



A Narrative Review of Oral Health for Indigenous Gender and Sexual Minorities

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Abstract

Background: Queer Indigenous communities experience unique oral health disparities due to their intersecting racial, cultural, and gender identities. There have been previous studies that have looked at oral health outcomes for Indigenous communities and Queer communities separately; however, limited research has been conducted that addresses their combined impact. This narrative review intends to fill the existing research gap by investigating health access, oral health outcomes, and cultural inclusion for Queer Indigenous communities.

Methods: A narrative review was conducted to assess the current literature and evidence surrounding the oral health of 2SLGBTQIA+ Indigenous people, recognizing that the available research within the intersection of these three interest areas is limited.

Results: Despite the limited research, there were clear key themes that emerged: 1) gaps in data collection, 2) social and cultural determinants, 3) barriers to care, and 4) the role of health conditions and other risk factors that exacerbate outcomes. Additionally, the findings identified that economic hardship, geographic location, and systemic discrimination block Queer Indigenous patients from dental and oral healthcare.

Conclusions: Addressing disparities requires targeted and improved data collection on gender and sexuality identities; culturally affirming health programs; and expanded access to inclusive, community-driven care models. Furthermore, this review emphasizes the critical need for further research and policy work to support the dental and oral health for Queer Indigenous communities.

Keywords: oral health, social determinants of health, American Indian/Alaska Native, oral healthcare, LGBTQ+, 2SLGBTQIA+, Native American health disparities, Native American dental care

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INTRODUCTION

Background & Purpose

There are an estimated 3.7 million people living in the United States (U.S.) who identify as Indigenous, while an additional 5.9 million identify as Indigenous in combination with another race.^{1,2} According to the U.S. Census Bureau, the Indigenous population has grown exponentially since 2010. The American Indian/Alaska Native (AI/AN) population alone has increased by 27% and the broader Indigenous population in combination increased by a staggering 160%.³ Compared to the broader American population, AI/AN people experience significantly poorer oral health outcomes and dental care access as a result of historical exclusion and marginalization from healthcare systems.⁴ Recent data released by the Indian Health Service (IHS) acknowledge that AI/AN communities experience higher rates of untreated caries, edentulism, and periodontal disease - a trend that has decreased over the past few decades but still remains disproportionately higher than many other comparative communities.⁴ Oral health issues result in higher rates of emergency department visits and high experiences of dental pain, a costly result that complicates other social issues like substance use and self-medication.^{5,6} Among certain Indigenous communities, dental care access and health outcomes have been raised to crisis levels, recognizing the impact of poor oral health and connections to overall health.⁷⁻¹¹ Taken together, oral health is a critical priority in understanding and addressing both structural and social drivers of disparate outcomes within Indigenous communities.

Among Indigenous Americans, approximately 285,000 (6.7%) identify within the Two-Spirit (2Squeer)/queer community, with the largest proportion residing in the southern U.S. states.¹² This is slightly fewer but still commensurate with the number of Americans who identify as queer (7.6%).¹³ The intersection of Indigenous experience and queer identity creates a multiple minority community, of which many experience disproportionately negative health outcomes as a result of overlapping inequity.¹² When examined separately, both Indigenous and queer communities experience disproportionate oral health disparities.^{4,13,14} However, these communities have not been evaluated together to identify gaps in the knowledge base and create culturally-driven solutions for improving oral health and wellbeing for queer Indigenous populations.



There is a profound gap in the existing literature and research exploring health outcomes broadly, and almost no literature can be found examining oral health outcomes.

As such, this narrative review aimed to address the following guiding questions:

- What does the existing literature highlight regarding oral healthcare access, outcomes, and cultural inclusion for queer Indigenous Americans?
- What are the overlapping medical, social, and cultural issues that impact the oral health of queer Indigenous Americans?
- What knowledge gaps exist in the literature and the broader evidence base surrounding oral health for queer Indigenous Americans?
- How should researchers, advocates, and community members strategically support the oral health of queer Indigenous Americans?

Language and Terminology

Within both Indigenous and queer communities, a range of terminology is used to describe lived experience, personal expression, and cultural affirmation. Recognizing and honoring both tribal sovereignty and self-determination for Indigenous people and the evolving and diverse community of gender expression and sexual orientation, specific terminology was chosen for this manuscript for consistency. While researchers and demographers use Native American, and American Indian/Alaskan Native for data collection purposes, Indigenous is the most culturally accepted terminology in referencing tribal and native communities.¹⁵ Similarly, sexual orientation and gender identity have been defined disparately and incorrectly in research, and Indigenous culture is often excluded from consideration.¹⁶ Queer is used as an umbrella term to encompass the broad spectrum of gender, sexuality, and culture within this community.^{17,18} As such, both queer and Indigenous terminology are used throughout this paper to describe these communities and their oral health implications.



Methods

An extensive literature search and review was conducted in March of 2024, with an additional scan completed in August of 2025, to assess the evidence base and create a narrative review for queer Indigenous oral health and auxiliary topics. PubMed, EMBASE, Google Scholar, and CINAHL were used to search both peer-reviewed and gray literature related to oral health, queer communities, and the intersection with Indigenous Americans published within the last 10 years. Initial searches using basic key terms such as "Native American LGBTQ oral health"; "AI/AN queer oral health"; "LGBT dental health Native Americans" returned very few citations with no directly relevant topical results. To broaden the catchment of grey literature and other types of self-reported experiences, basic Google searches were conducted using similar terms.

To improve sensitivity and specificity, a librarian at the University of Colorado-Anschutz was consulted to strengthen the search process and identify MeSH terms for improving sensitivity. ***Final searches used Boolean combinations of the following terms:***

1. Oral health terms: "oral health," "dental health," "oral disease," "dental care"
2. LGBTQIA+/Two-Spirit terms: LGBT*, GLBT*, Lesbian*, gay, bisexual*, transgender*, "two-spirit", queer, "gender non-conforming," "gender diverse," "nonbinary," TS
3. Indigenous identity terms: Indigenous, "Native American*," "American Indian*," "Alaska Native*," AI/AN, "First Nation**"

An example of a combined search string would be:

("oral health" OR "dental health") AND (LGBT OR lesbian OR gay OR bisexual* OR transgender* OR "two spirit*" OR queer OR "gender non conforming" OR nonbinary) AND (Indigenous OR "Native American*" OR "American Indian*" OR "Alaska Native*" OR "First Nation**").**



The body of literature directly focused on queer Indigenous oral health is extremely limited and therefore the inclusion criteria for this review were intentionally broad. Peer-reviewed articles, government or tribal reports, community-authored documents, and other gray literature that addressed oral health, health disparities, or social determinants relevant to either Indigenous or LGBTQIA+ populations were included as evidence. Studies involving LGBTQIA+ Indigenous communities, Two-Spirit communities, or Indigenous groups with any relevance to oral health or structural determinants of health were prioritized. Literature on LGBTQIA+ health where the findings were transferable to oral health concerns, particularly research examining discrimination, identity-related stressors, or barriers to accessing care, was considered as part of article inclusion.

Sources were excluded when they lacked relevance to Indigenous or LGBTQIA+ populations, when oral health was entirely absent from the study or could not be meaningfully connected through social or structural determinants, or when materials offered commentary without substantive evidence. This approach captured the full extent of the available evidence while maintaining methodological transparency about what could and could not be included given the profound scarcity of directly relevant research. Despite this robust methodology and broad inclusion criteria, the search returned very few citations with no directly relevant topical results.



Even with very broad inclusion criteria, the final literature included a mix of empirical and non-empirical sources due to the scarcity of research directly addressing queer Indigenous oral health. Of the 12 sources included in the synthesis, two were systematic or scoping reviews, six were empirical quantitative studies (primarily cross-sectional designs), and four were narrative, conceptual, or gray literature sources such as community reports, theoretical analyses, and policy briefs. No articles selected in the final synthesis had direct connection to the topic of interest, reinforcing the dearth of research connecting queer Indigenous people to oral health outcomes. This distribution reflects the fragmented nature of the available evidence and underscores the absence of peer-reviewed research that directly examines oral health among queer or Two-Spirit Indigenous people.

Table 1: Articles Included in the Narrative Review

Systematic Reviews / Scoping Reviews	
Fakhrjahani et al., 2023	Scoping review
Thomas et al., 2022	Systematic review
Narrative, Conceptual, or Grey Literature	
Driskill, 2010	Review in queer and Native studies
A Spotlight on Native LGBT (NCAI report)	Gray literature/community report
Waisel, 2013	Narrative review/commentary on vulnerable populations
Bosworth et al., 2021	Policy/issue brief (gray literature)
Quantitative Empirical Research (Cross-sectional, observational)	
Clift & Kirby, 2012	Cross-sectional analysis of MEPS data
Clark et al., 2023	Cross-sectional study
Batliner, 2016	Perspective supported by descriptive epidemiology
Schwartz et al., 2019	Cross-sectional analysis of national survey data
Manpreet et al., 2021	Cross-sectional study
Heima et al., 2017	Cross-sectional survey



As a result of the profound lack of directly available research, the literature included in the narrative review focuses on queer Indigenous communities, health disparities, and related Indigenous oral health outcomes. Given the absence of direct literature, the review synthesized findings from adjacent domains to construct a narrative describing structural, social, and clinical factors relevant to queer Indigenous oral health. Sources were organized into thematic categories: (1) social determinants and cultural considerations; (2) access and oral health outcomes; and (3) exacerbating health conditions and risk factors. These themes were used to contextualize underlying inequities and to articulate implications for research and practice.

Results

THEME ONE:

Measurement and Data Collection for Queer Indigenous Oral Health

Measurement and surveillance are critical aspects contributing to the lack of literature in queer Indigenous oral health. While Indigenous Americans generally struggle with adequate inclusion in the public health surveillance system and research inclusion, the added layer of queer identity creates particular struggles with measuring oral health outcomes in this community.⁴ While there are limited data on the exact number of Indigenous gender minorities, research and anecdotal evidence suggest that queer people are present within Indigenous communities throughout America, making it critical that oral healthcare providers are prepared to provide care for their unique oral health needs.

Data surrounding queer Indigenous oral health may be limited due to several factors. Indigenous gender minorities may not openly identify due to fear of cultural stigma and discrimination, which can lead to underreporting in surveys and data collection efforts. Data collection may not include questions related to sexual orientation and gender identity, making it difficult to capture queer oral health statuses within Indigenous populations accurately. Additionally, the term “two-spirit” is not a common orientation when studying queer patient populations. By disregarding their existence, the health care system may also overlook the unique oral health needs of this population.

Recognizing this gap in how data are collected, the Indian Health Services (IHS) Office of Information Technology, Office of Clinical and Preventive Services, and Office of Resource Access and Partnership initiated IHS staff training to collect voluntary sexual orientation and gender identity data critical for healthcare services in 2019.¹⁹



The data collected in patients' electronic health records include gender, pronouns, sexual orientation, and legal sex; allowing patients to differentiate between sex assigned at birth and legal sex.¹⁹ At this time, however, IHS sexual orientation and gender identity data are not available to the public, and therefore, implications for oral health related to queer Indigenous Americans cannot be analyzed outside of IHS.

THEME TWO:

Social Determinants and Cultural Considerations for Queer Indigenous Oral Health

In 2015, the National Congress of American Indians (NCAI) General Assembly adopted Resolution MSP-15-047, declaring its support of the full equality of queer tribal citizens.¹⁰ Additionally, in 2020, the U.S. Department of Health and Human Services issued a rule to expand nondiscrimination protection for the queer community.²¹ When passed, this rule supported those in the queer community receiving healthcare services from federally funded programs. As of November 2025, these protections have been overturned and now impact queer people's access to healthcare within federally funded care delivery systems.²² Queer Indigenous communities have experienced both strides and setbacks in recognition and support, economic status, distribution of power, policy, and societal values - all of which significantly affect the health and well-being of Indigenous people.^{15,20} For Indigenous Americans, health disparities rooted in colonization and racism further perpetuated disease rates.²³ Historically excluded populations like Indigenous gender and sexual minorities are often overlooked by society, further increasing their risk of experiencing health disparities.

Indigenous Americans have the highest poverty rate in the nation at 25.4%, nearly three times the poverty rate of white Americans (8.1%), impacting one-in-four Indigenous people.²⁴⁻²⁶ In 2022, the Indigenous population held the highest unemployment rate (6.2%), compared to their white counterparts (3.2%), and the general population (3.6%).²⁶ In a 2019 report analysis of the Behavioral Risk Factor Surveillance System (BRFSS) data, 22% of gender minority adults lived in poverty, which was 4% higher than that of their cisgender counterparts (16%). Within the queer community, transgender adults and cisgender bisexual women experienced the highest rates of poverty (29%), followed by cisgender bisexual men (19.5%). Cisgender gay men experienced the lowest rate of poverty (12%), even compared to cisgender heterosexual men (13%) and women (18%).^{27,28} While no direct data are available to confirm the relationship between economic status and queer Indigenous communities, given that the data for each demographic separately confirms this relationship, there is a high likelihood that this influence exists (and may be more prominent) within the queer Indigenous community.



Queer people have long faced challenges accessing equitable healthcare. Health disparities within the gender minority population stem from systemic inequities related to stigma, discrimination, and barriers to health care.^{29,30} According to the Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, gender minorities are more likely to experience delayed care, less likely to have a consistent source of care, and are more likely to be concerned about healthcare bills.²⁹ In 2023, Clark et al., explored the relationship between stigma and mistreatment in healthcare settings. Nearly 19% of participants reported being denied or given lower quality medical care in the past year and 12.5% reported denial or lower quality of mental health in the past year.³¹ Similar research also found that same-gender couples experience difficulty receiving care from specialists, obtaining prescriptions, and getting necessary medical care.³⁰

THEME THREE:

Access and Outcomes for Queer Indigenous Oral Health

Indigenous and queer people experience numerous barriers to accessing healthcare, including provider-to-patient ratios, geographic barriers, and socioeconomic status. Though research is virtually non-existent on the oral health statuses of Indigenous gender minorities, common oral health risk factors exist across Indigenous and queer communities. With over 350 dental clinics nationwide, the IHS dental workforce is a mere 3,800 people, providing 5-6.5 million dental services and procedures annually.³² This low provider-to-patient ratio and underfunded workforce has historically struggled to keep up with the oral health demands of the Indigenous community, contributing to the oral disease burden of this vulnerable population.³³

Timely dental care is essential for reducing health disparities. According to the parsimonious prediction model for the prevalence of dental visits, several factors influenced dental care visit frequency, including gender, minority race/ethnicity status, and socioeconomic status.³⁴ Recent research investigating dental care utilization among Indigenous communities indicates that Indigenous Americans experienced higher levels of delayed and unmet dental needs compared to other racial and ethnic groups.³⁵ Adult members of the Indigenous community experience more oral disease compared to any other ethnic minority group in the United States.^{5,36} According to the IHS, 20% of Indigenous adults age 45 and older have severe periodontal disease compared to 10% of the general U.S. population.³⁶ A staggering 57% of Indigenous adults 35-44 years old experience untreated dental caries compared to their White (24%), Black (40%), and Mexican American (43%) counterparts.³⁶ People who identify as Indigenous are three times more likely to visit an emergency room for dental concerns or mouth pain (13.5%) compared to those who do not identify as Indigenous (3.9%).⁵





Previous research suggests that gender minorities have an increased risk of experiencing oral malignancy, ulcerations, and leukoplakia.³⁷ In a collection of National Health and Nutrition Examination Surveys (NHANES) from 2009 to 2014 that examined dental caries, tooth loss, chronic periodontitis, oral human papillomavirus (HPV) and subjective reports of oral health status and use of dental services, gender minority patients reported having worse health outcomes compared to their cisgender counterparts.³⁸ The results included 1.9% gay/lesbian, 3.3% bisexual, and 93.7% heterosexual.³⁸ The study further reported that gay men experience more periodontal bone loss (35%) compared to cisgender counterparts (11%), and rated their oral health unfavorably (41%) compared to the cisgender (27%) population.³⁸

Little is known regarding dental benefit coverage outside of the IHS for the Indigenous population. However, in 2019, an estimated 52% of Indigenous Americans had private health insurance, 42% relied on Medicaid or public health benefits, and 15% had no health benefits.² Additionally, Indigenous people who qualify for Medicaid are exempt from out-of-pocket costs, Medicaid premiums, or enrollment fees that are typically required for most enrollees.³⁹

The gender minority community faces healthcare barriers more frequently compared to the cisgender, heterosexual community. According to Ramous et al., employment status, education, income, and dental insurance coverage were reported variables that affected gender minority access to dental care.⁴⁰ Moreover, trends were observed between the aforementioned variables and dental care utilization in the past year and those having visited two years prior.⁴⁰ In 2019, Schwartz, et al.; reported that bisexual men were more likely to face access to dental care barriers (30%) compared to cisgender counterparts (19%).³⁸ A 2017 study by Heima, et al. explored dental fear in the transgender community and found that fear and experience of discrimination were significant predictors of dental fear,⁴¹ and a potential barrier to dental care utilization.

THEME FOUR:

Exacerbating Health Conditions and Risk Factors for Queer Indigenous Oral Health

The IHS is a federal healthcare agency that provides healthcare services exclusively to Indigenous people who are members of 574 federally recognized tribes.⁴² The IHS is divided into twelve regions. Each region provides federally recognized tribal communities with health programs and centers to address Indigenous patients' overall health. More than 400 non-federally recognized tribes are limited in federal funding, impacting affordable access to primary care.⁴² The Indigenous population continues to experience higher rates of preventable diseases, poorer health outcomes, and higher mortality rates compared to the general U.S. population.^{5,7,43} In 2018, the leading cause of death for adult Indigenous men was heart disease (18.4%), followed by cancer (15.9%) and unintentional injuries (13.7%).⁴³ Similarly, the leading causes of death for adult Indigenous women were cancer (17.9%), heart disease (17.1%) and unintentional injuries (8.2%).⁴³ In 2021, the Centers for Disease Control and Prevention (CDC) reported the life expectancy of Indigenous people to be 65.2 years, nearly a decade less than that of their non-Hispanic White counterparts, and 5.5 years less compared to all U.S. populations.⁴³

Substance abuse and dependence increase the risk of oral health disparities, including but not limited to periodontal diseases, dental caries, oral lesions, and oral cancers.^{44,45} Furthermore, the rate of substance abuse or dependence is higher among Indigenous and queer populations compared to other populations in the U.S.⁴⁶⁻⁴⁸ According to the National Survey on Drug Use and Health (NSDUH), nearly 25% of Indigenous Americans report binge drinking in the past month, 10% have a substance use disorder, and 7.1% report an alcohol use disorder.⁴⁹ Opioid abuse is a growing concern for the Indigenous population, such that the rate of opioid-related deaths was nearly five times (14.2 per 100,000) the rate in 1999 (2.9 per 100,000).^{47, 50}

Members of the queer community are two-to-four times more likely to have a substance use disorder compared to their cisgender counterparts.^{51,52} Alcohol abuse trends are higher in the queer community with bisexual and lesbian women experiencing significantly higher rates of tobacco abuse compared to their straight counterparts.^{51,52} Research further suggests that queer adults (41.3%) are twice as likely to abuse marijuana compared to their cisgender counterparts (18.7%), as well as twice as likely to misuse opioids (6.7%) than the general U.S. population (3.6%).⁵²





Discussion and Strategic Recommendations

Limitations exist with this narrative review, most notably the lack of available data directly linked to the intended topic. Despite this limitation, there is utility in highlighting both the gaps and needs while establishing a literature base for future research. This review is the first evaluation intended to examine the oral health and well-being of queer Indigenous communities, a clearly under-considered topic area.

This review focused on uncovering available evidence on queer Indigenous communities that evaluate oral health access and outcomes. While search results were limited, the lack of literature creates a clear call to action for researchers, community members, and oral health professionals to address the gaps in knowledge and evidence. To address these gaps, strategic recommendations have been included that follow the themes of the narrative review.

- » **Improve measurement and data collection to facilitate research on the oral health of Queer Indigenous communities.** Incorporate Sexual Orientation and Gender Identity (SOGI) questions in all public health surveys and data collection efforts that focus on Indigenous populations, with direct engagement from communities on the data collection, indicator design, and interpretation. Many surveillance systems neither accurately capture the array of Indigenous representation, nor do they accurately capture the spectrum of sexual orientation and gender identity. As such, simply improving the existing opportunities in health surveillance systems like the Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, National Health Interview Survey, etc., to include these data and allow for more granular analysis. When collected, aggregated data should be released publicly to democratize access and promote analysis of available data. Ensure that inclusive language is utilized in demographic questions, such as “two-spirit,” to accurately capture the identities of Indigenous gender minorities. Researchers and other data collectors should be trained in cultural humility and the importance of creating a safe and inclusive environment for respondents to disclose their SOGI status.

- » **Develop inclusive clinical practices that include a holistic and person-centered approach to queer Indigenous oral health.** Indigenous and queer people disproportionately experience discrimination, stigma, and structural exclusion that impact their social determinants of health. Aside from more inclusive and rigorous data collection to understand the drivers of these disparities, healthcare programs that are both culturally responsive and include wraparound services may be most successful in addressing the unique oral healthcare needs of this population. Vested partners should advocate for increased funding and resources for healthcare facilities serving queer Indigenous populations to ensure high-quality care. Importantly, empowering leadership from these communities to identify barriers and drive solutions are key to a critical path forward. Vested partners should support the development and implementation of community-led health programs that address the specific health needs of queer Indigenous people. Engage community leaders and members in designing and evaluating health programs to ensure they are culturally relevant and effective.
- » **Increase attention and infrastructure to support queer oral healthcare access and delivery.** Oral healthcare access in Indigenous communities can be challenging for a variety of reasons that may be more complicated for queer community members. IHS is the largest national provider of oral healthcare to Indigenous communities in the U.S., and recently recognized the value of more inclusive data collection. Vested partners can advocate for increased funding and resources to expand their dental workforce and improve service delivery. Generating support for initiatives to enhance the infrastructure of IHS dental clinics, Tribal Nations, and Urban Indian Health Programs will ensure they can meet the growing demand for oral health services. Expanding the oral health workforce to include more Indigenous and queer providers will create more inclusive care environments that meet the cultural needs of patients. Developing educational campaigns to raise awareness of the importance of oral health and the specific needs of queer Indigenous communities may increase access to and utilization of dental care, thereby expanding opportunities for data collection.
- » **Develop and support integrated care environments that address other health conditions that influence oral health.** Indigenous and queer people both experience more health risk factors and poorer health outcomes primarily due to historical exclusion from the healthcare system and repeated experiences of discrimination. As such, it is critical to develop integrated care models that combine oral health services with general healthcare to address the holistic needs of queer Indigenous people. Programs that expand access to substance abuse prevention, treatment programs, and other risk mitigation initiatives specifically tailored to the needs of queer Indigenous populations have the potential to improve health outcomes and build trust from these communities. Programs should provide culturally appropriate education on self-managing health risks and empower patients to improve their own oral health and wellbeing through inclusive care practices. These community-based health programs should incorporate traditional healing practices and community engagement to address health disparities. Vested partners should collaborate with Indigenous leaders and organizations to create programs that are culturally relevant and effective.



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Abbreviation Key:

2SLGBTQIA+ (2S)Two-spirit; (L) Lesbian; (G) Gay; (B) Bisexual; (T) Transgender; (Q) Queer, (I) Intersex, (A) Asexual, (+) people who identify as part of sexual and gender diverse communities



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The [American Institute on Disparities in Public Health](#) is a nonprofit organization empowering our community to eliminate health disparities through research, education, and advocacy. AIDPH operates at the intersection of health issues, communities, and systems change. Our framework reflects the belief that health disparities emerge where health systems, social drivers, and community experiences intersect. We recognize that issues like oral health, mental health, chronic disease, and women's health are shaped by policy environments, care delivery structures, workforce capacity, and the lived experiences of the communities most affected.

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