

ORAL HEALTH CARE FOR REFUGEES: “ SMILES WITHOUT BORDER” A NARRATIVE REVIEW

INTRODUCTION

When peace is broken and the systems that keep society safe are not working, women and children are the ones who suffer the most. The years of war and fighting have caused a serious crisis where people don't have access to food, clean water, and basic services like healthcare and medicine.¹Conflicts destroys people, families, and communities, creating many refugees and people who have left their homes. It also breaks human rights and the rules that protect people in emergencies.²

The number of immigrants and refugees have increased dramatically in recent years all over the world. The biggest numbers come from countries in Eastern Europe, Africa, Asia, and Latin America.³ According to the United Nations High Commissioner for Refugees (UNHCR), the number of people who have been forced to leave their homes worldwide went from 70.8 million in 2018 to 100 million by 2022. This increase is probably because of the situation in Afghanistan after the US left, and new conflicts in Ukraine, Ethiopia, and Myanmar.⁴The health of refugees and migrants is closely connected to factors like employments, income, education, and residence. Refugees and migrants are among the most vulnerable groups in society, and they often face hatred, unfair treatment, bad living and working conditions, and limited access to general health services.⁵

Many refugees come from places where there is poor disease control, diagnosis, and treatment, and war or conflict has broken down the health care system. For example, refugee children often suffer from malnutrition, anaemiaand poor growth, hepatitis, intestinal worms and dental problems etc... The countries that refugees come from reflect the current political situation in the world.⁶

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28 **METHODS**

29 Related articles were searched using databases such as ScienceDirect, Scopus, PubMed, and
30 Google Scholar from inception. All studies, published from 2004 - 2023 were included in the
31 study. Relevant articles in the topic and abstract were assessed and included in the study.

32 **Oral care for Refugees: Factors for consider**

33 ***Role of Country of Origin***

34 Refugee children from East African countries, like Somalia and Ethiopia, have lower rates of
35 tooth decay when compared to Eastern European countries. This is because their traditional
36 diet has very little sugar, and their cultural practices, such as using chewing sticks, help
37 prevent tooth decay.⁶

38 ***Role of Diet***

39 Several factors affect the development of tooth decay, and one of the main causes is how
40 much sugar someone eats. For example, in some Latino households, it's common to calm a
41 crying baby by giving them a bottle of sweetened milk or juice. Because of this, it's more
42 helpful to provide specific advice about the risks of letting a child drink sugary liquids from a
43 bottle for long periods, including cow's milk and juice.⁷

44 ***The role of acculturation***

45 A key factor that can slow down the acceptance of health messages is the common belief in
46 fatalism about certain health issues, especially dental problems like tooth decay. One study
47 found that Chinese immigrants often try home remedies first and only visit a dentist when all
48 else fails. These cultural beliefs need thorough conversations and clear information for

families to understand the importance of preventing dental issues.⁷ This lack of action is a major public health and ethical concern, especially since providing equal healthcare is important for achieving fairness and well-being.⁸

Oral health is multifaceted in nature and includes physical, mental, and social aspects.⁹ The absence of dental assessments in basic care makes refugees more at risk, and the lack of dentists being involved in the care curtails the importance given to oral health.¹⁰ The rate of tooth decay in refugee children, even in high-income countries, ranges from 27% to 65%.⁹ Changes in eating habits and oral hygiene caused by the difficult conditions of migration and living in a new country might explain this high rate of tooth decay.¹¹

Studies looked at the oral health of patients and checked what oral care they needed. They found several factors that were connected to these needs. Here are the findings:

Systematic Review¹⁰

A detailed review of 14 studies showed that eight studies focused on oral health and found that caries prevalence between 50% and 100% of people. In six general health studies, the rate was between 3% and 65%. The more aged someone was, the more likely they had caries. Education level had the opposite effect — the lower the education, the higher the caries rate.

Scoping Review¹

Forty-five studies in this review, revealed that untreated caries was more common among migrants, refugees, and internally displaced people compared to those in the host community. In children, Early Childhood Caries (ECC) was more common among those who had experienced abuse, neglect, or were in protective care.

Refugees from the Asia Pacific, Africa, the Middle East, and Syria living in Canada were studied^{12,13,14}

The chance of reporting dental problems increased in the first two years after arrival and then decreased between two and four years. Women were more likely to report dental problems than men (OR 1.34). Immigrants who had received social assistance or reported being discriminated against were more likely to report dental problems over time. Those with household income of \$40,000 or less had lower chances of reporting dental problems.

For children under 18, with better self-rated physical health ($p=0.002$) and mental health ($p=0.044$) had better oral health. Children who had access to oral care insurance — whether it was full or partial coverage ($p=0.001$ and $p=0.028$, respectively) — had better self-rated oral health compared to those without insurance.

***Refugees from East Africa and Asia living in the USA*^{15,16}**

Children aged 18 or younger - Asian refugees needed urgent (46.1%) and emergent (13.2%) dental treatment more often than African refugees (30.0% and 9.9%); this difference was significant ($p=0.032$). Young children between the ages of 2 to 5 required surgery under general anaesthesia in 15.3% of cases ($p=0.002$).

Refugees aged 18 to 60 - A one-point increase in the mother's KCOH score meant her child had 10% fewer filled surfaces on average. A one-point increase in the mother's COHI score meant her child had 42% fewer filled surfaces. Mothers who brushed their teeth for "salat" (prayer) had children with 92% fewer filled surfaces compared to mothers who brushed to prevent disease. Children who never brushed their teeth had 7.07 times more filled surfaces and 4.08 times more decayed and filled surfaces than those who brushed twice a day or more.

***Refugees from Sub-Saharan and Caucasian regions living in Rennes (France)*¹¹**

Children aged 4 to 7 - 72% had dental caries, and 17.7% had more than 3. Almost half (49.2%) had at least one missing tooth. A third (36.2%) needed scaling. More than half needed

restorative treatments. 42.4% needed tooth extraction, with 8.5% needing more than two teeth removed. 22.3% needed prosthetic treatments. Children from Sub-Saharan regions were less likely to have major oral care needs (30.2%), while those from the Caucasus were more likely to (64.5%) compared to the overall population (45.4%).

***Refugees living in Switzerland*⁴**

Fifty-eight studies were included in the review - Caries rates among refugees ranged from 4.6% to 98.7%, and gingivitis from 5.7% to 100%, showing a wide range in oral health. Regarding access to dental care, 17% to 72% of refugees had never visited a dentist.

***Refugees from Africa living in Victoria (Australia)*¹⁸**

Children aged 0 to 18 - 46.1% had visible caries, and 51.6% had caries experience (dmft/DMFT > 0). African children with primary teeth were less likely to have any caries experience ($p=0.017$), had a lower mean dmft score, and were less likely to have severe caries ($p=0.004$) compared to children with primary teeth born in other countries.

***Refugees from Syria living in Turkey*¹⁹**

Children (5,12&15 years) – The 5-year-old children had the highest percentage of tooth extraction, which was 42.2%. For the 12-year-olds-33.5% of the fissure sealants were in first molars, and 52.8% were in premolars. Restorative treatments were the most common dental service for the 15-year-olds, making up 44.4% of all caries-related dental services, Of these 68.2% were applied to the posterior teeth.

***Refugees from Tibet living in Bylakuppe, Karnataka, India*²⁰**

Children (11-13 years) – The mean number of sextants with healthy periodontal tissue, bleeding, and calculus was 2.02 ± 2.0 for the Tibetan children and 2.49 ± 2.40 for the non-Tibetan children ($p < 0.05$).

***Refugees from Syria living in Bekka, Lebanon*⁹**

Children (4 – 15 years) – 57% of children reported having current dental pain. Out of these, 55% had moderate to severe pain (scores 4–10), and 38% had this pain for more than a month. About 8.9% had dental abscesses. Children who have been displaced for more than five years, along with their age and gender, were more likely to have more decayed teeth compared to others.

ORAL HEALTH RELATED QUALITY OF LIFE (OHRQOL)

In the field of oral health, the term oral health-related quality of life (OHRQoL) includes how a person feels about their own oral health, in addition to what a dentist finds during an exam.¹⁰ The refugee experience often includes displacement, conflict, human rights issues, family separation, and long periods without access to basic needs or services. A study found that almost half of Syrian men in refugee camps suffer from anxiety or depression, and most refugees say their health is ‘bad’ or ‘very bad’.²¹

Following studies have evaluated OHRQoL:

***Refugees from Eritrea, Cameroon, Myanmar, Turkey, Nepal, Iraq, and Afghanistan living in Texas, USA*²²**

Children <12 years- study found differences in the changes in the DMFT/dmft and MOHRQoL-P scores from baseline to the three- and six-month follow-up visits between groups were not significant ($p > 0.05$).

***Refugees from Arab and Sub-Saharan origin living in Melilla, Spain*¹⁵**

Children aged 4–16 years – The overall average OHIP-14 score for all patients was 11.25, which shows an acceptable self-perception of oral health.

***Refugees from Syria living in Kirikhan (Turkey)*²³**

22 parents – The P-CPQ-8 score revealed that oral symptoms were the main concern for parents, especially dental pain. Mothers had higher P-CPQ-8 scores across all areas compared to fathers.

***Refugees from Syria living in Azara camp (Jordan)*¹⁶**

Refugees aged over 16 years – The average OHRQoL score was 56.55. Factors linked to OHRQoL scores included age ($p=0.048$), how often they brushed their teeth ($p = 0.001$), and whether they visited a dentist in the past year ($p=0.004$).

UTILIZATION OF DENTAL SERVICES

The inverse care law in dental care shows that people who need dental treatment the most often have the least access to it.²⁵ Even though many people understand the importance of good oral health for overall health this understanding does not always translate into access to care.²⁶

In the model developed by Penchansky and Thomas, access is seen as how well a patient fit with the healthcare system, which is influenced by several factors like accessibility, availability, acceptability, affordability, and accommodation.²⁷

Studies that evaluate access to dental care and the barriers or facilitators contributing to access

***Systematic Review*²⁷**

Nine papers were included in this review- Both the characteristics of the population and the healthcare system affect dental care access. The most common barriers to dental care for this group are affordability, awareness, and accommodation.

***Systematic Review*²⁸**

Nine studies were included in this review. Refugees in Sweden are more likely to use dental services if they are older ($p'.$ $p<0.001$). Preference for English language for

communication and level of education showed significant associations with increased access to dental care ($p<0.001$).

Scoping Review²⁹

Seven studies were included in the review on nutrition interventions in refugee settings aimed at restoring healthy body weight. A significant improvement in weight-for-height was seen in all the study children, and a 90% reduction in anaemia was achieved.

Mexican and Somali Refugees living in the USA^{30,31}

Refugees aged over 18 years—The proxy for increased access to dental care was significantly positively linked with understanding and speaking English ($p<0.001$).

A study looked at how well people remember information about oral health and how their habits change. Four types of knowledge were found: increased general knowledge about oral health (40. 6%) and better brushing practices (37. 5%). When it comes to changing oral hygiene behaviours, there were four main areas: more frequent flossing (50%), better brushing habits (43. 8%), improved brushing techniques (12. 5%), and overall oral care (9. 4%).

Refugees from Algeria, Canada, Australia, and the USA living in Halle (Saale), Germany³²

On average, there were 568 people, with about 1.44 treatment cases and 2. 53 dentist visits per person. Most visited the dentist due to localized (43. 2%) or non-localized (32. 0%) pain. The most common issue was tooth decay.

Refugees in New South Wales (Australia)³³

At baseline, only 50% of staff felt confident in providing Trauma of Informed Care (TIC) to refugees and asylum seekers. After training, 97% felt confident in understanding and delivering treatment.

Refugees from Syria in Turkey³⁴

Aged 18 years- reported that 71. 9% hadn't visited a dentist in the last year, and 82. 8% hadn't gone in over 12 months. Most had no trouble getting oral and dental hygiene products (68. 4%), but about 62. 6% had trouble getting dental treatment.

Refugees from Syria in Zatari camp, Jordan³⁴

Women who had never heard of dental implants were more than men ($p < 0.001$). A small group, 6. 2%, believed that implants need more care than natural teeth, while 47. 6% thought that diseases could affect the success of implants. Friends were the most common source of information, with 61. 4% of the people getting their information from them.

Refugees from Central Africa who are living in Gado-Badzeré (Cameroon)³⁵

Aged 6 to 80 years- showed poor knowledge about oral health. 42. 6% of those who visited the health post for their oral health problems were not satisfied with the care they received.

ACCULTURATION AND ORAL HEALTH LITERACY IMPACT ON ORAL HEALTH

Acculturation is the process of adapting to a new culture when people from different backgrounds come into regular contact. It can influence lifestyle, behaviours, and social norms, and it is often connected with socioeconomic changes.³¹ According to the "cultural marginality model," refugees with moderate levels of acculturation may lose some of the beneficial traditional dental practices they had before, without fully adopting the preventive practices of their new environment.³⁷

Oral health literacy is the ability of individuals to get, understand, and use basic oral health information and services to make good health decisions. Health literacy can be divided into two types: functional, which is the ability to read and understand health-related information,

and comprehensive, which is the ability to use health knowledge to make informed decisions about one's health.³⁸

Studies looking at how refugees adjust to new cultures and their understanding of oral health:

Refugees from Somalia, Iraq, and Syria living in Massachusetts, USA^{37,38}

People who had better health literacy were 2.0 times more likely to get preventive care ($p=0.02$). Those who could read words better were 1.8 times more likely to get preventive care ($p=0.04$).

Maternal dental health and its relationship to caries experience among refugees

Refugees from Mosul, Iraq living in Mamyza province, Iraq³⁹

Seventy-nine pre-school children – The mothers' knowledge oral health was low, and 63% of the children's had tooth decay. Five-year-olds had more tooth decay (77. 8%) than four-year-olds (51. 20%). The main reasons for the high tooth decay were frequent eating of sweets, help with brushing teeth, and irregular dental visit.

A TELE-HEALTH APPROACH TO ADDRESS REFUGEES' URGENT ORAL HEALTH CARE⁴⁰

This telehealth approach connects patients with doctors when they had a main problem. By handling their urgent dental needs quickly, they were less likely to go to the county's emergency room during the pandemic.

ADVANTAGES

- Technology and software made it possible to have remote check-ups, triage, and quick or timely evaluation of dental issues.

• Refugee patients learned about how to navigate healthcare and what to expect from providers through a teach-back method.

• The time saved through the telehealth screening process allowed for an extra urgent care session (3 instead of twice a year), where 120 patients received multiple procedures in one session.

• This was especially significant because the pandemic had shut down clinics, making it hard to provide care for this vulnerable group.

CHALLENGES

• The dentist had to frequently access the online link, which increased their workload.

• More time was needed for communication and training between the dentist, dental team, urgent care clinic organizers, and all those using the tool.

CONCLUSION

As a result, it is likely that refugees face a high level of oral health issues. This is even more true in low and middle-income countries. A major reason for differences in oral health is limited access to dental care. The difficulties in accessing proper oral healthcare for this growing group raise public health and ethical concerns, such as fairness in healthcare distribution and respecting individuals' choices. Understanding the common oral health problems among refugees and asylum seekers can help policymakers plan better treatments and strategies that fit into the healthcare systems of host countries, which are often already under heavy strain when many refugees arrive suddenly.

Conflict of interest: No conflict/competing interest

Funding: Not applicable

Ethical approval: Not applicable

Patient Consent: Not applicable

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