



# CDA BULLETIN

The Newsletter of the Commonwealth Dental Association  
CDA is supported by The Commonwealth Foundation

## EDITORIAL

Professor Martin Hobdell, Editor

This issue contains articles that celebrate the successes of CDA on its tenth anniversary and present some of the challenges that are ahead.

The President pays tribute to the founding 'movers and shakers' of the Association, but at the same time points out the need to broaden the leadership with the inclusion of younger colleagues in the Association's work. But there are other challenges: the article by Dr Bebermeyer, which provides up-to-date information on the diagnosis and oral health care of HIV infected people, places squarely before us the single most serious problem that faces many dentists and other oral health workers in the Commonwealth. As professionals we have no choice but to accept the challenges of this disease. It is not just the clinical challenge but the emotional and moral ones as well. Clinically, we are challenged to become oral physicians in order to manage the opportunistic infections that occur. Emotionally we are challenged because most dental workers are neither trained nor accustomed to dealing with terminally ill patients. And morally we are challenged because HIV infection is a sexually transmitted disease, with the taboos that attach to such illnesses. Added to this HIV affects more people of low socio-economic status than others. As Dr Bebermeyer points out, for example, 70% of the 36 million people who are living with HIV infection today are to be found in sub-Saharan Africa where the greatest number of the world's Least Developed Nations are also found. For those who see economic success and health determined solely by individual effort and determination it is all too easy to forget the impact of poverty on education, social structures and choice in personal behaviour. Those with HIV infection are

often perceived as moral degenerates unwilling to make sufficient efforts to improve themselves and prevent infection. The result all too often is that the victims get blamed for misfortunes that they could do little to avoid. The moral challenge that CDA is seeking to meet, is to reach out to even the poorest communities and find ways to provide relief from such suffering.

## MESSAGE FROM THE CDA PRESIDENT

Dr Brian Mouatt CBE

### Now we are ten

Most children can't wait to grow up; sadly some never get the chance.



Most adults look back on their formative years and remember the ambitions and innocence with a nostalgic sense of what might have been. The CDA is still in formative stages – ten years is not long in the life of a professional body, as we saw when we celebrated the centenary of the FDI last year. Nevertheless we are well out of our infancy and experiencing a bit of a growth spurt. There is a new feeling of achievement in CDA as some of the initiatives we have worked upon come to maturity. The CDA computer project has delivered computers to 20 or more countries. We are working now on a second phase. The London Cariogenicity Conference, our first real piece of scientific work, has just been published as an important peer-reviewed paper in the British Dental Journal. Our new collaboration with Jo Frencken and his colleagues at Nijmegen University has made available the excellent CD-ROM on ART. It

includes a protocol on how to run an ART course – cascade learning in its true form; our workshop in Kuala Lumpur will be on HIV/AIDS as part of the global initiative on this subject. Our international work continues and CDA is a respected player in the world of dental politics at WHO, FDI and with the Commonwealth Health Ministers. This came home with the welcome success of the Commonwealth Oral Health Statement. What lessons can we learn from our early years to enhance our future role? As so often happens in life, progress is made through the dedication and ideas of few. Among those who initiated the CDA three names stand out, Sonny Akpabio OBE, Norman Whitehouse, the then Chief Executive of the BDA, and Dr Ratnanesan, now famously the incoming President of FDI. I pay tribute to their vision and innovation. Perhaps one lesson to consider is that we should not now depend so much on these few outstanding individuals to move things on. The work of CDA needs to be spread to the many talented and younger colleagues who abound and whose enthusiasm will be necessary to carry us forward through the years.

There are welcome signs that this is happening with more rapid electronic communications throughout the Commonwealth. We have had a welcome surge in the number of Friends of CDA both individual and corporate. The Foundation has rewarded our increased activity with improved funding arrangements. All this surely is progress of which we can be proud for a moment or two on our tenth birthday. Yet we have fuller and more useful times calling us. When we contemplate the plight of our disadvantaged colleagues and the magnitude of the task, it might be easy to become discouraged; but that's not our style. If we achieved so much in ten years, how much more in a hundred? Some of us never grow up!

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## CDA MATTERS

*CDA Friends* - We are pleased to welcome the CDA Friends who have recently joined - both individual and corporate members. New members are always welcome; if you wish to join please contact:

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*CDA Annual Subscriptions* - We would like to thank the NDAs who have paid their CDA subscriptions for 2001 so promptly. It would be appreciated if any unpaid invoices for CDA subscriptions could be dealt with by the respective NDAs as soon as possible.

*CDA Website* - The website has a Guest Book so that anyone accessing it can leave a message and make comments for CDA. It also enables anyone to air their views on CDA-related matters likely to be of general interest for others to respond to views so expressed. It is hoped that this facility might be more used than it is at present. It is intended that this Bulletin will be available for viewing and downloading from the website in Adobe Acrobat format.

## CONGRATULATIONS

Our congratulations to Sudeshni Naidoo who has recently been appointed Professor in the Department of Community Dentistry at Stellenbosch University, South Africa.

## ACKNOWLEDGEMENTS

Editor: Professor Martin Hobdell  
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Designed by: Julia Campion  
Printed by: Hammond Vivian Ltd

## MESSAGES FROM CDA PAST-PRESIDENTS

**Dato' Dr A Ratnanesan**  
*CDA President 1994-1997*

Dear colleagues  
A decade has passed swiftly since the official inauguration of the Commonwealth Dental Association by the Honourable Prime Minister of Malaysia Datuk Seri Dr. Mahathir Mohamad at the Putra World Trade Centre, Kuala Lumpur on 24<sup>th</sup> April 1991. The Malaysian Dental Association was indeed privileged to host the event. Ten years hence, the CDA has stamped its rightful place on the mantle amongst its peers in organised dentistry. The CDA must continue to assert itself for the improved provision of oral health care in disadvantaged communities in the Commonwealth and be a respected advocate for Oral Health in international fora.

Once again Kuala Lumpur is privileged to play host - this time to the ultimate dental extravaganza, the FDI World Dental Congress 2001. The Local Organising Committee would like to invite all our colleagues from the CDA to support this mammoth event. It would be most appropriate and timely for CDA to take stock, reassess and chart its future direction for the next decade in Kuala Lumpur, where it was formally inaugurated. The auspicious beginning of the new millennium beckons innovation and constructive efforts.

The CDA must work in close cooperation with the FDI to address the inequities in Oral Health regionally and globally and participate in the establishment of high ethical and professional standards for the dental fraternity worldwide. All efforts must be synergistic to ensure maximum results for the objectives at hand. The challenges of dentistry and oral health care are daunting. Effective strategies must be adopted to meet our commitments to the community and profession. Close collaboration between our allied organisations is imperative.

Even as I have moved on, my feelings and sense of belonging remain with the CDA. I earnestly look forward to enhancing the already close cooperation and fraternal ties between the FDI and CDA during my term as FDI President (2001-2003).

In the mean time, let us all have a reunion in Kuala Lumpur at the FDI World Dental Congress 2001. It promises to be exciting and will rekindle memories.

**Dr Victor Eastmond**  
*CDA President 1997-2000*

It was an honour to be present at the conception of the Commonwealth Dental Association (CDA) in London in 1990 and at its birth in Malaysia in 1991. All inaugural members are aware of the immense work during the gestation period that conceived this Association whose aim was to improve Dental Health for the people of the Commonwealth who represent a third of the world's population.

I am also honoured to be the Immediate Past-President of this prestigious organisation which promotes equity in a shrinking world where globalisation and information technology demands that essential services should no longer be limited.

It is through the efforts of CDA that the FDI has acknowledged the need to assist developing countries in this changing environment. CDA's current President, Dr Brian Mouatt CBE now chairs this FDI section. We must congratulate Brian on this position and at the same time congratulate the Incoming President of FDI, Dato Ratanesan, who is a Past-President of CDA.

Our Association has grown in enormous proportion with resultant improvements in Oral Health and to have achieved this in ten years of maturity, makes an indelible statement of management. Praise must be showered on the unselfish leadership of the Executive members and to the British, Malaysian, Trinidadian and Indian Dental Associations that hosted the CDA's Triennial Meetings. Such dedication needs to be rewarded.

Congratulations to CDA on its tenth birthday and to all Member-Associations which have participated in providing an improvement in Dental Health through collaborative efforts with the Commonwealth Foundation, WHO/PAHO, FDI, and Friends of CDA. I look forward to Dental Associations of all Commonwealth countries being members of CDA and providing the unity to lobby assistance in providing essential dental health for those most in need.

## MOVING FORWARD THROUGH COLLABORATION AND COOPERATION

### Report on CARDA Meeting Nassau, 20-23 June 2001

*Dr Brian Mouatt OBE*

#### Introduction

I was kindly invited to attend the 11<sup>th</sup> Biennial Conference of the Caribbean Atlantic Regional Dental Association (CARDA) in my capacity as President of the Commonwealth Dental Association (CDA).



*Dr Brian Mouatt & Professor Jacob Kaimenyi*  
CARDA was formed in 1977 with assistance from The Commonwealth Foundation, Pan American Health Organisation (PAHO), the CARICOM secretariat and the Commonwealth Caribbean countries. The member countries are: Anguila, Antigua and Barbuda, Bahamas, Barbados, Belize, Bermuda, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St Kitts & Nevis, the Grenadines, Trinidad & Tobago, Turks & Caicos Islands.

The objectives of CARDA are:

- ◆ To promote the art & science of dentistry among its members
- ◆ To cooperate with, inform, advise and assist all Governments in the area with regard to health care, dental education, dental standards and all matters pertaining to the dental profession
- ◆ To represent the views of the member associations at all related regional and international conferences

There were many opportunities to explain the role of CDA to delegates during the course of the 4-day meeting. The warm hospitality extended to other opportunities including;

- ◆ A meeting with Dr Ronald Knowles, Minister of Health (Bahamas) where CDA activity was discussed in relation to educational initiatives CPD and risk management
- ◆ A courtesy meeting at Government House with the Governor General, Sir Orville Turnquest
- ◆ At the invitation of the CARDA Executive Committee, an opportunity to address the CARDA AGM to expand on the virtues of CDA.

There were useful meetings too with Dr Richard van West-Charles of PAHO/WHO, Dr Munir Rashad, consultant oral surgeon, Dr Victor Eastmond (CDA's immediate past President) and Dr Joyous Pickstock, the current President of CARDA.

#### The Conference

The meeting had as its headline title 'Moving Forward Through Collaboration & Cooperation'

The conference opened with a keynote address from Dr Anthony Lewis, Chief Dental Officer of Jamaica, after which the Minister of Health spoke of his aspirations for health services in the Bahamas. As CDA President, I then followed with a resume of the work of CDA. Other speakers include Dr Edward Scott of the National Dental Association of the USA and Dr Joyous Pickstock our own Regional Vice-President and the hardworking and ever-cheerful organiser of the whole event. The proceedings were considerably enlivened by the enthusiastic efforts of the Royal Bahamas Police Force Band.



*Delegates at the CARDA Conference*

The education programme included sessions on:

- ◆ Health Reform and Oral Health Implications - *Dr R van West-Charles*
- ◆ The situation of the West-Indies School of Dentistry - *Professor Robin Matthew*
- ◆ Review of National Oral Health Status & Experience in Bahamas, Barbados, Jamaica, Grenada, Turks & Caicos, Cayman Islands, Trinidad
- ◆ The undesirable consequences of periodontal disease - *Professor B Thuraia*
- ◆ Open session on CARDA funding
- ◆ Indications for third molar surgery – recent advances - *Dr M Rashad*
- ◆ The well-motivated dental team - *Miss Anita Jupp*
- ◆ Risk management in practice – *Dr Brian Mouatt*
- ◆ Back to basics in dental radiography - *Dr Victor Eastmond*
- ◆ Systemic illness as related to dental disease - *Dr S G Gross*
- ◆ Open session on the role of the Auxiliary in 2001 and Beyond

- ◆ Utilisation technology for practical development - *Miss Anita Jupp*
  - ◆ Oral manifestations of HIV/AIDS - *Professor J Kaimenyi*
  - ◆ Telescopic copings - *Dr Lindl Brooks*
- Altogether a stimulating mix of continuing professional development and updating education. Dr Joyous Pickstock and her team are to be heartily congratulated. All in all this was a vibrant, instructive, well organised and intensive event involving the many differing countries of the Caribbean Region which gave ample opportunity to maintain the positive profile of CDA in the area.

## HIV/AIDS AND ORAL HEALTH

*Richard D. Bebermeyer*  
*Univ. of Texas Health Science Center at Houston, Dental Branch*

In the early 1980's, the disease known as the Acquired Immunodeficiency Syndrome (AIDS) was identified. UN AIDS estimates, as of December 2000, that more than 36 million people worldwide were infected with the Human Immunodeficiency Virus (HIV); more than 95% in developing countries. The epidemic continues to spread globally, with 5.3 million new infections in 2000. Mortality continues to increase with 3 million deaths resulting from HIV/AIDS in 2000. HIV/AIDS is the leading cause of death in sub-Saharan Africa where 70% of all persons living with HIV/AIDS are found. Many persons die within several years of the first signs of AIDS; however, with recent discoveries of new drugs, some patients can live with this chronic illness. Educational approaches to alter behavior patterns are essential to controlling the spread of HIV. With current knowledge and with emerging research and treatment there is cause for hope in preventing new infections and in treating those with HIV/AIDS. There are practically no known incidents of transmission of the HIV in the dental setting. This is because we know that taking "universal precautions" prevents transmission of disease. This means that we treat all blood and body fluids of each patient as if they are potentially infectious. To prevent transmission, it is recommended that the caregiver use disposable gloves whenever possible. Certainly, scrubbing the hands with soap and water reduces transmission. A mask and protective eyewear can also serve as barriers to transmission. Disposable supplies and instruments prevent transmission. When instruments are not disposable, sterilization is essen-

tial. About 90% of persons with HIV will develop at least one oral manifestation at some time during the course of the infection. It is necessary to be able to identify and manage the oral manifestation, and common HIV-related conditions. This can affect the overall health of the patient. This article is a summary of the identification and management of the common oral conditions associated with HIV. Suggestions for ways of treating these conditions are outlined in the accompanying chart.

#### Common HIV-Related Infections

**Candidiasis or 'Thrush':** Candidiasis is a very common oral and esophageal infection in persons with HIV, and is often one of the first indicators of HIV/AIDS. This lesion is probably the most overlooked oral disease seen in those with HIV/AIDS. The patient's chief complaint is of burning in the mouth, usually associated with eating salty or spicy foods. As outlined in the chart, candida can appear as pseudo-membranous, erythematous, hyperplastic and/or as angular cheilitis. Topical treatment is often effective, but persistent candidiasis in HIV persons usually requires systemic drug therapy. The treatment usually lasts for at least two weeks. It is important to understand that just because the candida is no longer visible, the infection may still be present. Therefore, treatment should always be completed to help prevent recurrence. **Advanced periodontal disease:** HIV associated gum disease is often rapidly progressive and unusually painful. The most likely cause is a change in the normal oral bacteria, along with a decrease in the function of the immune system. This infection can progress to a painful, ulcerative type of gum and bone disease, which may be generalised or more local. The more severe gum and bone infection may progress to a condition called *cancrem oris (noma)*—a serious and life-threatening infection. **Persistent herpes simplex or herpes zoster infection:** This appears as blisters on the lips and adjacent skin; it ulcerates and then crusts over. In the mouth, lesions are seen as clusters of small vesicles or blisters on the roof of the mouth or the gums, becoming ulcerated with a yellow membrane covering. These lesions can be very painful, can interfere with normal functions such as eating, and can be spread to other membranes (such as the eyes or the genitals). **Oral Kaposi's Sarcoma:** The most common malignancy seen in HIV disease is Kaposi's Sarcoma (a serious cancer) that oc-

curs in about 15-20 percent of AIDS patients. It can occur on the skin; however, more than half the patients have oral lesions. Other oral symptoms can include *oral hairy leukoplakia, papillomavirus lesions, recurrent aphthous ulcers, and xerostomia.*

#### Adapting Dental Treatment for Persons Living with HIV/AIDS

In general, there is no need to modify dental treatment based solely on a patient's HIV status. A patient with HIV benefits from use of an antibacterial mouth rinse, such as chlorhexidine gluconate, prior to any treatment, to reduce the potential for infections from intraoral bacteria. When dental treatment is indicated, decisions regarding the appropriateness of ongoing and long-term dental care of patients with HIV infection should take into account the patient's general medical status, and should not be based solely on HIV status. The immunocompetent, asymptomatic HIV-infected individual usually does not require any special consideration when planning, and in the provision of, dental treatment. However, as the infection advances to AIDS, laboratory tests evaluating the progression of HIV disease may become important in determining an appropriate treatment plan. Patients with CD4+lymphocyte counts above 200cells/mm<sup>3</sup> ideally have their immunologic status assessed at least every 6 months by their physician, while those patients with CD4+lymphocyte counts below 200 cells/mm<sup>3</sup> usually have appropriate tests at least every three month (where possible). It is important to consider general trends in CD4+lymphocyte counts and other laboratory values, rather than any single value, as counts may vary considerably even on a daily basis. The recommendations should only be used as general guidelines. Each patient should be evaluated on a case-by-case basis. When there is a requirement for urgent dental care, a degree of flexibility may be necessary with the critical values.

**Restorative & Prosthetic Dental Care:** There are generally no special restorative or prosthetic treatment considerations for the immunocompetent HIV-infected individual. However, as the disease advances and AIDS develops, treatment decisions may be influenced by the patient's ability to attend and/or tolerate dental visits and by the patients changing medical/mental status.

**Surgical Care:** Surgical procedures should be done in a manner to mini-

mize invasion of bacteria from the mouth into the deeper planes and spaces. Persons with AIDS may become thrombocytopenic (less than 150,000 platelets/mm<sup>3</sup>). Dental procedures, including extractions, can usually be safely performed in patients with platelet counts above 60,000 platelets/mm<sup>3</sup> and prothrombin time of no more than twice the normal value. For patients with possibility of increased bleeding tendencies, oral surgical procedures should be approached conservatively (i.e., tooth by tooth approach), assessing control of bleeding after a single extraction before proceeding. No significant impaired oral healing has been documented even in HIV-infected patients with severe immune suppression.

**Preventive oral health care:** It is important to reduce potential oral complications by maintaining good oral hygiene. Decreased salivary flow increases the incidence of caries. The importance of meticulous oral hygiene should be emphasized for the HIV-infected patient, establishing oral health as early as possible after HIV diagnosis. Suggested therapies include:

- 1) *Prophylaxis of the teeth every six months. This should be done every three months in those with oral lesions, or more serious immune compromise.*
- 2) *Use daily antimicrobial mouth rinses for those with periodontal disease.*
- 3) *Use fluoride supplements, particularly for those with xerostomia or increased dental decay.*

**Antibiotic Coverage and the HIV-Infected Patient:** For the HIV-infected patient, there are no data supporting routine antibiotic coverage to prevent bacteremia or septicemia arising from dental procedures. Antibiotic coverage, prior to procedures likely to cause bleeding and bacteremia, is however recommended for the immunocompromised HIV-infected patient when the neutrophil count drops below 500 cells/mm<sup>3</sup> (neutropenia). When antibiotic coverage is indicated, regimens similar to those for the prevention of bacterial endocarditis are considered effective. Signs and symptoms of postoperative infections may be different from those in healthy patients. Inflammation may be reduced, and there may be no purulence.

#### Conclusion

Every dentist is probably now treating persons living with HIV/AIDS - knowingly, or not. With a change in attitudes and additional knowledge, each dentist can treat patients more safely and thoroughly.

TREATMENT GUIDELINES FOR COMMON HIV-RELATED ORAL INFECTIONS		
Diseases	Management	Comments
<p><b>Aphthous Ulcers</b>  <b>Appearance:</b>            Single or multiple, obvious ulcers with a whitish covering surrounded by a reddish ring.            Usually limited to the soft palate, the cheeks, tongue and tonsil area.            Extremely painful.            Often recurs.</p>	<p>The aims of treatment are to control the pain and reduce the length of time for which the person has the ulcer(s). Treatment depends on the severity of ulcers.</p> <ul style="list-style-type: none"> <li>▪ 0.5% <i>gentian violet</i> aqueous solution painted on the ulcers may be useful.</li> <li>▪ 0.2% <i>chlorhexidine gluconate</i> mouth rinse 2-4 times daily.</li> </ul> <p>For severe ulcerations with swollen lymph glands: 500 mg <i>amoxycillin</i> 3 times a day for 7 days.</p>	<p>Note: <i>chlorhexidine</i> and <i>nystatin</i> should NOT be used at the same time.            Antibiotics may be required for severe infections.            Ulcers can be associated with the use of some HIV antiviral drugs.            For any oral ulcers, a coating agent such as <i>kaopectate</i> could be beneficial. A liquid preparation of <i>Benadryl</i> can be mixed with the coating agent to provide relief from pain</p>
<p><b>Oral Candidiasis (Thrush)</b>  <b>Appearance:</b>  <i>Pseudomembranous:</i> Creamy white or yellow patches located anywhere in the mouth, that can be easily wiped off, leaving a reddish surface.  <i>Erythematous:</i> Multiple flat red patches on surfaces like the roof palate, top surface of tongue and cheeks.  <i>Angular Cheilitis:</i> Cracks or linear ulcers at the corners of mouth. Typically the lesions are on both sides.  <i>Hyperplastic</i></p>	<ul style="list-style-type: none"> <li>▪ 0.5% <i>gentian violet</i> aqueous solution painted in mouth 3 times daily.</li> <li>▪ 0.2% <i>chlorhexidine gluconate</i> mouth rinse 2-4 times a day is useful.</li> <li>▪ a <i>clotrimazole</i> vaginal suppository, broken in half, dissolved slowly in the mouth without swallowing, 2 times a day for 7-14 days depending how bad the infection is. Men and women tolerate the taste of the suppository.</li> </ul> <p>In severe cases or if the above treatment fails: <i>fluconazole</i> 50-100mg oral once a day for at least 7 days.</p>	<p>Different types may occur simultaneously. Involvement of the throat makes swallowing painful. Treat promptly.            Note: <i>chlorhexidine</i> and <i>nystatin</i> should NOT be used at the same time.            Remove dentures when using the antifungal medicine.            Minimize local contributory factors like continuous denture wear, poor denture hygiene and smoking.</p>
<p><b>Advanced Periodontal Disease</b>  <b>Appearance:</b>            Rapid loss and destruction of one or more areas of periodontium between the teeth. The teeth may become loose.            Bleeding, ulcerated and necrotic periodontium.            Severe pain &amp; bad breath.</p>	<p>Good mouth cleaning is necessary; tooth brushing, scaling and local cleaning should be done.            Gargle with saltwater mouthwash (a teaspoon of salt in a cup of lukewarm water) for 1 minute 2 times a day.</p> <ul style="list-style-type: none"> <li>▪ 0.5% <i>gentian violet</i> aqueous solution painted in the mouth 3 times a day until healed.</li> <li>▪ 0.2% <i>chlorhexidine gluconate</i> mouth rinse 2-4 times a day.</li> <li>▪ <i>amoxycillin</i> 500mg oral 3 times a day for 7 days.</li> <li>▪ <i>metronidazole</i> 400mg oral two times a day for 7 days.</li> </ul> <p>Recall patient every 4 weeks until they are better.</p>	<p>Repeat antibiotic treatment if the infection is not better after 7 days.            Mobile teeth may need to be extracted.            Infected bone should be removed when the person is taking the antibiotics.            Smoking exacerbates gum disease.</p>
<p><b>Herpes Simplex</b>  <b>Appearance:</b>            Small blisters on the gingiva, palate and/or lips.            The blisters soon rupture to become painful irregular ulcers. A yellow crust may form around the ulcers on the lips.</p>	<p>Gargle with saltwater mouthwash (a tsp. of salt in cup of lukewarm water) for 1 minute 2 times a day.</p> <ul style="list-style-type: none"> <li>▪ 0.5% <i>gentian Violet</i> aqueous solution painted in mouth 3 times a day.</li> <li>▪ <i>acyclovir</i> 400-800 mg oral 3 times a day for 5-10 days</li> <li>▪ <i>amoxycillin</i> 500mg 3 times a day for 7 days.</li> </ul> <p><i>bacitracin</i> cream spread thinly on infected skin around the lips 2-5 times a day for 5 days.</p>	<p>Antiviral therapy is useful if administered early. Viruses may occasionally become resistant to the drugs.            Refer the person if the condition is severe and/or the patient is dehydrated.            Give a fluid diet, as this is less painful and will help stop the patient becoming dehydrated. Avoid acidic foods and drinks.</p>
<p><b>Kaposi's Sarcoma</b>  <b>Appearance:</b>            One or more reddish or slightly bluish swellings with or without ulcerations. Seen most frequently on the gums and palate.</p>	<p>If necessary, refer the person to a physician for a definitive diagnosis (e.g. biopsy) and treatment.            Small lesions confined to the mouth may be treated with intralesional injections of 0.2 mg/cc of <i>vinblastin sulfate</i>, or with surgical excision.</p>	<p>Some types of treatment may cause inflammation of the mucosa of the mouth and a dry mouth (<i>xerostomia</i>).            Good oral hygiene, plaque control &amp; antibiotics to prevent secondary infection.</p>

**Acknowledgements:** This table is based on a more comprehensive poster provided by Professor Sudeshni Naidoo, Department of Community Dentistry, Faculty of Health Sciences, University of Stellenbosch; Private Bag X1, Tygerberg, 7505, South Africa.

**Useful Web-Based References:** [www.hivdent.org](http://www.hivdent.org) [www.aegis.com](http://www.aegis.com) [www.UNAIDS.org](http://www.UNAIDS.org) [www.immunet.org](http://www.immunet.org)  
[www.ama-assn.org/special/hiv/treatment/updates/oral.htm](http://www.ama-assn.org/special/hiv/treatment/updates/oral.htm) [www.WHO.int/HIV\\_AIDS/](http://www.WHO.int/HIV_AIDS/)

**THE COMMONWEALTH DENTAL ASSOCIATION (CDA) - THE FIRST TEN YEARS**  
*Dr S Prince Akpabio OBE - CDA Founder President 1991-1994*

The vivid memory of the formal Inauguration Ceremony of the Commonwealth Dental Association in Kuala Lumpur 10 years ago is still crystal clear in my memory today. It is difficult to accept that 10 years have already elapsed since that historic Commonwealth event.



*1990 Oral Health Initiative, London, UK*

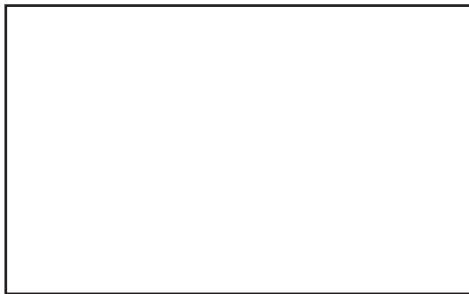
The Commonwealth Dental Association (CDA) was formed in London on 15 May 1990, following the unanimous decision of dental representatives of 23 Commonwealth countries of the 6 Regions of the Commonwealth, who met in London on 14 & 15 May 1990, to discuss the increasing dental and oral health problems facing the Commonwealth developing countries, and what to do about it. The Commonwealth Foundation (under Mr Inoke Faletau, its Director) funded the meeting, which was also supported by the Commonwealth Secretariat (under HE Chief Emeka Anyaoku). The British Dental Association (BDA) and the Commonwealth Medical Association (CMA) did much to facilitate the meeting.

Following this historic decision, the conference appointed a Steering Committee to be chaired by Dr Sonny Akpabio OBE, assisted by Professor Norman Whitehouse, Professor Abdul Adatia and Dr George Gillespie, as members, to work towards the formal launching of the CDA. Through dedicated hard work the plans and details were completed within a year. That very impressive Ceremony took place at the Putra World Trade Centre, Kuala Lumpur, Malaysia, on 25 April 1991, through the most generous support of the Malaysian Dental Association headed by Dato Dr Ratnesan (its President) and Dr Mahathir Mohamed (the Prime Minister of Malaysia) who performed the Inauguration Ceremony.

Looking back nostalgically now, as CDA's first and Founder President, I

ask myself "What has the CDA done and achieved within the first 10 years of its existence to justify the very high hopes with which the Commonwealth welcomed its formation 10 years ago?"

My mind goes back to those poignant words of the Prime Minister, Dr Mahathir Mohamad, when in his address to the packed international audience gathered at CDA's Inauguration Ceremony, before he solemnly struck the gong twice, in accordance with Malaysia's custom and tradition, to launch the CDA, he said the following words with deep feeling and obvious emotion:



*1991 1st CDA Executive Meeting  
Kuala Lumpur, Malaysia*

.....With the improvement in the living standards of people, the demand for better dental health-care will also increase. As knowledge in Health and Dentistry is ever changing, the role of the CDA is particularly significant in the area of Continuing Education..... The CDA can provide the right forum for the exchange of information and experience amongst member countries. The purpose of the coming together of the National Dental Associations of the Commonwealth must be clearly defined, documented, and actively pursued. The formation of the CDA

should bring benefit not only to the more advanced countries with greater influence, but equally so to the smaller nations striving to achieve a better standard of oral health. The more than one billion population within the Commonwealth must ultimately derive some benefit in the formation of the CDA, otherwise this whole effort would not be worthwhile."

Dr Mahathir Mohamad's words have lived with me ever since the CDA was inaugurated and have influenced and guided my thoughts about CDA's work, my visions, and my innermost views about what the CDA should do in order to serve the deprived and ill-served sections of our human community who so desperately need our services to improve their Oral Health.

To this end, I am pleased and proud to record that the CDA, through its successive Presidents and Executives, has undertaken and achieved the following significant objectives since its birth - only 10 years ago:

- ◆ The CDA has produced an exciting *CDA News* now renamed, with this edition, the *CDA Bulletin*, which not only provides an essential forum for news and communication about its work and other Commonwealth health matters, but prints abstracts from other important international health journals to provide *Continuing Education* to our Commonwealth colleagues and other readers in more distant, often isolated, Commonwealth countries.



*1993 Oral Health Workshop, Nairobi, Kenya  
'Improving Oral Health in the African Region'*

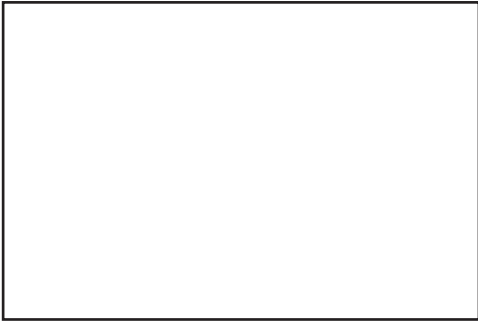
◆ The CDA, through hard work, secured the important *Commonwealth Observer Status* in May 1994. This has enabled the CDA to receive essential papers and published documents on health issues within the Commonwealth and also to attend, as an Observer, most of the meetings of the Commonwealth Health Ministers, including the Triennial Meetings where very important priority health issues of the Commonwealth are discussed.

This status gives important professional recognition to the CDA and its work, and enables the CDA to work and relate closely with WHO, FDI, PAHO, IADR and other Regional and International Health Organisations.

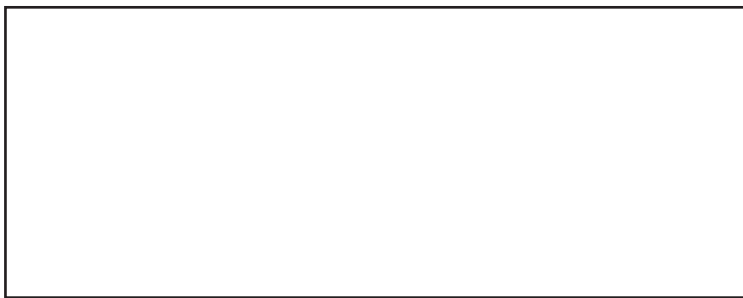
(Sri Lanka), *Noma* (Nigeria), *HIV/AIDS*, and Commonwealth countries particularly affected by these Oral Health Diseases.

(h) *Appropriate Training and Usage of Auxiliary Oral Health Personnel*.

(i) The recent *Commonwealth Oral Health Statement*, initiated by the CDA and unanimously approved and adopted by the Commonwealth Health Ministers at their Pre-WHA Meeting on 15 May 2001, provides the CDA with an important mechanism and a tool to further its work in Commonwealth countries for improving Oral Health.



1996 CDA Oral Health Workshop  
Cape Town, South Africa  
*'Promoting Equity in Oral Health - Striving towards a Public Private Partnership in South Africa'*



1994 Workshop, New Delhi, India  
*'Oral Health Policy Guidelines in Commonwealth Countries'*

◆ Relevant and carefully planned workshops are important in any health organisation, be it national, regional or international. Since its formation, the CDA has produced and widely distributed Reports and Proceedings on the following Workshops which it has held:

(a) *Improving Oral Health in the African Region* (Kenya 1993).

(b) *HIV/AIDS - The Prevention of Cross Infection* (Nigeria 1992 and Trinidad 1994).

(c) *Oral Health Policy Guidelines in Commonwealth Countries* (India 1994).

(d) *The ART Technique - to deal with Dental Caries - Prevention and Control* (Zimbabwe 2000).

(e) *Electronic Communication - Email, Computers in Dentistry* (UK 2000).

(f) *Cariogenicity Workshop* (UK 1999).

(g) Preliminary and on-going discussions with the FDI, WHO and National Dental Associations on *Oral Cancer*

Working closely and effectively with such major International Health Organisations as WHO, FDI, PAHO, IADR and Commonwealth and non-Commonwealth National Dental Associations, the CDA has certainly grown from strength to strength.

However, we should like to see our younger colleagues, throughout the Commonwealth, join with us to become involved with CDA's work and be prepared and ready to play their roles in the vibrant Commonwealth and International Health Organisations of the new 21<sup>st</sup> Century. I am convinced that, in time, they will respond.

I wish the CDA even greater achievements for the future, be it for the Commonwealth and/or internationally.



1997 CDA 2nd Triennial Meeting  
Bournemouth, UK  
*'Fluoride - Its Benefits and Dilemmas in Dental Public Health'*  
Dr S Prince Akpabio & Professor John Murray

**CDA Mission Statement**

*The Commonwealth Dental Association is committed to the promotion of Oral Health in the Commonwealth and, in particular, in the underserved and underdeveloped communities, in co-operation with the National Dental Associations and the respective Commonwealth Governments.*

## PRE-WHA MEETING

Dr S Prince Akpabio OBE

The *Pre-WHA Meeting* of Commonwealth Health Ministers is the annual one-day meeting which now takes place in Geneva, usually on the 2nd Sunday in May, the day before the annual *World Health Assembly* (WHA), organised by the World Health Organization (WHO/HQ), commences. Invitations to attend and participate in the Pre-WHA Meetings



(left to right) Dr Brian Mouatt, Dr Gro Harlem Brundtland, Dr S Prince Akpabio

are issued by the Director & Head of the Health Department (Human Resource Development Division) of the Commonwealth Secretariat in London. The Secretariat's Health Department is responsible for the entire administrative arrangements and organisation of this one-day meeting in Geneva, and the publication of the subsequent report. They are on site, in Geneva, with several support staff on the day of the meeting. The first Pre-WHA Meeting took place in Geneva in May 1968.

In addition to the Honourable Commonwealth Health Ministers and their accompanying Advisers, other delegates attending are accredited representatives of international and commonwealth health organisations such as the World Health Organization and the Directors from the various WHO Regional Offices (AFRO, AMRO, EMRO, EURO, SEARO, WPRO) and the CARICOM delegates (Health Sector Development Section).

Observers include accredited officials representing: *CHOGM Committee on Cooperation through Sport*; *British Council*; *Caribbean Health Research Council*; *Commonwealth Association for Mental Handicap & Development Disabilities (CAMHADD)*; *Commonwealth Association of Paediatric Gastroenterology & Nutrition (CAPGAN)*; *Commonwealth Dental Association (CDA)*; *Commonwealth Health Foundation*; *Commonwealth Health Research Inter-Regional Consultation Group*; *Commonwealth Medical Association (CMA)*; *Commonwealth Nurses Federation*; *Global Initia-*

*tive for Traditional Systems of Health*; *International Obesity Task Force*; *Pan-American Health Organisation (PAHO)*; *International Planned Parenthood Federation*; *Sighsavers International*; *UNAIDS (WHO Geneva)*; *United Nations Children's Fund (UNICEF)*; *United Nations International Institute on Ageing (Malta)*; *United Nations Population Fund (UNFPA)*; *Commonwealth Pharmaceutical Association (CPA)*; *Association of Commonwealth Universities (ACU)*. I am reliably informed that the average number of participants at each Pre-WHA Meeting is 250-275.

### Format of current Pre-WHA Meetings

Usually, the agenda for the one-day Pre-WHA Meetings in Geneva is agreed upon by the Commonwealth Health Ministers at the previous meeting, assisted by the Secretariat's Health Department. However, a short business meeting, attended by a small number of invited participants, takes place on the Saturday afternoon to discuss certain Commonwealth health matters. On the Sunday morning there is an intensive flurry of activities at the registration desk as some of the Hon Ministers of Health and other delegates might only just have arrived from various distant Commonwealth countries. Nevertheless, the warm *Commonwealth Family* feeling of reunion shows through strongly as Commonwealth colleagues and friends meet each other once again, and are ready for the day's intensive work ahead. The meeting is called to order and the *Election of Chairperson* signals the start of serious, intensive discussions and exchanges of views on *Commonwealth Health Issues*. The Commonwealth, with its unique diversity of nationalities, cultures and cultural habits and lifestyles, affluence and poverty, diversities in health and living standards, and available appropriately trained health professionals, and the financial means to address serious, with very limited resources, often present our Commonwealth Health Ministers with serious problems to discuss and try to find effective solutions. The coming together at the Pre-WHA meetings in Geneva and at the 3-yearly CHMM Triennial Commonwealth Health Ministers' Meetings provide opportunities for important health issues to be discussed seriously but informally, and hopefully tackled, sharing professional expertise and experience. At current Pre-WHA Meetings the basic format of the agenda can be broken down as follows:

- ◆ *Priority Health Issues in the Commonwealth, and the Secretariat's response.*
- ◆ *Review of activities of the Technical Support Group and the TSG's future.*
- ◆ *HIV/AIDS - which has now been declared a Commonwealth Emergency, since the 1999 CHOGM Meeting in Durban, by the Commonwealth Heads of Government.*
- ◆ *Exchange of views on WHA Agenda Items, and the Commonwealth response.*
- ◆ *Preparations for any forthcoming CHMM Meetings.*
- ◆ *Other important Commonwealth health issues.*

### The 3-yearly Triennial Meeting of Commonwealth Health Ministers

The CHMM meeting works in close collaboration with the annual meetings of Commonwealth Health Ministers. It takes place every 3 years, in different Commonwealth countries, at the invitation of the Commonwealth host government which is fully responsible for the organisation, administrative arrangements, and for hosting the meeting. The host government works close with HE The Commonwealth Secretary-General who is responsible for issuing the invitations to delegates. This important Commonwealth Triennial Health Meeting, originally called the Commonwealth Medical Conference usually lasts for about 5 days; the dates, venues and issues discussed are recorded in the archives of the Secretariat's Health Department as follows:

**Commonwealth Medical Conference:** 1965 Edinburgh (organised by British Government); 1968 Uganda (first to be organised by Commonwealth Secretariat, 1st Medical Adviser, Health Bureau appointed 1.10.69, recommended by Sierra Leone); 1971 Mauritius; 1974 Sri Lanka; 1977 New Zealand *Community Health*; 1977 name changed to **Commonwealth Health Ministers Meeting:** 1980 Tanzania *Health & the Family*; 1983 Canada *Health Planning & Management*; 1986 Bahamas *Financing Health Care*; 1989 Australia *Community Approaches to Health Promotion & Disease Prevention*; 1992 Cyprus *Environment & Health*; 1995 South Africa *Women & Health*; 1998 Barbados *Health Sector Reform in the interest of Health For All*; 2001 New Zealand *Priority Setting in the Health Sector*.

### WHO (HQ) Geneva and the Commonwealth Health Ministers - An Emerging Closer Collaboration

Although the Commonwealth Health Ministers and the World Health Organization have collaborated and worked together on health issues for so many years in the past, it was only

when Dr Gro Harlem Brundtland took over as WHO Director-General in 1998 from Dr Hiroshi Nakajima that it became so obvious and abundantly clear that a much closer working together between WHO's DG (with the world's community health problems to deal with) and the health problems of 54 Commonwealth countries (with a quarter billion of the world's population to address by the Commonwealth Health Ministers) had much to share and gain through informal frank dialogue - at the Pre-WHA Meetings, before the formal dialogue at the following WHA roundtable and committee workshops. The Secretariat's health Department and the Commonwealth Dental Association worked hard to facilitate such an informal coming together each year for the WHO D-G to address the Commonwealth Health Ministers on WHA agenda items and take questions. Notwithstanding the enormous international pressures on her very precious time the day before the World Health Assembly, the Pre-WHA Meeting of Commonwealth Health Ministers feels very greatly honoured that Dr Gro Harlem Brundtland creates the time to address the meeting and take questions on international health issues, despite the pressure on her time prior to the Opening Ceremony of the annual World Health Assembly the following day. Dr Brundtland's attendance and informal address at the Pre-WHA Meeting is now an event greatly looked forward to.



*Dr Gro Harlem Brundtland addressing the Pre-WHA Meeting  
16 May 1999*

### **CDA's Reception for Commonwealth Health Ministers**

The Commonwealth Dental Association (CDA) is very greatly privileged to be given the opportunity each year, by the Secretariat's Health Department, to hold a Reception for the Commonwealth Health Ministers and other participants. This very generous hospitality has been made possible by ILSI (Brussels) which appreciates CDA's work to improve Oral Health in the Commonwealth and, like The Commonwealth Foundation in London, has done much to support the CDA. This annual CDA Reception has enabled the Commonwealth Health Ministers, and other commonwealth and international delegates, to talk informally with each other, meet friends and colleagues and to share thoughts and views on some of the important Commonwealth health issues. The CDA looks forward to being given the opportunity to continue to provide this important Commonwealth service, and I am particularly pleased to have been very actively involved in it.

### **13 May 2001**

At the 34<sup>th</sup> Pre-WHA Commonwealth Health Ministers Meeting, in Geneva, on Sunday 13 May 2001 *The Commonwealth Oral Health Statement*, initiated by the Commonwealth Dental Association (CDA) at its 3rd Triennial Meeting in New Delhi, India (28 January - 1 February 2000), was unanimously approved and adopted by the Commonwealth Health Ministers.

## **The Commonwealth Oral Health Statement**

*Approved and Adopted, unanimously, by the  
Commonwealth Health Ministers  
at the 34<sup>th</sup> Pre-WHA Meeting of Commonwealth Health Ministers  
Geneva, Switzerland - 13 May 2001*

Biology is not the sole determinant of health status. There may be social, economic, environmental, and other factors of importance. Oral Health, an integral part of general health, is subject to these same determinants.

Growing disparities between rich and poor countries and different population groups within the same nation are significant characteristics of economic globalisation in the late 20<sup>th</sup> and early 21<sup>st</sup> Century. These differences are reflected in the growing disparities in oral health between the rich and poor throughout the world.

Besides dental caries and periodontal diseases, increasing physical violence, maxillo-facial injuries and cranio-facial anomalies, there are several life threatening conditions which affect both the mouth and Oral Health, and are of major public health concern. These include Oro-pharyngeal Cancer, HIV/AIDS and the oral manifestations of HIV infection, Hepatitis B and C, Tuberculosis and Noma (Cancrum Oris). Their prevalence is increasing, and in some areas of the world has already reached epidemic proportions. All are associated with multiple risk factors and have a high mortality and morbidity rate. Poverty, lifestyle, public ignorance, and lack of proper information are important determinants of these conditions.

Commonwealth Health Ministers:

- ◆ Recognise the increased responsibility that this upward trend in disease burden places on all members of the oral health care team, e.g the Commonwealth Dental Association (CDA) and the National Dental Association in each Commonwealth country, to be ever vigilant in the prevention, early detection, management and care of those at risk.

- ◆ Request the collaboration, support of governments, international bodies (e.g WHO, FDI, CDA, PAHO) and other agencies to:

- (1) Develop partnerships with the dental profession to devise population strategies to prevent and control these conditions;

- (2) Develop health promotion activities and educational programmes that will create healthier environments and increase:

- *public awareness of hazardous lifestyles;*

- *people's access to health education;*

- *the early detection of oral diseases through regular screening and self-examination;*

- *access to simple effective treatment for these and other important oral conditions.*

- ◆ Encourage National Dental Associations to continue their efforts to:

- (1) Improve continuing education for the oral health care team through regional collaboration and increased use of new information technologies;

- (2) Work with their governments to improve access to oral health care for the disadvantaged and deprived communities;

- (3) Assist their members in reducing disparities in oral health throughout the Commonwealth.

## ADOPT-A-DENTIST

Mr Robin Wild

The CDA has launched the Adopt-a-Dentist scheme - an initiative to establish one-to-one relationships between colleagues in the more developed countries and those in the developing countries.

Dentists throughout the Commonwealth are invited to join this scheme through the CDA central register. The idea is that by joining the scheme, participating dentists will have the opportunity to exchange views, send surplus professional journals, books, materials and even equipment to their named contact in the other country. In this way, dentists in the more developed Commonwealth can offer support and assistance by very practical means to their colleagues who are working in less favourable clinical conditions at very little cost to themselves.

Opportunities also exist for other forms of professional cooperation such as sponsorship of continuing professional development and clinical work in other countries.

Dentists volunteer to join the scheme by contacting the central register and they may express a preference for the country in which they would like to make their professional link. Then the register sends each dentist in the prospective link the name and address of the other. The register would subsequently like to have evidence that the link has been made.

It is expected that those involved in successful links will find the experience mutually rewarding.

So far the scheme has been well supported particularly by African and UK colleagues with a few from other regions. CDA Vice-Presidents will be spreading news of the scheme and soon it will be an important feature amongst the many worthwhile initiatives of the CDA.

If you would like to join please contact:  
*Julia Champion, CDA Administrator*  
 Email: [JuliaChampion@cs.com](mailto:JuliaChampion@cs.com)  
 Fax: +44 20 7681 2758

## FACING AFRICA - NOMA

Mr Robin Wild

At a meeting in London in July, we heard about a new initiative to try to help children who have survived Noma. Allan Thom told the meeting about how he and Chris Lawrence had considered how they could assist the terrible plight of children suffering this hideous affliction. Together, they conceived and registered the charity '*Facing Africa - Noma*'.

After great consideration, they decided that the most effective way to help would be to put together occasional expeditions to a chosen location in Africa and to operate as often as volunteers could be found and as often as could be financially viable.

They then met with Dr Klaas Marck, founder and President of Nederlandse Noma Stichting (NNS), a charity set up in 1996 which sends teams of volunteer surgeons, anaesthetists and nurses to Sokoto in northern Nigeria. It was agreed that '*Facing Africa*' would work initially under the guidance of, and in cooperation with, NNS and participate in medical campaigns to Sokoto.

The Noma Children Hospital in Sokoto has 60 beds and a small fulltime staff. Joint efforts by German and Dutch medical teams has increased visits to four per year and, with the additional participation of French and British specialists, it is hoped to increase the visits further - to six per year initially.

Each visiting team spends two weeks in Sokoto Hospital and is generally able to perform 50-70 operations, mainly on children suffering the horrible and ongoing consequences of Noma as well as some reconstructive operations which are mostly on cleft lip and palate and on burns. The cost of sending each team is around £30,000, most of which is to cover the costs of travel and medical supplies.

'*Facing Africa*' hopes for donations to help to pay these costs and to help pay for the essential medical supplies that are needed all the time at Sokoto. There is also a target to raise funds for the construction of a rehabilitation and recovery wing at Sokoto at an estimated cost of £50,000.

Contributions may be sent to '*Facing Africa - Noma*', Seend Park, Seend, Wiltshire SN12 6NZ, UK

## REPORT FROM THE KENYA DENTAL ASSOCIATION

Professor Jacob Kaimenyi

Bravo, Commonwealth Dental Association for empowering dentists worldwide.

Since my humble days in 1994 as the CDA Regional Vice-President, representing East, Central & Southern Africa on the Executive Committee of the Commonwealth Dental Association, I must admit that the Association has grown from strength to strength since its formation in 1991. Its two principal objectives are: *working towards improving oral health and the prevention of oral diseases*, in the Commonwealth countries. This is demonstrated in the manner that the CDA has organised its activities in various parts of the Commonwealth in an attempt to fulfil these objectives.

For example, CDA has held several workshops on various issues such as: *Promotion of Oral Health in the African Region, Oral Health Policy Guidelines for Commonwealth Countries, Promotion of Equity in Oral Health, Fluoride - Its Benefits and Dilemmas in Dental Public Health*. CDA has also organised scientific meetings where other issues such as the *Prevention of Cross-Infection in Dental Practice* have been discussed. The published Proceedings of such meetings should do well in helping to educate oral health personnel on how to prevent the spread of HIV/AIDS, especially in Africa where the pandemic has been declared a national disaster in some of the countries such as Kenya.

It was in 1998 that CDA played a significant role in the deliberations on the implementation of the African Regional Oral Health Strategy, organised by WHO/AFRO (30.3-15.4.98). Armed with this type of information and that based on CDA workshops, dentists in the Commonwealth, especially those who have no access to dental journals and the latest textbooks have now been empowered to confidently improve oral health and prevent oral diseases in their respective countries.

## NEWS FROM THE REGIONS

### Report from the East, Central & Southern African Region

*Dr Pashane Mtolo*

Zambia has been implementing Health Reforms since 1994. The major focus was decentralisation of power (shifting decision making from the centre to the lower levels), strengthening accountability, building leadership and, indeed, developing partnerships. All these were aimed at achieving the Zambia Health Vision 'providing Zambians with equity of access to cost-effective quality health-care as close to the family as possible'. In all these efforts Oral Health has been fully involved as an active participant.

We have greatly improved awareness of oral health to over 75% of the population, mainly through school oral health and community programmes. However, slightly over 80% of the population is still affected by oral health problems, and mainly dental caries (untreated cavities). Our immediate priority is to strengthen ART. We are focusing on plaque control of the 6-year molars and try to attend to the unmet restorative needs coupled with oral health education. Although ART was unknowingly being practised, we have now officially put it as a national priority.

We are working with *Teethsavers International* through Dr Jack Rudd from Texas who is already in this country. So far we have trained 18 district dental therapists, 2 from each province, 15 dental therapists from Lusaka district and dental therapist tutors from the Dental Training School. Each of them will be followed to monitor implementation of the ART technique. We are using Fuji 9 glass ionomer. The aim is to train all the dental therapists (140) who are located throughout Zambia (9 provinces and 72 districts) and then train all willing dentists. ART has also been included in the curriculum for training dental therapists.

Considering that the status of dental equipment is very bad, 10% is functional while 90% needs repair, use of ART will provide dental therapists an opportunity to practice restorative dentistry as opposed to the over 90% exodontia they have been doing. Generally, access to restorative care will improve. Initially, we shall face problems of procuring Fuji 9 since we do

not have a dental company in Zambia. For sustainability of supply, we are encouraging each district to include ART in their annual plans.

The impact of ART may take long to be felt, but we are motivated by the fact that most of the population who, all along, only had oralhealth education will now access restorative care 'with a human face'.

\* \* \* \* \*

### Report from the West African Region

*Dr Francis Poku*

This report is based on the activities of the National Dental Association of Ghana which meets once a month at the new dental school lecture theatre. Every other month is devoted to continuing dental education.

*Continuing Dental Education:* The programmes range from lectures on oral dental hygiene to surgical procedures in dentistry. These lectures have been very useful to most of the dental surgeons as it brings them in focus with new trends in dentistry.

*Outreach Programmes:* The Association, in conjunction with Lever Brothers (Gh) Ltd, has continued to undertake outreach programmes by visiting deprived homes like Help The Aged, Orphanages and Mentally Retarded establishments to perform screening and treatment as well as educate the inmates on dental hygiene. The programme of training teachers and community health nurses on dental health education is still on-going.

*Conference:* The Annual Dental Congress took place 28-30 June 2001. The Guest of Honour was the new Minister of Health, Hon Dr Richard Asare. The Guest Speaker was the President of the Ghana Medical Association, Professor A B Akosa. The theme of the Congress was 'Oral Health Care in Ghana - Issues and Challenges'. A new dental magazine was launched by Dr M George, WHO representative in Ghana.

*Dental Week:* This year's Dental Week was organised in the northern part of Ghana. The theme of the week was 'Oral Hygiene - Improving Traditional Methods of Cleaning the Teeth'. Logistics were supplied by the Ministry of Health and Lever Brothers. This took place 23-27 July 2001. A team of about 20 dental surgeons and dental assistants participated in the exercise.

*Health Insurance Scheme:* The new Government is planning to introduce a National Health Insurance Scheme within the next one year. It is hoped that this would encourage attendance at clinics and hospitals and thus help to improve dental awareness and education in the country.

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### Report from the Caribbean Region

*Dr Joyous Pickstock*

The National Dental Associations within the Caribbean Region have been very active over the past months. Most recently, members of the Caribbean Atlantic Regional Dental Association which represents, 18 English-speaking countries in the Region, convened its 11<sup>th</sup> Biennial Session in Nassau, Bahamas (20-23 June 2001). The Conference was a very successful one, and brought together partners in oral health with an emphasis on achieving oral health goals through collaboration and co-ordination. It brought together stakeholders from the Government, dental schools, National Dental Associations, dental trade and manufacturing organisations and dental allied health professionals. We were pleased to have the President of CDA, Dr Brian Mouatt, who in addition to being a full participant in all the deliberations, addressed the delegates in the opening session. (*Page 3 carries a report on the conference*). New officers elected at the Annual General Meeting include: Dr Lindel Brookes (President) a native of Anguilla and Doreen James (Executive Secretary/Treasurer) a dental nurse from Anguilla.

Among the resolutions made at the conference, Ms Anita Jupp, renowned Practice Management expert, agreed to sponsor and host a CARDA website for the next two years. Delegates were elated about this partnership for it will mean accessing information about the organisation on a continual basis. In addition, another resolution was made by Dr Kenneth Judy of ICOI to sponsor the next CARDA conference on Montego Bay, Jamaica, in 2003.

In addition to the CARDA conference held this year, member countries including Jamaica, Barbados and Trinidad and Tobago have all held annual local conferences for the benefit of educating their members and the public at large, these conferences are often well attended by the local oral health personnel.

