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LETTER TO THE EDITOR

Children's Oral Health in the Shadow of War: Priorities for Paediatric Dentistry in Conflict Settings

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Dear Editor,

Armed conflicts are reshaping the lives of millions of children worldwide. Yet oral health is still often treated as a secondary concern in humanitarian response and remains largely outside planning for essential health services. Prioritising immediate needs such as physical safety, nutrition and mental health is understandably necessary in humanitarian settings. However, evidence from conflict-affected regions suggests that oral health problems may represent an overlooked part of the wider health burden experienced by children [1]. At the same time, the available literature remains limited and is largely based on observational studies [2]. There is therefore a need for more systematic assessment of the oral health needs of conflict-affected children and for greater consideration of these needs in humanitarian planning. This letter focuses on how paediatric dentists and professional organisations can contribute to this effort and proposes practical steps for clinical care, data collection and service organisation.

Armed conflict can severely disrupt the systems that provide oral healthcare to children. Disruptions to health services, together with food insecurity, limited access to clean water and sanitation, psychological stress and forced displacement, may contribute to poorer oral health among children affected by conflict [1, 2]. Conflict-related disruptions may extend beyond clinical services, affecting the continuity of dental education and academic activities.

In Gaza, most dental clinics have become non-functional, while the territory's only two universities providing dental education have also been damaged. In addition, dozens of dentists and dental students, as well as academic staff, have lost their lives [1]. In Sudan, conflict has similarly disrupted dental education and academic and research activities and may have contributed to the departure of qualified academics and graduates from the country [3]. The impact of these losses may extend beyond immediate disruptions to care, limiting children's access to oral health services while also reducing the workforce capacity needed to sustain service provision in the post-conflict period [1–3].

For children displaced by conflict, reaching a safer setting does not necessarily mean gaining access to oral healthcare. Among Ukrainian refugee children, untreated oral disease and unmet treatment needs remain common [4, 5]. Access may be complicated by language difficulties [5], limited awareness of available dental services, and socioeconomic disadvantage [4]. The available evidence may also provide an incomplete picture of need, as it is drawn largely from clinics in urban areas and may therefore underrepresent children living in rural settings [4]. These findings support consideration of oral health within the wider healthcare needs of refugee children rather than as a separate concern.

Beyond these service and access barriers, conflict-affected children may experience a broader range of oral health problems. Psychological stress has been associated with gingival changes [6], while limited access to healthcare may hinder the timely management of traumatic dental injuries. In a study of conflict-affected schoolchildren in Damascus, a substantial proportion of traumatic dental injuries remained untreated [7].

Evidence regarding possible developmental and biological associations in conflict-affected children is more limited. Individual studies have reported higher lead levels in the deciduous teeth of children from heavily bombarded areas [8] and molar-incisor hypomineralisation among children whose enamel development coincided with periods of conflict [9]. However, these findings are based on small or exploratory observational studies and do

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not establish causality. They should therefore be regarded as preliminary evidence of possible associations that require further investigation.

Taken together, these service disruptions, access barriers, clinical concerns and evidence gaps point to three practical priorities for the paediatric oral health community.

First, integrate oral health into emergency and refugee healthcare. In resource-constrained settings, initial efforts could prioritise pain relief, disease control and prevention, using low-resource interventions where feasible and clinically appropriate. Options may include preventive and minimally invasive approaches, such as fluoride varnish, silver diamine fluoride and atraumatic restorative treatment, alongside the provision of oral hygiene supplies and, where infrastructure permits, teledentistry. In countries hosting refugees, incorporating a basic oral health assessment into initial health evaluations and establishing referral pathways for children requiring further care could help connect emergency support with continuing care. Providing families with clear, culturally and linguistically appropriate information on available dental services and preventive measures may further support access to and continuity of oral care.

Second, adapt clinical care for children affected by conflict. Routine aspects of dental care, including reclining in the dental chair, bright operating lights, unfamiliar sounds, and the use of instruments, may be distressing for children who have experienced violence or displacement. Without requiring children to recount traumatic experiences, care can be made more predictable and child-centred through simple adaptations. These may include explaining each step before proceeding, allowing sufficient time for familiarisation with the dental environment, beginning with less invasive procedures where appropriate, and offering children simple choices and an agreed way to pause treatment. Access to professional interpretation, where available, may facilitate communication, while continuity with the same dental team, where feasible, may help build trust. Clear referral pathways to appropriate mental health services should also be established for children requiring additional psychological support.

Third, strengthen the role of professional organisations. National and international dental organisations can advocate for the inclusion of oral health within emergency and refugee health services and support the development of freely accessible, multilingual, trauma-informed guidance. They may also help maintain educational continuity for dental students and academic institutions affected by conflict by facilitating access to educational and scientific resources, training opportunities and essential equipment. In parallel, promoting a core dataset for conflict-affected children—including oral health and treatment needs, access to care and dental trauma—could improve comparability across settings and strengthen the evidence base for future service planning.

The paediatric dentistry community has an important role in ensuring that children's oral health needs are appropriately considered in humanitarian planning and in identifying practical ways to address them. Although the limitations of the current evidence should be recognised, consideration of oral health within humanitarian preparedness and response may help address children's immediate needs while also creating opportunities to generate stronger evidence to guide future care.

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