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The First Step Towards Reducing Oral Health Inequalities In Ethnic Minorities

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Abstract

Tower Hamlets has the largest Bangladeshi population in the UK, making up nearly 32% of the borough. Within the area, there are significant language and cultural barriers that hinder the effective delivery of preventative oral health care. A project comprising of visits to local day centres in the borough was devised to explore these barriers, as well as attitudes to oral health care and the chewing of betel-nut (a known carcinogen and risk to oral cancer).

The project identified many challenges that community members are facing, including social isolation, barriers in accessing dental care and deeply rooted cultural beliefs. The impact through a single project is limited, and as discussed in this article, a more extensive multidisciplinary approach is required. Building upon this work, there is scope for raising awareness of the importance of oral health care as well as providing basic support to those in communities who are otherwise not accessing any dental prevention.

Introduction

Tower Hamlets has the largest Bangladeshi population in the UK, making up 32% of the borough, alongside other ethnic minorities. 38% of residents are Muslim, which is the highest proportion in the UK (1). A total of 84 languages are spoken in Tower Hamlets, with the major languages being English, Sylheti and Bengali (1). As such, there are significant language and cultural barriers that hinder the effective delivery of preventative oral health advice.

A project comprising of visits to local day centres and mosques in the borough was devised to explore these barriers, as well as attitudes toward oral health care. One of the common practices in the Bangladeshi culture is the chewing of areca -nut and paan; both are known carcinogens, linked to oral cancer. Oral cancer is an umbrella term covering cancer that can develop on the tongue, inside of the cheeks, palate, lips or gums; it may also extend to the oropharynx or salivary glands. The treatment for oral cancer is often life-changing and carries a high morbidity. 5 year survival for oral cancer is dependent upon the specific cancer site, however the average is 60-65% (2).

Areca nut (also known as betel quid) is a seed of Areca catechu, a type of palm tree. It is commonly chewed after being ground up or sliced, and wrapped in leaves of the Piper betel vine (commonly called ‘Paan’), often coated in lime. Tobacco and spices may be added to this (3). Areca nut is classified as a carcinogen by the World Health Organisation. Areca nut is not considered safe for chewing or eating by the Food and Drug Administration, and has been placed on the Poisonous Plants Database (4). Areca nut is implication in oral submucous fibrosis,

and if used alongside tobacco can cause leukoplakia - both which are potentially malignant (5). The packaging of these products does not contain any information about the carcinogenic effects and the risk of oral cancer, by contrast with warning labels on tobacco products in line with the Tobacco Products Directive (from the WHO Framework Convention on Tobacco Control) (6). These products are also not subject to any other form of regulation in the UK (7). Areca nut is chewed for several reasons, these include: providing an energy boost, beliefs that it relieves ailments such as dry mouth, and a tradition of chewing it after meals.

Aims

1. Explore attitudes towards oral health and betel-nut/paan chewing.
2. Identify challenges and barriers in accessing dental care.
3. To gain an insight into the impact of oral health problems on service users within the day centres.

Methods:

A total of four workshops were undertaken in two day centres during April-August 2018, with volunteers comprised of dentists and dental students.

The first day care centre had majority Bangladeshi users, with over 90% of users speaking Bengali as their only language. Two of our volunteers were able to speak Bengali and assisted in translating. The centre has daily activities such as exercise, socialising and prayers. There are separate male and female lounges to be sensitive to religious and cultural norms. The centre reports to have approximately 40 users daily. Service users are picked up in the morning by transport and brought to the centre from four surrounding areas: Wapping, Shoreditch, Whitechapel and Shadwell.

The second centre is open to the elderly in the Somali community. The centre is used by males Monday to Thursday (up to 40 males per day), and for females on Friday (up to 20 females). A member of staff from the centre assisted in translating.

The workshops were run in an informal fashion; we begun with individual discussions, including exploring the patients background, access to dental care and any dental concerns. In the Bangladeshi community, further discussions involved gaining an insight towards their attitude towards paan and betel-nut chewing. Brushing demonstrations were given using a large toothbrush and model, both individually and as a group. A list of local NHS practices were given to those who were not registered.

Results:

When the harmful effects of paan and betel nut were discussed with the day care users, many were unable to consider or accept the health risks. Further discussion allowed the authors to gain an insight into why this may be the case. Many patients felt that the paan was improving their oral health and helped to keep their teeth clean and strong. One of the recurring themes whilst discussing the harmful effects of paan, is users reported that themselves and others in the community have been using paan for decades, yet they have not seen any negative effects such as oral cancer.

Others barriers included users relying on carers or children to arrange dental visits for them, and concerns that their children may be unable to take them. In most cases users were not able to communicate with the local dentist and were not sure where to seek oral health advice.

Whilst demonstrating the modified bass technique on the model, many users expressed a lack of interest as they rely on their carers to brush their teeth. In one of the centres, 80% of the male users relied upon their carers for brushing their teeth. A basic lack of understanding of the importance of dental care was evident through discussions. In one of the centres, 20% of the male users brushed without toothpaste. Dental concerns which users expressed included pain, wobbly teeth and having gaps; in all cases, these patients were not under the care of a dental practitioner.

Discussion

A study carried out in 1997 found that majority of Bangladeshi people in this area are exposed to carcinogens in betel nut, but are unaware of the risk (8). During our discussions, when users were made aware of the risk of betel nut, they were unable to accept this. Various reasons were presented by users as an opposition to the risk, which are mainly derived from anecdotal experiences. This could be overcome by inviting patients who have experienced oral cancer secondary to paan-chewing to share their experience first-hand; this could be carried out via workshops in community hubs or day care centres. The discussions with users taught the authors the deeply ingrained culture within Bangladeshi

elderly communities with regard to paan and betel nut chewing.

We have acknowledged that our interventions at this stage will have limited impact; a multi-disciplinary approach is required to make a holistic and long term improvement in the community. Many of the service users mentioned their medical complications and that they have regular contact with healthcare professionals through hospital and GP appointments. Medical professionals could aid in signposting patients and their family members to where to access dental care, and the importance of doing so.

As healthcare professionals we have very little contact with members of the community who do not present to our services, and in such cases we have not yet built the rapport that is necessary to influence deeply rooted cultural norms and beliefs which are harmful to health. Whilst we strive to develop this, we can utilise members of the community who are in a position of influence and have regular interaction, such as staff members at day care centres. By developing a working relationship with day care centres, we are able to work alongside those who have a greater understanding of the users individual circumstances and daily challenges. This would be invaluable in allowing us to gain a greater insight and in developing effective interventions.

A list of local NHS practices were given to users who were not registered, however there are users who are not registered due to their difficulty in finding a family member to take them to the dentist. Many of the users rely on their carers and family members for their oral health, from their daily oral hygiene regime, to arranging dental appointments. Therefore it is vital to ensure oral health care is incorporated into training which carers receive. This should be monitored at the initial stages to ensure that there is adequate oral care and access to dental services, including an interpreter being arranged for dental visits.

This project opened our eyes to the challenges that members of our community are facing, such as social isolation in the elderly community, barriers in accessing dental care and deeply rooted cultural beliefs. Although the impact through a single project is limited, and as discussed, a multidisciplinary approach is required, through this project there is scope for raising awareness of the importance of oral health care, and providing basic support to those in communities who are otherwise not accessing any dental prevention.

Conclusion:

This project has revealed the stark reality in our community; from misconceptions about oral health, to difficulties in accessing care. We encourage further initiatives to take place in communities with similar demographics, to obtain further research on the barriers to oral health, and interventions on how these can be overcome. Involvement of our colleagues in the medical profession would provide an insight into whether these barriers extend to general medical health and access to healthcare. Dental and medical students are encouraged to take part in such initiatives, to improve their communication skills and provide them with an insight into challenges faced within the local community.

A multidisplinary approach needs to be taken in order to provide holistic care to members of our community who are experiencing multiple barriers in accessing dental care. We are just at the tip of the iceberg; further exploration of barriers to oral health is necessary, through a root cause analysis and interventions developed accordingly. By doing so, we can aim to reduce health inequalities which are due to language and culture.

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