The Oral Health of Refugees - for dental professionals

Oro-facial disease and disabilities, including pain, are significant health issues for refugees worldwide. Eighty-eight per cent of Liberian refugees surveyed by WHO were suffering from dental disease or pain (Ogunbodede et al, 2000).

In Australia, a Sydney Dental Hospital study found that 29% of refugees surveyed had 5 or more untreated decayed teeth, compared with 14% of Australian-bom emergency dental care recipients (Kingsford Smith et al 2000). A Perth study found that every refugee assessed exhibited gingivitis or periodontitis at moderate to severe levels (Davies et al, 1998).

Those refugees most at risk are not necessarily those who come from countries with poor comparative dental services. Davies et al (1998) found that refugees from the Balkan region were at particular risk due to diet and the lack of maintenance therapy for existing dental work. They found up to 50 times the rate of dental decay than that of the Australian population.

If not treated, the consequences of oral health problems in refugees can include continued pain and stress, difficulties learning to pronounce English, and loss of self-esteem and social status.

Why refugees have a high risk of poor oral health

The reasons can include:

- torture-related injuries to the mouth and face
- closure of dental services in war and/or disruption to dental hygiene practices, including shortages of brushes, toothpaste and clean water
- prolonged stays in refugee camps with few, if any, dental services or oral health education
- poor diet and nutrition whilst in exile
- lack of water fluoridation
- the impact of prolonged anxiety including acidic reflux, grinding, bruxism, and reduced motivation for self-care.

The availability of low cost high-sugar foods in Australia can exacerbate existing problems. Language and transport difficulties, financial pressures, and the ongoing effects of torture and psychological trauma may make it more difficult for refugees to get treatment in Australia.

Usage of private and public services

Refugees generally arrive in Australia with very little. Until they are more established they are unlikely to be in a position to afford private dentists, and are dependent almost wholly on public dental services.

Most newly-arrived refugees will be eligible to use public dental services as they have a Medicare and a Health Care card. In recognition of the fact that refugees are unlikely to have had access to dental services for a prolonged period, the Priority Oral Health Program gives refugees a slightly higher priority than those with less complex needs.

Dental services available to asylum seekers

Asylum seekers living in the community are not eligible for Centrelink benefits, and a third are not eligible to work in Australia, so they face severe financial barriers to accessing private dental services. They may be able to access certain public dental health services but only for emergency treatment and relief of pain.

If you are a dentist in private practice and would like to join a register of dentists who provide occasional pro bono work to asylum seekers, please contact RHS.

Working with torture survivors

Survivors of torture are at particular risk of poor oral health: Davis et al (1998) found that torture survivors had a mean of only 9.7 teeth that did not require treatment, compared to 12.7 teeth of a non-tortured refugee group.

Torture techniques that cause dental damage include beatings around the face and head, electro-shock torture and the removal of teeth. The oro-facial consequences of torture may include: consequences of withholding dental care; dental avulsion; soft tissue damage; the loss of fillings; broken crowns and false teeth; mandibular/maxillary fracture; malocclusion; and/or TMJ syndrome.
Tooth loss from direct trauma & electric shock torture  
Source: Amnesty International  
The Lancet Vol 359 March 2002

As a result of their experiences, survivors may experience intense fear of dental procedures, particularly if surgical instruments were used in torture. Anxiety will be lessened if interpreters are used, and supportive family or friends are present. Explaining to dentists how the damage was caused is likely to be traumatic for torture survivors, and dental staff.

Witnessing the physical damage inflicted by torture and being exposed to patients' torture histories is unfamiliar territory for most dentists. It is not uncommon for people to have an emotional reaction.

Avoid holding consultations in areas that might be reminiscent of torture (eg windowless rooms). Try to create a welcoming environment & explain procedures to give the patient a sense of control. Create opportunities for staff to debrief. Consider training on how to manage the emotional impact, & how to use an interpreter.

The impact of poor diet

Nutritional deficiencies are a common part of the refugee experience. Davies et al (1998) found nearly 50% of refugees studied had dietary deficiencies associated with the development of oral candidiasis.

Uncontrolled intake of high-sugar foods resulting from long periods of deprivation, the novelty of having traditionally high-status foods (such as Cola) available at low-cost, and limited knowledge of the sugar content in foods are also factors for some communities.

The impact of culture on oral health

Some cultural practices will be unfamiliar to dental staff. For example, one tribe in Southern Sudan traditionally extracts six permanent, lower anterior teeth during puberty. Traditional healing practices involving removing or mutilating teeth to cure fever or other illness are also used in some rural areas in Africa (although this is rare).

Some refugees will be used to very different dental hygiene practices, for example ‘chewing sticks’ used to clean teeth in parts of Africa and the Middle East. While most refugees end up adopting western oral hygiene practices when in Australia, they may not know how to get the best results. Unfamiliarity with practices such as flossing can contribute to problems.

Others may have different expectations of oral health. For example, bleeding may be seen as normal - not a symptom of more widespread oral disease. Michaels (2002) reports that Afghan Hazara refugees extract teeth once they were considered ‘finished’ or when the pain became unbearable.

Advising on basic dental hygiene may be important. Translated materials on dental health are available at www.mhcs.health.nsw.gov.au

When making appointments

It may also be difficult for some people of a refugee background to remember appointment times because of the multiple demands of settlement, poor English, and the impact of psychological trauma. This is harder where there is a delay of several months between referral and the appointment.

In addition, people who are unfamiliar with preventative care may not see the point of attending an appointment if their pain has subsided.

Where possible, ring the patient beforehand & remind them about their appointment. Explain expected costs. Always pre-book an interpreter if needed.

Relevant services

NSW Refugee Health Service 8778 0770  
STARTTS (torture/trauma counselling & services) 9794 1900

Recommended Readings