Policy on Diversity, Equity, and Inclusion

Adopted
2022

How to Cite: American Academy of Pediatric Dentistry. Policy on diversity, equity, and inclusion. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2026:62-65.

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) advocates for the health and well-being of all infants, children, and adolescents, regardless of their race, ethnicity, religion, sexual or gender identity, medical status, family structure, or financial circumstances[1] and supports efforts to increase health equity among youth. Diversity, equity, and inclusion (**DEI**) are critical to achieve the AAPD'S vision of optimal oral health for all children.[2] The intent of this policy is to review the published literature on how race, ethnicity, and other identifiers are related to children's oral health and health inequities, to identify barriers to DEI within the dental profession, and to encourage clinicians, educators, researchers, and policy makers to advance DEI within the specialty of pediatric dentistry.

Methods

This policy was developed by the Council on Clinical Affairs. A review of current dental and medical literature and sources of recognized professional expertise related to DEI was completed. The literature search of the PubMed/MEDLINE database was conducted using the terms: *diversity*, e*quity*, *inclusion*; fields: all; limits: within the last 10 years, English. Papers for review were chosen from this list and from the references within selected articles. Expert and/or consensus opinion by experienced researchers and clinicians was also considered.

Definitions

Diversity: constitutes "a broad range of individual, population, and social characteristics, including but not limited to age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; physical, functional, and learning abilities; religious beliefs; and socioeconomic status".[3] In addition, other characteristics of diversity include body/size image, veteran status, housing status, and mental health status.[4]

Equity: is defined as "the state, quality or ideal of being just, impartial and fair."[5] The concept of equity is synonymous with fairness and justice. To be achieved and sustained, equity needs to be thought of as a structural and systemic concept.[5] Moreover, health equity is described as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities".[6]

Inclusion: "is a dynamic state of operating in which diversity is leveraged to create a fair, healthy, and high-performing organization or community. An inclusive environment ensures equitable access to resources and opportunities for all. It also enables individuals and groups to feel safe, respected, engaged, motivated, and valued, for who they are and for their contributions toward organizational and societal goals."[7]

Background

Marked oral health disparities exist by race and ethnicity for children and adolescents in the United States.[8-11] Children of American Indian and/or Alaska Native descent and Native Hawaiian children have the highest documented prevalence of early childhood caries, and a significantly higher percentage of non-Hispanic Black and Mexican American children have dental caries, compared to non-Hispanic White children.[12-15] Reasons such as consumption of more added sugars and less utilization of preventive dental care have been used to explain the higher caries risk assigned to racial and ethnic minorities.[16,17] While behavior modification strategies are important to improve oral health, the overarching role of social determinants of health must be addressed if oral heath disparities are to be reduced in a long-lasting and meaningful way.[18,19]

Structural racism (ie, processes that are embedded in laws, policies, and institutions[20,21]) impacts social determinants of oral health.[22,23] Discriminatory policies such as unfair lending practices, employment standards, and workplace policies heavily influence factors such as income level, insurance coverage, quality of education, food security, housing, chronic stress, and neighborhood resources that lead to poorer oral health outcomes for marginalized populations.[9,10,18,24,25] Access to dental services, nutritious food, and safe and fluoridated drinking water[10,25] are significantly hindered by barriers such as housing instability, food deserts, inflexible work schedules, lack of transportation, and high costs of care that disproportionately affect non-Caucasian families.[26-29] Recognition of the influence of discrimination on the social determinants of oral health is necessary to advocate for greater health equity.[25,30]

Available literature has discussed more direct effects of bias on oral health. Racial minorities often receive lower quality health care than their White counterparts even when

ABBREVIATIONS
AAPD: American Academy of Pediatric Dentistry. **DEI:** Diversity, equity, and inclusion.

accounting for factors related to access, socioeconomic status, and education.[10,31] Negative effects on self-perceptions of oral health status[31,32], diminished oral health-related self-efficacy[33], and avoidance of dental appointments due to fear of maltreatment[10,34] have been reported. Caregivers of minority children have expressed unmet dental needs and inattentiveness from dental providers.[10]

Heightened awareness of oral health inequities and related social injustices have inspired professional efforts to enhance diversity and inclusion in the pediatric dental workforce and to combat discrimination that leads to oral health inequities. Dental schools and professional organizations have created strategies to increase diversity among their students, members, and leadership.[36,37] The increased presence of underrepresented populations among health care professionals is important for building trust between providers and marginalized families.[10,19] AAPD legislative priorities align with aims to increase professional diversity and health equity through the support of provider training programs, recommended Medicaid reform, and expansion of the dental workforce.[38,39]

Both intentional and non-intentional provider biases affect the health care that children receive. The National Institutes of Health report *Oral Health in America: Advances and Challenges* calls for a new framework in dental education that emphasizes the social determinants of health, inequities, and population diversity.[19] Improved cultural competency training in practices, residency programs, dental schools, universities, and other institutions relevant to the practice of dentistry is necessary to address discriminatory assumptions and behaviors among dental providers.[35,40-43] Relevant training may encourage providers to be mindful of the ways in which personal and professional biases influence practice settings, treatment decisions, office policies, and patient relationships[22] and motivate them to create an inclusive and respectful environment for all children in their care. Barriers to implementation of DEI principles, including lack of social supports to help manage children's needs, have been reported.[44,45]

Policy statement

The AAPD acknowledges and celebrates the increasing diversity of children, including their racial and ethnic backgrounds, national origin and citizenship, languages spoken, religious beliefs, abilities, gender and sexual identities, and cultural norms. Additionally, the AAPD welcomes greater diversity within the profession and appreciates the personal experiences, skills, and knowledge possessed by each of its individual members. The AAPD supports broader inclusivity in leadership, membership, education, and practice and deeper engagement with communities to promote necessary collaboration, respect, and dignity for all children and families. Programs, initiatives, and policies that address and overcome social barriers, including racism and other forms of discrimination, are necessary to achieve greater health equity and the AAPD's vision of optimal oral health for children.

Recognizing the importance of DEI to pediatric dentistry, the AAPD

- supports social and economic policies, research, and initiatives to address social determinants of oral health that result in racial and ethnic oral inequities.
- encourages providers to implement DEI training within the dental office.
- urges dental educators to implement strategies to mitigate bias in applicant and trainee evaluation processes and to enhance institutional DEI curricula.

References

1. American Academy of Pediatric Dentistry. Policy on care for vulnerable populations in a dental setting. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2022:34-40.
2. American Academy of Pediatric Dentistry. Strategic plan. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2022:10-11.
3. Diversity, inclusion, and equity in academic nursing: AACN position statement. American Association of Colleges of Nursing; 2017. Accessed July 26, 2022. https://www.aacnnursing.org/Portals/42/News/Position-Statements/Diversity-Inclusion.pdf
4. Buchanan DT, O'Connor MR. Integrating diversity, equity, and inclusion into a simulation program. *Clin Simul Nurs*. 2020;49(C):58-65. DOI: 10.1016/j.ecns.2020.05.007
5. Annie E Casey Foundation. Race equity and inclusion action guide. 2015. Accessed July 26, 2022. https://www.aecf.org/resources/race-equity-and-inclusion-action-guide
6. Office of Disease Control and Prevention. Disparities. Foundation Health Measures. *Healthy People 2020*. US Dept of Health and Human Services. December, 2010. Accessed June 22, 2022. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
7. Centre for Global Inclusion. Diversity, equity, and inclusion policy. Accessed August 15, 2022. https://centreforglobalinclusion.org/resources/dei-policy.html
8. Lau M, Lin H, Flores G. Racial/ethnic disparities in health and health care among U.S. adolescents. *Health Serv Res*. 2012;47(5):2031-2059. DOI: 10.1111/j.1475-6773.2012.01394.x
9. McLaren L, McNeil DA, Potestio M, et al. Equity in children's dental caries before and after cessation of community water fluoridation: Differential impact by dental insurance status and geographic material deprivation. *Int J Equity Health*. 2016;15:24. DOI: 10.1186/s12939-016-0312-1
10. Como DH, Stein Duker LI, Polido JC, Cermak SA. The persistence of oral health disparities for African American children: A scoping review. *Int J Environ Res Public Health*. 2019;16(5):710. DOI: 10.3390/ijerph16050710

References continued on the next page.

11. Oral health: Disparities in oral health. Centers for Disease Control and Prevention; February 5, 2021. Accessed May 31, 2022. https://www.cdc.gov/oralhealth/oral_health_disparities/ index.htm
12. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America's children. *Acad Pediatr*. 2009;9(6):415-419. DOI: 10.1016/j.acap.2009.09.010
13. Deguchi M, Valente T, Efird J, Oropeza M, Niederman R, Nigg CR. Hawai'i's silent epidemic: Children's caries (dental decay). *Hawaii J Med Public Health*. 2013;72(6):204-208.
14. Matsuo G, Rozier RG, Kranz AM. Dental caries: Racial and ethnic disparities among North Carolina kindergarten students. *Am J Public Health*. 2015;105(12):2503-2509. DOI: 10.2105/AJPH.2015.302884
15. Holve S, Braun P, Irvine JD, et al. Early childhood caries in Indigenous communities. *Paediatr Child Health*. 2021;26(4):255-258. DOI: 10.1093/pch/pxab023
16. Chi DL, Hopkins S, O'Brien D, Mancl L, Orr E, Lenaker D. Association between added sugar intake and dental caries in Yup'ik children using a novel hair biomarker. *BMC Oral Health*. 2015;15(1):121. DOI: 10.1186/s12903-015-0101-z
17. Choi YY, Andreyeva T, Fleming-Milici F, Harris JL. U.S. households' children's drink purchases: 2006-2017 trends and associations with marketing. *Am J Prev Med*. 2022;62(1):9-17. DOI: 10.1016/j.amepre.2021.06.013
18. American Academy of Pediatric Dentistry. Policy on social determinants of children's oral health and health disparities. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2022:29-33.
19. National Institutes of Health. *Oral Health in America: Advances and Challenges*. US Dept of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research; 2021. Accessed August 15, 2022. https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf
20. Williams DR, Lawrence JA, Davis BA. Racism and health: Evidence and needed research. *Ann Rev Public Health*. 2019;40:105-125. DOI: 10.1146/annurev-publhealth-040218-043750
21. National Academies of Sciences, Engineering, and Medicine. Addressing diversity, equity, inclusion, and anti-racism in 21st century STEMM organizations: Proceedings of a workshop–In brief. The National Academies Press; 2021. Accessed July 26, 2022. https://doi.org/10.17226/26294
22. Jamieson L, Peres MA, Guarnizo-Herreño CC, Bastos JL. Racism and oral health inequities: An overview. *EClinical-Medicine.* 2021;34:100827. DOI: 10.1016/j.eclinm.2021.100827
23. Bastos JL, Constante HM, Jamieson LM. Making science and doing justice: The need to reframe research on racial inequities in oral health. *Community Dent Health.* 2021;38(2):132-137. DOI: 10.1922/CDH_IADRBastos06
24. Lee JY, Divaris K. The ethical imperative of addressing oral health disparities: A unifying framework. *J Dent Res* 2014;93(3):224-230. DOI: 10.1177/0022034513511821
25. Braveman P, Gottlieb L. The social determinants of health: It's time to consider the causes of the causes. *Public Health Rep*. 2014;129(Suppl 2):19-31. DOI: 10.1177/00333549141291S206
26. Cao S, Gentili M, Griffin PM, Griffin SO, Serban N. Disparities in preventive dental care among children in Georgia. *Prev Chronic Dis*. 2017;14:E104. DOI: 10.5888/pcd14.170176
27. da Fonseca MA, Avenetti D. Social determinants of pediatric oral health. *Dent Clin North Am*. 2017;61(3):519-532. DOI: 10.1016/j.cden.2017.02.002
28. Chi DL. Oral health for US children with special health care needs. *Pediatr Clin North Am*. 2018;65(5):981-993. DOI: 10.1016/j.pcl.2018.05.007
29. Vujicic M, Fosse C. Time for dental care to be considered essential in US health care policy. *AMA J Ethics*. 2022;24(1):E57-63. DOI: 10.1001/amajethics.2022.57
30. Evans, CA, Smith, P. Effects of racism on oral health in the United States. *Community Dent Health*. 2021;38(2):138-141. DOI: 10.1922/CDH_IADREvans04
31. Smith WR, Betancourt JR, Wynia MK, et al. Recommendations for teaching about racial and ethnic disparities in health and health care. *Ann Intern Med.* 2007;147(9):654-665. DOI: 10.7326/0003-4819-147-9-200711060-00010
32. Schwartz SB, Sanders AE, Lee JY, Divaris K. Sexual orientation-related oral health disparities in the United States. *J Public Health Dent*. 2019;79(1):18-24. DOI: 10.1111/jphd.12290
33. Gibson LB, Blake M, Baker S. Inequalities in oral health: The role of sociology. *Community Dent Health*. 2016;33(2):156-160.
34. Schwartz SB. L.G.B.T: Let's go beyond teeth. *Pediatr Dent*. 2017;39(2):90-92.
35. Access, diversity and inclusion strategic framework 1-1. American Dental Education Association; 2018. Accessed June 22, 2022. https://www.adea.org/diversity/framework/
36. 2019-2020 Key ADEA Access, Diversity and Inclusion Initiatives and Activities. American Dental Education Association; 2018. Accessed July 26, 2022. https://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/policy_advocacy/diversity_equity/Documents/2019-20_Key-ADEA-ADI-Intiatives.pdf
37. 2020-2025 Diversity and Inclusion Plan. Advancing inclusion while growing membership diversity. American Dental Association; 2020. Accessed June 22, 2022. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/about/ada_diversity_inclusion_plan.pdf?rev=7c532219f8ad4c308bc15d6011af7c73&hash=CF41B5AACADDDD99122AA15C1054876C
38. Legislative priorities. American Academy of Pediatric Dentistry. Accessed March 12, 2022. https://www.aapd.org/globalassets/2022-legislative-priorities-for-website.pdf

39. American Academy of Pediatric Dentistry. Policy on workforce issues and delivery of oral health care services in a dental home. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2022:45-49.
40. Goodman XY, Nugent RL. Teaching cultural competence and cultural humility in dental medicine. *Med Ref Serv Q*. 2020;39(4):309-322. DOI: 10.1080/02763869.2020.1826183
41. Forsyth C, Short S, Gilroy J, Tennant M, Irving M. An Indigenous cultural competence model for dentistry education. *Br Dent J*. 2020;228(9):719-725. DOI: 10.1038/s41415-020-1480-3
42. Noushi N, Enriquez N, Esfandiari S. A scoping review on social justice education in current undergraduate dental curricula. *J Dent Educ*. 2020;84(5):593-606. DOI: 10.1002/jdd.12039
43. Accreditation standards for dental education programs. Commission on Dental Accreditation; Revised August 5, 2021. Accessed July 26, 2022. https://coda.ada.org/~/media/CODA/Files/predoc_standards.pdf?la=en
44. *HHS Action Plan to Reduce Racial and Ethnic Disparities. A Nation Free of Disparities in Health and Health Care*. US Dept of Health and Human Services. Office of Minority Health. 2013. Accessed July 26, 2022. https://www.minorityhealth.hhs.gov/assetspdf/hhs/HHS_Plan_complete.pdf
45. Olzmann JA. Diversity through equity and inclusion: The responsibility belongs to all of us. *Mol Biol Cell*. 2020;31(25):2757-2760. DOI: 10.1091/mbc.E20-09-0575