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DENTAL VOLUNTEERISM FOR MARGINALIZED COMMUNITY

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Abstract

Marginalized community refers to a small group of people who are vulnerable, oppressed or underserved which include low-income individuals, homeless, native people and refugees. Oral healthcare among this group of people requires more attention. This predicament led a group of students and lecturers from the Faculty of Dentistry, University Sains Islam Malaysia to develop a dental community service programme. This study aimed to determine the background of patients involved in the programme, to identify the common medical problems and treatment needs for the patients in the marginalized community. Periodic visits were arranged for the selected centre for the past three years. During the visits, dental screening and treatment were documented in the dental treatment card. The dental screenings were carried out for 431 patients in the Chow Kit area and 217 patients in the Rohingya Refugees centre. More than a quarter of the total number of patients received basic dental treatment such as restorations and scaling. The study found that the distribution of patients attending both programmes differs in terms of the age range. The most common medical problems among patients are hypertension and diabetes mellitus and in comparison, communicable diseases were more common to be found among the homeless. The need for restoration and extraction were high in both programmes.

Keywords: *Dental, Homeless, Community, Refugees, Volunteerism.*

INTRODUCTION

The marginalized community are socially excluded groups of people that are separated from the mainstream population. Marginalization is not a new phenomenon, it is multidimensional and multicausal.

These small group of people are secluded due to different reasons such as their race, identity, gender, sexuality, religion or social hierarchy. Due to marginalization, they are often neglected and stay outside of the existing system (economic, political, social and cultural) which makes them vulnerable with difficulty in surviving day to day hardship and exposed to a series of disadvantages.

Marginality is mainly described by two major conceptual frameworks. The first one is the societal framework which is based on social conditions and the second one is a spatial dimension of marginality, based on physical location and distance from the centre of development (GS Gurung & M Kollmair, 2005).

Homeless and refugees are the two groups of a marginalized community that can be found in Malaysia. The number of homeless in Kuala Lumpur had a significant increase from 600 homeless in 2014 to almost 2000 in 2016 (WK Li, 2018).

Established factors that contributed to homelessness are individual factors (mental health problems, poverty and substance abuse) and structural factors (absence of low-cost housing, lack of opportunities and unemployment) (WK Li, 2018). High rates of unmet need for health care services have been observed among the homeless (TP Bagget et al., 2010).

In 2019, there are around 170,460 estimated refugees and asylum seekers registered with United Nations High Commissioner for Refugees (UNHCR), Malaysia. Rohingya refugees constitute about half of the total number of refugees in this country. Selangor have the highest number of registered refugees compared to other states in Malaysia (www.unhcr.org).

Dental Volunteerism

Dental volunteerism via community service can make a significant contribution in helping to reduce the global burden of oral disease among the marginalized community (C Holmgren & H Benzian, 2011).

Other than prevention strategies, the aim of dental volunteerism is also to eliminate dental pain among its sufferer. In a dental community program, often a basic package of oral care is incorporated such as oral urgent treatment, affordable fluoride toothpaste and atraumatic restorative treatment (ART) (SJ Han & CR Quinonez, 2013).

USIM@DFTN

Driven by compassion and desire to help, a group of dental students and lecturers from Faculty of Dentistry, Universiti Sains Islam Malaysia have initiated a collaboration with Dentistry For The Needy (DFTN) in providing oral health service for the marginalized community.

DFTN is an NGO under the Islamic Dental Association of Malaysia which strives on the practice of Islamic culture to meet the aspirations of Muslim communities in Malaysia.

USIM, being the leader in integration naqli aqli curriculum aimed to develop holistic students that would contribute back to the ummah. The unique degree curriculum was designated to produce a balanced professional in their work-life (Abdullah et al., 2019).

In line with this, the objectives of USIM@DFTN was founded to provide continuous basic oral health treatment to the needy (homeless and refugees), to educate them on oral hygiene care and to expose dental students in participating community service program.

OBJECTIVES

The objectives of this study are:

1. To identify the demographic background of the patients attending the community dental service.
2. To determine the common medical problems among patients attending the community dental service.
3. To determine the dental treatment need among patients attending the community dental service.

METHODOLOGY

Monthly dental community service was organized continuously by USIM@DFTN to the homeless and refugees in Kuala Lumpur areas. The programme is supported by DFTN and the Faculty of Dentistry, USIM. In each program, there will be around 8 to 15 dental students involved. They were accompanied by 2 to 4 lecturers-in-charge.

Activities include providing dental treatment, oral health education and distributing free oral hygiene kit. Each patient's details and dental record were documented in the treatment card. The dental examinations and treatment were done by qualified dentists.

Data collected from January 2017 until April 2019 were analyzed and results are shown below. For homeless programme, the visit was done almost

every month, while for the Rohingya refugees the frequency was once every two months.

RESULTS

A total of 431 homeless patients and 217 Rohingya refugees patients were screened throughout the program for the past 2 years. Female patients (58%) were seen more among the homeless compared to Rohingya refugees where the majority of the patients were male (54.4%).

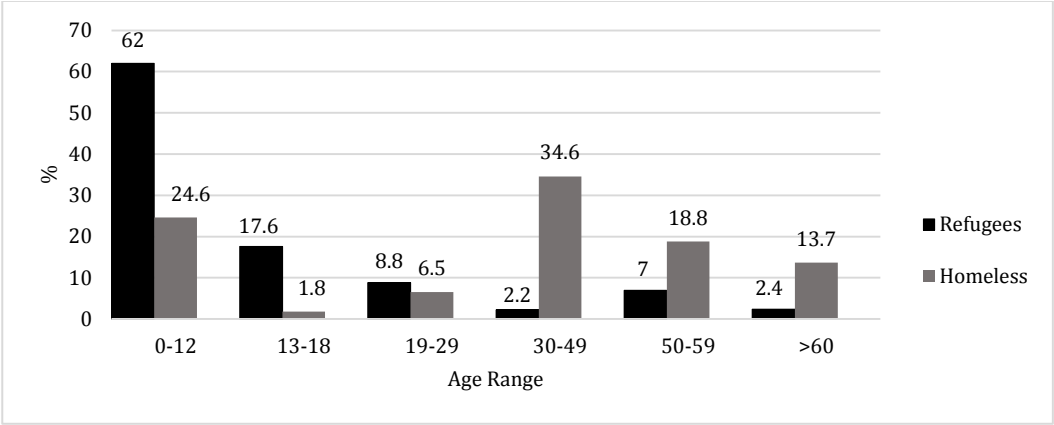

Figure 1: The Age Range Of Patients Who The Attended The Dental Community Service

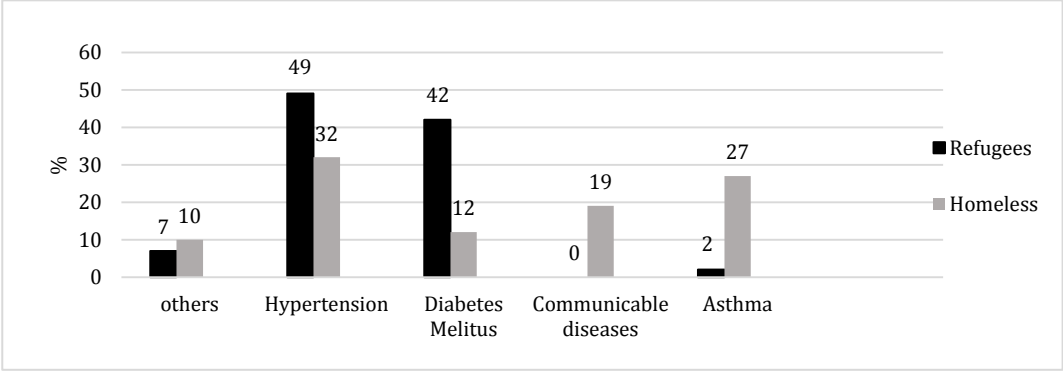

Figure 2: Medical Problems Among Patients Who Attended The Dental Community Service Programme

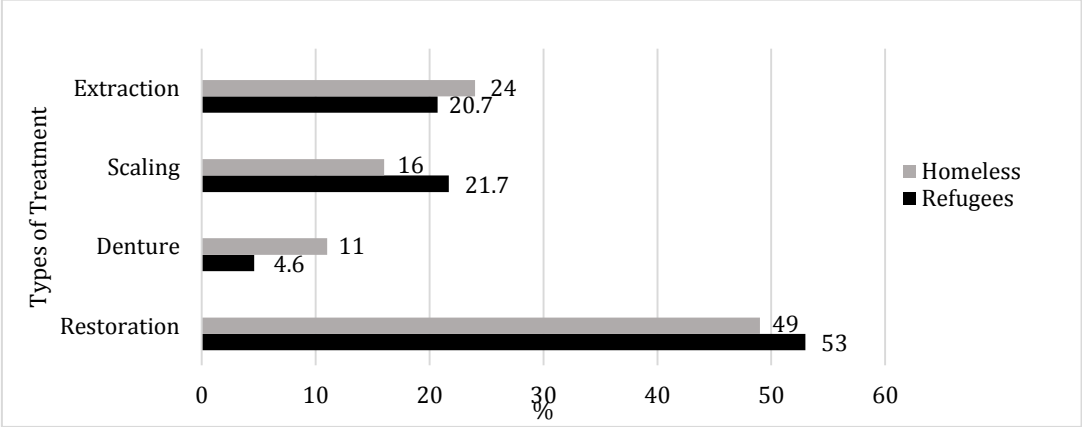

Figure 3: Treatment Needs Among Patients Who Attended Dental Community Programme

Majority of patients involved in the program for Rohingya refugees mainly consist of paediatric patients below 12 years old. While the majority of patients in the homeless program were 30 years and above as shown in Figure 1.

The most common treatment needed among the homeless were tooth restoration (49%), extraction (24%), scaling (16%) and followed by denture (11%).

In Rohingya refugees patients, restorative treatment (53%) recorded as the highest treatment needed followed by scaling (21.7%), extraction (20.7%) and denture (4.6%). The pattern of treatment need for underserved populations was similar for dental restoration, scaling and extraction.

DISCUSSION

Oral health is considered as a basic human right. Studies in the past had expressed their concern about the short-term effect of the program to provide oral health care to the marginalized community or underprivileged population (Holmgren & Benzian, 2011).

USIM@DFTN focus was based on the concern to commit on a continuous oral health education and check-ups for the homeless and Rohingya refugees. For the past two years, dental community program conducted under USIM@DFTN had served hundreds of homeless and Rohingya refugees patient by giving them free dental check-up, free dental treatments, free oral hygiene kit and most importantly delivering dental health education.

This study however, could not compare frequency of dental visits and dental treatment for both population because the number of visit for the homeless is more frequent (once in a month) than the visit to the Rohingya shelter which was carried out once in two month. This includes the fact that the smaller community in the Rohingya's shelter in comparison to the homeless Chow Kit area.

Most of the attendee in the Rohingya refugees programme particularly were below 12 years old. This is mainly because the program was conducted in a shelter that was purposely exclusive to educate the children of Rohingya refugees. In the shelter itself, they were around 80 children under the care of Human Aid.

Overall, homeless patients aged more than 30 years old were the majority (67.1%) among the patients examined during the dental community service program. Homelessness usually affecting adults more than children. Factors contributed to this phenomena were unemployment, low income, old age, drug addiction and mental health issues (WK Li, 2018).

The common non-communicable diseases presented among the homeless and Rohingya refugees include hypertension, asthma and diabetes mellitus. It is important to note that there were several homeless patients in this program who claimed to have communicable diseases such as hepatitis, infected with human immunodeficiency virus (HIV) and tuberculosis.

This fact, coupled with the recommendation to treat every patient as high risk makes infection control during the program very important and vital for the protection of both volunteers and all patients (Ministry of Health Malaysia, 2010).

The volunteers were constantly reminded to adhere strictly to the infection control guidelines during dental community service. An invasive dental procedure is not recommended due to this issue. On this basis too that although extractions were among the highest treatment needed and requested from the patients, we did not offer the treatment until the mobile clinic is fully equipped to handle complications.

The result showed a high percentage of restoration and extraction needs. Oral health is considered as a basic human right but many homeless and refugees are still in need of proper and affordable oral health care (P De Palma et al, 2005; Keboa et al, 2016).

The marginalized community faces challenges in maintaining their health and thus become vulnerable to

mental and chronic diseases (S Medlow, E Klineberg, K Steinbeck, 2014).

Oral health is often neglected in this group of people are due to high cost, limited oral health access, time consuming, and stigma from society. Dental caries and periodontal diseases were the most prevalent condition observed among the homeless and refugees that need to be addressed (P De Palma et al, 2005; Keboa et al, 2016).

Poor oral health, untreated oral disease and missing teeth will probably contribute to the exacerbation of their general health and quality of life as dental health impacts all aspects of life from physical to emotional distress (E. Coles et al., 2011).

The current concept of dental volunteerism to approach a community for a short-term aid and move on to the next community has no lingering benefits in the long run (C Holmgren & H Benzian, 2011).

Therefore, the project was planned to engage the marginalized population for a long-term aid and better oral health education. Future planning would include a well equipped mobile dental clinic that is able to cater to the need for more complicated treatments while providing a comfortable treatment zone to the marginalized community.

The conventional approach is simply not feasible for this marginalized population. World Health Organization (WHO) developed the Basic Package of Oral Care (BPOC) as a framework to meet the basic oral health need (Helderman & Benzian, 2006).

It comprises of three main components: 1. Oral Urgent Treatment (OUT) to relief pain, to attend to emergency cases, referral of complicated cases, 2. Affordable Flouride Toothpaste (AFT) and lastly 3. The Atraumatic Restorative Treatment (ART). In this programme, we educate the attendee on the importance of oral health while distributing oral hygiene kit sponsored by the collaborative partner.

LIMITATIONS AND RECOMMENDATIONS OF THE PROGRAMME

Continuity of this project is expensive and require a dedicated team and volunteers. Donation from the public plays a major role in the programme continuation. This has become an obstacle in the past. Collaboration between the government and non-governmental organization NGO) is seen as one of the strategies in reaching to the needy and providing them oral health service (C Holmgren & H Benzian, 2011).

USIM overcome this by merging with DFTN, a non-governmental organization who organize the monthly check-ups and donation with USIM contributing to human resources and instrumentation. This collaboration enables resources to merge from different sectors.

Even though extraction constitutes a high treatment need, the project was unable to meet these demands. This is due to the lack of proper instrumentation for an invasive procedure and handling possible complications. However, to tackle this problem we advise and encourage patients to go to the nearest dental clinics which provide a much cheaper option for extractions.

It was reported by Benzian et al 2002 that the quality and performance of volunteers within this program were lacking with little accountability (Benzian & Gelbier, 2002). An audit for this program is welcome so that the room for improvements will not be overlooked. Where evidence-based clinical decisions are crucial, it is a luxury to strictly adhering the recommended BPOC guidelines from WHO.

Although we were able to distribute some oral hygiene kits, we are still reliant from the donation of the public to provide this basic need and materials for restorations. At large, we are still in the blue on how to generate income to become self-reliant.

It could be suggested that a team from the homeless and refugee community band up to generate income and thus helping not only in this program

but also beyond oral health care. It is a far-fetched dream but it is not impossible with the right planning.

CONCLUSION

In conclusion:

1. Distribution of patients attending both programmes are different in terms of age distribution but almost equal in gender distribution
2. The most common medical problems among patients are hypertension and diabetes mellitus. Communicable diseases were more common to be found among the homeless.
3. From both programmes, the need for restoration and extraction was the highest.

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