LEAVE NO ONE BEHIND

A quick guide to improving the oral health of refugees

LEADING THE WORLD TO OPTIMAL ORAL HEALTH

FDI World Dental Federation

Refugees are among the most vulnerable groups worldwide. They have limited access to oral health education, oral disease prevention and therapeutic dental care. This is due, in part, to the relatively high cost of restorative treatment, limited access and availability of dentists, unaffordability of dental insurance, and language barriers.

This quick guide summarizes the key challenges to improving refugee oral health and what advocates can do to help achieve improvements. For those ready to lead the response to this issue in their country, more information and guidance can be found in the *Promoting Oral Health for Refugees: An Advocacy Guide*.

Migration as a social determinant of health

Migration is a process that exists as a complex social determinant of health. It is a multi-phase journey that poses risks at every stage. Refugees can be from countries ridden with conflict, poverty or climate change and undertake dangerous journeys to reach a place of relative safety. Any pre-existing health conditions can be exacerbated by the harsh living conditions and inaccessibility of health services during migration. Prolonged stress has been connected to negative oral health effects, such as periodontal diseases and joint dysfunction.[1] Other studies found that providing required oral healthcare resulted in reduced psychological stress and improved sleep quality.[2,3]

In addition, neglecting oral health and a persistent unavailability of preventive and therapeutic services may lead to higher rates of dental caries and its consequences, such as tooth abscess or tooth loss.[4-6]

At the arrival phase, refugees may find themselves living in shelters in urban areas, such as collective centers, slums, or informal settlements. Around 6.6 million refugees live in camps; of these, 2 million are in self-settled camps[7]. Many refugee camps have poor infrastructure and lack sanitation and hygiene services, food, oral hygiene products or access to healthcare. Camps in arid climates often experience water shortages.[8]

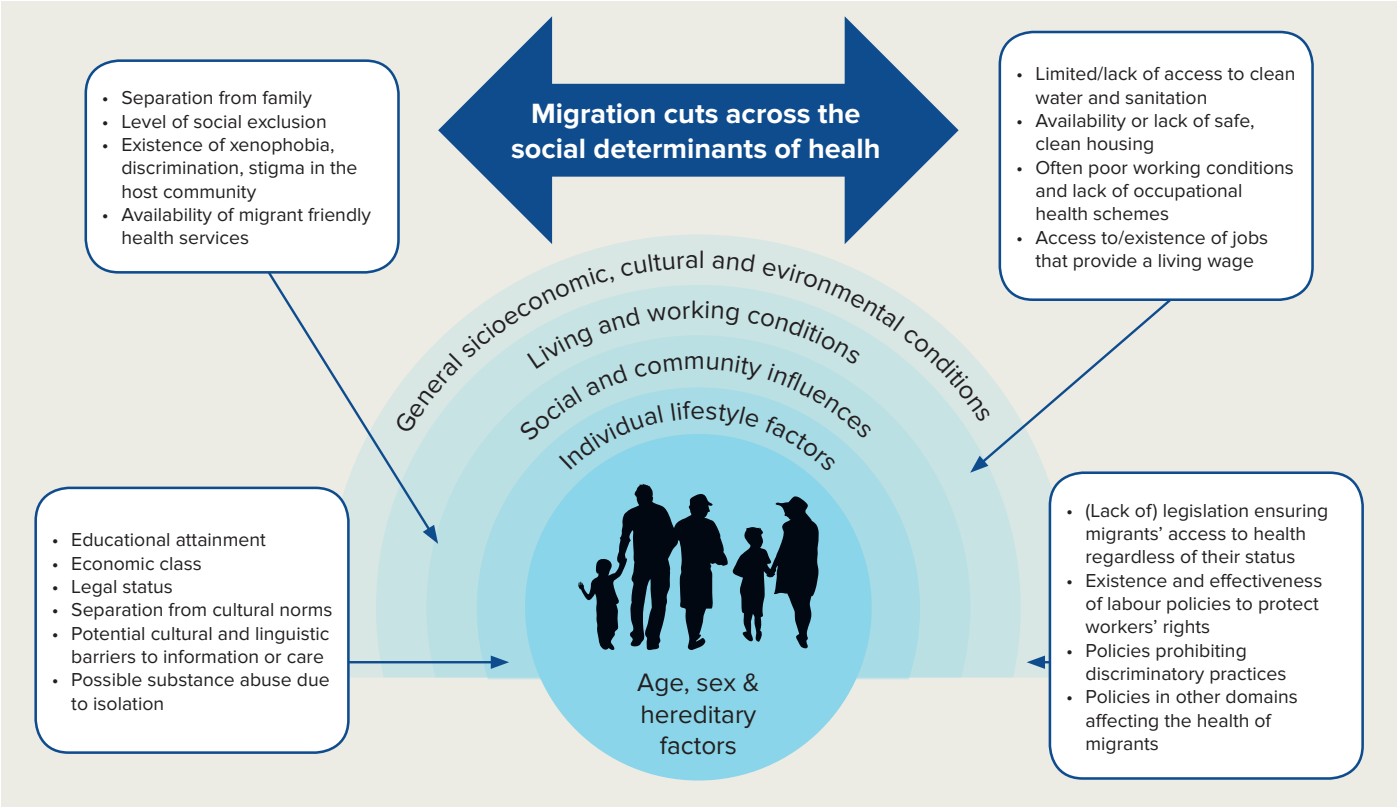


Figure 1: Social determinants of health in refugees, adapted from the International Organization of Migration.[9]

Prevalence of oral disease in refugee populations

Studies have indicated a high prevalence of oral disease and unmet oral healthcare needs in refugees, often exceeding the levels experienced by the most disadvantaged communities of the host country.[4-6] Most commonly, refugees experience high levels of dental caries, periodontal disease, oral lesions and traumatic dental injuries.[5] There is also evidence that refugees are less likely to access oral healthcare, and their first contact will often be for pain relief.[10]

However, most of the literature addresses the oral health challenges faced by refugees hosted in high-income countries. Very limited research is available on the oral health of refugees who are in transit and live in refugee camps.

Healthcare for refugees

Access to healthcare for refugees varies greatly across the globe. Often, there is a lack of access to primary healthcare services, which results in an over-reliance on emergency services.[11] The legal status of refugees is the most crucial factor in determining what services they have access to. In a report by UNHCR, only a third of UNHCR operations reported that urban refugees are covered by the national health insurance schemes of their respective host countries.

Barriers to accessing oral healthcare

In general, there is a lack of dental personnel in refugee camp settings[12]. Even if healthcare professionals are available, managing transportation costs to health centers and finding childcare to attend medical appointments can be challenging. In addition, when reimbursement does not cover the healthcare costs partially or at all, refugees often become hesitant to receive dental care.[10]

Barriers to access oral health services vary according to the policies in pace and a refugees' status. For refugees who are already settled in host countries, long wait times, high cost, lack of dental insurance, and language barriers can be the main challenges.[13-16] Refugees in transit camps often have to settle for tooth extraction instead of restoration due to the unavailability of dental professionals and a lack of funds to pay for treatment.[17-18] These transit camps are usually located in limited-resource settings that prioritize prevention and treatment of infectious diseases over oral diseases and NCDs in general.[19]

Types of barriers	Consequences
Language	Limited understanding of: • services available • overall benefit of oral health • social benefits available
Prior beliefs about oral health (low priority)	• Under-utilization of oral health services
Trauma	• Fear and distrust of oral health professionals
Lack of oral health professionals	• Difficulties in reaching oral health professionals • High transportation costs
Oral health care is not covered by the government	• Cannot afford oral healthcare • Low rate of utilization

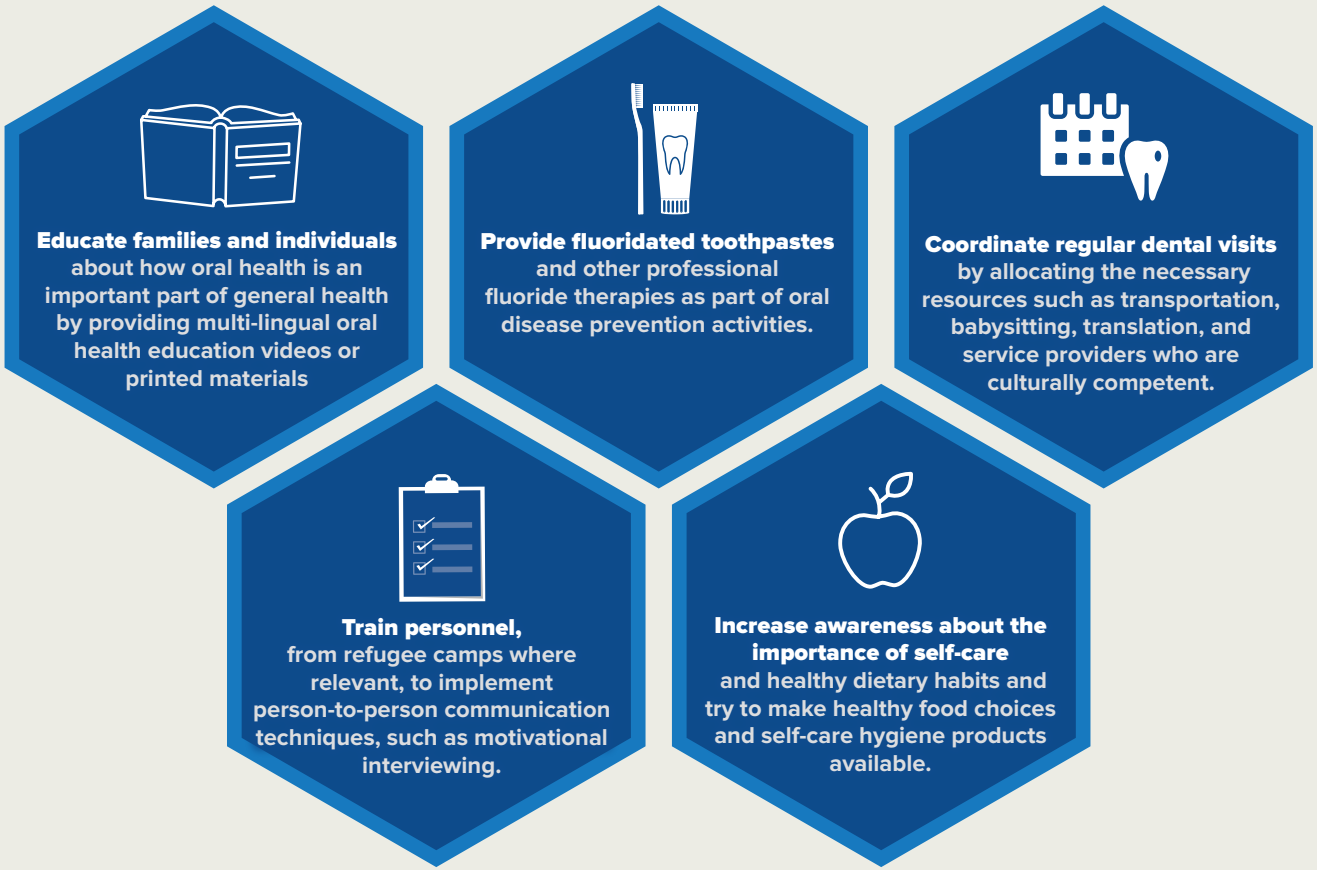
Table 1: Barriers to accessing oral healthcare among refugees

What can be done?

A range of actions proposed below could contribute to improving access to oral healthcare for refugees.

Depending on the local context and needs, different measures are conceivable to strengthen the health system for refugees and ensure access to oral healthcare:

Strengthen oral health promotion programmes for refugees through empowerment

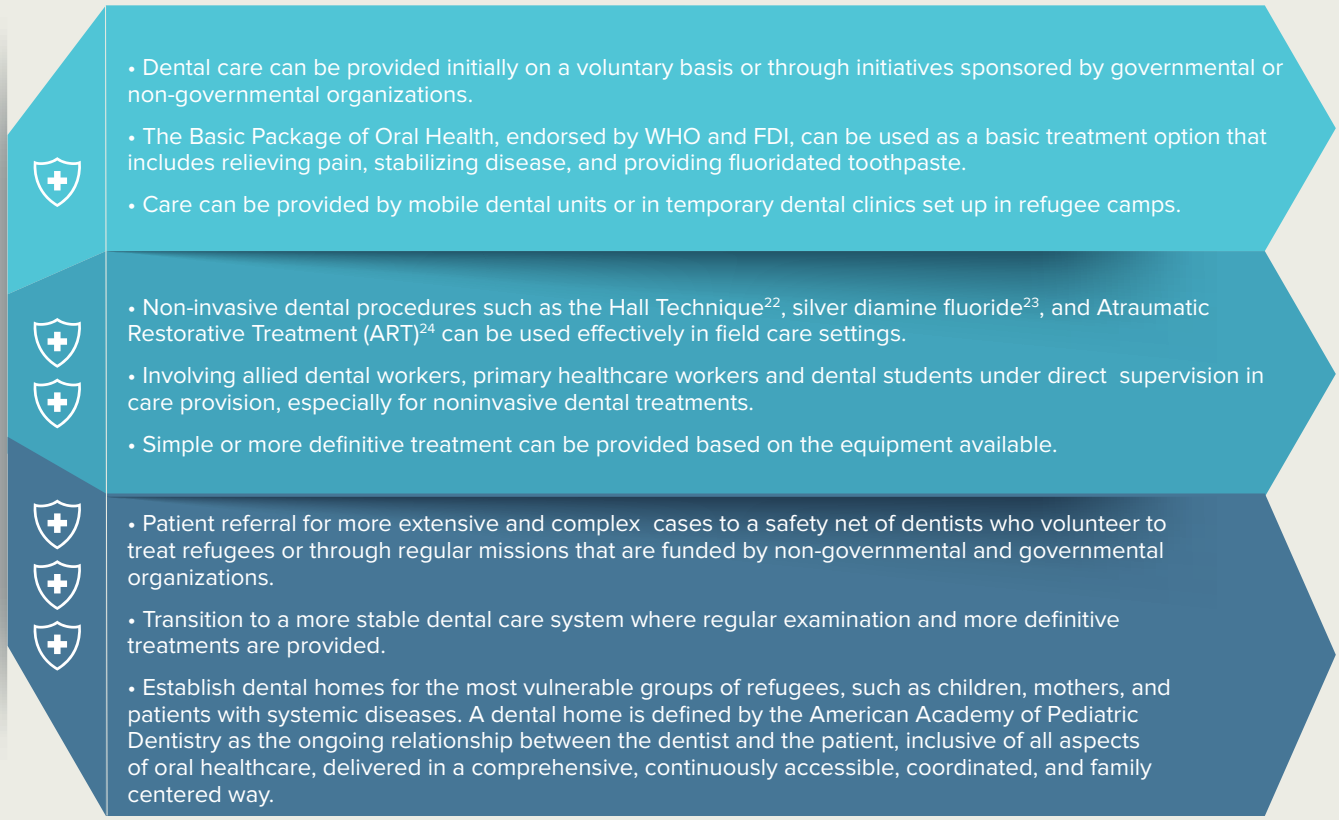


Insist on establishing a screening and referral system upon arrival in the host country

Quantifying the oral disease burden in the refugee population is important for designing and advocating appropriate oral health interventions. Oral health screenings should be integrated with overall health screenings for refugees that are usually carried out upon arrival.

The WHO Oral Health Survey can be a good road map to establish oral health screenings at arrival camps.[20] In addition to this, FDI and the International Consortium for Health Outcomes Measurement has developed the Adult Oral Health Standard Set (AOHSS), to be used in clinical practice, research, advocacy and population health.[21] We must continue to emphasize that if oral health screenings are not followed up by referrals to therapeutic or preventive services, these will have a very limited impact on refugees' oral health.

Providing care



Empower and engage community oral health workers

Training available healthcare workers in the refugee camps to conduct preventive activities is a cost-effective intervention for low-resource settings to ensure good oral health in the population. This can also establish trust between health workers and refugees and strengthen the overall health system.

An opportunity for National Dental Associations

National Dental Associations (NDAs) can contribute effectively to implement the measures mentioned above when collaborating with educational, governmental and non-governmental organizations through education, awareness raising, developing best practices to serve this population, and advocating for changing policies.

Lobbying and advocating for comprehensive health policies for refugees: NDAs can pressure governments to adopt policies guaranteeing oral health access to refugees. Oral health must be recognized as an issue of high concern when designing health policies.

Coordinate with other relevant sectors for joint solutions: Strengthening coordination among potential influential actors in the private sector, refugee associations, civil society or affected populations themselves to develop joint actions would greatly benefit the oral health of refugees.

Advocating to include access to oral health for refugees in universal health coverage essential services and to create special insurance plans to provide necessary treatments.

Emphasize community outreach efforts to act on cultural and language barriers: NDAs can engage community leaders who can act as interpreters, signpost to services, and collaborate with the local department of public health. Moreover, oral hygiene education should be incorporated into community outreach events.

Developing sets of best practices and lessons learned about improving oral health in the refugee population.

UNHCR operations and advocacy efforts and results

Most UNHCR offices are involved with advocacy efforts to expand access to services for refugees. Offices around the globe are either in talks with the host government authorities, municipal authorities, and/or specific service providers. Furthermore, UNHCR is currently investing in building existing service provision systems to provide health, education, and child protection and social welfare services.[25]

Successful intervention stories

Ghent, Belgium, 2015-2017

A collaborative programme between Ghent university and the De Tinten project was set up to improve the referral system and to increase dental appointment attendance for undocumented migrants. Volunteering dentists provided oral healthcare and trained social workers to be community oral health workers. Missed dental appointments decreased from 40% in 2015 to 8% in 2017.[26]

Breaking the barriers

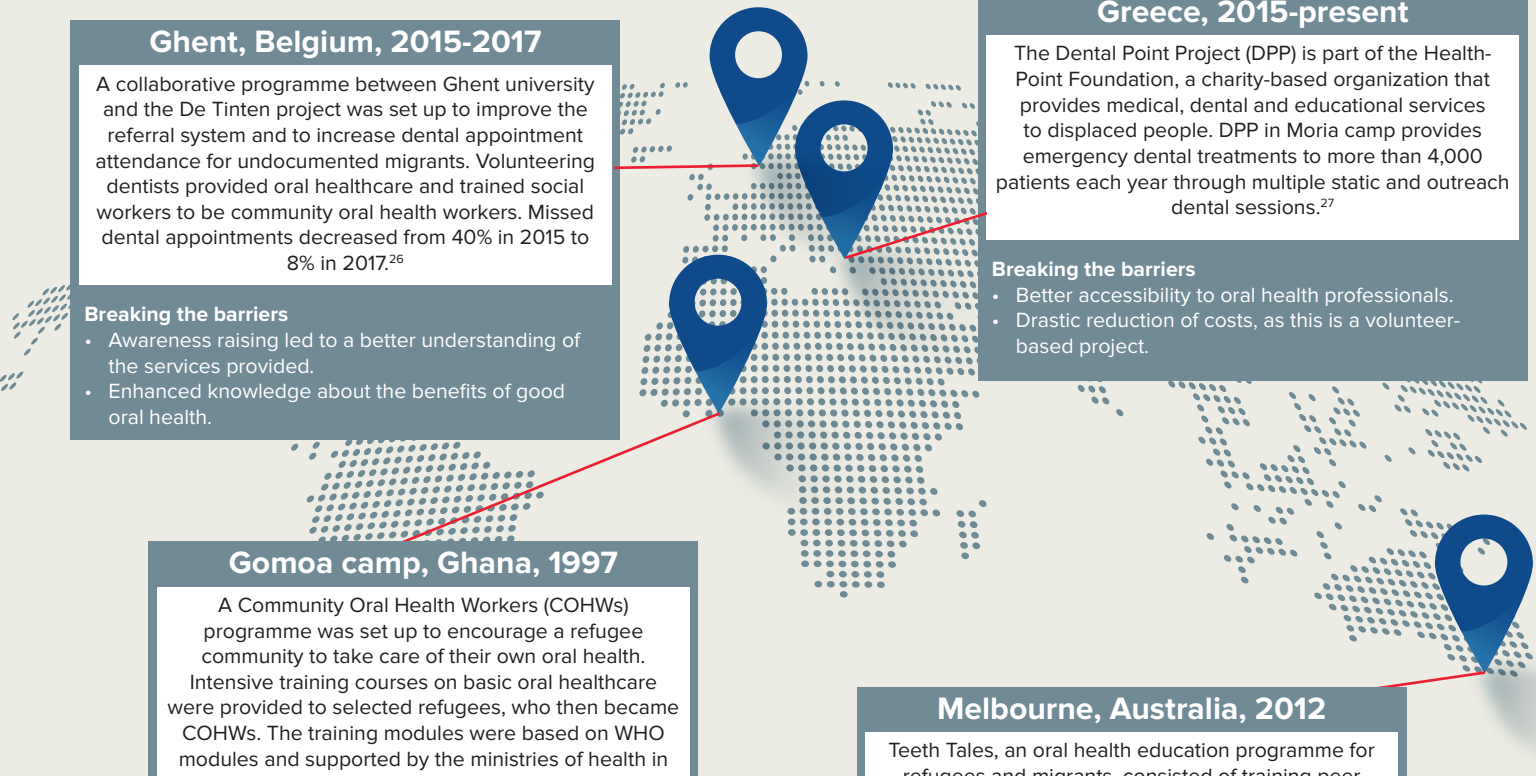
- Awareness raising led to a better understanding of the services provided.
- Enhanced knowledge about the benefits of good oral health.

Moria camp, Lesvos Island, Greece, 2015-present

The Dental Point Project (DPP) is part of the Health-Point Foundation, a charity-based organization that provides medical, dental and educational services to displaced people. DPP in Moria camp provides emergency dental treatments to more than 4,000 patients each year through multiple static and outreach dental sessions.[27]

Breaking the barriers

- Better accessibility to oral health professionals.
- Drastic reduction of costs, as this is a volunteer-based project.



Gomoa camp, Ghana, 1997

A Community Oral Health Workers (COHWs) programme was set up to encourage a refugee community to take care of their own oral health. Intensive training courses on basic oral healthcare were provided to selected refugees, who then became COHWs. The training modules were based on WHO modules and supported by the ministries of health in Ghana and Liberia. COHWs could then deliver certain types of oral care through central clinics and organize certain activities related to oral health promotion in collaboration with the National Dental Association of Ghana.[18]

Breaking the barriers

- Interactions were generally friendly and co-operative, which helped to build trust between the COHWs and the wider community.
- The language barrier was broken.
- Better availability and accessibility to oral healthcare.

Melbourne, Australia, 2012

Teeth Tales, an oral health education programme for refugees and migrants, consisted of training peer educators to promote oral health and improve access to oral healthcare for families from specific cultural backgrounds. The intervention had positive impacts on the families' oral hygiene and the parents' knowledge of the proper tooth-brushing method.[28]

Breaking the barriers

- Peer educators who were recruited from the same cultural background allowed for a better understanding of the services available in the host country and the overall benefit of good oral health.

For more information, visit: www.fdiworlddental.org/refugee-oral-health-promotion-and-care-project.
All references available here

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