Promoting Oral Health for Refugees: An Advocacy Guide

LEADING THE WORLD TO OPTIMAL ORAL HEALTH

REFUGEE Oral Health Promotion & Care

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FDI World Dental Federation

FDI is an international, membership-based organization that serves as the main representative body for more than 1 million dentists worldwide, active in some 200 National Dental Associations (NDAs) and specialist groups in close to 130 countries. Founded in 1900, FDI is a pioneer in the field of modern dentistry.

As a convener of the oral health community, FDI fosters exchange and develops a common vision to advance the science and practice of dentistry. FDI delivers innovative congresses, campaigns, and projects to address the global oral disease burden and improve oral health. As the leading global advocate for oral health, FDI strives to achieve our vision of leading the world to optimal oral health by working at both the national and international level.

FDI is committed to representing the interests of member NDAs globally to help support their national efforts to raise awareness on oral health. FDI transforms this commitment into action through active engagement with the World Health Organization, as well as other United Nations agencies, health organizations, governments, and global partners to ensure that oral health is recognized as an essential component of general health and well-being.

Contents

Executive summary

One of the main objectives of the FDI World Dental Federation (FDI) 2018-2021 strategy is to promote oral health among underserved populations globally. The first pillar of FDI's Vision 2030 advocacy strategy states that essential oral health services should be integrated into universal healthcare packages in every country, and quality oral healthcare should become available, accessible, and affordable to all, with special attention paid to marginalized and vulnerable populations. Refugees are among the most vulnerable groups worldwide. They have limited access to oral health education, oral disease prevention and therapeutic dental care. This is due, in part, to the relatively high cost of restorative treatment, limited access and availability of dentists, unaffordability of dental insurance, and language barriers. Data collected by FDI from 105 National Dental Associations found that a very significant gap exists in oral health policies at global, regional, and national levels. There are limited oral health advocacy initiatives for refugees, who have poor access to therapeutic and preventive interventions related to oral care.

This guide was developed to address this gap and to lead the way for national dental associations (NDAs) and other interested stakeholders to:

- raise awareness of the burden that refugees face to maintain their own oral health and the challenges that host countries face to maintain good oral health in their populations;
- highlight the gaps in data collection and the importance of oral health screening/surveillance for refugees;
- provide guidance on measuring and understanding the problem with focused attention on the social determinants of oral health;
- support countries that host refugees with tools and strategies that can strengthen their own oral health strategies and programmes;
- integrate the management of oral health conditions among refugees into general health services and the provision of care;
- mainstream oral health through health systems planning, funding, and implementing oral health promotion and disease prevention intervention among this group.

The health and well-being of refugees takes place in complex and constantly evolving environments. A unified approach at a global level is critical to create an enabling environment for action and provide coherent and consistent advocacy at global, regional and national levels. The provision of refugee care that leaves no-one behind is a complicated and complex task. The authors hope that this guide will act as a road map for the reader to plan and implement successful strategies and advocacy that can improve the oral health of refugees around the world.

The guide is aimed mainly at FDI member NDAs; however, it can also be used by oral health professionals, healthcare organizations, governments, and educational institutions. It emphasizes that oral health is an essential and integral part of general health and should be included in any overall health promotion programme. It also acknowledges that refugees' living conditions and access to health and dental care are country-unique and bound by local policies and legislation. General recommendations are, however, applicable in many situations.

This practical guide will allow you to build your own advocacy strategy and translate your objectives into an action plan through the following six steps:

1. Setting the context	2. Establishing goals and objectives	3. Identifying target audiences	4. Developing key messages	5. Implementing your advocacy plan	6. Monitoring and evaluation

This guide also identifies strategic value for oral health advocacy through NDAs in engaging with governments and stakeholder groups to advocate for better oral health using, for example, the UN Sustainable Development Goals (SDGs) and presents successful stories and lessons learned from many projects around the world that have advocated for access to oral healthcare of refugees. In addition, this guide also provides NDAs with tools and protocols to use for their advocacy, including key communications messages.

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Overview

Why do we need this advocacy guide?

One of the main objectives of FDI's current strategy is to promote oral health among underserved populations globally. The first pillar of FDI's Vision 2030 advocacy strategy indicates that essential oral health services should be integrated into universal health coverage (UHC) in every country, and quality oral healthcare should become available, accessible, and affordable to all, with special attention paid to marginalized and vulnerable populations. Refugees are among the most vulnerable groups worldwide. They have limited access to oral health education, oral disease prevention and therapeutic dental care. This is due, in part, to the relatively high cost of restorative treatment, limited access and availability of dentists, unaffordability of dental insurance, and language barriers. Data collected by FDI from 105 National Dental Associations found that a very significant gap exists in oral health policies at global, regional, and national levels. There are limited oral health advocacy initiatives for this vulnerable group, who have poor access to therapeutic and preventive interventions related to oral care.

The health and well-being needs of refugees exist in a complex environment; thus, developing a unified approach to health and well-being of refugees that integrates oral health and the social determinants of health in any overall health promotion programme worldwide is a complicated task. This guide acknowledges that refugees' conditions and access to health and dental care are country-unique and bound to local policies and legislation; however, general recommendations can be applicable in many situations, and advocacy efforts can help improve the health of this vulnerable population.

This guide was developed to lead the way for national dental associations (NDAs) and other interested stakeholders to:

- raise awareness of the burden that refugees face to maintain their own oral health and the challenges that host countries face to maintain good oral health in their populations;
- highlight the gaps in data collection and the importance of oral health screening/surveillance for refugees;
- provide guidance on measuring and understanding the problem, with focused attention on the social determinants of oral health;
- support countries that host refugees with tools and strategies that can strengthen their own oral health strategies and programmes;
- integrate the management of oral health conditions among refugees into general health services and the provision of care;
- mainstream oral health through health systems planning, funding, and implementing oral health promotion and disease prevention intervention among this group;
- rebuild the social contract for oral health with society;
- engage with new groups of international and national stakeholders who could promote the oral health agenda;
- prepare for the future of education by enabling institutions to partner with other healthcare providers (inter-professional education) and work in complex environments.

What is the problem?

In the United Nations International Covenant on Economic, Social, and Cultural Rights, all member states agreed that all categories of migrants should receive the highest attainable standard of physical and mental health[1]. This has not been achieved, especially when considering oral health. Furthermore, to achieve the pledge outlined by the 2030 Agenda for Sustainable Development—to leave no one behind—the health needs of refugees and migrants should be addressed accordingly. The oral health needs of refugees should be considered as part of the overall health picture and not neglected any longer.

Who is this guide for?

The guide is developed specifically for FDI member NDAs, but can also be used by:

- governments and ministries/agencies when relevant policies are being formulated;
- oral health professionals to learn about the challenges that refugees face when it comes to oral health;
- healthcare organizations to advocate integrating refugees and oral health in general health promotion and noncommunicable disease (NCD) prevention programmes;
- educational authorities when relevant policies are being formulated in curriculum development and planning community outreach programmes;
- media outlets to advocate refugees' rights to access necessary oral health services.

HOW TO USE THIS GUIDE

This practical guide uses six steps to guide NDAs in building their advocacy strategy to promote access to oral health for refugee populations by[2]:

1. **Setting the context**
2. **Establishing goals and objectives**
3. **Identifying target audiences**
4. **Developing key messages**
5. **Implementing your advocacy plan**
6. **Monitoring and evaluation**

Problem background:

The refugee crisis

As of June 2019, there are 25.9 million refugees globally. Of these, on average less than 5% are resettled in host countries annually[3]. Refugees are defined and protected in international law. The 1951 Refugee Convention[4] is a key legal document and defines a refugee as:

"someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion."

Refugees are a highly vulnerable population, and many having experienced physical and psychological trauma because of war, traumatic injuries, sexual violence, and gender-based violence. Many refugees suffer pre-existing medical conditions and may have been exposed to communicable diseases during their perilous journeys or while residing in temporary accommodation, such as refugee camp[5].

When refugees arrive in their host countries and undergo the process of acculturation (adaptation to the new culture), they are likely to be under high stress and often suffer racism, discrimination, and experience language and cultural barriers, leading to high unemployment and lower incomes among those who do find work. These barriers also present challenges in being able to find accommodation, navigate the welfare and healthcare systems, and access and understand community services[6].

Migration as a social determinant of health

Migration is a process that exists as a complex social determinant of health. It is a multi-phase journey that poses risks at every stage. Refugees can be from countries ridden with conflict, poverty or climate change and undertake dangerous journeys to reach a place of relative safety. Any pre-existing health conditions can be exacerbated by the harsh living conditions and inaccessibility of health services during migration. Prolonged stress has been connected to negative oral health effects, such as periodontal diseases and joint dysfunction[7]. Other studies found that providing required oral healthcare resulted in reduced psychological stress and improved the quality of sleep of participants[8,9]. In addition, neglecting oral health and a persistent unavailability of preventive and therapeutic services may lead to higher rates of dental caries and its consequences, such as tooth abscess or tooth loss[10-12].

At the arrival phase, refugees may find themselves living in shelters in urban areas, such as collective centers, slums, or informal settlements. Around 6.6 million refugees live in camps; of these, 2 million are in self-settled camps[13]. Many refugee camps have poor infrastructure and lack sanitation and hygiene services, food, oral hygiene products or access to healthcare. Camps in arid climates often experience water shortages[14].

Prevalence of oral disease in refugee populations

Studies have indicated a high prevalence of oral disease and unmet oral healthcare needs in refugees, often exceeding the levels experienced by the most disadvantaged communities of the host country[10-12]. Most commonly, refugees experience high levels of dental caries, periodontal disease, oral lesions and traumatic dental injuries[11]. One study conducted in Massachusetts, USA, showed that 49% of refugee children had untreated caries, a prevalence over twice that of children from the United States[10]. Another study reported a mean of untreated tooth decay of between 2.0 to 5.2 for refugees in Australia, compared with 0.6 to 1.4 for the host population[11]. In both studies, the oral health status and needs of refugees varied notably according to region of origin. In a study on adult refugees in Canada, it was reported that 85% of them presented one or more teeth with untreated decay, compared to 20% of the Canadian population studied[16]. There is also evidence that refugees are less likely to access oral healthcare, and their first contact will often be for pain relief[17].

However, most of the literature assessed the oral health challenges faced by refugees hosted in high-income countries. Very limited research is available on the oral health of refugees who are in transit and live in refugee camps. Less than one-fifth of all refugees and asylum seekers end up in wealthy countries; the majority are settled in low-income

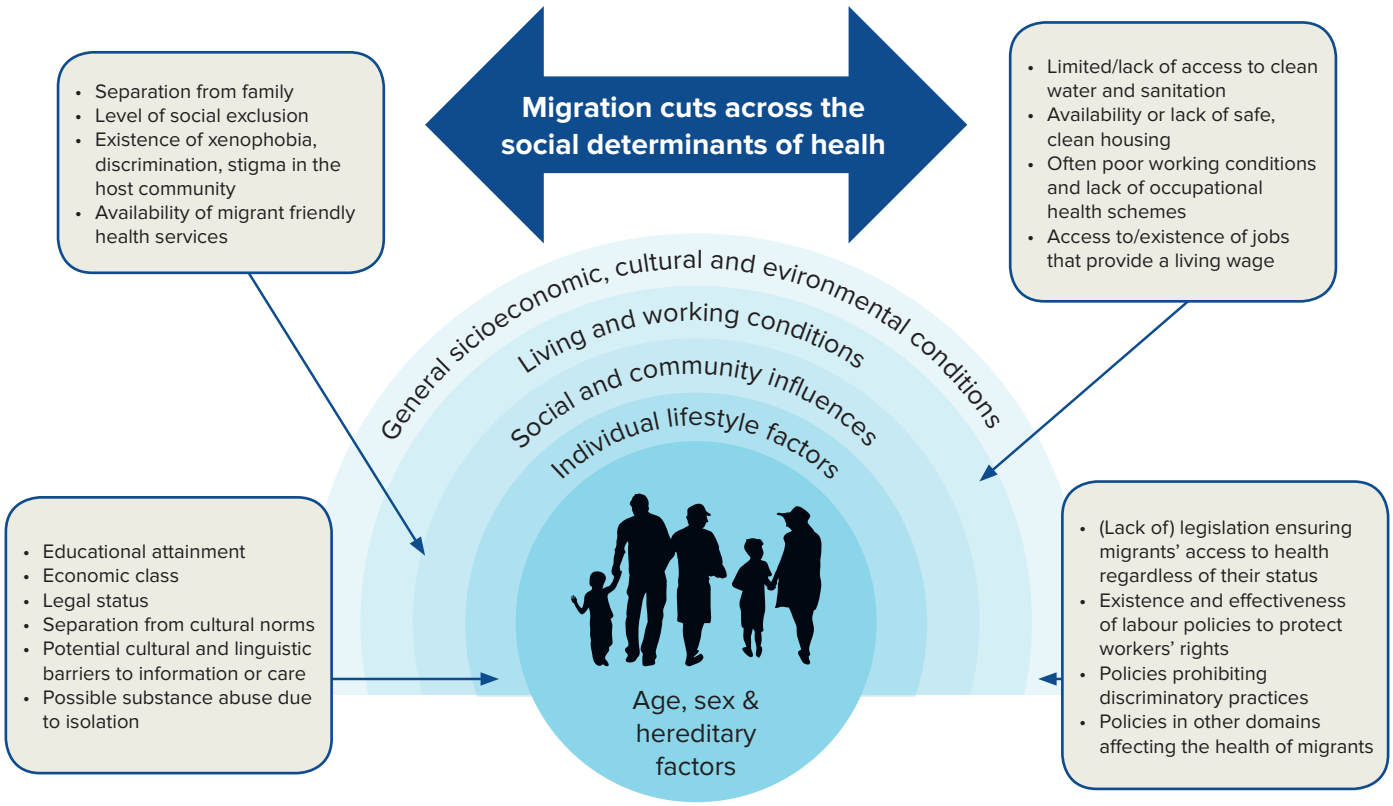

Figure 1: Social determinants of health in refugees[15]

countries (86%)[18]. Thus, the real oral health needs of the majority of refugees are still unknown.

The oral health status within the refugee population varies according to hosting settings and resulting legal status. Three distinct settings have been identified as potentially impacting access to healthcare services:

Refugees under United Nations High Commissioner for Refugees (UNHCR) supervision:
Two types of refugee settlements exist under UNHCR supervision.

1. Camps are administered jointly by UNHCR and non-governmental organizations (NGOs). NGOs subcontracted by UNHCR provide essential services such as food, sanitation, water, or healthcare. These camps are meant to be temporary and are not expected to be self-sufficient. Providing quality healthcare can therefore be challenging, but access to care is generally ensured by UNHCR or its implementing partners. A 2019 study that examined the oral health status and dental treatment needs of children Syrian refugees at al-Zaatari camp in Jordan, found that 50% of the children had high caries risk according to CAMBRA scale and 55.2% reported that they needed dental treatment during their stay in the camp[19].
2. Organized settlements are initially administered by UNHCR, but refugees are expected to become self-sufficient in the long term. International relief agencies provide essential services until the host government takes over the management of the site to integrate it into the local district[20].

Refugees under the United Nations Relief and Work Agency for Palestine Refugees in the Near East (UNRWA) supervision:
UNRWA has existed for more than 70 years, and serves about 5.4 million registered Palestinian refugees living outside and inside of refugee camps[21]. Due to its long-standing commitment, UNRWA makes essential services available through a solidified health system[22]. A total of 106 dental clinics and nine mobile dental teams are available to refugees. Despite better oral health services provision than in other refugee-hosting settings, caries data are still observed to be higher than those reported in neighboring countries. In 2016, 73% of Palestinian refugee students surveyed had experienced caries in their permanent teeth[21].

Settled or semi-settled refugees:
When they receive full refugee status from their host government, refugees often have access to the public health and dental care system. Depending on the national dental care system, refugees can have free access, subsidized care, or pay out of pocket. Even if access to dental care is simplified, numerous barriers remain, which are showcased in the next section below[17].

What can good oral health lead to?

Healthy refugees improve public health outcomes, which is beneficial for both the host communities and the countries of origin. In addition, healthy refugees contribute to the global economy if their new host environment allows them to thrive. Lastly, refugee and migrant health is a key element of global health security.

On the other hand, poor oral health can have complications beyond the mouth. Chronic pain from treatable ailments left untreated is a global issue, not just an issue affecting refugees. Oral diseases are closely related to general health and quality of life and well-being. Pain and dysfunction from oral diseases change how people eat, speak, and interact with others. Oral health is also associated with several other chronic diseases[23].

Oral-systemic link:

Oral diseases share common risk factors with many NCDs, such as diet and hygiene practices, smoking, alcohol consumption, risky behaviors causing injuries, and stress. Chronic diseases, such as obesity, diabetes, cancer and heart disease, have health determinants in common with oral disease; thus, more emphasis should be on the common risk factor approach to address these conditions[24].

Quality of life:

Oral health affects people physically and psychologically and influences how they grow, enjoy life, look, speak, chew, taste food and socialize, and affects their feelings of social well-being[25]. Severe oral diseases negatively affect quality of life, especially in children; they can cause pain, discomfort, disfigurement, acute and chronic infections, and eating and sleep disruption. Oral diseases can lead to a higher risk of hospitalization, high treatment costs, and loss of school days, which also leads to a diminished ability to learn.

Nutrition and growth:

Caries affects nutrition, growth, and weight gain. One study showed that three-year-old children with early childhood caries weighed about 1 kg less than control children because toothache and infection altered their eating and sleeping habits, dietary intake, and metabolic processes[26]. Disturbed sleep affects Glucocorticoids production. In addition, there

is a suppression of hemoglobin from depressed erythrocyte production. Dental problems that cause painful chewing affect intake of dietary fiber and some nutrient-rich foods; consequently, serum levels of beta carotene, folate and vitamin C may be significantly lower in those with poorer oral status[27].

Economic consequences:
In some countries, oral diseases are the fourth most expensive diseases to treat. Treating caries, estimated at US$ 3513 per 1,000 children, would exceed the total health budget for children of most low-income countries[28].

Barriers to accessing oral healthcare

Refugees' immediate needs, such as water, food and housing, can overshadow their oral health status[23]. What's more, language barriers can negatively impact refugees' health literacy, limiting their understanding of what services they are eligible for and what social benefits they qualify for. Many refugees may also have little prior knowledge about oral health. They may fear oral health professionals and invasive treatments due to previous experiences or trauma involving injury from torture[24]. Fear can also stem from deportation, discrimination, and/or stigmatization.

In general, there is a lack of healthcare personnel in refugee camp settings[25]. This is also the case for dental professionals[26]. Even if healthcare professionals are available, managing transportation costs to health centers and finding childcare to attend medical appointments can be challenging for the refugee population. In addition, when reimbursement does not cover the healthcare costs partially or at all, refugees often become hesitant to receive dental care[17]. However, in some cases, even when dental care is fully covered by the government, the rate of utilization remains low[12]. These barriers need to be addressed to increase dental care utilization and lower the burden of oral disease in this population.

Due to diverse policies related to oral health across regional and national contexts, oral health services available for refugees can vary within the same country and from one country to the next. Therefore, barriers to access oral health services vary according to status. For refugees who are already settled in host countries, long wait times, high cost, lack of dental insurance, and language barriers can be the main challenges[16,27-29]. On the other hand, refugees in transit camps often have to settle for tooth extraction instead of restoration due to the unavailability of dental professionals and a lack of funds to pay for treatment costs[30-31]. These transit camps are usually located in limited-resource settings that prioritize prevention and treatment of infectious diseases over oral diseases and NCDs in general[32].

Types of barriers	Consequences
Language	Limited understanding of: • services available • overall benefit of oral health • social benefits available.
Prior beliefs about oral health (low priority)	• under-utilization of oral health services
Trauma	• Fear and distrust of oral health professionals
Lack of oral health professionals	• Difficulties in reaching oral health professionals • High transportation costs
Oral health care is not covered by the government	• Cannot afford oral healthcare • Low rate of utilization

Table 1: Barriers to accessing oral healthcare among refugees

Healthcare for refugees

Access to healthcare for refugees varies greatly across the globe. Oftentimes, there is a lack of primary healthcare services provided, which results in an over-reliance on emergency services[5]. The legal status of refugees is the most crucial factor in determining what services they have access to. In a report by UNHCR, only a third of UNHCR operations reported that urban refugees are covered by the national health insurance schemes of their respective host countries. In Turkey, refugees have access to the universal healthcare system, but asylum seekers do not. Meanwhile, in Iraq and India, UNHCR is working to incorporate refugee healthcare under the government healthcare system[32]. It is also important to realize that a great variation in ethnic groups exists amongst refugees, which means there should be more attention paid to the specific needs and concerns of each group.

MIPEX - the Migrant Integration Policy Index

This index is a useful tool to evaluate and compare what governments are doing to promote the integration of migrants in all the countries analyzed. As migrant policy includes refugees, it provides useful information related to refugee rights and health policies. The 2015 edition (MIPEX2015) included information on 38 countries: all EU member states, Australia, Canada, Iceland, Japan, New Zealand, Norway, South Korea, Switzerland, Turkey, and the USA[34].

In a report that discussed European and some non-European country policies regarding migration and health, MIPEX showed that major differences exist among countries in healthcare coverage for migrants and the ability to access services. Policies often fail to take migrants' specific situations into account.

In general, the report indicated that countries deemed by MIPEX to have a strong commitment to equal rights have more favourable health policies. On the other end, health systems are rarely inclusive or responsive in countries with restrictive integration policies. As expected, policies related to migrants' health are stronger and services are more responsive in countries with greater wealth (GDP), more immigrants, and tax-based (as opposed to insurance-based) health systems.

The report also found that the most responsive services are found in countries with good mechanisms for promoting change. This does not mean that such countries necessarily grant migrants the best entitlements. Some countries offer migrants legal entitlements to healthcare but make little adaptations to services to fit their needs. To learn more about this report and its findings, please visit the website: http://www.mipex.eu/download-pdf#/add-selection.

Current activities related to oral health for refugees: an FDI member survey

The FDI Public Health Committee designed and distributed a questionnaire to collect data from NDAs, Chief Dental Officers (CDOs), and NDA-affiliated oral health organizations about activities related to oral health promotion and oral healthcare provision among refugees.

The aim of this survey was to summarize data, assess the needs and collect lessons learned from countries' feedback. The questionnaire was sent out in June 2019.

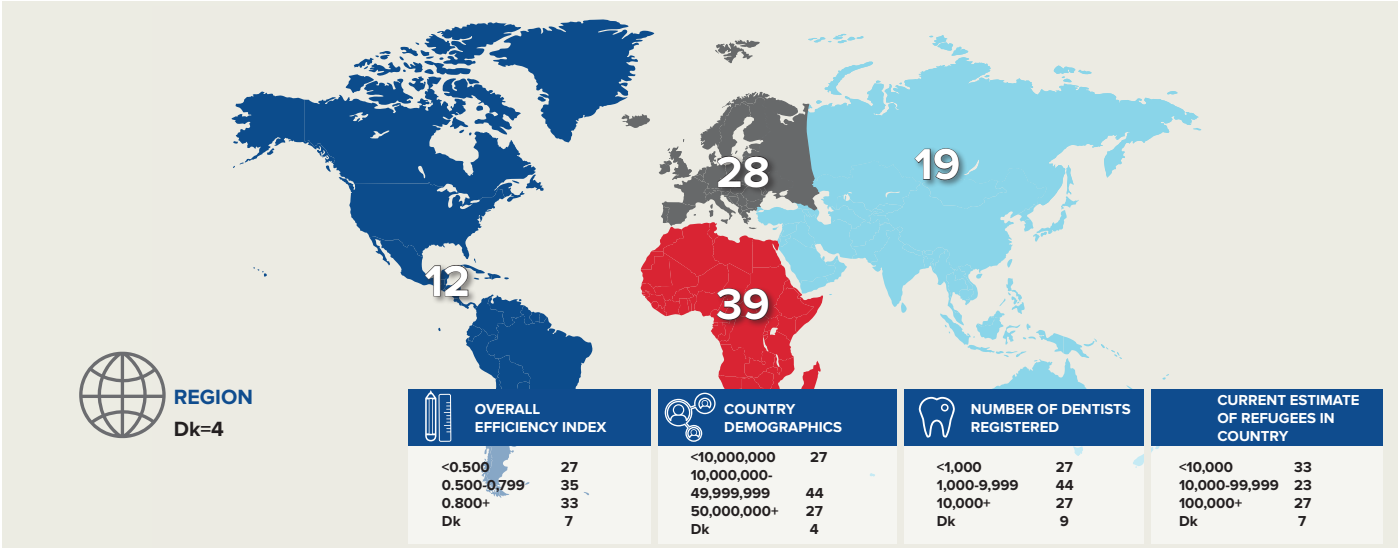

Figure 2: Characteristics of countries that responded to the survey

By mid-july 2019 and as shown in ***Figure 2***, we received 102 responses mostly from Africa (n=39) with a population between 10-50 million, a high number of refugees, and few dentists. From the Americas, 12 countries responded, 28 responded from Europe and 19 responded from Asia. Most countries that have a high influx of refugees such as Turkey, Jordan, State of Palestine, Lebanon, and Uganda responded to this survey. In addition, countries from different levels of the Health Efficiency Index (HEI) responded to the survey, which enabled us to better understand how different economies in the world deal with refugees' access to oral health. HEI is a score based on three weighted metrics: life expectancy (60%), relative and absolute health expenditure (30% and 10%, respectively), which rank countries that have a GDP per-capita exceeding USD$5,000 and a minimum population of 5 million.

Our main respondents in this sample were representatives from NDAs (72%) and CDOs (13%). However, some NDAs left certain questions unanswered, likely reflecting the fact that they are not very involved in the provision of oral health services for refugees, which is often left for NGOs, charities, or other agencies in charge of refugee support to handle.

UNHCR was the main agency responsible for refugee healthcare, especially in low-income countries. Local charities and national health systems were also frequently involved. UNRWA is responsible only for Palestinian refugees in the State of Palestine, Lebanon, and Jordan. ***Figure 3*** shows other organizations responsible for refugees' health.

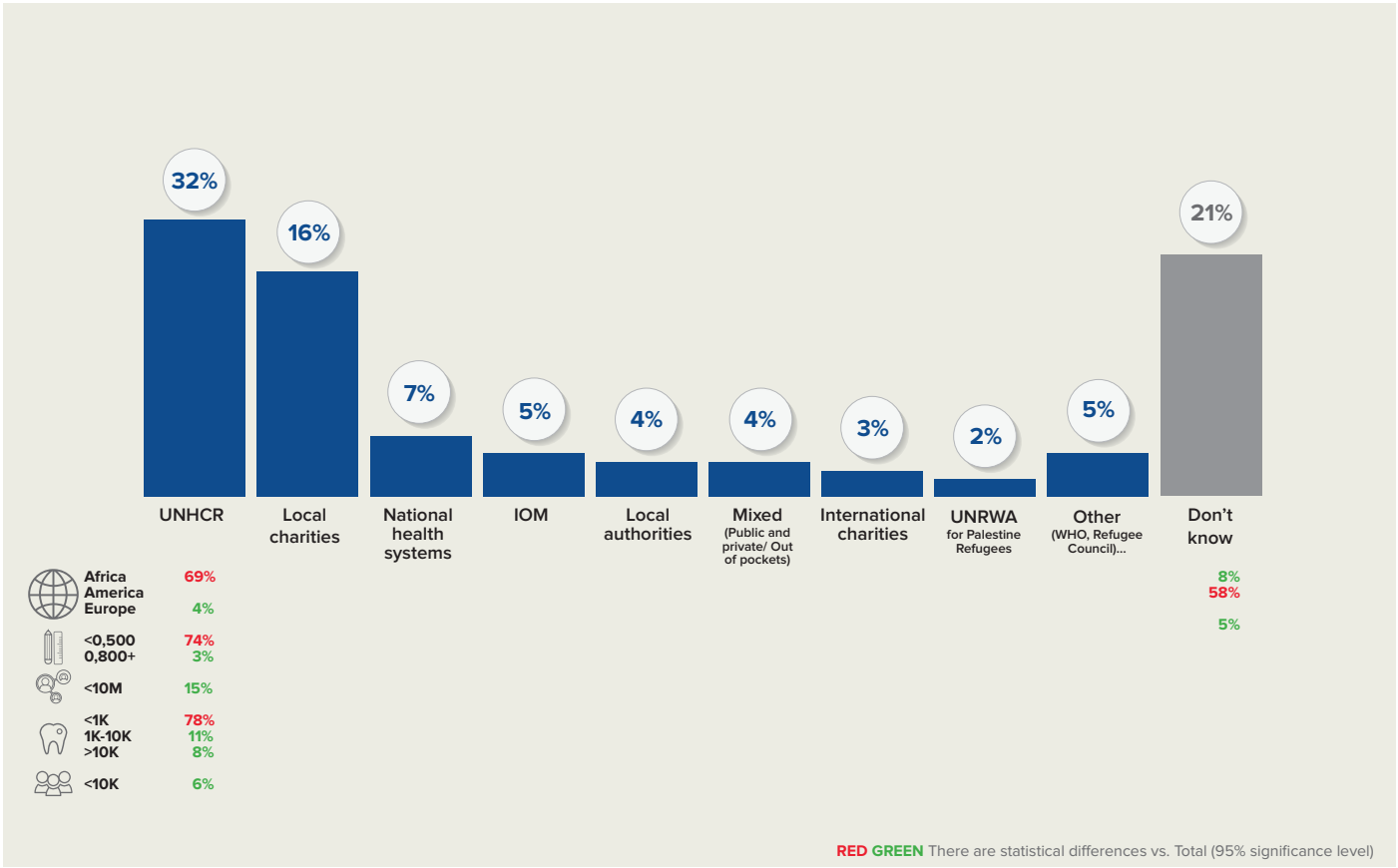

Figure 3: Organizations responsible for refugees' health

In the respondent countries, just over half of refugees benefit from some type of medical care. Access to free healthcare was lowest in low-income countries and there were fewer subsidies reported in more populated countries.

More information about types of healthcare provided to refugees is shown in ***Figure 4***.

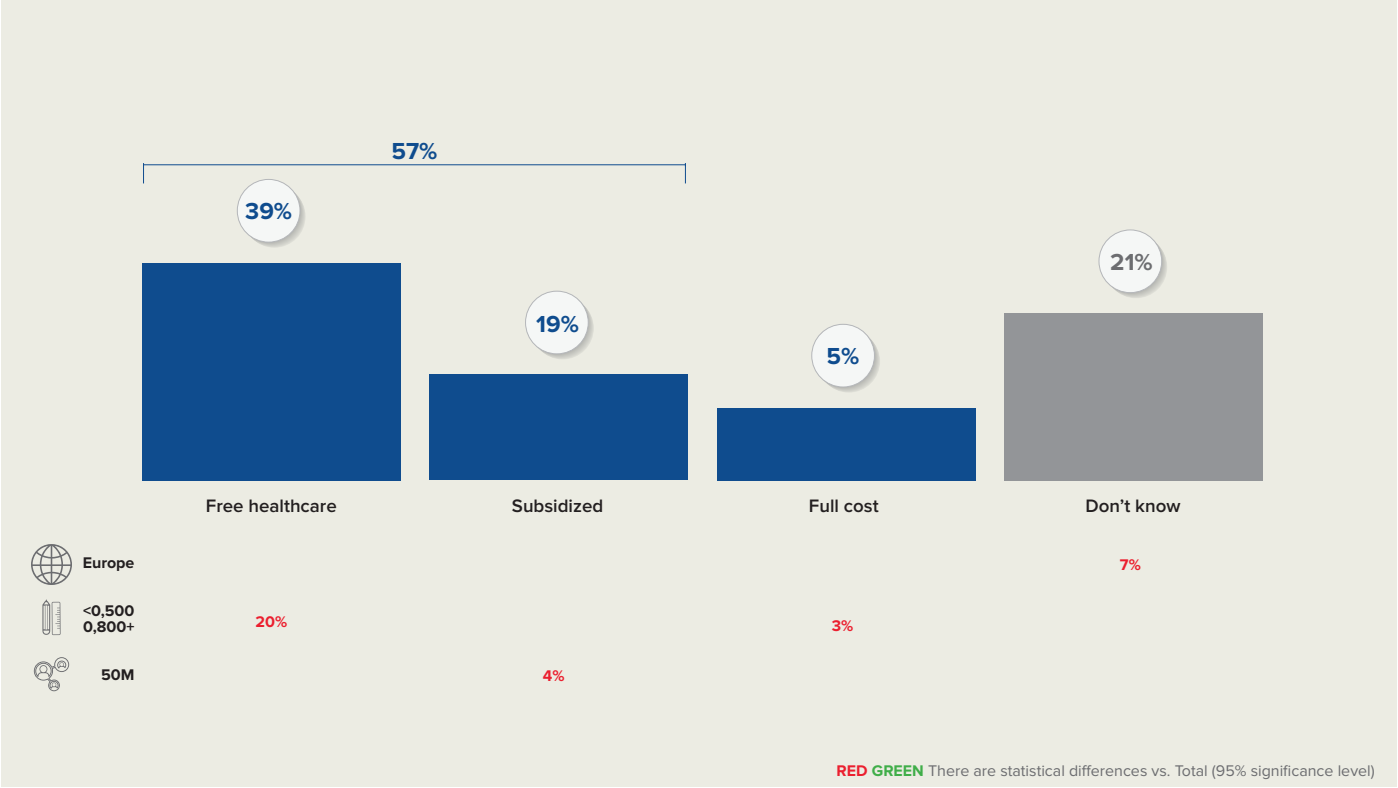

Figure 4: Types of access to healthcare for refugees

As shown in ***Figure 5***, in 41% of the countries surveyed, and especially common in low HEI countries, dental care was mainly paid out of pocket.

In 31% of countries surveyed, dental care was financed through a public health system, and this was more common in countries with a higher HEI.

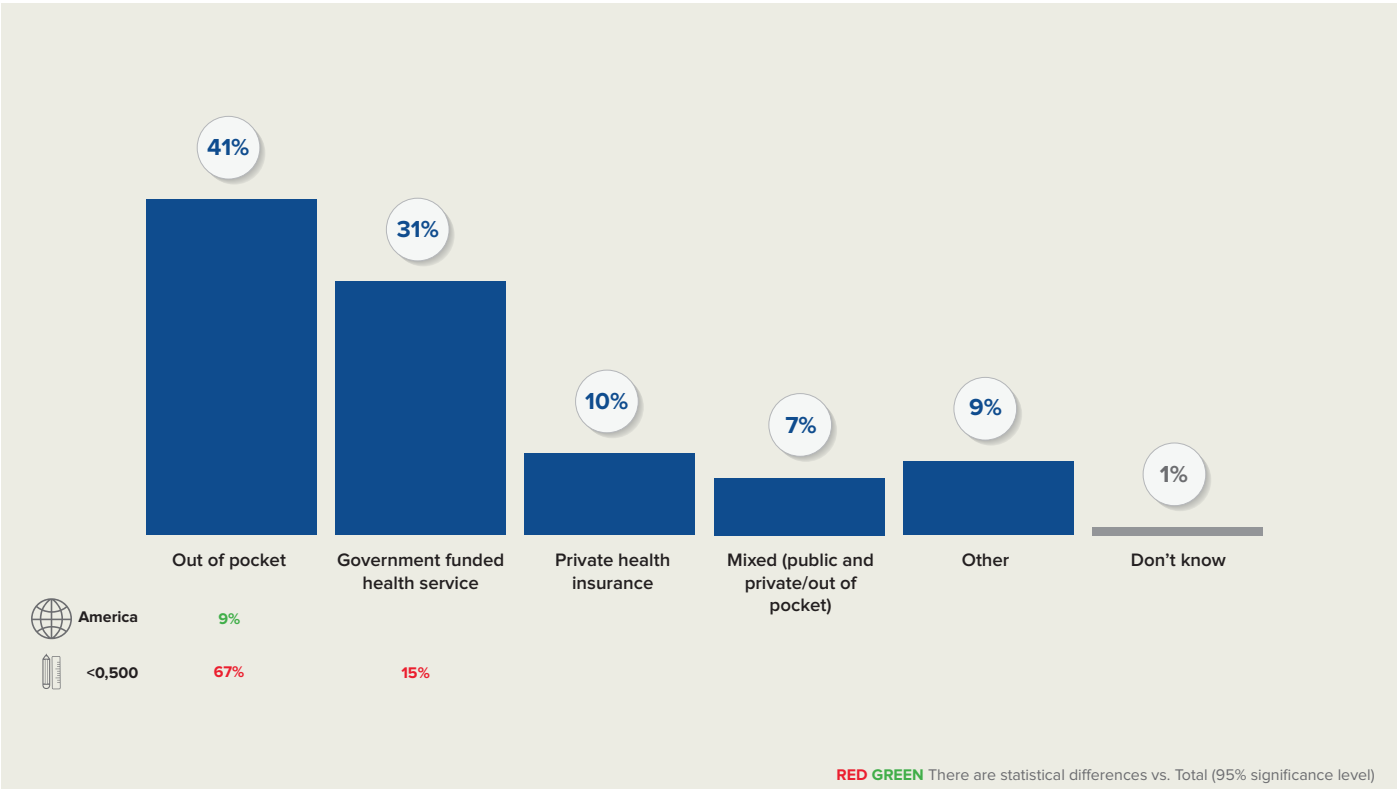

Figure 5: Financing dental care in respondent countries

For refugees, we notice different financing patterns for dental healthcare. In high HEI countries, governments provide more support for dental care; in low HEI, international NGOs (INGOs) provide the main support for dental care services. ***Figure 6*** shows the source of dental care financing for refugees.

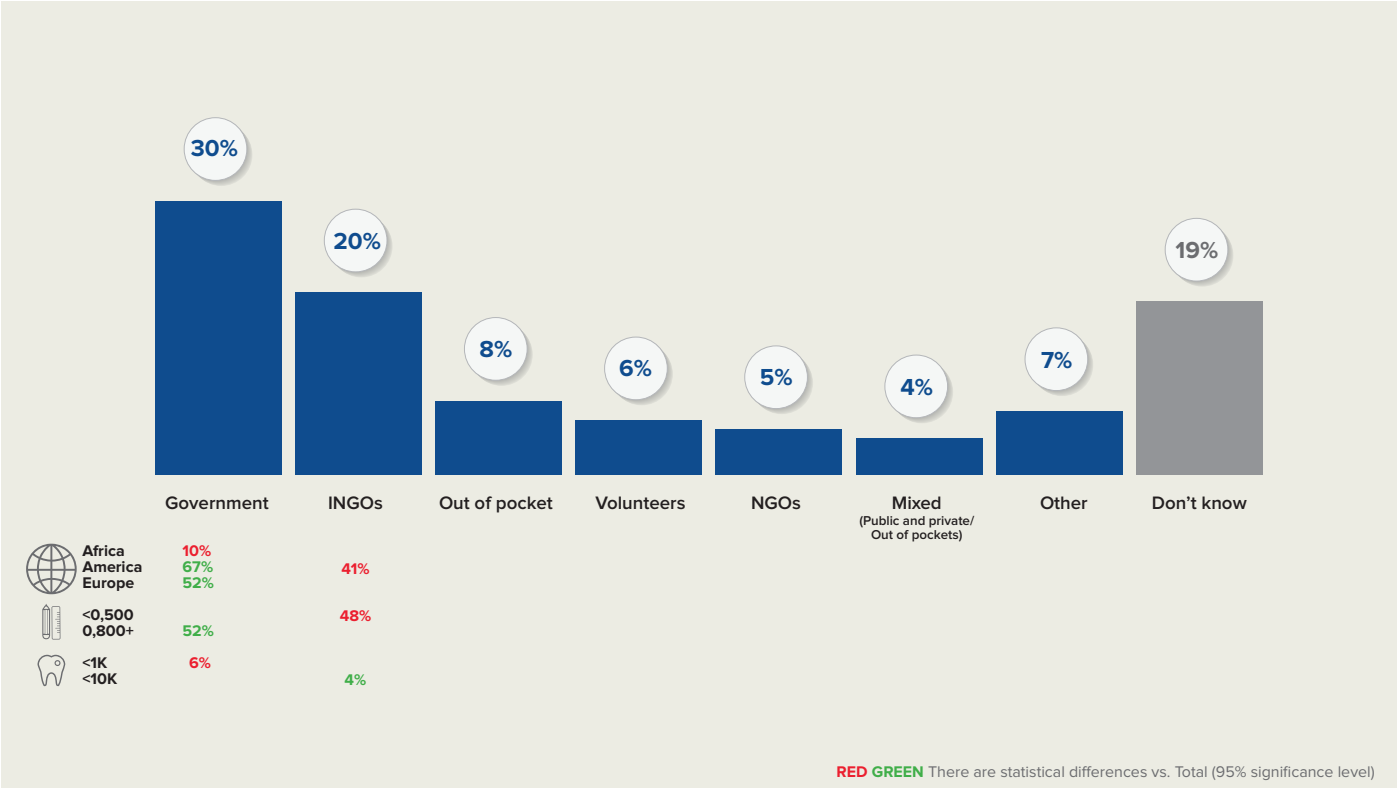

Figure 6: Dental care financing for refugees

Oral health screening for refugees upon arrival to the host country was unusual, with only four countries (Armenia, Canada, Iran, Italy) reporting obligatory oral health screenings upon arrival. Among these countries, only one reported that a referral system was in place in case a condition was identified during the screening.

Other than oral health screening, 35% of the survey sample did not offer any type of dental care service

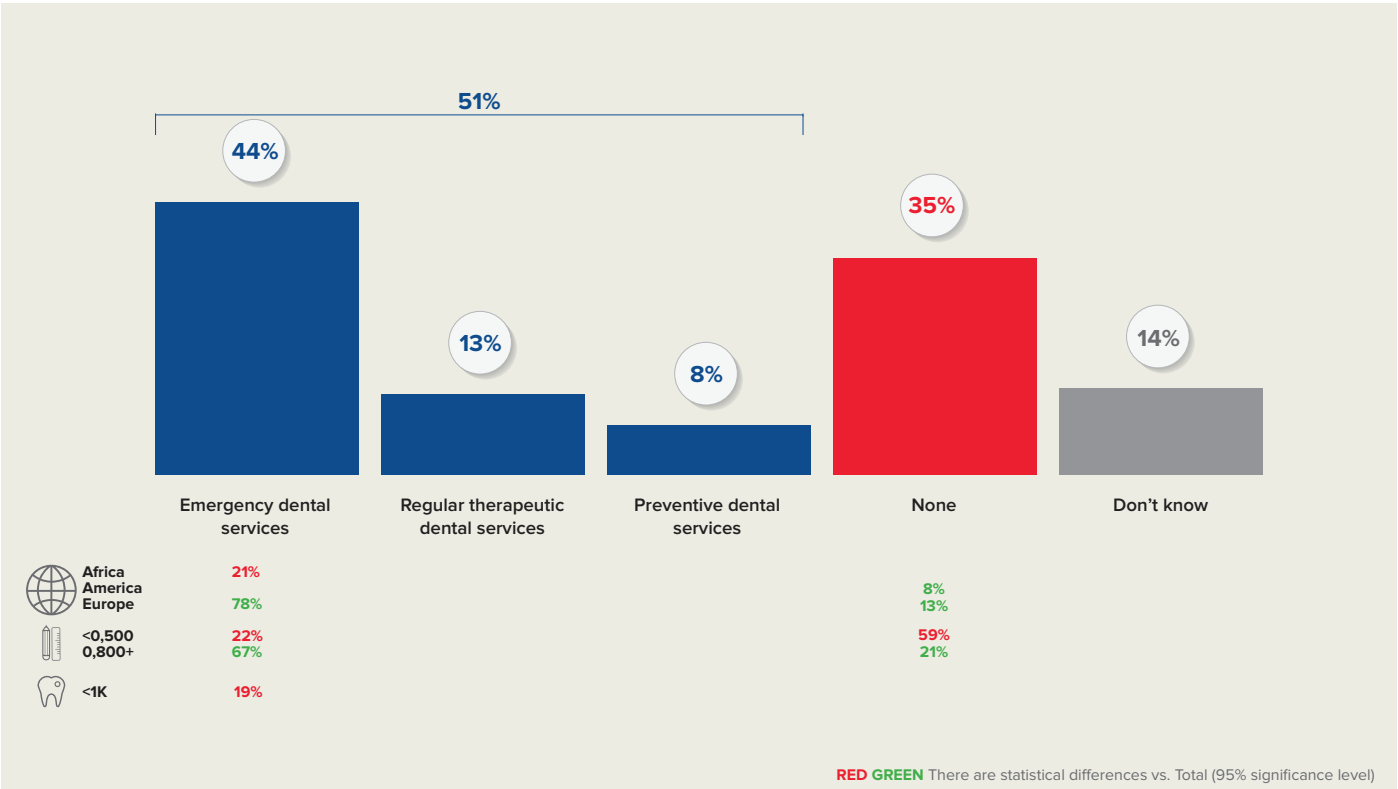

Figure 7: Types of dental treatment offered to refugees

to refugees. This was especially common in low HEI countries. Among the types of service provided, 44% reported that emergency dental services and 13% reported that regular therapeutic dental care were offered to refugees. As expected in the settings where it is most needed, preventive dental care was the least-provided service (8%). ***Figure 7***

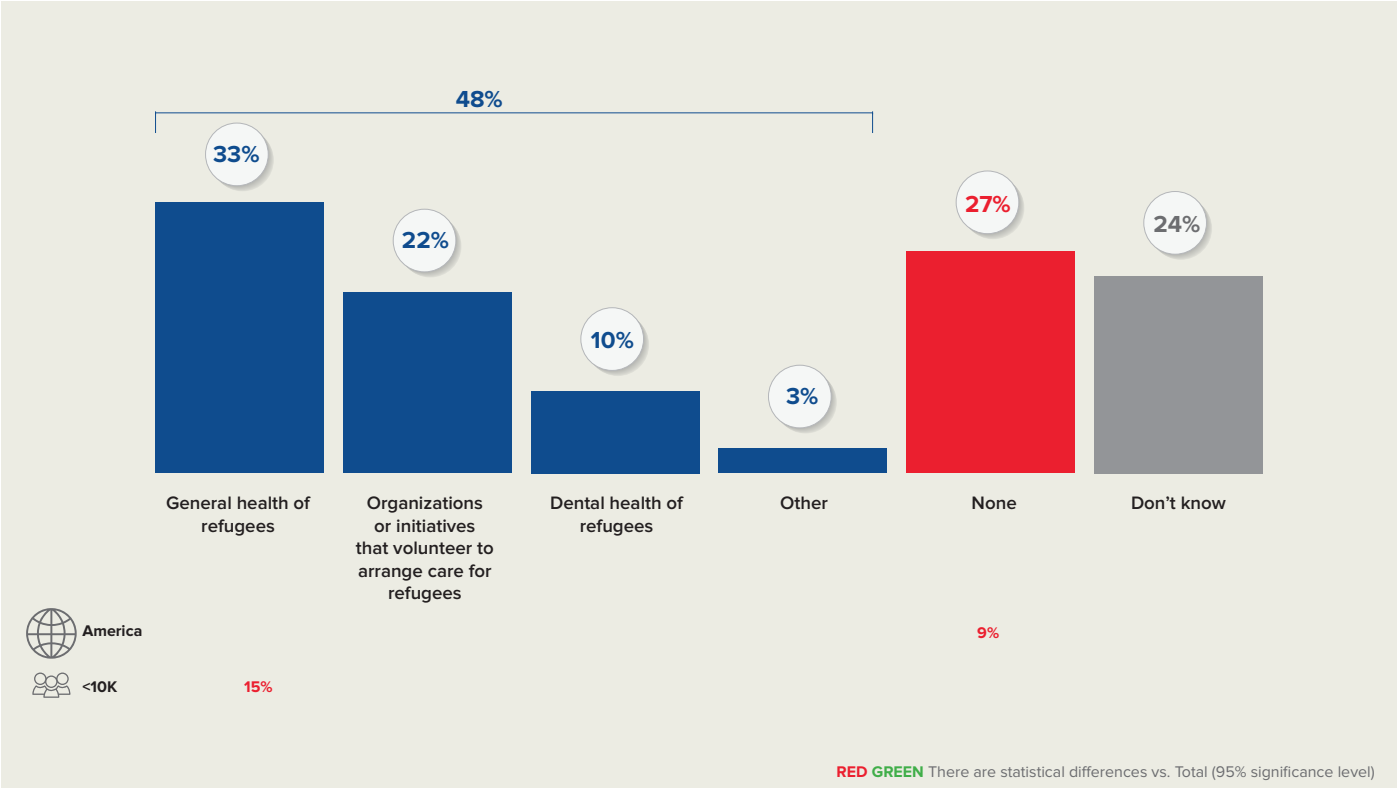

Figure 8: Policies related to addressing the health of refugees

Almost half of the respondents reported that their country has national policies directed at the general health of refugees, especially in countries with a high influx of refugees ***(Figure 8).*** However, 51% of respondent associations were not involved in any aspect related to the oral health of refugees.

The remaining 49% were involved in oral healthcare promotion activities (21%), providing care (20%), and lobbying and advocacy, especially those in European countries with high HEI (17%). Only 8% of respondent NDAs were involved directly in implementing policies (***Figure 9***).

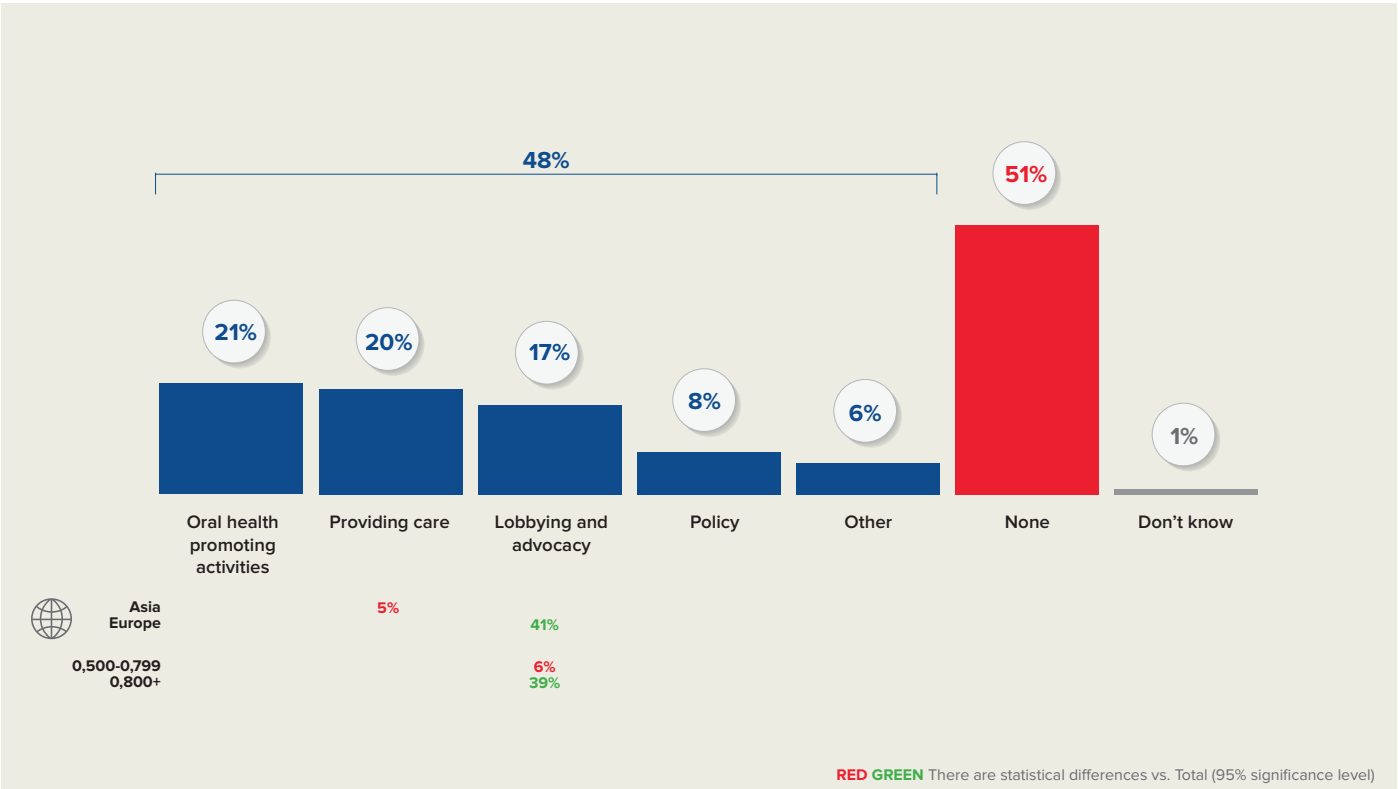

Figure 9: Role of national dental associations in ensuring access to oral health for refugees

Why these results matter

Challenges expressed by the NDAs in their work with refugees included that governments and international organizations do not include them in any response plan for the influx of refugees. In general, NDAs thought that their role should be limited to oral health promotion activities and mobilizing volunteers to provide preventive and therapeutic oral health care. Others thought that their focus should be on supporting underserved populations among their citizens, not on refugees, and very few thought that they needed to raise awareness and advocate for better oral health for refugees.

In general, providing emergency and therapeutic dental care is necessary among refugees, but the provision of this care is insufficient. Prevention and oral health promotion activities should be integrated in all health promotion activities. The Basic Package of Oral Care (BPOC) could be a good start to provide basic essential services to each member of this population, especially women and children. The BPOC focuses mainly on pain relief and emergency treatment, stabilizing the disease, and providing fluoridated toothpaste[35].

Oral health screening for refugees upon arrival in the host country should be mandatory and integrated with screenings for other health conditions. This can be achieved when all health agencies, organizations and authorities work together to promote better health among refugees and recognize that oral health is an important element of refugees' well-being.

Building your advocacy strategy

Several steps are necessary to implement an advocacy strategy efficiently and appropriately. Barriers to implementation are frequent and are often due to[42]:

- a lack of awareness among political decision makers;
- different national priorities;
- insufficient financial means.

Therefore, an advocacy strategy should focus on these points:

- Making key decision makers aware of the current policies in the country and their central role in the implementation process.
- Developing new policies with mutual goals with the involvement of NDAs.
- Ensuring that financial support is provided to the relevant programmes.
- Persuading decision makers to prioritize specific programme approaches.
- Creating demand for the adoption of government policies through the strong support of community members.

A succession of distinct actions should be followed to ensure an impactful advocacy campaign. A precise sequence of measures is described below to carefully plan and prepare an advocacy campaign. Successful examples of such strategies are provided in the last section.

1) SETTING UP THE CONTEXT

Gathering information:

Policymakers listen to the data. It is important to get facts straight and present solid evidence to support the argument. Oral health prevention and care can have potentially high overall benefits for public authorities, and this should be emphasized. When they are planning priority programmes and associated budgets, policy makers can be influenced by potential financial savings when making their final decision. Studies show that every dollar spent in preventive oral healthcare saves between $8 to $50 in restorative care[43]. Adapting those numbers to a specific country by reviewing existing research or evaluating previous programmes could also help improve the robustness of the assertion. Therefore, it is highly advised to prepare accurate data highlighting the most striking element of the country-specific situation before meeting with policymakers.

General data about refugees	• Socioeconomic data on refugees compared to the rest of the population • Barriers to access available services
Oral-health-related data	• Refugee oral health profile • Impact of oral diseases on their psychosocial function and productivity
Cost-benefit analysis	• What are the current costs for the government? • Compared to other study data, what could be saved from public expenses?

Understanding the local situation and existing policies

Identifying existing government policies on refugees and health is useful as a first step to understand the government's position. A whole range of different measures, programmes and actions could potentially affect the oral health of refugees, not only policies from the department of health. An exhaustive list of policies developed by the government should be analyzed and potential gaps should be identified.

Type of policy	Decision-making bodies
National refugee plan **Migration policies** **Human rights strategy**	• Ministry of foreign affairs
Health insurance policies	• Ministry of health and social affairs
Oral health education programmes for refugees	• Ministry of education
Integration programmes for refugees	• Ministry of interior affairs
Peace and international agreements related to health and refugees	• Ministry of foreign or interior affairs

2) ESTABLISHING GOALS AND OBJECTIVES

Goals vs objectives

Differentiation between goals and objectives is important. While goals have a broader vision, which express general outcomes of the advocacy campaign, objectives are more specific in the sense that they will set a range of concrete results that should be achieved over a limited period of time.

To improve oral health for refugees, special attention should be directed to education, raising awareness, and developing best practices.

Examples of goals and objectives are provided below.

Goal: Ensure equitable access to oral care for various refugee groups	***Goal: Decrease the rate of oral diseases among refugees by 30%***	***Goal: Empower the refugee community to raise awareness about the importance of good oral health***
Objectives: • Include essential oral health services for refugees in national universal health coverage plans within two years. • Create a special insurance plan for refugees to provide necessary treatment. • Improve training and formal cultural sensibilization education for dentists to work with refugees.	Objectives: • Pass a law to implement regular standard procedures for refugees, which include free screenings, care coordination services and a referral system for all camps in the country within three years. • Establish a screening programme for refugees in urban settings through different refugee associations. • Establish a safety net system to provide treatment for refugee camps in the country.	Objectives: • Provide basic training in oral healthcare to selected refugees as a method to overcome shortages in dental staff and to provide basic dental education. • Promote oral healthcare to specific health-orientated NGOs and charities already working with refugees by providing resources with key oral healthcare messages.

Sustainable Development Goals (SDGs)

It is good practice to use the Sustainable Developmental Goals (SDGs) to support the goals and objectives of the advocacy campaign:

The core principle of the 2030 UN Sustainable Developmental Goals (SDGs) is to ‘leave no one behind’, which emphasizes that people are the center of all actions, including the marginalized and the vulnerable, in an equitable and inclusive societies. Thus, the health needs of migrants and displaced persons, including refugees, should be integrated by governments, humanitarian and development actors into global and national plans, policies, and strategies across sectors and across borders.

Oral health of refugees as an essential part of general health can be promoted through the following SDG goals:

TARGET 1.3 Implement social protection systems and achieve sustainable coverage of the poor and vulnerable.

To include refugees; reduce out-of-pocket payments for healthcare, including dental care; and achieve coverage through sustainable and innovative financing.

TARGET 1.5 Strengthen resilience of the poor and most vulnerable to economic, social and environmental shocks and disasters.

To ensure refugees' resilience and reduce their health vulnerability linked to climate change, extreme events, and other economic, social and environmental shocks.

TARGET 3.8 Achieve universal health coverage.

To ensure the inclusion of refugees (regardless of their legal status) into universal health coverage and ensure that they are accounted for in financial risk protection schemes. Refugees need to have access to quality, equitable healthcare services, including oral health services.

TARGET 3.c Increase health financing and establish a sufficient health workforce in developing countries.

To increase the health workforce, including oral health workforce financing, recruitment, development, training and retention in developing countries; enhance the local integration of health personnel who are refugees or displaced persons; manage migration of healthcare workers and implement an international code of recruitment of health personnel.

TARGET 10.7 Orderly and safe migration through well-managed migration policies.

To recognize that migration is a determinant of health and can expose migrants to multiple health risks during all phases of the migration process. This goal encourages enhancing the health of refugees (including their oral health) through improved policy coordination among sectors that impact the health of refugees and through respecting refugees' right to health to ensure equitable access to health services, including oral health services. One of the important strategies is to implement a health assessment for refugees that includes oral health and follows public health principles and international standards of care.

TARGET 17.16 Utilize global and multi-stakeholder partnerships to support the achievement of sustainable development goals in all countries.

Utilize multi-sectoral and international partnerships, as refugees inherently connect sectors, communities, countries, and regions. Enhance the health of refugees by including their health (including their oral health) as an essential topic of cross-border, regional and global development dialogues and humanitarian responses.

TARGET 17.18 Assist developing countries to increase the availability of high-quality data disaggregated by migratory status.

Enhance capacity building to increase the availability of data disaggregated by income, gender, age, race, ethnicity, migration status. [...] including oral health data to allow the monitoring of the refugees oral health and the implementation of policies and legislations affecting the oral health needs of refugees.

3) IDENTIFYING TARGET AUDIENCES

Once the goals and objectives are set, determining the right target audience is an essential step. This could be either influential or supportive groups, those interested in the topic, and even influential opponents. Not only should individuals or groups directly influencing the intended goal be targeted, but also those influencing the primary audience.

Concentrate on the most influential among those groups, with a special focus on the influential opponents. Convincing an opponent with strong arguments could be an opportunity to create more allies.

Examples of primary target audiences

Influential	Supportive	Interested	Opponents
• Government/ policy makers • WHO • Local community leaders • Public authorities • Media	• NGOs • UNHCR • Healthcare professionals • Political parties • Public health community • The wider public	• Universities • Dental schools • Product manufacturers • Education services	• Political parties • Media • The wider public

4) DEVELOPING KEY MESSAGES

NDAs and other organizations working to ensure that refugees have access to oral healthcare need to develop simple and direct messages, tailored to the country's unique context, that convey a strong call to action. Primary messages should advocate for the main goal of a project or an initiative, and the secondary messages support the main messages but are more specific and technical.

An example:

PRIMARY MESSAGE #1:

Leaving no one behind: Ensure universal and equitable access to dental care.

Secondary messages:

1. Universal health coverage will be only successful if oral health is included and refugees' oral health is addressed within it.
2. Universal and equitable access to adequate dental care needs to be guaranteed to all regardless of their immigration status.
3. Adequate and affordable preventive and therapeutic oral health services should be guaranteed to all, including refugees.

PRIMARY MESSAGE #2:

Introduce responsible, transparent, and refugee-inclusive public information strategies.

Secondary messages:

1. Public communication must be linguistically and culturally accessible to all in order to be effective.
2. The government should actively counter racism, xenophobia, and discrimination.

Selecting appropriate communication channels

The way of communicating your message will very much depend on your target audience. Their different characteristics (position, age, level of education, access to media, social media, knowledge about the issue, etc.) indicate the most suitable way of approaching them. The advocacy activities and materials you use should be selected according to the likely preferences of your target audience. A list of such activities and materials is detailed below.

- Workshops and meetings: Organizing meetings and workshops with community leaders or local authorities to highlight the oral health situation of refugees can be an efficient way to initiate actions from influential stakeholders.
- Social media: Raising awareness through social media (Twitter, Facebook, Instagram, blog posts, etc.) can be a useful means to reach large audiences rapidly and at a very low cost. It can also be an opportunity to connect refugees' stories with the larger public and create powerful support for this cause.
- Mass media campaigns: Using newspaper, radio or TV can also reach a large audience and generate pressure on elected officials to work on this issue and implement impactful measures. However, it might not be the best method to reach very specific types of individuals, such as decision makers.
- Printed materials: Leaflets, fact sheets or guidelines can serve as great resources for an advocacy campaign. In low-resource settings like refugee camps, these kinds of communication channels can be very suitable to bring simple and concise messages to the target audience. However, it is not advisable to distribute printed materials without undertaking any additional activities, as the results are often unsatisfactory.
- High-level meetings: Organizing a meeting with high-level officials has to be meticulously prepared to maximize the chances of persuading them within the brief timeframe you will spend with them. When successfully managed, these meetings can have direct and effective results because of the key role that the official plays in the decision-making process. If direct support is granted from a high-level official, such as a minister of health, better chances of success are ensured to achieve your goals and objectives.
- Public events: Preparing events in public spaces to raise awareness of the importance of ensuring access to oral health for refugees can allow a wider community to be engaged. The celebration of World Oral Health Day on 20 March can also be an opportunity to organize interactive activities to raise awareness about refugees' oral health status. This might obtain significant media coverage and provoke consequent actions from local authorities.

Building collaboration

Forming partnerships with influential actors to improve refugees' oral health is also a major step in the advocacy process. This can mean partnering with dental and non-dental healthcare workers, but also associations, public authorities, or universities. Depending on your objectives, the selection of the partners will be different. Better collaboration will solidify actions taken to achieve the objectives and increase the chances of success. According to the legislation in each country, all other allied dental health members should be used effectively in oral health education, promotion, prevention,

and care provision in this population. When multiple stakeholders are involved and working together, goals and objectives might be broader.

However, separate and complementary goals can be envisioned for each partner. Ensuring that those different goals are in line with each other is still important and should be primarily discussed between the partners. Long-term and temporary partnerships can both be productive.

Example of objectives with potential partners

Objectives	Partners
Train community oral healthcare workers that could do preventive activities but also basic oral health treatments for refugee camps A and B	• Refugee associations • Dental schools • Product manufacturers
Convince governments to give free access to basic and essential oral health care to refugees and internally displaced persons (IDPs)	• Governments/policymakers • Public health community • Coalition of oral health professionals
Establish oral health education programmes for refugees living in camp A	• Universities • Education services • health professionals

NDAs should collaborate with other health organizations to:

- Enable refugees to have the same healthcare coverage as citizens of the host country in law and in practice;
- Enable refugees to access their entitlements by getting information in various languages and through various methods, including cultural mediators;
- Enable healthcare providers to be informed of these entitlements and to be equipped to meet refugees' needs through training, various interpretation methods, adapted diagnostic methods, and a diverse staff;
- Enable health policies to support these changes and be equipped to respond to the needs of an increasingly diverse society.

NDAs should collaborate with other health organizations to advocate to change the current situation in some countries where:

- refugees cannot access the healthcare system, except perhaps emergency care;
- access to care depends on providers' discretion and burdensome documentation;
- refugees do not know how to access the health system or address major health issues;
- service providers are forced to report undocumented refugees and are sanctioned for serving them;
- providers do not have the training or staff to serve refugees or address their health needs;
- refugees' health is ignored in health policy, data and research.

In addition, NDAs can collaborate with academic and research institutions to conduct the necessary research to inform policy makers and healthcare professionals about refugees' oral health needs and limited access to oral healthcare[12].

Important opportunities for collaboration:

UNHCR operations and advocacy efforts and results

Most UNHCR offices are involved with advocacy efforts to expand access to services for refugees. Offices around the globe are either in talks with the host government authorities, municipal authorities, and/or specific service providers. Furthermore, UNHCR is currently investing in building existing service provision systems to provide health, education, and child protection and social welfare services[44].

Upon arrival, refugees often have access to medical care but not to dental care[45]. Even though there is a lack of data surrounding the oral disease burden for refugees, the global growth in the number of refugees and asylum seekers is undeniable. Many healthcare professionals remain unaware of the importance of oral health for the refugee population.

Integrating oral health into universal health coverage

The World Health Organization (WHO) has dedicated great efforts to achieve universal health coverage (UHC) globally. Oral health must be considered together with UHC when efforts are concentrated in this manner. Oral disease can be present at any stage of life and affects general well-being. For example, severe periodontal disease can lead to tooth loss and is the eleventh most prevalent disease globally[46].

Incorporating oral health into UHC means integrating essential oral health services into the basic primary care package. So far, WHO has promoted the Basic Package of Oral Care (BPOC) in low-resource settings in Africa as part of essential noncommunicable disease (NCD) interventions, but this can be expanded to other vulnerable populations (such as refugees) as well[46]. In addition, incorporating oral health into UHC encourages a stronger commitment to improve data collection surrounding oral health to understand what specific needs a community may have.

5) IMPLEMENTING YOUR ADVOCACY PLAN

A range of actions proposed below could contribute to improving access to oral healthcare for refugees.

Depending on the local context and needs, different measures are conceivable to strengthen the health system for refugees and ensure access to oral healthcare:

Raise awareness about this issue

Oral health for refugees can be considered in a broader political context by identifying gaps in national policies on refugees' health as a first step. Afterwards, recommendations of how to lobby and take contact policy makers to amend these policies to include oral health should be undertaken.

Strengthen health education through oral health promotion and oral disease prevention activities

- Increase awareness about the importance of self-care: This can include personalized oral care instructions and dietary counselling, focused especially on the harm of high sugar consumption. However, finding the resources to access healthy food and self-care hygiene products may be challenging in most of the cases.
- Educate families and individuals about how oral health is an important part of general health and correct misconceptions and unhealthy habits. This should be implemented using materials provided through multi-lingual oral health education videos or printed materials.
- Design more tailored person-to-person educational methods, such as motivational interviewing, that can be implemented when adequately trained personnel are available.
- Provide fluoridated toothpastes and other professional fluoride therapies as part of oral disease prevention activities.
- Recommend regular dental visits if they are available.

Insist on establishing a screening and referral system upon arrival in the host country

This is very important to quantify the oral disease burden in the refugee population and design appropriate oral health interventions. A review of the oral health status of refugees and asylum seekers found very little data about refugees' oral health that could be used to design interventions or advocate for policies[12]. In addition, the data we collected showed that only 4% of respondent countries have mandatory oral health screenings. Oral health screenings should be integrated with the other health screenings for refugees that are usually carried out upon arrival.

Standardized oral health screening tools can be used to follow up on the outcomes of this mobile community. The WHO Oral Health Survey can be a good road map to establish oral health screenings at arrival camps[47]. In addition to this, FDI and the International Consortium for Health Outcomes Measurement has developed the Adult Oral Health Standard Set (AOHSS), to be used in clinical practice, research, advocacy and population health[48]. We must continue to emphasize that if oral health screenings are not followed up by referrals to therapeutic or preventive services, these will have a very limited impact on refugees' oral health.

Providing care

- Dental care provision can be conducted initially through free oral health treatment on a voluntary basis or through initiatives sponsored by governmental or non-governmental organizations.
- The Basic Package of Oral Health, endorsed by WHO and FDI, can be used as a basic treatment option that includes relieving pain, stabilizing the disease, and providing fluoridated toothpaste.
- Care can be provided by mobile dental units or in temporary dental clinics set up in refugee camps.
- Non-invasive dental procedures such as Hall techniques[49], silver diamine fluoride[50], and Atraumatic Restorative Treatment (ART)[51] can be used effectively in field care settings.
- Involving allied dental workers, primary healthcare workers and dental students under direct supervision in care provision, especially for non-invasive dental treatments.
- Simple or more definitive treatment can be provided based on the equipment available.
- Patient referral for more extensive and complex cases to a safety net of dentists who volunteer to treat refugees or through regular missions that are funded by non-governmental and governmental organizations.
- Transition to a more stable dental care system where regular examination and more definitive treatments are provided.
- Establish dental homes for the most vulnerable groups of refugees, such as children, mothers, and patients with systemic diseases. A dental home is defined by the American Academy of Pediatric Dentistry as the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral healthcare, delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Empower and engage community oral health workers

Training available healthcare workers in the refugee camps to conduct preventive activities is a cost-effective intervention for low-resource settings to ensure good oral health in the population. This can also establish trust between health workers and refugees and strengthen the overall health system.

6) MONITORING AND EVALUATION

Monitoring and evaluation of oral health programmes are essential for developing effective programmes to prevent and control oral diseases among refugees. It usually involves collecting and analyzing information about the activities and outcomes of these programmes. Their main goals are accountability, enhancement, and engaging stakeholders.

Three types of evaluation are usually conducted to assess programme implementation and effectiveness:

1. Process/implementation evaluation and outcome/effectiveness evaluation.

2. Process evaluation determines whether programme activities have been implemented as intended. Outcome evaluation measures programme effects in the target population by assessing the progress in the outcomes or outcome objectives that the programme is to achieve.

3. Impact evaluation assesses programme effectiveness in achieving its ultimate goals.

Evaluation of different oral health programmes for refugees is not a straightforward procedure. The instability of the refugee population due to the continuous influx and outflux of refugees from the camp community makes it very difficult to evaluate outcomes. Thus, simple, repeated cross-sectional surveys at baseline and at different points of time are inaccurate in assessing the effectiveness of oral health programmes for this population.

Therefore, programme evaluation can be heavily focused instead on success in implementing specific programme activities. Different implementation indicators can be used based on the objectives of each programme. Some of the useful indicators that can be used are:

- percentage of refugees screened upon arrival;
- percentage of refugees referred to receive treatment;
- percentage of refugees who received an awareness-raising educational session;
- percentage of refugees who received preventive measures;
- percentage of refugees who received emergency treatment;
- percentage of refugees who received non-emergency treatment;
- percentage of refugees who were given access to a dental home;
- percentage of refugees who received an insurance plan;
- number of new policies implemented devoted to refugees' oral health.

An opportunity for national dental associations

NDAs can contribute effectively to implement the measures mentioned above when collaborating with educational, governmental and non-governmental organizations through education, awareness raising, developing best practices to serve this population, and advocating for changing policies.

Lobbying and advocating for comprehensive health policies for refugees: NDAs can pressure governments to adopt policies guaranteeing oral health access to refugees. Oral health must be recognized as an issue of high concern when designing health policies.

Coordinate with other relevant sectors for joint solutions: Strengthening coordination among potential influential actors in the private sector, refugee associations, civil society or affected populations themselves to develop joint actions would greatly benefit the oral health of refugees.

Emphasize community outreach efforts to act on cultural and language barriers: NDAs can engage community leaders who can act as interpreters, signpost to services, and collaborate with the local department of public health. Moreover, oral hygiene education should be incorporated into community outreach events.

Advocating to include access to oral health for refugees in UHC essential services and to create special insurance plans to provide necessary treatments.

Developing sets of best practices and lessons learned about improving oral health in the refugee population.

Successful intervention stories

Where	When	Type of intervention	Breaking the barriers
Gomoa camp, Ghana	1997	A Community Oral Health Workers (COHWs) programme was set up to encourage a refugee community to take care of their own oral health. Intensive training courses on basic oral healthcare were provided to selected refugees, who then became COHWs. The training modules were based on WHO modules and supported by the ministries of health in Ghana and Liberia. COHWs could then deliver certain types of oral care through central clinics and organize certain activities related to oral health promotion in collaboration with the national dental association of Ghana[31].	• Interactions were generally friendly and co-operative, which helped to build trust between the COHWs and the wider community. • The language barrier was broken. • Better availability and accessibility to oral healthcare.
Melbourne, Australia	2012	***Teeth Tales***, an oral health education programme for refugees and migrants, consisted of training peer educators to promote oral health and improve access to oral healthcare for families from specific cultural backgrounds. The intervention had positive impacts on the families' oral hygiene and the parents' knowledge of the proper tooth-brushing method[52].	• Peer educators who were recruited from the same cultural background allowed for a better understanding of the services available in the host country and the overall benefit of good oral health.
Moria camp, Lesvos Island, Greece	2015-present	The Dental Point Project (DPP) is part of the Health-Point Foundation, a charity-based organization that provides medical, dental and educational services to displaced people. DPP in Moria camp provides emergency dental treatments to more than 4,000 patients each year through multiple static and outreach dental sessions[53].	• Better accessibility to oral health professionals. • Drastic reduction of costs, as this is a volunteer-based project.
Ghent, Belgium	2015-2017	A collaborative programme between Ghent university and the ***De Tinten project*** was set up to improve the referral system and to increase dental appointment attendance for undocumented migrants. Volunteering dentists provided oral healthcare and trained social workers to be community oral health workers. Missed dental appointments decreased from 40% in 2015 to 8% in 2017[54].	• Awareness raising led to a better understanding of the services provided. • Enhanced knowledge about the benefits of good oral health.
Northern Ireland, UK	2018	A community-based oral health education intervention was carried out among undocumented migrant mothers from China to promote their infants' oral health. A home-visiting programme and telephones calls focused on oral health education were provided to the mothers in the intervention group. These mothers had better knowledge, attitudes, and behaviours about oral health for their children compared to the control group[55].	• The language barrier was diminished, which allowed for a better understanding of the importance of oral health and the related services available.

Appendix 1

Write to decision makers

A well-written letter to decision makers or political leaders is a good way to address the need for policy change and present your arguments. Be respectful, clear, and concise when you introduce yourself, your position, and your call to action.

Template letter for decision makers

Dear [format title and name],

As a dentist and member of the [name of your national dental association], I would like to bring the issue of refugees' access to oral health to your attention.

Refugees are at particular risk of suffering from high stress, trauma, discrimination and of experiencing language and cultural barriers. This leads to difficulties accessing the healthcare system and in understanding the community services available. Therefore, refugees very often have a higher prevalence than the rest of the population of oral diseases, chronic toothache, untreated caries and oral lesions. Periodontal diseases can also worsen diabetes and may increase the risk of developing cardiovascular conditions. General quality of life, including self-esteem and productivity, is also negatively impacted by oral diseases.

In our country, a population of [insert number of refugees in your country] refugees has limited access to primary healthcare, including oral health services. Oral diseases affect [X% indicate percentage according to available data from your country or see the "Healthcare for refugees" section of this document] of refugees compared with [X% indicate percentage according to available data from your country] in the general population. This difference is mainly due to [describe the public health services available in your country for refugees and how it is financed or detail other reasons for limited access to oral healthcare]. Moreover, improving access to and investing in dental care have proven to be cost effective. Every dollar spent in preventive oral health saves between $8 to $50 in restorative care.

Host government authorities must act to ensure equal access to oral healthcare for their refugees and general population by identifying gaps in current policies and taking appropriate measures. As oral diseases are among the most preventable noncommunicable diseases, cost-effective interventions could have a significant impact on refugees' well-being and oral health. Raising awareness, strengthening health education by training community oral health workers, and financing oral health services could dramatically reduce the long-term costs of oral diseases. I would therefore like to take this opportunity to request a meeting to further discuss this with you.

I may be reached at [insert your contact details].

I look forward to addressing this major public health issue with you.

Sincerely,

[Your signature]

[Your name]

[Your address]

[Your phone number]

Appendix 2

Template letter for advocacy

To any public authority (national, communal or municipal level)

National dental association letterhead

Dear xxx [please insert title as appropriate],

As refugees are a highly vulnerable population, they face numerous barriers to accessing good oral healthcare. Language and cultural differences, as well as possible mistrust in health authorities due to trauma or financial constraints, can have significant, negative impacts on the oral health of refugees. [Your country] hosts [number of] refugees and measures can be undertaken to ensure affordable and accessible oral healthcare for them. The prevalence of oral diseases among the refugee population is [number], with most being easily preventable. In this regard, [name of national dental association] urges you to take the following actions:

1) Increase accessibility to oral healthcare for refugees by establishing a standard oral health screening protocol upon arrival, including basic emergency treatment and a referral system.

2) Ensure affordable access to oral healthcare by financing services to relieve pain, stabilize the disease, and screen as part of the basic package of primary care that refugees should receive from their host community.

3) Empower the refugee community to raise awareness about the importance of oral health for general health and engage this community by providing trainings for them to be able to conduct preventive activities in their own communities.

4) Strengthen coordination between health service providers, authorities, and private sector actors to encourage multi-sectoral interventions that cover every aspect of good oral health.

The [name of national dental association] with its [number of] members is committed to guaranteeing equal access to oral healthcare among the refugee community and the host community and therefore asks the government to take the necessary actions to reduce the prevalence of oral diseases for refugees through comprehensive policies, aimed at providing to refugees the highest attainable standard of physical and mental health.

Yours faithfully,

[National dental association]

[Name of signatory]

[Number of members]

Resources and links

Funds available from FDI to finance your refugee-oral-health-related projects

World Dental Development Fund

The aim of the FDI World Dental Development Fund (WDDF) is to improve oral health globally, primarily through the establishment of innovative prevention and access programmes in disadvantaged populations. WDDF illustrates FDI's commitment to its members and the funded projects reflect the core values and principles of FDI: integrity, a culture of inclusiveness, excellence, and ethical behaviour.

More information at: https://www.fdiworlddental.org/what-we-do/awards-grants/world-dental-development-fund

The Smile Grant

The Smile Grant is designed to reward oral health projects that have been actively rolled out for at least one year and that will continue for at least one year more. Eligible projects may address any oral health issue and/or disease, with a strong focus on oral health education and oral health prevention and promotion.

More information at: https://www.fdiworlddental.org/what-we-do/awards-grants/fdi-smile-award.

Organizations that can provide important and updated information about refugees

United Nations High Commissioner for Refugees

UNHCR, the UN Refugee Agency, is a global organization dedicated to saving lives, protecting rights and building a better future for refugees, forcibly displaced communities and stateless people.

More information at: https://www.unhcr.org/

United Nations Relief and Works Agency

UNRWA human development and humanitarian services encompass primary and vocational education, primary healthcare, relief and social services, infrastructure and camp improvement, microfinance and emergency response, including in situations of armed conflict.

More information at: https://www.unrwa.org/

International Committee of the Red Cross

The work of the ICRC is based on the Geneva Conventions of 1949, their Additional Protocols, its Statutes – and those of the International Red Cross and Red Crescent Movement – and the resolutions of the International Conferences of the Red Cross and Red Crescent. The ICRC is an independent, neutral organization ensuring humanitarian protection and assistance for victims of armed conflict and other situations of violence. It takes action in response to emergencies and, at the same time, promotes respect for international humanitarian law and its implementation in national law.

More information at: https://www.icrc.org/en/

Evidence Aid

Evidence Aid aims to save lives and livelihoods in disasters by providing decision makers with the best available evidence and by championing its use.

More information at: http://evidenceaid.org/launch-of-new-priority-area-oral-health-for-refugees-and-asylum-seekers/

Migration Integration Policy Index

MIPEX is a unique tool that measures policies to integrate migrants in all EU member states, Australia, Canada, Iceland, Japan, South Korea, New Zealand, Norway, Switzerland, Turkey, and the United States of America.

More information at: http://www.mipex.eu/

Documents that can support your advocacy efforts

- FDI Vision 2030: https://www.fdiworlddental.org/what-we-do/advocacy
- FDI Refugee Oral Health Promotion and Care Project: https://www.fdiworlddental.org/what-we-do/projects/refugee-oral-health-promotion-and-care-project
- FDI Policy Statement on providing basic oral healthcare for displaced persons: https://www.fdiworlddental.org/resources/policy-statements/providing-basic-oral-healthcare-for-displaced-persons

Tools that help in screening and implementing preventive and therapeutic programmes

WHO Basic Package of Oral Care

The concept of the Basic Package of Oral Care (BPOC) gives a guiding framework for dental NGO and volunteer activities. The main components of the BPOC (oral urgent treatment, affordable fluoride toothpaste, atraumatic restorative treatment) offer many opportunities for effective, affordable and sustainable activities that aim to improve oral health on the community and population level.

More information at: https://pubmed.ncbi.nlm.nih.gov/16515012/

Oral healthcare in camps for refugees and displaced persons

This document was prepared to guide organizations involved in the administration and management of camps for refugees and displaced persons, especially those that implement oral health programmes. It gives guidance on how to handle dental emergencies and how to stabilize oral disease in camp settings.

More information at: https://apps.who.int/iris/handle/10665/66506

Adult Oral Health Standard Set (AOHSS)

FDI and the International Consortium for Health Outcomes Measurement has developed the Adult Oral Health Standard Set (AOHSS), to be used in clinical practice, research, advocacy and population health[48].

More information at: https://onlinelibrary.wiley.com/doi/full/10.1111/idj.12604

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