Refugees and oral health: lessons learned from stories of Hazara refugees

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Abstract

Australia is one of a few countries with a resettlement program for refugees. The organisation and provision of health services for refugees pose challenges to health service managers and service providers. Some groups have experienced severe trauma and, in the case of Hazara refugees, years of persecution and displacement. This qualitative study gained access to Hazara refugees in order to gain an understanding of their oral health experiences and to seek participant views on factors that impacted on their oral health status. All participants had poor oral health status, multiple tooth extractions, and had placed a low priority on their oral health. They had experienced violence and traumatic events associated with war and looting. Participants reported that they had limited access to dental practitioners and oral education; lived for extended periods with oral pain and untreated oral problems; and treated oral pain with traditional pain remedies and tooth extractions. Service providers need to consider that elements of the refugee experience may affect health-seeking behavior and adherence to treatment.

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What is known about the topic?

A body of literature documents oral health experiences of migrants from developing countries, namely the use of traditional oral hygiene tools such as chewing sticks, poor access to dentists, untreated oral problems and the use of tooth extractions to manage pain. However, little research has been conducted about how exposure to conflict, displacement or refugee flight impacts on these experiences.

What does this paper add?

Hazara refugees who participated in this study described oral health experiences that have been commonly reported in developing countries. They also reported that exposure to conflict, displacement or refugee flight could result in stress and dry mouth, diminished attention to oral care due to preoccupation with survival, and difficulties accessing oral hygiene tools and dental practitioners.

What are the implications for practitioners?

Service providers should consider the following issues with Hazaras and other resettling refugees: oral pain and untreated oral problems, disrupted oral hygiene practices, lack of prior exposure to fluoride-based oral hygiene resources, persistent refugee trauma and different beliefs about oral health. This has implications for preventive and restorative dental care, health education for resettling refugees upon arrival, and the provision of culturally competent and trauma-sensitive care.

AUSTRALIA IS A MAJOR country of resettlement for refugees. Since the end of World War II, over 675 000 refugees and people in humanitarian need have been resettled in Australia. Each year between 12 000–15 000 people enter under the Humanitarian Program.[1] Resettled refugees face major challenges, including access to health services. The status of various visa categories significantly affects asylum seekers and refugees in accessing basic health services, including dental care.[2,3] This paper focuses on refugees and their oral health.

Refugees who have undergone conflict and forced exile may experience persecution, physical and psychological trauma, deprivation, unhealthy environmental conditions, and disrupted access to health care in general.[4] Due to the nature of their experiences, refugees may have specific oral

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service needs in the area of clinical and interpersonal care, and public health or health promotion.[5] All health services and clinicians, including dental clinicians, have a responsibility to provide culturally competent and trauma-sensitive care that upholds human rights.[5]

Oral health professionals who provide care for refugees through mainstream oral health services may have had little opportunity to understand refugees' oral health experiences because they comprise only a small part of their clientele group. In this paper, we use qualitative methods to examine the refugee and oral health experiences of Hazara refugees from Afghanistan, and discuss the implications of these experiences for oral service provision within resettlement countries. The aim of this study was to describe the oral health experiences of Hazara refugees while in Afghanistan and in transit, and the impact of conflict, persecution, refugee flight and displacement on these experiences.

The Hazara population group has intensely experienced core elements of the refugee experience — conflict, persecution, and displacement. Hazaras are one of four main ethnic groups in Afghanistan. They differ from most other Afghans in that they speak Dari and follow the Shi'a Muslim faith.[6] Over the past 25 years in Afghanistan, prolonged and repetitive episodes of conflict have accompanied each of the five successive changes to regime.[7] In addition, the religious and linguistic background of Hazaras has resulted in marginalisation and persecution as a minority ethnic group. Between 1929 and 1978, Hazaras experienced isolationist policies from successive regimes.[6] Since the coup d'etat in 1978, Hazaras have suffered persecution under several regimes.[7] Conflict and persecution of Hazaras has led to forced migration and prolonged periods of displacement within Afghanistan or in neighbouring countries.[6,7]

Impact of refugee experience on oral health status

The level of oral disease of the refugee population groups that have been examined varies considerably.[8-15] Differences in disease rates are likely to reflect different exposure to oral health determinants in the country of origin.[9] A high level of untreated dental decay[9,12] or unmet need for dental treatment[8,10,13] has been reported in some refugee groups. Low utilisation of dental services has also been reported in refugee groups.[4,16]

Refugees from developing countries are likely to share many oral health experiences that are common in the developing world. For example, access to oral health services in developing countries is limited because they are under-resourced[17] and are unable to offer universal, affordable care.[18] Resources are generally allocated to pain relief and emergency care.[19,20] As a result, untreated decay and tooth extractions are common.[19,20] Access to water fluoridation and affordable fluoride toothpaste is limited in developing countries.[19] Traditional oral hygiene routines using chewing sticks are common and have an important role as they have been shown to improve dental hygiene.[21]

There is little information about how the experiences of conflict and refugee flight can impact on oral health experiences. Conflict can contribute to decline in health service infrastructure and the loss of health professionals to forced exile.[22] Refugees may have suffered oral injury and trauma, due to beatings or torture around the mouth.[23-27] Poor access to safe water and poor sanitation are risk factors for oral disease[28] and contribute to poor oral health within refugee camps. Refugees may also experience the dental effects of prolonged periods of living with anxiety and stress, such as bruxism and mucosal lesions.[25,29]

Special oral health care needs among refugees

Literature on refugee health care describes approaches to health care that are culturally competent, trauma-sensitive and uphold human rights. Trauma-sensitive care seeks to avoid clinical situations that may retraumatise clients, and to ensure that care does not disregard a client's trauma.[30,31] It also seeks to empower refugees

1 Characteristics of selected participants

Participant type	Individual profile
Refugee	Female; early 40s; rural; low literacy; recent arrival*
	Male; late 20s; urban; educated; resident in Australia 4 years*
	Male; early 60s; rural; religious education; resident in Australia 18 months*
	Female; late 20s; urban/rural; educated; resident in Australia 4 years *
Afghan dentist (also refugee)	Early 60s; educated in dentistry in Afghanistan; rural and urban experience; resident of Australia approximately 10 years*
	Late 30s; educated in medicine and dentistry in Ukraine; rural and urban experience; resident of Australia 13 years*

* Information about the length of residency is at the time of interview, July–August, 2001.

who are living with residual trauma and to rebuild their sense of integrity.[32-34] Oral service provision that upholds human rights aims to redress former human rights violations by ensuring that the client's rights within the clinical experience are explicit. This involves affirming the client's dignity, and respecting and upholding their rights to informed consent and decision making about their health care.[35,36] It also upholds the client's rights to service access,[36] particularly by recognising the social and cultural factors that deny access.[4,5] Refugees who have experienced human rights abuses at the hands of government authorities, or torture in which health service providers participated, may not access health services because they have difficulty trusting health service providers.[4] Such lack of trust also makes it difficult to reach such groups in order to determine factors that may affect access once they are resettled. This study aimed to gain an in-depth understanding about oral health from one group of highly vulnerable refugees.

Methods

This research was a qualitative descriptive study which analysed the oral health stories of Hazara refugees who have resettled in Australia, using semi-structured in-depth interviews. Data collection was undertaken in Australia during July–August 2001, before the American invasion of Afghanistan in 2002. Study participants were selected who could provide detailed information about factors that impact on oral health of Hazara refugees and who represented a range of demographic variables or life experiences that may influence oral health: males and females; younger (20–40 years) and older (41–65 years) adults; refugees who had lived in rural and urban areas in Afghanistan; refugees who had had high levels of education and who had little or no education; refugees who were recent arrivals and who had been settled here for 2 to 5 years; and refugees who had experienced higher and lower levels of psychological trauma. Perspectives were also sought from refugees who had worked as dentists in Afghanistan.

As there was no community organisation or leader who represented the Hazara ethnic group in Sydney, access to the community was a challenge. The interviewer [CM] used community snowballing strategies to recruit participants, including a visit to a local Shi'a mosque. Field notes about oral health during preliminary consultations with community members and workers informed the development of the interview protocol. A trusted community member was invited to act as a cultural advisor to the project. She was instrumental in identifying community members who met the selection criteria for the study, and introducing them to the interviewer.

Six Hazara refugees and two dentists who had worked in Afghanistan were interviewed. The demographic characteristics of the study participants are listed in Box 1. Both dentists had resided in Australia for 10 years or more. Com-

ments from the cultural advisor were also treated as data. Ethics approval was granted. Two semi-structured interview guides were used in the interviews; one for the Hazara refugees and one for the professional Afghans who had an oral health background. Interviews were conducted through an interpreter and were taped, translated and the English version transcribed. Analysis was conducted in two stages. In the first stage, a multi-investigator team, including the community advisor, conducted a thematic analysis of the data. In the second stage, the research team double-coded the transcripts, to ensure that no themes were missed in the analysis.

Results

All Hazara interviewees had poor oral health. They had tooth extractions, and two interviewees had lost all of their teeth. The interviewees had all experienced violence associated with civil war. They also reported that Hazaras had suffered persecution and genocide during the Communist revolution and under the Taliban regime. Persecution took the form of imprisonment, disappearances, torture, massacres and looting of homes, particularly in the areas in which Hazaras lived. Interviewees had watched family members killed in front of them, witnessed massacres, and been imprisoned and tortured.

> Especially during the Taliban regime, I witnessed the killing of 800 men of Hazara and whenever I remember this it is a kind of engraving in my mind, and it is very disappointing and the aim of these people is absolutely abolishing the Hazara tribe in Afghanistan and especially in Mazar-e-Sharif.

All interviewees reported that they fled their homes to save themselves from "killing and torture" and "rocket attacks". Within Afghanistan, they moved between city and rural areas. One reported moving to remote mountainous areas and sheltering in caves and abandoned houses. All participants had fled to a neighbouring country before coming to Australia. In neighbouring countries, participants' experience of displacement differed according to the level of financial support they had from family overseas or welfare agencies and whether or not they were legally recognised as a refugee by the United Nations High Commissioner for Refugees (UNHCR) and other international organisations. Those who were not recognised as refugees found it difficult to find enough work and had the additional stress of being deported.

> If they realise that they do not have any legal documents they deport them. And soon as they get to Afghanistan they are killing them.

Oral health experiences

Risk factors

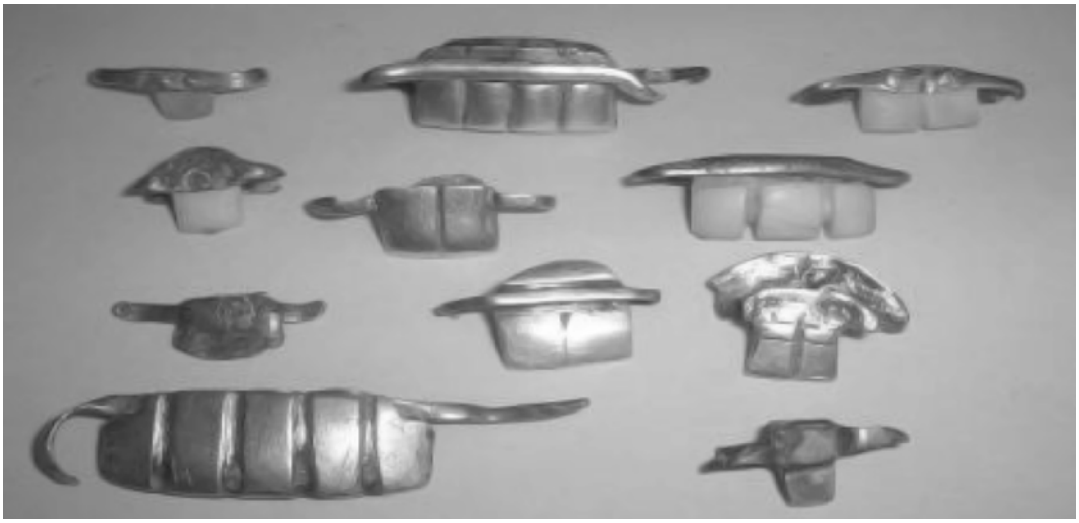
Several risk factors for oral disease were reported. These included smoking *chelam* (which is similar to the Middle Eastern sheesha pipe) and sucking *naswar* (a mixture of powdered tobacco, wood dust and lime). Participants reported that breaking nuts and dried foods or removing needles with their teeth could damage their teeth. One Hazara dentist who participated in the study reported that the stress of survival during prolonged periods of conflict and displacement commonly resulted in dry mouth, a risk factor for oral decay and periodontal disease.

Motivations for oral care

Study participants had a variety of motivations for cleaning their teeth. Some rinsed their mouth for religious reasons. Islamic teaching requires followers to wash parts of the body exposed to dust or smog before each prayer (3–5 times a day). As part of this ritual, the mouth is rinsed three times, preferably using a *miswak*. The *miswak* was described as "A special twig-like root, shredded about 1 cm at one end and used for brushing teeth, usually with salt". Other participants were motivated to clean their teeth to counter bad odour or prevent further tooth problems.

Interviewees reported that people could no longer prioritise their teeth after the conflict began. Oral hygiene did not happen routinely because safety and survival became the major

2 Brass dentures made by jewellers in Jaghori district of Afghanistan during the 1950s, from the collection of Mr Murad



priority in their life. Oral care was a "small thing" among these other concerns.

> You know this is already 20–25 years going on in the fighting so everybody's life is at risk that and they need to find shelter and a place to live peacefully and … be secure. So they are looking first for a place to live and be secure and safe. And second they are looking for food to not remain hungry and then the question of children is another thing … and these are the questions they have. It's priorities. They don't have time to think about their teeth and they don't have time to think about their mouth and oral health. So it's problems which prevent, which create barriers against the person looking after their oral health.

A participant who had been imprisoned for 6 months and beaten with razor wire reported that he had not been allowed to care for his teeth or bathe during this time.

Access to oral hygiene resources

Participants reported that in Afghanistan they used toothpastes and toothbrushes, or the *miswak* with a salt or a salt-water rinse to clean their teeth. Toothpaste and toothbrushes were only available in cities and industrialised regional centres. The *miswak* was available seasonally at the market in rural areas and was sold by a wandering salesman in more remote areas. When a toothbrush or the miswak were not available, participants reported that they used salt. Several participants reported that they used their finger to rub salt over their teeth and gums. One participant explained that she did not take her toothbrush with her because she fled her home during a rocket attack.

> It was the winter time and a war situation with a rocket attack. So we just could to save our lives, so we left home without taking anything.

Pain management and use of dentists

Participants reported that they were used to living with oral pain for extended periods of time.

> It's almost 10 years since I first felt pain in my teeth, and then it got worse and worse.
>
> The pain is like fighting and nobody likes fighting.

Powdered herbs that had an antiseptic component were used as traditional remedies to dull pain. Hazaras also put a number of substances within tooth cavities to dull the pain, including cloves,

takhak (a black pepper-like substance), aspirin, yeast that had been made into dough, and a "glue" made from powder. A saltwater rinse was also used to reduce tooth pain. Participants reported that they waited until they were in severe oral pain before they visited the dentist. They associated visits to the dentist with tooth loss.

Access to dentists and lay practitioners

Participants reported that most dentists in Afghanistan had been locally trained. Many people had difficulty accessing dentists in regional areas due to transport and availability, and dentists in these areas had poor materials and primitive equipment. Hazaras also used barbers or an ironsmith to perform extractions, or would perform extractions themselves. Interviewees reported that these were done without anaesthetic, and in some cases, patients could be left unconscious or with broken bits of tooth in their mouth. Historically, jewellers and ironsmiths made false teeth out of gold, bronze or plastic and clipped them on to remaining teeth using metal tags (Box 2).

> The poor would go to their local barber who would straight away pull out the tooth that is causing the pain. In Kabul, in elite areas, barbers have shops. Ordinary barbers would sit on the street usually in crowded areas in order to make themselves more accessible to their customers. They are equipped with a toolbox and a small cloth spread on the ground in front of them. Customers with a dental problem would be attended to on the street in public. After the operation, the mouth and tools are washed in plain water, the job is done, the barber gets paid and a family member takes the patient home.

> Mainly just that they putting a sort of fishing rod sort of things in a nail on the street and just pulling themselves or pliers helping someone else.

Both of the dentists reported that there was a widespread belief that fillings do not work and that most of their work was extractions. They reported that their patients preferred to have a tooth extracted rather than filled, so that they did not need to revisit the dentist or barber if the filling did not work. Participants reported that they visited a dentist or barber when they no longer had "temporary pains", but were in "excessive" or "severe" pain that they could no longer tolerate. They also reported that they attended a dentist when they had come to a decision that a tooth was "finished", or completely worn out; because they had signs of major decay, for example, a black stain or large hole; or because a filling had become infected or a dentist had damaged a nerve.

> Whenever you feel like there is a small problem you go and ask for the cure, but for us, it is at the time that it is completely worn out and then we go and ask . . . and we have time to go and fill . . . and still it doesn't work.

Interviewees described several problems in accessing emergency oral care during refugee flight. One participant reported he delayed having his teeth extracted during because he needed to wait until he was "in a safe place". Others reported that when they were caught in the "middle of nowhere" they had to accept whatever local dental care was available. Several participants who sought local dental care during refugee flight and in neighbouring countries reported that they subsequently had to have a "healthy tooth" extracted because of the dentist's mistakes.

> That extraction was when I was caught in the middle of nowhere, you know on the border of Afghanistan and Iran — when I was travelling on the way I had a toothache and I went to the dentist. I know what he did . . . he just put the material, the amalgam that he used on the nerve and then it started shooting pain.

Oral health education

Most study participants were unaware of any oral health information in Afghanistan. However, they pointed out that oral hygiene principles were contained in Islamic religious teachings. Several participants reported that they received education in oral health care for the first time by non-

government organisations. This happened when organisations such as Médecins Sans Frontières began working in Afghanistan, or after they had fled over the border to Peshawar in Pakistan.

Discussion

Participant oral health stories highlight issues that health services need to address in resettlement settings: oral pain and untreated oral health problems, disrupted oral hygiene practices, lack of prior exposure to fluoride-based oral hygiene resources and persistent refugee trauma. In addition, the stories raise the possibility of persistent patterns of dental service use that may affect decisions about seeking health care in a new oral health service environment.

Refugees from developing countries may have been living with oral pain and untreated oral problems for extended periods of time. Refugees may also have difficulty obtaining emergency care in transit settings such as neighbouring countries if they are not legally recognised, and may find it difficult to pay for private dental care. Oral health programs within refugee camps are a low priority.[37] Disruptions to physical, psychological and social wellbeing can occur with oral problems[17] and are likely to impede the settlement process. Constant severe pain impacts significantly on quality of life.[17] Untreated dental infections are also considered a risk factor for general health conditions and can aggravate other infections in the body.[19]

Conflict, refugee flight and a preoccupation with activities required for survival clearly disrupted regular oral hygiene practices. Refugees may have reduced access to oral hygiene tools due to the closure of markets, inability to access oral hygiene tools in remote areas and because they are unlikely to carry oral hygiene tools with them when fleeing to safety. Imprisonment may also place restrictions on oral hygiene. Refugees with these types of oral health experiences are likely to need support in establishing oral hygiene practices once resettled in Western countries, particularly if not used to toothbrushes and toothpaste. Stress is a recognised risk factor for oral diseases.[38] Participant stories illustrate that stress may be a factor in refugee contexts through exposure to traumatic events. Refugees who have experienced trauma such as human rights violations, threat to life, loss, dispossession and eviction may live for prolonged periods with symptoms and psychosocial impairment that are associated with post-traumatic stress disorder.[39,40] Persistent trauma is likely to impact on refugees' ability to function[41] and may impact on oral hygiene behaviour.

Recent theories about the social determinants of health emphasise the need to understand the broader context of oral health experiences and behaviour.[42] Findings from this study illustrate ways in which the oral health environment in Afghanistan shaped and reinforced psychosocial and behavioural factors related to oral health among these participants. In the absence of adequate oral health services, participants reported that Hazaras commonly use barbers or lay practitioners to extract teeth or apply traditional remedies to treat the oral pain, rather than seek dental treatment. They also described a set of concomitant beliefs that arose within this environment; namely the need to wait until there is severe pain or dental decay, or until their tooth is "finished", before visiting a dentist. These beliefs are likely to shape and reinforce oral behaviours, and may persist in a new setting where effective remedial dental care is available.

Service responses

Dental health clinicians need training in providing culturally competent and trauma-sensitive care for refugees. For example, some refugees may choose to retain traditional oral practices that do not use fluoride products within the settlement country.[43] Culturally competent care will recognise that traditional oral beliefs and behaviours are understandable and understand why motivations for personal oral care may have been diminished during conflict and refugee flight. Refugees may also consider the loss of teeth to be an inevitable part of ageing.[28] They may not have received any oral health education, and may

not be aware of factors that contribute to oral decay. They may therefore not believe that looking after their teeth is important. Oral health professionals also need to recognise cultural and religious beliefs that may influence oral hygiene practices.

Dental clinicians need to be sensitive and respectful in discussing dental problems and decisions with refugee clients who are living with residual trauma,[5] particularly if their dental injuries are a result of torture or interpersonal violence. Trauma-sensitive care also needs to be cognisant of the impact of persistent refugee trauma on daily functioning,[41] including personal dental care. It is particularly important that clinicians uphold consumer rights for informed consent among refugees who have suffered human rights violations. They can do this by providing them with information they need to make oral health choices in this new setting.

Settlement programs for newly arrived refugees can respond to the immediate needs for dental care by offering oral health education and dental treatment. The provision of emergency and remedial care upon arrival is important for relieving pain and preventing escalation of oral problems in resettling refugees. It is important to provide oral health education within a resettlement country to inform refugees about restorative oral services, to help them re-establish disrupted oral hygiene patterns and educate them on how to procure and use fluoride-based oral care products. This should be delivered upon arrival and reinforced later on. Health education messages may need to address risk factors which are common to oral diseases and other major non-communicable diseases.[38,44] These include stress, diet, hygiene, smoking, alcohol, and risky behaviors causing injury. Within the context of refugee resettlement, this may include programs that help refugees re-establish dietary habits within a new food environment,[45] and tobacco cessation activities[46] that are culturally tailored to the target group.

Health service managers need to ensure that programs which provide comprehensive health and dental care for newly arrived refugees[12] provide the structured support that is necessary to overcome obstacles to oral health service use in resettlement country. It is important for clinicians to understand that refugees from developing countries may have not previously had access to preventive or restorative dental care. Newly arrived refugees have to attend to many immediate settlement needs upon arrival and are unlikely to make oral health a priority. Barriers they face in accessing oral services include language and cultural differences, difficulty in navigating the transport system, and an inability to trust service providers.[4] Newly arrived refugees do not have the financial resources to pay for private care, particularly if they are unemployed. Accessing publicly funded oral health services in Australia can also be problematic as there are often long waiting lists.[4]

Limitations

The aim of this qualitative study was to explore refugee views on oral health and was not designed to be representative of all refugees. The study's sample size limits our ability to extrapolate to other refugee groups but provides important insights into factors that impact on refugee oral health. Further research is warranted about the impact of refugee experience on health in general and oral health in particular.

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Competing interests

The authors declare that they have no competing interests.

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