

A70308

WHO/NMH/MNC/ORH/00.1
Distribution: General
Original: English

Oral health care in camps for refugees and displaced persons

**H.M. Htoon
S. Mickenautsch**



Oral Health Programme
Management of Noncommunicable Diseases
World Health Organization
Geneva, 2000

© World Health Organization, 2000

This document is not a formal publication of the World Health Organization (WHO) and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

List of Contents

Introduction	1
Phase 1 — Emergency	3
Assessment.....	3
Decisions on oral care objectives	4
Manpower requirements	5
Referral network and procurement of instruments and materials.....	5
Treatment.....	6
Reporting.....	6
Phase 2 — Stability	7
Transition	7
Programme preparation	7
Training refugees as community oral health workers	8
Self-management of community oral health workers	13
Phase 3 —Repatriation	15
Reintegration of community oral health workers.....	15
Phase-down of oral health services	16
Documentation and termination of programme	16
Annex List of essential instruments and materials.....	17
Recommended further reading	19

Introduction

This document is written for organizations involved in the administration and management of camps for refugees and displaced persons, including the health authorities of the host country, the United Nations High Commissioner for Refugees (UNHCR), nongovernmental organizations (NGOs), and other relief agencies. Its intended audience is principally those individuals with responsibility for implementing oral health care programmes in refugee camps.

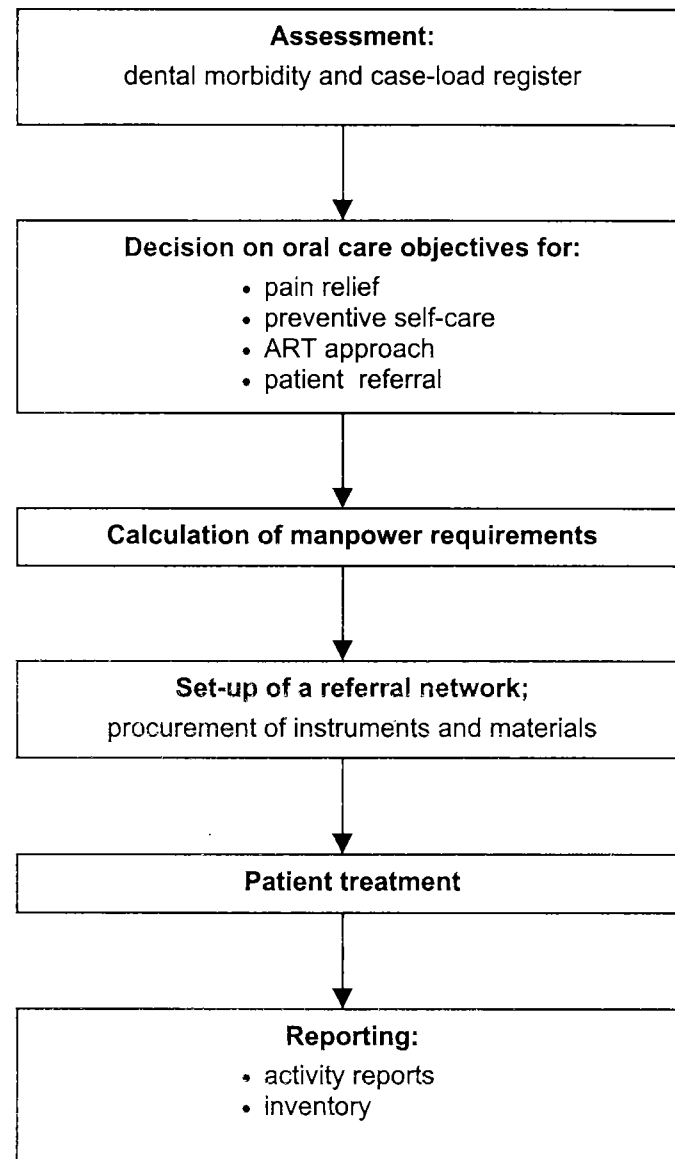
The authors have based their recommendations on personal experience. While acknowledging that most refugee situations are unique, the authors feel that there is enough common ground for these recommendations to be widely applicable.

For practical reasons, the oral health programme is described under three headings — Emergency, Stability, and Repatriation — although it is probable that there will be significant overlap between them. Although most care in the emergency phase is likely to be provided by non-refugees, the emphasis throughout programme planning is on self-care. Indeed, dental caries and gum infection, which are the two most common oral health problems, can be managed to a very large extent by self-care and through the use of low-cost instruments and materials. There is therefore little need for sophisticated dental equipment in refugee camps.

The authors also stress the advisability of oral health care and health promotion being integral elements of the overall health programme.

Additional publications on ART and how to implement a community scheme are available from WHO/Oral Health Programme.

Phase 1 — Emergency



Assessment

In emergency situations, the first step in oral health care activities must be an assessment of dental problems and treatment needs. This should be based on *morbidity* and can be undertaken by field staff in the course of their routine work.

Figure 1 Registering Cambodian dental patients in a refugee camp — Thailand, 1988



[Photo: H.M. Htoon]

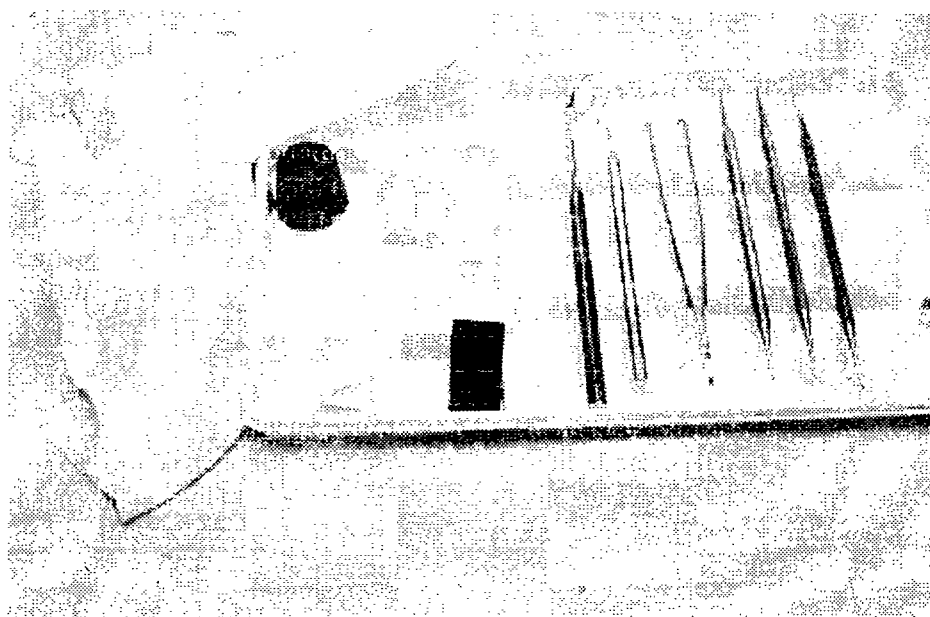
Decisions on oral care objectives

Oral health care objectives will not be the same in every refugee situation and will be dictated by the needs assessment. Appropriate dental personnel will need to be recruited to achieve these objectives. At this stage, it is likely that the principal needs will be for pain relief, preventive and curative care, improved self-care, and referral, which may be summarized as follows:

- *Pain relief*
 - tooth extraction
 - medication.
- *Preventive care and self-care*
 - individual oral hygiene instructions
 - use of fluoridate toothpaste.
- *Curative care*
 - atraumatic restorative treatment (ART).
- *Referral*

Depending on the circumstances, application of an ART sealant may be the appropriate method of preventing tooth decay. It is widely accepted that dental caries and gum infection can be largely prevented by use of a fluoridated toothpaste for brushing teeth and gums, and this appears to be true also of the refugee situation. However, once a cavity has developed in a tooth, the most appropriate approach to its management is ART. This involves removal of the soft, decayed tissue with hand instruments (see Figure 2). The cleaned tooth cavity is then filled with a material that bonds to the remaining healthy tooth tissue.

Figure 2 Instruments and material required for ART and application of sealant



[Photo: J.E. Frencken]

In 1994, WHO adopted ART as a promising low-cost approach to the treatment of dental caries in situations where there is no electricity. Longevity studies have since shown that the survival of ART restorations after three years to be as good as that of conventional (amalgam) restorations, which require teeth to be drilled.

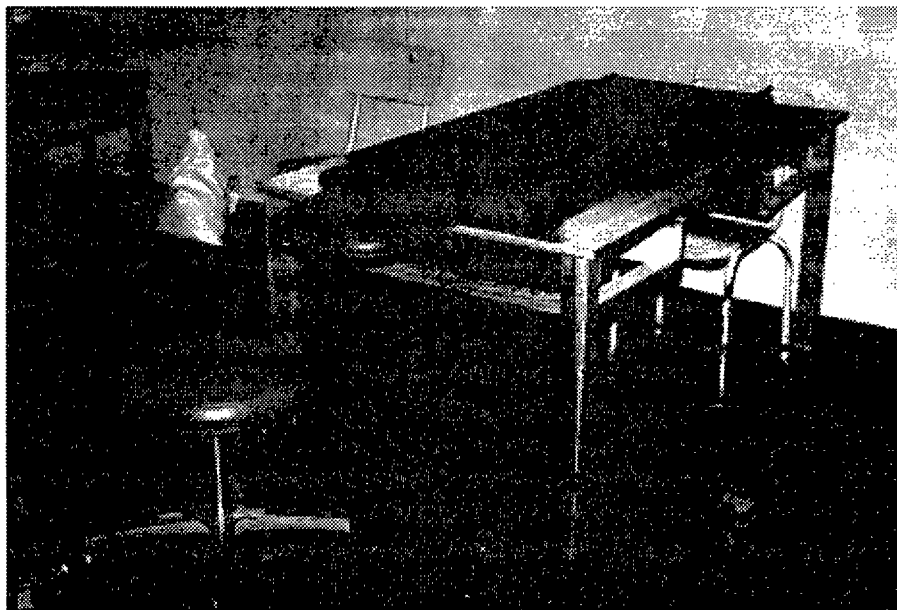
Manpower requirements

The organization responsible for overall health care in a refugee or displaced-person camp will probably determine the manpower needs for oral care activities. Initially, short-term personnel should be externally recruited, but every effort should be made to find individuals who can communicate in the language of the refugees.

Referral network and procurement of instruments and materials

The oral health care team should establish a referral network within the host country. They should also make use of any existing procurement system for the purchase of materials and instruments, although many supplies may be donated. The equipment and materials needed for most oral health activities during this phase (tooth extraction and ART) are listed in the Annex; it should be stressed again that expensive and sophisticated equipment is not necessary. During treatment, patients can be placed on a padded table or similar surface, or on a locally made bed (see Figure 3).

Figure 3 Treatment table. A padded cover and a head support are provided



[Photo: J.E. Frencken]

Treatment

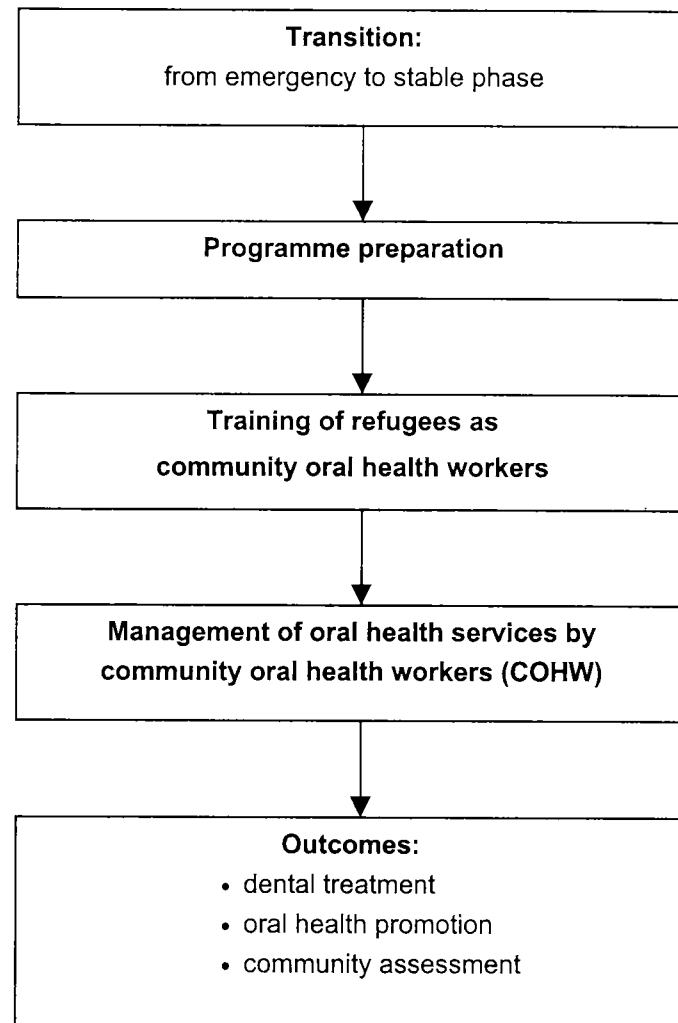
Depending on the resources available, oral health activities among refugees and displaced persons may include the following:

- *In the camp*
 - tooth extraction, ART
 - oral medication
 - preventive treatment, oral health promotion
 - screening and referral.
- *Outside the camp*
 - diagnosis, using outpatient laboratory and X-ray facilities
 - oral surgery, hospitalization.

Reporting

The report should be sent regularly to the responsible authorities on oral health activities and usage of resources.

Phase 2 — Stability



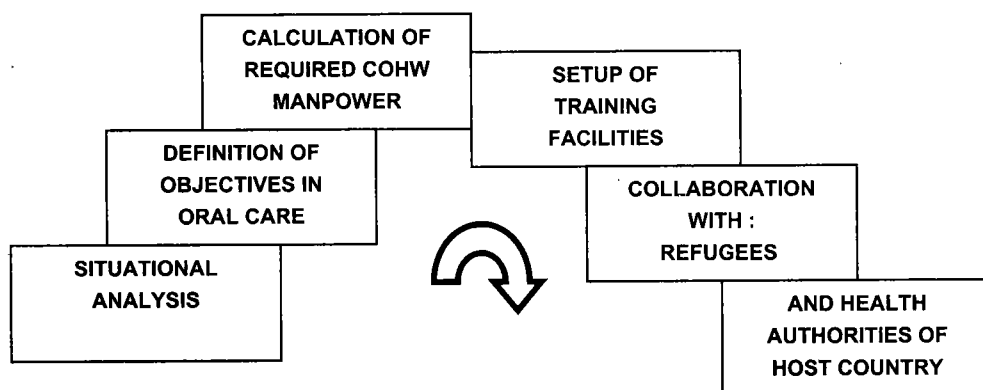
Transition

The responsible authorities will be able to identify the point at which the refugee situation stabilizes. Oral health care in the stable phase will build upon the programme put in place during the emergency phase.

Programme preparation

Once conditions of stability are achieved, it is probable that externally recruited oral health personnel will no longer be available. Where that is the case, individuals selected from among the refugee population will need to be recruited to take their place. The emphasis of the oral health programme will therefore shift to the training of "community oral health workers" COHW. A typical sequence of steps in the preparation of an appropriate oral health care programme for a stable refugee situation is illustrated in Figure 4.

Figure 4 Steps in preparation of an oral health care programme under conditions of stability



Training refugees as community oral health workers

Following a joint decision by all relevant parties, a selected group of refugees will be trained as community oral health workers. Training should make use of recognized training modules and should be in accordance with any legal requirements of the host country.

Successful trainees should receive appropriate certificates as evidence of their achievements and should be provided with detailed job descriptions. Typically, a job description might outline the oral health worker's responsibilities as follows:

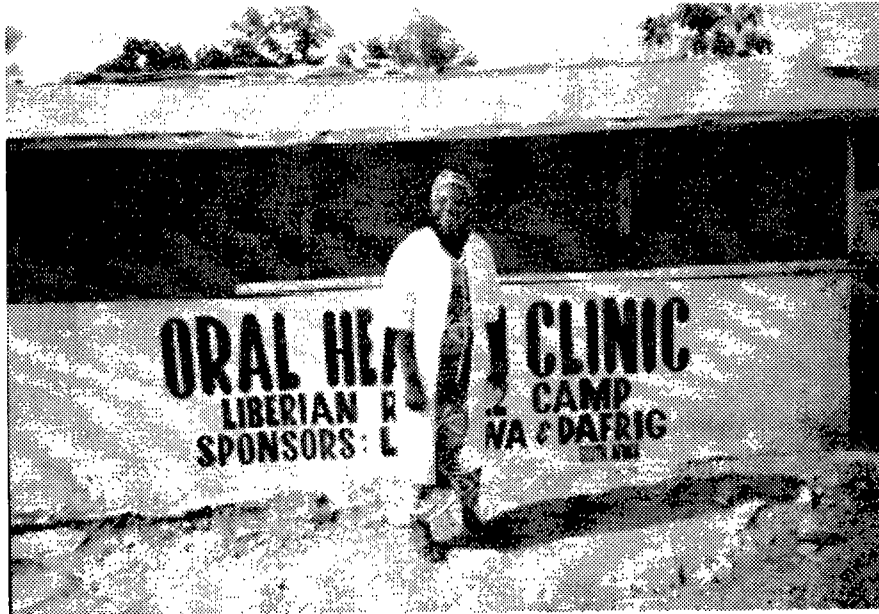
1. Manage and maintain dental equipment, instruments, and supplies.
2. Carry out all procedures relating to hygiene, disinfection, and sterilization.
3. Take patient histories.
4. Examine the oral cavity. Identify healthy structures, diagnose the common oral diseases, and make appropriate treatment plans. When necessary, refer patients to a higher level of care.
5. Maintain a registration file and fill out patient record cards. Use these for evaluation procedures and for reports to your supervisor.

6. Provide pain relief and treatment for common oral diseases:
 - perform uncomplicated extractions
 - prescribe appropriate medication
 - perform first aid procedures when necessary, e.g. management of dislocated jaw.
7. Provide preventive and curative care for dental caries, using the ART approach.
8. Provide preventive care for periodontal diseases, through health education and instruction in oral hygiene and by removal of dental calculus, where necessary, using hand instruments.
9. Organize and participate in diagnostic surveys of community oral health; analyse data with a view to planning feasible oral health interventions.
10. Promote and organize realistic programmes for prevention of oral health problems based on, for example:
 - home visits
 - school visits
 - community visits.
11. Collaborate with your supervisor in planning oral health care objectives, using measurable criteria to evaluate your progress.
12. In all your work, be aware of the need to provide a positive role model. Respect for patients and a positive attitude to preventive oral health care are essential.

In summary, community oral health workers are responsible for assessing oral health status and dental treatment needs in the refugee community; maintaining oral health clinics within the refugee camp; promoting oral health during visits to families and to schools, by organizing oral health awareness weeks, running workshops for parents and teachers, and encouraging the use of fluoridated toothpaste to maintain oral hygiene. Their clinical responsibilities extend to examination of the oral cavity, ART and application of sealants, extractions, and referral of patients with problems requiring more sophisticated treatment.

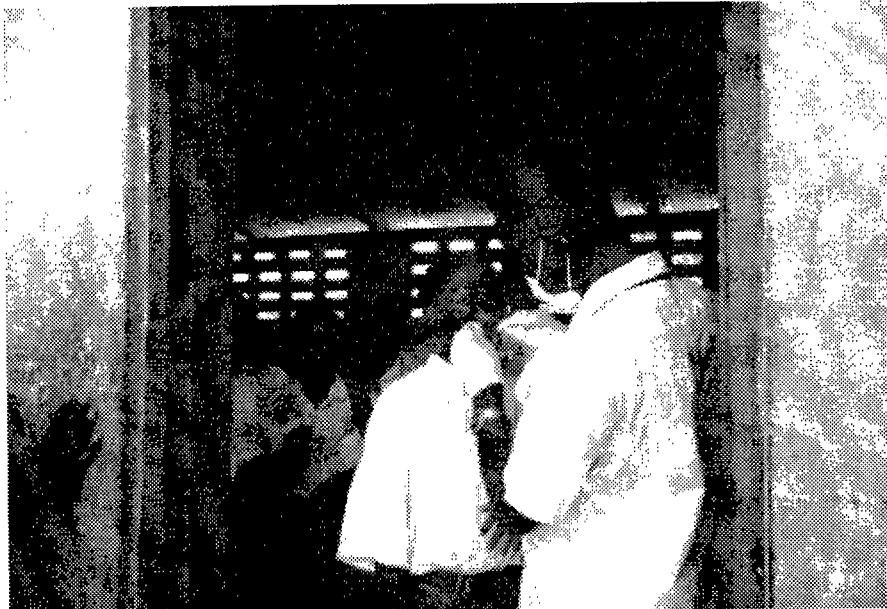
Various aspects of the work of the typical community oral health worker are illustrated in Figures 5–11.

Figure 5 Oral health clinic managed by community oral health workers —
Liberian refugee camp, Gomoa Buduburam, Ghana, 1997



[Photo: Liberian Community Oral Health Worker Association]

Figure 6 Oral screening of refugee children by community oral health workers —Liberian refugee camp, Gomoa Buduburam, Ghana, 1998



[Photo: Liberian Community Oral Health Worker Association]

Figure 7 Oral examination of refugee children by Khmer refugee dental worker — Cambodian Refugee camp, Thailand, 1988



[Photo: H.M. Htoon]

Figure 8 Using the ART technique for dental treatment of Liberian refugees workers — Liberian refugee camp, Gomoa Buduburam, Ghana, 1998



[Photo: Liberian Community Oral Health Worker Association]

Figure 9 Khmer refugee dental worker demonstrating tooth brushing techniques in a refugee school worker — Cambodian Refugee camp, Thailand, 1988



[Photo: H.M. Htoon]

Figure 10 Khmer refugee dental worker on a home visit worker — Cambodian Refugee camp, Thailand, 1988



[Photo: H.M. Htoon]

Figure 11 Oral Health Awareness Week organized by community oral health workers —Liberian refugee camp, Gomoa Buduburam, Ghana, 1998



[Photo: Liberian Community Oral Health Worker Association]

Self-management of community oral health workers

The community oral health workers will be responsible for the management of their own work programmes, although programmes should be regularly monitored and evaluated. Their work should be fully integrated into the general health services within the refugee camp — there is no reason to separate the two.

Training refugees for placement as oral health workers in their own encampments has been successfully demonstrated, and UN agencies and health authorities have endorsed the community oral health worker programmes for Cambodian (1978–1993), Laotian (1993–1994), and Liberian (1997, continuing) refugees:

- “....UNHCR/WHO endorses and supports the Oral Health Pilot Project for Liberian refugees in Buduburam Refugee Camp, Ghana.”
UNHCR, Ghana, 9 December 1996

- “WHO fully supports the approach being proposed and the use of the set of training manuals for community oral health workers....[WHO will] provide further input....for both the training course and for the community care services being developed for the refugees....”

WHO, 17 March 1997

- “A team of ten Liberian refugees resident at Buduburam Camp near Accra in Ghana were trained....to promote oral health among inhabitants in and around the camp....The zeal and enthusiasm that the group has exhibited in promoting oral health at the camp is highly commendable. Their activities have no doubt had tremendous impact on the creation of oral health awareness among the inhabitants at the camp and Ghanaians living nearby.”

Ministry of Health, Ghana, 9 September 1998

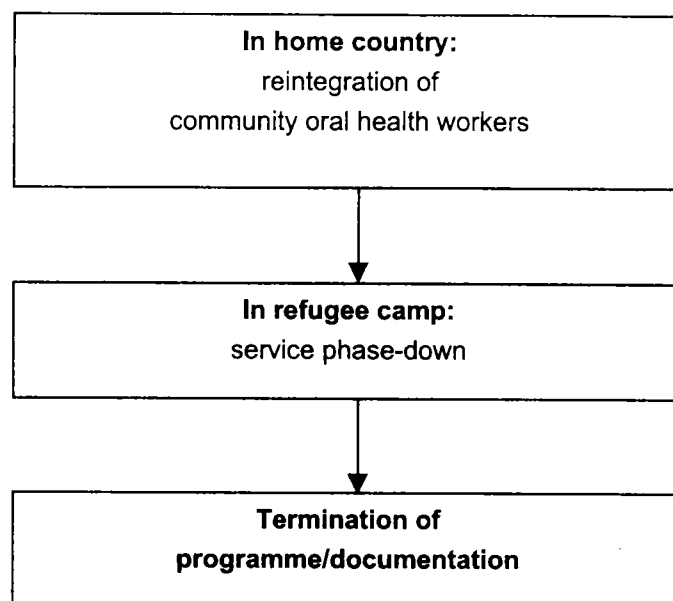
- “...we are convinced that the proposed curriculum is relevant to our situation in Liberia. The training of auxiliary staff would help in meeting the needs of oral health care in Liberia.”

(interim) Ministry of Health, Liberia, 24 June, 1997

- “I can only support the introduction of ART in any primary oral health programme aimed at improving oral health of refugee populations.”

Ministry of Health, Zimbabwe, 15 April 1997

Phase 3 — Repatriation



Reintegration of community oral health workers

The desirable outcome of any refugee situation is repatriation of the refugees, to their country of origin or to a third country. Refugee oral health programmes, developed in the emergency phase and operated throughout the stable phase, provide the refugee community with its own primary oral health care service. The empowerment of community oral health workers through their training has also produced a valuable manpower resource for the repatriated community. As a matter of policy, reintegration of these workers should be undertaken in parallel with the reintegration of all repatriated health personnel. Experience gained from the repatriation of refugee community oral health workers to Cambodia showed that:

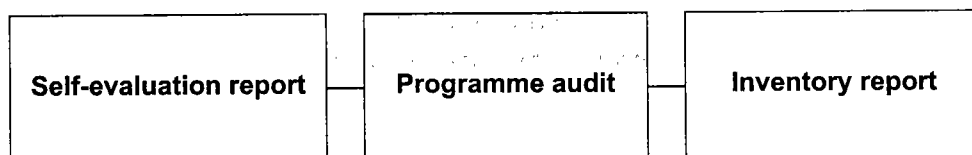
- without such a policy, reintegration of refugee community oral health workers is a lengthy process;
- circumstances permitting, repatriated oral health workers are likely to remain within the oral health care profession;
- the most likely employers of repatriated oral health workers are ministries of health, nongovernmental organizations, and private dental practitioners.

Phase-down of oral health care services

As the population of the refugee camp decreases, oral health care services can be systematically phased-down. The rate at which this happens can be calculated by the community oral health workers and the operational partners from data on the oral care needs of the remaining camp population. Where a programme of oral health maintenance is well established, continuing needs for basic care can be met by the volunteer oral health workers; otherwise, it may be necessary to seek help from outside the camp.

Documentation and termination of programme

All data collected during the oral care programme should be collated and analysed by the oral health workers and the camp's operational partners. A *self-evaluation report* and a *programme audit* should be produced. Additionally, each oral health care provider should deliver an *inventory report* to the authorities.



Annex

List of essential instruments and materials

Examination and diagnosis

- Mirror and handle
- Periodontal probe
- Explorer
- Tweezers

Prevention

- Hand scaler
- Fluoride toothpaste
- Toothbrushes

Extractions

- Straight elevator
- Pair of universal forceps
- Cartridge syringe

Miscellaneous items

- Water syringe
- Suture scissors
- Glass mixing slab
- Mixing spatula
- Latex gloves
- Eye protector

Other support items

- Stainless steel tray
- Pressure cooker
- Instrument forceps
- Plastic water buckets
- Head lights
- Torch
- Plastic sheet
- Plastic bags for prescriptions
- Gas tank and burner
- Large lockable chest for all items
- Foam headrest

Consumables

- Needles, disposable
- Zinc oxide/Eugenol
- Glass ionomer cement
- Cotton wool rolls
- Cotton pellets
- Gauze
- Mouth mask, disposable
- Examination gloves
- Local anaesthetic
- Disinfectant
- Paper towels
- Soap
- Antiseptic
- Petroleum jelly
- Matrix bands
- Wedges
- Articulating paper
- Plastic refuse bags
- Torch batteries
- Analgesic
- Antibiotic
- Haemofibrin
- Portable water
- Chlorhexidine mouthwash
- Autoclave paper packs
- Oral health record cards
- Inventory card
- Requisition/order form
- Printed oral health messages

Recommended further reading

SITUATIONAL ANALYSIS

Oral Health Surveys Basic Methods, 4th edition, 1996. World Health Organization.
Source: World Health Organization, Oral Health Programme, Management of Noncommunicable Diseases, 1211 Geneva 27, Switzerland.
Fax: +41 22 791 3111.

PREVENTION/PROMOTION

The Berlin Declaration 1992 on oral health and oral health services in deprived communities – The oral health alliance, promoting oral health in deprived communities. Mautsch, Sheiham, Berlin, 1995.
Source: Dr W. Mautsch, Klinik f.Zahnaerztliche Prothetik, University Aachen, Pauwelstr. 30, D-52057 Aachen, Germany. Fax: +49 241 88 88 410.

PAIN RELIEF AND CURATIVE CARE

Atraumatic Restorative Treatment (ART) for dental caries, Frencken, (textbook), 1999.
Source: Dr J. Frencken, College of Dental Science, Department of Preventive Dentistry, University of Nijmegen, P.O. Box 9101, 6500 HB Nijmegen, The Netherlands. email: j.frencken@dent.kun.nl

COMMUNITY ORAL HEALTH WORKERS (COHW) TRAINING

Case study on oral health care provision in refugee and displaced persons encampments along the Thai-Cambodian border 1978-1993. Frencken, Htoon, Pilot, December 1993.
Source: Professor T. Pilot, Woerdakkers 5, 9461 EB Gieten, The Netherlands.
Fax: +31 592 264 158.

Development of a model for primary oral health care in refugee and displaced persons encampments, Pilot, December 1995.
Source: Professor T. Pilot, Woerdakkers 5, 9461 EB Gieten, The Netherlands.
Fax: +31 592 264 158.

La formación de refugiados liberianos en Ghana como asistentes de cuidado dental (Oral health worker training for Liberian Refugees in Ghana)
Mickenautsch. Anales de Odontoestomatología, 1998 5(1): 37-39
Source: Dr S. Mickenautsch, Division of Community Dentistry, University of the Witwatersrand, Johannesburg (Medical School), 7 York Road, Parktown, 2193 South Africa. email: neem@altavista.net

(COHW) Selection of students and project sustainability

(COHW) Subject Areas

(COHW) Course Timetable

(COHW) Student Assessment, Formal Examination

Walker, Australia/Ghana, 1997

Source: Dr D. Walker, 275 Elizabeth Bay Road, Lake Munmorah, 2259 Australia.
email: d.wal@hunterlink.net.au

Oral health among Liberian refugees in Ghana, Mickenautsch, Rudolph, Ogunbodede, Chikte.

East African Medical Journal, Vol.76, No.4 April 1999, pp206-211.

Source: Dr S. Mickenautsch, Division of Community Dentistry, University of the Witwatersrand, Johannesburg (Medical School), 7 York Road, Parktown, 2193 South Africa. email: neem@altavista.net

Guidelines on how to run an ART Training Course, Frencken, Holmgren, 1999

Source: Dr J.E. Frencken, College of Dental Science, Department of Preventive Dentistry, University of Nijmegen, P.O. Box 9101 6500 HB Nijmegen, The Netherlands. email: j.frencken@dent.kun.nl

or World Health Organization, Oral Health Programme, Management of Noncommunicable Diseases, 1211 Geneva 27, Switzerland. Fax: +41 22 791 3111.

SELF MANAGEMENT

Oral health care for displaced persons on the Thai-Cambodian border.

Htoon, Promoting oral health in deprived communities, Berlin, 1995.

Source: Dr H.M. Htoon, 6 Charles Bullock Av., Belvedere, Harare, Zimbabwe. email: htoon@africaonline.co.zw

EVALUATION

Monitoring and evaluation of oral health. Technical Report Series No. 782., World Health Organization, Geneva, 1989.

Source: World Health Organization, Oral Health Programme, Management of Noncommunicable Diseases, 1211 Geneva 27, Switzerland. Fax: +41 22 791 3111.

REPATRIATION/REINTEGRATION

Preliminary survey of basic dental assistants after repatriation.

Htoon, Chew, Klaipo, Menh Khin, 1999

Source: Dr H.M. Htoon, 6 Charles Bullock Av., Belvedere, Harare, Zimbabwe. email: htoon@africaonline.co.zw