Richard Watt 25:13
Great. Well, look, we've discussed a lot, some profoundly important issues have been raised by both of you, just pulling things towards the end now. Perhaps my final question for both of you is sort of moving forwards, looking in a sort of positive creative direction. Could you identify sort of key priority in terms of how we can support the development of the next generation of dental public health researchers? What would your final message be as a priority? Lisa?

Lisa Jamieson 25:44
Well, the priority has to be prioritising our young developing superstars that are moving forward. I think that we can do that, I think that there are enough keen, eager beavers out there who have the capacity to really take on the challenges that we're facing globally. Because there's so much connection now, there's such benefit and social media, and even the podcasts that we're doing now can have a global reach. And I think that there is a willingness for high income countries, low-income countries to work together in partnership, because I completely agree with what David was saying, it's a two way learning. It's a two way, a double approach of seeing the world if you like there is much to be gained for high income researchers to be working in low-income communities, and just recognising the richness and the wealth and the humour and the legacies that many other sort of programmes have have impacted there. So I think that there is a huge push for us to let go of some of the smugness perhaps is the word, or the sort of idea that it's always going to be better if it's from the west, because it's not always the case. And so yes, I have great excitement when I think about the future workforce moving forward, because there's a humility there that I think was lacking. Certainly, when I was coming through.

Richard Watt 27:02
Brilliant. David, what about you final thoughts?

David Conway 27:05
I think open our doors, share our opportunities, shared leadership, step out of the leadership role, devolve that leadership, challenge our own power structures. And I'd be really optimistic. I mean, before the pandemic, we couldn't get a video Skype call with rural parts in Ireland and Scotland, and post pandemic we Teams, Zoom, there's a lot of ways of connecting that can really help open these doors and make these connections. And I think we need to do that in a genuinely equitable partnership way. And I think there's a lot of optimism to be had around trying to improve population oral health.

Richard Watt 27:50
It's been a fascinating discussion. And maybe just to try and summarise some of the big issues that we've heard about. I think, you know, we've all acknowledged the legacy of colonisation, the legacy of power differentials, the legacy of control and authority led by mostly white men in positions of authority. But I think, you know, from an optimistic perspective, looking forward, that connected interconnected world, the strengthening capacity, the respect, we can show the more inclusive approach to research, to community development, to community partnership working. That all feels very positive, it feels exciting, it feels a really good way forward, that can make a meaningful difference in oral health. So thank you both very much indeed. So I'd like to thank our guests, Lisa Jamison, and David Conway, and to you for listening. In our next episode we'll be in conversation with Professor Sharon Friel, from the Australian National University, and Professor Professor Delan Devakumar from University College London, and we'll be discussing the issues of commercial determinants of health and health equity. Oral Health Matters is produced by the dental Public Health Group at UCL with production support from Research Podcasts, and funding from the UK National Institutes for Health and Social Care Research. Thank you for listening.