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Editorial

Migrant and refugee Oral Health

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This issue contains two papers on the oral health of migrant people. The oral health of migrants, refugees, and asylum seekers is often worse than the general oral health of the host country's population (Crespo, 2019; Davidson *et al.*, 2006). Poor oral health outcomes in migrants are due to a combination of upstream, psychosocial, and behavioral factors. Migrant communities might then have vital priorities that compete with oral health. Consequently, they may express lower needs and may not focus on oral health; all these factors lead to a higher risk of developing dental diseases. Lack of oral health services is commonly seen due to limited financial resources or lack of dental providers in the vicinity of migrant communities or refugee camps. They face additional cultural and linguistic barriers in navigating the health care system of a new country.

In many countries, preventive oral health care is not a part of routine health care and may affect individuals' attitudes on when and how to seek care. Gaps in oral health knowledge, such as understanding the importance of primary teeth in children or teeth retention in older adults, moderate their beliefs in the value of preventive dental care and could predispose them to higher risk. It may also be that refugees have been disadvantaged or marginalized for some time in their country of origin.

Migrant communities then endure lifestyle and behavioral changes as they move from their own country and adapt to the host country's culture (Garcia *et al.*, 2008). This concept, also known as acculturation, impacts dietary changes leading to higher consumption of high-sugar foods and drinks, leading to higher dental caries. Acculturation increases the risk of developing dental diseases in migrants because it may influence their ability to cope with a stressful situation, such as undergoing dental procedures.

While most refugees worldwide are located in developing countries, oral health refugee studies (86%) tend to be performed in developed countries (Ben Taleb *et al.*, 2015; Keboa *et al.*, 2016). Consequently, the oral health needs and issues of most refugees remain largely undisclosed (Keboa *et al.*, 2016). Host nations, especially developing nations face challenges related to health care provider shortages for the refugee communities. Health professionals are frequently unfamiliar with working in these settings, are further complicated by a dense refugee population, remote location of refugee camps, pre-existing health problems, a propensity to give priority to other more pressing health needs compared to oral health.

Salim et al. (2021) found that although the services were available, most refugees sought treatment only for acute symptoms such as pain. Unexpectedly, in a previous study, many teeth were extracted in accordance with parents' requests even when the tooth could have been saved. This might be explained by a long-standing lack of access to dental treatment in primary teeth and because dental care is not frequently a main concern among refugees (Salim *et al.*, 2020a).

Barriers to care are also seen in Tiwari et al.'s (2021) needs assessment with African migrants to the United States. The community faced barriers in accessing dental services, including financial barriers, lack of time and transportation. Again, with little history of using dental services, there was a similar lack of perceived need for oral health care where participants largely accessed dental care only in response to pain. Little knowledge about preventive oral health care was present in the community, and instead, a dental visit without pain was considered unnecessary. In this very different situation however, the African community leaders were energized due to their involvement in the project towards bringing oral health care services to their community. This may be a positive example of acculturation.

These studies provide strong evidence that migrant and refugee communities, although in different countries and circumstances, share common challenges and barriers. There is a high need to increase community-based efforts in research and oral health promotion programs at national and international levels that will shed light on the oral health needs of migrant communities. Also, there is a need for systematic surveillance, policy reorientation, efficient utilization of available resources and expanded knowledge of all areas of health. These efforts can also help organizations and countries to develop policies to bring health care and dental services to these vulnerable underprivileged communities. Implementation of successful policies would also involve a high degree of engagement and commitment from all stakeholders. In addition, the creation of joint initiatives with other international organizations, multi-country dialogs and civil society is highly important to enhance the health sector level and health care services provided for such disadvantaged communities.

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Also, standardized and reproducible data identifying migrants/refugees are important to understand their ever-changing health status. This awareness will help to quantify the effect of migration on health systems in migrant-receiving locations and encourage the efficient adaptation of programs and initiatives aimed at enhancing the utilization of services and health outcomes. Some of the suggested approaches to the monitoring of migrant health include standardized documentation of health social determinants influencing migrant health outcomes, including poverty, schooling, employment and environmental factors. Tools that can aid in the acquisition of migrant-relevant health information include the incorporation of basic migration problems into existing data collection systems, such as national statistics reports and health surveys, as well as regular medical/health information gathering. When structured and uniform health information on migrants is exchanged between countries and sectors (e.g. between immigration and job data sets and health), regional and global trends can be more easily understood.

The international community cites oral diseases as one of the health priorities for refugees and asylum seekers. Disparities in oral health for this group remain a major concern. More research is urgently needed on migrants and refugees in both developed and developing countries, to inform strategies to bridge any oral health gaps. Both these studies provide a valuable perceptive for researchers and other stakeholders working to improve the oral health of these vulnerable communities.

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