



# CDA BULLETIN

The Newsletter of the Commonwealth Dental Association

CDA is supported by the Commonwealth Foundation

## EDITORIAL

*Professor Martin Hobdell, Editor*

In this issue of the CDA Bulletin there seems to be more news than usual about new developments in dentistry - welcoming the Canadian Dental Association to the CDA family; the appointment of Dr Poul Erik Petersen to the Oral Health Desk at WHO in Geneva and the newly formatted FDI World Dental Development Committee, chaired by our President. The excitement of these developments is tempered, however, by the news that Dr Per Ake Zillen has taken early retirement from his post as Executive Director of the FDI on account of ill health. We wish him well in his retirement in Sweden.

Notwithstanding the importance of these organisational developments, the concerns of the CDA are primarily of oral health in the Commonwealth. Because of the importance of the HIV pandemic in Commonwealth countries we continue to report on its impact globally and in different parts of the Commonwealth in particular. Dr Akpabio summarises recent WHO statistics and Dr Ranganathan reports of the situation in India (pp 6-7). But statistics are one thing, caring for those infected with the virus is another and probably the area of most concern. In this issue Dr Bebermeyer concludes his two-part series on the care and management of those living with HIV/AIDS. In any discussion about HIV/AIDS Sub-Saharan Africa is never far from mind. In mid-April Dr Thorpe, Regional Adviser for Oral Health WHOAFRO, has organised the first ever meeting for the Deans of the African dental schools in Cape Town. The Dental Faculty of the University of the Western Cape is hosting the meeting. HIV/AIDS is certain to feature prominently in their discussions. We will carry a report in our next issue.

## MESSAGE FROM THE CDA PRESIDENT

*Dr Brian Mouatt CBE  
BDS Edin, MGDS RCS Eng, FFGDP RCS(UK)*

It struck me the other day that I am now more than halfway through my Presidential term although the time has simply flown by.



*(left to right) Dr Pashane Mtolu,  
Dr Ben Chirwa, Dr Brian Mouatt*

This must be a good point at which to take stock. There is, I believe, plenty to be proud of, but the high ambition of the early days has been tempered by reality and pragmatism. It has been more difficult than I realised to shake off the old image of CDA being a travel club with accounts of our work reading like a Court Circular. This was and is, of course, a completely false image and the importance and depth of our work is well recognised by international dentistry throughout the global health scene.

This has been endorsed in a splendid way by the decision of the Canadian Dental Association to join us. Canada is a major contributor to health development, as I mention below, and to have our Canadian colleagues on board is excellent news. We send them the warmest of welcomes.

I am pleased to say our Individual and Corporate Friends have increased in number significantly thanks to some hard work by our Administrator, Julia Campion. Our focus on Information

Technology and Distance Learning has been especially rewarding and is something we shall continue to press forward. Most recently there has been the distribution of the CD-ROMs on ART, which has been made possible by the generous help of Jo Frencken. These have gone to all our National Dental Associations and to the WHO/AFRO Group of Oral Health Institutes. We shall be following this well received initiative with a similar distribution of an interesting CD ROM on Noma entitled *Facing Africa* when it is available. A video on 'Right First Time in Radiography - A Simple Process', generously donated by the Faculty of General Dental Practitioners of the Royal College of Surgeons of England, has also been distributed to our National Dental Associations. Similarly, dental books and journals, which have been donated, have been sent to the Dental Schools in Nigeria and also to the Inter-Country Centre for Oral Health (ICOH) in Jos, Nigeria.

The computer distribution programme completed its second phase and has been very popular. I am trying now to negotiate a continuation but we may have to wait for a few months. The CDA has enrolled as a corporate partner in the Commonwealth of Learning's Virtual Conference Series and will be participating in this ground breaking initiative over the spring and summer months. The theme is Distance Learning and Information Technology for developing countries and we hope to learn a lot. Individuals can join in too. Information is available from: [info@col.org](mailto:info@col.org) or at [www.col.org/virtual](http://www.col.org/virtual) conferences. There are no costs involved. The Commonwealth of learning is based in Vancouver, Canada and is like a virtual university created by Commonwealth Heads of Government to encourage the development and shar-

*(continued overleaf)*

ing of open learning and distance education knowledge, resources and technologies. The more we use it the more we will get out of it - like so many things in life.

As to the future we are already planning for the 4<sup>th</sup> Triennial Conference which will be held in Manchester UK in April 2003 - at present your Executive is trying to secure the funding to allow as many delegates as possible to attend. Our work with WHO continues and we will try to build a new more productive relationship with WHO and Dr Petersen, the new adviser at the Oral Health desk at WHO HQ in Geneva. Our continued support for ART projects remains a high priority and it is gratifying to see others taking up the promotion of this technique which we have supported strongly over the past two years or so.

On a personal role some of you may know that I have been asked to take on the Chairmanship of the FDI's World Dental Development Committee of which there is more detail in this issue of the CDA Bulletin. The work of FDI in this area and that of CDA will allow useful and symbiotic collaboration.

I send my warm personal greetings to every one of our CDA supporters with the pledge that the work will go on to the best of my ability for the remainder of my term. With your support and encouragement together we will succeed.

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**Please Note!**  
 The emails you write to [JuliaCampion@aol.com](mailto:JuliaCampion@aol.com) will still reach the intended recipients (Julia Campion, CDA Administrator and Dr S Prince Akpabio, CDA Executive Secretary) even though the messages you receive from them will come from [JuliaCampion@aol.com](mailto:JuliaCampion@aol.com)

**CDA 4<sup>th</sup> TRIENNIAL MEETING**

The CDA's 4<sup>th</sup> Triennial Meeting '*Balancing Information Technology with Appropriate Technology*' will be held in Manchester UK 23-26 April 2003 in collaboration with the British Dental Association's Annual Conference. If you are interested in receiving further information about this exciting event please complete the form below, or submit your details on a separate sheet, and send it to the CDA Administrator.

Please complete and return to:  
 Julia Campion, CDA Administrator  
 13 Rodney House, Pembridge Crescent  
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**I would like to receive information about the CDA 4<sup>th</sup> Triennial Meeting.**

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## HONOURS IN DENTISTRY

Congratulations to Michael Watson (former Editor, BDA News), currently BDA Special Adviser, who was awarded the OBE, in Her Majesty The Queen's New Years Honours, for his services to the Dental Profession. The Commonwealth Dental Association is very grateful to Michael for the continued support which he has given to them over the years.

Other Honours awarded were:  
*Professor Sir Graeme Catto*  
 President  
 General Medical Council (Aberdeen)

*Steven Clements MBE*  
 General Dental Practitioner

*Professor Sir Liam Donaldson*  
 Chief Medical Officer for England

*Manjul Vasant MBE*  
 General Dental Practitioner

## ORAL HEALTH DESK WHO GENEVA

Dr Poul Erik Petersen took over as Responsible Officer, Oral Health at the World Health Organization's headquarters in Geneva on 3 April 2002.



Prior to this Dr Petersen was Professor in Community Dentistry at the University of Copenhagen. He has an academic background encompassing dentistry, public health and sociology, combined with broad international experience. Dr Petersen has worked in community oral health research, enhancement of public health in universities worldwide, health systems development as well as in planning and implementation of community health projects in an exten-

sive number of industrialised countries, countries with economies in transition and in developing countries.

Dr Petersen has worked in the WHO Regional Office for Europe as a consultant for several years, as a Director for the WHO Collaborating Centre for Community Oral Health Programmes and Research, and worked closely with numerous WHO Collaborating Centres in the field of oral health. He has assisted ministries of health, health authorities and health care planners throughout the world.

In addition to Denmark, Dr Petersen has studied in the USA and the U.K. He was elected Dean of the School of Dentistry at the University of Copenhagen, and is also Vice-Director of the School of Public Health at the University of Copenhagen. He has an extensive list of scientific publications within epidemiology, health sociology, health systems research, disease prevention and health promotion, and international health.

Within WHO Headquarters the Oral Health Programme has recently moved to the Department of Noncommunicable Disease Prevention and Health Promotion, this emphasizes the links between oral health and general chronic disease prevention. Within the department, oral health will link with several of its activities, such as integrated NCD prevention networks, health promotion, nutrition, school health and healthy ageing.

The CDA Bulletin reaches Chief Dental Officers, Dentists, Dental Auxiliaries, Dental Schools, and others, worldwide but, in particular, in the 55 Commonwealth countries.

If you would like to advertise in the CDA Bulletin and would like to receive our advertising rates, please contact Julia Campion, the CDA Administrator at:

JuliaCampion@cs.com

## PROFESSOR WYNAND DREYER

Professor Wynand Dreyer retired as Dean of the Faculty of Dentistry of Stellenbosch University near Cape Town in South Africa, after more than 15 years in the position (1985-2000). He now holds a full-time contract post as Manager of Professional Development at the Faculty of Health Sciences of this University.



He started his career after graduating at the University of the Witwatersrand with the BDS in 1962. After some 10 years in general practice in Johannesburg, during which time he completed the HDipDent (Periodontology) at the University of Witwatersrand and held an appointment as part-time visiting member of staff, he moved to Stellenbosch University to become the first Head of Oral Medicine and Periodontics at the then new Faculty of Dentistry. He was admitted to the Chair of Oral Medicine and Periodontics in 1975 and was awarded the PhD (Odont)(Stell) in 1978.

Prof Dreyer contributed to his profession and the University of Stellenbosch in a multitude of ways. He was a member of:

- ◆ *Exco of the Senate of the University 1985-2000.*
- ◆ *Several Senate and University Committees and task groups.*
- ◆ *SA Medical and Dental Council (1990-1999) and chairperson of its Specialist Committee (Dental). Board of the Medical Research Council of South Africa (1990-1998).*
- ◆ *Deputy chairperson of the Board (1995-1998) and chairperson of*

the MRC's Finance and Audit Committee.

◆ Associate Founder member of the SA Colleges of Medicine and member of the Faculty Committee, Faculty of Dentistry of the College (1977-2002).

◆ Member of the Federal Council of the Dental Association of South Africa (1975-1996).

◆ National President of the DASA (1990-1993).

◆ Founder member, SA Society for Periodontology and President (1970-71; 1980-81).

◆ Member/officer of a number of other professional/scientific organizations.

Professor Dreyer is the recipient of a number of medals/distinctions, inter alia:

◆ Middleton Shaw Fellowship of DASA (1976).

◆ Distinguished membership of the SA Society for Periodontology (1987).

◆ RV Bird Gold Medal of DASA for distinguished service (1996).

He has some 75 scientific and professional publications to his credit and has presented more than 130 papers at national and international meetings during his career.

### Post Script

Dato Dr A Ratnanesan (currently FDI President and President of the Malaysian Dental Association) and Dr S Prince Akpabio OBE (CDA Founder President and currently CDA Executive Secretary) are pleased to add, and place on record, that Professor Wynand Dreyer, when he was the Dean of the Faculty of Dentistry at Stellenbosch University, gave them very considerable help and support during their frequent duty visits to South Africa on behalf of the Commonwealth Dental Association (CDA), in their efforts to help to bring about the unity of the various, and different, sections of the South African Dental Associations then in existence as one cohesive *South African Dental Association*, which now exists.

Credit must also be given to Dr Seymour Chertkov, and to the Hon Dr Nkosazana Dlamini Zuma who was then the Minister of Health of South Africa, who also gave considerable help, support and encouragement to Dr Prince Akpabio and Dato Dr Ratnanesan during this period towards achieving this very important objective of the unity of the South African Dental Association as one Professional Organisation representing *Dentistry* in South Africa, which has now been achieved by South Africa.

## STRENGTHENING COLLABORATION

*Dr Pashane Mtolo  
CDA Regional Vice-President  
(East, Central & Southern Africa)*

There is a general shortage of manpower resource in the Sub-Saharan region, especially that of dentists. Countries like Zambia, which have no dental schools to train dentists are worst hit. With a population of 10.2 million, Zambia has 40 dentists only. One of the solutions is to strengthen collaboration within the regions, so as to make the few dental schools accessible to other neighbouring countries. There is need to harmonise entry qualification to these dental schools.

Progress is being made in these collaboration efforts. For instance, Zimbabwe University Dental School has extended its hands of friendship to Zambia and offers two places annually. The university is also accessible to other SADC countries. Although not adequate, the offer will go a long way in improving capacity building for Zambia. Plans are at an advanced stage to open a Department of Dentistry at the School of Medicine, University of Zambia, most likely in 2003.

Some postgraduate courses are being offered by universities in South Africa (Dental Public Health and others) and at Nairobi University, Kenya (Dental Public Health).

Although the fees seem to be on the high side, they are much lower compared to those requested by overseas universities.

The Kenya Dental Association held a very successful Dental Health Action Month (6 October to 10 November 2001), including participants from India and the United Kingdom. A Masters Degree Programme in Oral and Maxillofacial Surgery has been launched by the Faculty of Dental Sciences, University of Nairobi.

There is great need to strengthen collaboration in order to build and improve our human resource. If we cannot do it, nobody will do it for us!

## A NEW NAME - NEW HOPE WORLD DENTAL DEVELOPMENT

*Dr Brian Mouatt  
President CDA, Chairman FDI WDDC*

The FDI has a new home in Ferney-Voltaire near Geneva but that is not all that has changed. The FDI's long held ambition to promote the benefits of oral health to all populations took an important step forward with the re-focusing of its energies in a new Committee, World Dental Development (WDDC).

In its new work WDDC will be guided by the aspirations of FDI and placed as its premier priority the FDI Mission Statement: '*To promote optimal oral and general health for all peoples*'. This illustrates the new focus of the work which clearly embraces the needs of the developing countries but does not exclude deprived communities in other populations, developed or otherwise.

It is, of course, the intention to work with and through the National Dental Association members of FDI and to promote their interests whenever and wherever possible. As part of the functional arm of

FDI, WDDC will follow the general goals of the parent body to be the authoritative professional independent worldwide voice of dentistry. Clearly bringing to bear on areas of need the collective talents of the FDI community has enormous potential for good. In promoting the art, science and practice of dentistry with particular regard to deprived populations WDDC aims to be the pragmatic deliverer of real help.

As a first step WDDC intends to bring together and strengthen the way the disparate dental aid agencies work. The focus of such work should be to give appropriate emphasis to the integration of oral health into primary health care. Linked with this is the aim of introducing effective oral health promotion to deprived communities by facilitating the exchange of information and by example. The work must also recognise the social responsibility, which rests on the profession to recognise and reduce inequalities in oral health whenever they are found. Leading by example will be an important aspect of the way these sometimes seemingly insurmountable problems are tackled. An integral part of the role of WDDC will therefore be the provision of guidance on oral health development projects and the use of 'demonstrator projects' to promulgate those systems and approaches which have in practical terms, been shown to have worked.

As a new entity in the FDI hierarchy WDDC will be reviewing closely its internal and external working relationships, open always to interaction and dialogue with NDAs, governments, the dental aid organisations, international and intergovernmental organisations such as WHO, industry, foundations and the media – all need to know of our work and work with us.

In the months ahead it is our earnest intention that the whole programme of WDDC will be seen as relevant, resourceful, proactive

and productive. It is a tall order, but nothing is impossible, miracles just take longer.

There is a rather sad sequel to this story. Very unexpectedly and unfortunately Dr Per Ake Zillen, the FDI Director, has decided to retire due to ill health. All those who know him will be extremely sorry that events have turned out this way. He has been a tower of strength to FDI as an innovator, a realist, a master of executive governance and a particular champion of the developing countries. We wish Per Ake and Eva a very happy retirement on their return to Sweden. We will all miss him.

*Just a reminder FDI's new address is:*  
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13 Chemin du Levant  
L'Avant Centre  
F 01210 Ferney-Voltaire  
France  
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## WELCOME TO CANADA

*Dr Brian Mouatt, CDA President*

It is with the greatest pleasure that we warmly welcome Canada as a full member of CDA. Canada has a fine tradition of working with developing countries, especially in the Caribbean. Vancouver is also the home of the Commonwealth of Learning with whom we are now cooperating. Our thanks go to Dr George Sweetnam, President of the Canadian Dental Association, and to George Weber, its dynamic Executive Director, who is also involved in the FDI's World Dental Development Committee. With this new bolstering of our ranks our mandate on the international scene grows ever more formidable. We look forward to a proactive and productive relationship with our Canadian colleagues.

Letter from George Weber to Brian Mouatt, CDA President:

"Dear Brian

**Re: Membership with the Commonwealth Dental Association**

*Further to my letter dated 20 February 2002, on behalf of the Canadian Dental Association, I am pleased to convey our decision that was taken last week by our Executive Council to re-join the Commonwealth Dental Association.*



*Dr George Sweetnam  
(President, Canadian Dental Association)*

*Through your impressive work and influence within the Commonwealth Secretariat's Health Department in London as well as with fellow Commonwealth national dental associations, the WHO/HQ in Geneva, and FDI World Dental Federation, we feel that your association has much to offer by way of increasing communication globally and through the exchange of knowledge and experiences within the international dental community.*



*George Weber (Executive Director,  
Canadian Dental Association)*

*Kindly forward all relevant application material to Katharine Acs-Charter, Coordinator, for processing.*

*We look forward to renewing our relationship with the Commonwealth Dental Association over the coming months.*

*Sincerely yours  
George Weber"*

**THE 'ART' APPROACH  
BROUGHT TO THE  
ANCIENT CITY OF ILE-IFE  
OSUN STATE, NIGERIA**

Dr A O Oginni  
Department of Restorative Dentistry  
Obafemi Awolowo University, Ile-Ife, Nigeria

Following the successful ART workshop organised for the Afro Region in Abuja, Nigeria, Dr Steffen Mickenautsch was at the Faculty of Dentistry, Obafemi Awolowo University located in the ancient city of Ile-Ife, Nigeria where he organised a 2-day training programme for the staff and students (12-13 November 2001). The theoretical aspect of the training was well attended with more than 50 participants from within the Faculty and from neighbouring Ondo State. However, for logistical reasons, only 5 selected participants were able to benefit from the practical session during which Dr Mickenautsch demonstrated the basic procedures involved in the Atraumatic Restorative Treatment approach for dental caries. On a lighter mood, the Provost of the College of Health Sciences, Professor 'Sanya Adejuyigbe, during a reception organised for Dr Mickenautsch, expressed his enthusiasm about the new technique "since it does not involve the use of an injection needle and no noise from the drilling handpiece since those are the things that scare patients away from the dentist".

One of the key outcomes of the Afro Region workshop in Abuja was a communiqué recommending that the 'ART' approach be included in the undergraduate and postgraduate curriculum of all dental schools in Africa. The Dean of the Faculty of Dentistry, Dr E O Ogunbodede confirmed the intention of the Obafemi Awolowo University Dental School to include the ART approach in the Bachelor of Dental Surgery curriculum and the proposed Masters in Dental Public Health programme.

Dr A O Oginni who coordinated the training programme at Ife is eager to assist sister dental schools in Nigeria in setting up their own ART programmes.

**FDI 2001 WORLD  
DENTAL CONGRESS**

Julia Champion, CDA Administrator

For CDA, FDI 2001 in Kuala Lumpur was an important and rather special occasion. Not only was the Commonwealth Dental Association inaugurated 10 years



(left to right) Dr H Prakash, Dr L K Gandhi,  
Dato Dr A Ratnanesan, Dr V P Jalili,  
Dr S P Akpabio, Dr K Ranganathan

ago in Kuala Lumpur but, also, the newly-elected FDI President, Dato Dr A Ratnanesan, had been the CDA President (1994-1997). CDA's half-day seminar on 'Focus on HIV/AIDS', chaired by Dr T Thurairatnam (CDA Regional



Dr P Mtolo (right) with a  
Commonwealth colleague

Vice-President - SE Asia), was well attended by delegates from the Bahamas, India, Kenya, Malaysia, Nigeria, Saudi Arabia, South Africa, Sri Lanka, United Kingdom, Zambia. The presentations on 'HIV/AIDS - The Global Picture' (p6) by Dr S Prince Akpabio and 'HIV/AIDS - The

Asian Experience' (p7) by Dr K Ranganathan were well received and generated a lively discussion. The CDA would like to thank the GC Corporation for sponsoring the informal reception which followed, the Commonwealth Foundation for funding support to enable delegates to attend the seminar and the FDI for having allocated time and a venue for this successful meeting.

**HIV/AIDS  
THE GLOBAL PICTURE**

Dr S Prince Akpabio OBE MDS(Lond)  
CDA Founder President & Executive Secretary

From the annual UNAIDS/WHO (Geneva) statistics, the global picture about HIV/AIDS is that:

◆ There is still a very significant annual increase in the percentage of people infected by HIV/AIDS, and killed by the disease globally. Perhaps it is only in the Australia and New Zealand regions that the trend does not show such persistent steady increase. Some Regions of the world now show very dramatic increases such as South and SE Asia, including India, the Caribbean Region, China, Central Europe and Central Asian countries.

◆ The Sub-Saharan African countries have faced, and continue to bear the greatest impact of the HIV/AIDS infection:

"Of the 2.5 million adult deaths from HIV/AIDS during 1998, 80% (i.e 2 million) were in Africa". (UNAIDS/WHO 1998)

“The likelihood of infection occurring in Africa is 10 times greater than in North America, and 20 times greater than in Europe”.

◆ What is particularly disturbing is that some Regions, which did not have so many HIV/AIDS problems are now beginning to experience epicentres of HIV/AIDS.

◆ The global percentage of children infected by HIV/AIDS has increased very significantly, probably due to maternal transmission through breast-feeding by HIV+ mothers.

◆ In its early stages, HIV/AIDS was regarded as the problem of the male homosexuals. Now the percentage of adult women who are HIV positive has increased very significantly to as much as 25-55%. This means that the *heterosexual* mode of transmission has increased very significantly.

◆ The preventive measure of ‘safe sex’ (i.e using condoms) seems to have gradually failed to make its initial impact on many communities.

◆ Death, through HIV/AIDS, continues to take its toll especially amongst the most productive age in the community, leaving so many children as orphans.

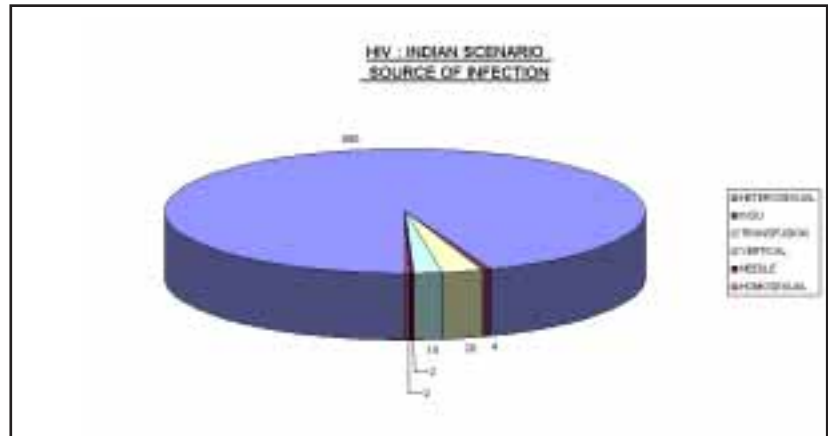
**HIV/AIDS  
THE ASIAN EXPERIENCE**

Prof K Ranganathan  
Oral Pathology, Chennai University, India  
Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) is a major health problem in India.

The National AIDS Control Organisation (NACO) of India estimates that there are about 3.6 million people infected with HIV in India, as of October 2000. These figures are based on data derived from 232 sentinel sites in various parts of the country. In spite of this high prevalence there are very few reports of oral lesions and conditions in Indian HIV/AIDS patients, which are important in early diagnosis and management of these patients. The present report describes the oral lesions in 722 HIV positive symptomatic patients presenting to us at RAGAS-YRG CARE, a non-governmental organization in Chennai, South India, over a period of 3 years from

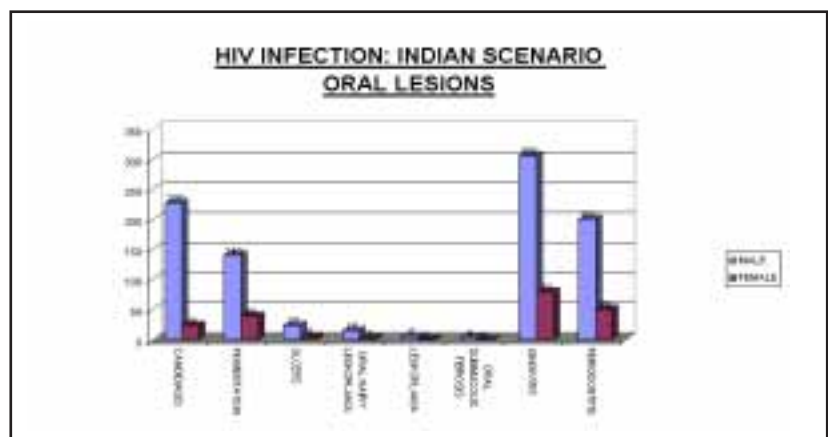
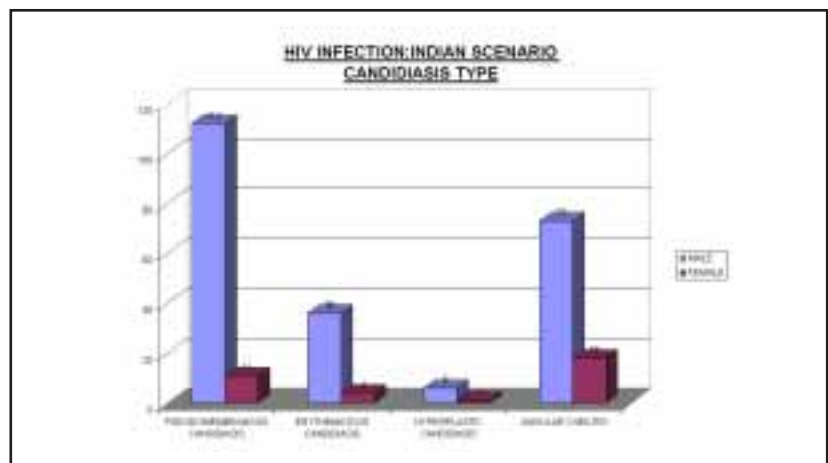
February 1998 to June 2001. Lesions were diagnosed on clinical appearance using international criteria. Of the 722 patients 94% had acquired the infection through heterosexual contact. There were 543 males and 179 females, aged from 7 months

common oral lesions. The other oral lesions seen were oral mucosal pigmentation (25%), periodontitis (35%), oral ulcers (4%), oral hairy leukoplakia (3%), four cases of oral submucous fibrosis and one case of leukoplakia. Oral lesions occur commonly in HIV



to 72 years. 47% of the patients were in the age group 21-30 years. CD4+ cell counts were ascertained for 350 patients, 148 (42%) had CD4+ cell counts = 200. A total of 518(72%) of the 722 patients had some oral lesions when examined. Gingivitis (53%) and candidiasis (36%) were the most

infection. A comprehensive oral examination may not only suggest HIV disease but may also be useful in monitoring the disease progression. This is a cost-effective procedure, which may be useful in screening large populations in developing countries like India.



## 13th COMMONWEALTH HEALTH MINISTER'S TRIENNIAL MEETING

Christchurch, New Zealand  
25-29 November 2001

*Dr S Prince Akpabio OBE*  
CDA Founder President & Executive Secretary  
Commonwealth Health Ministers met and deliberated on 'Priority Setting in Health Systems'. The meeting, chaired by the Hon Mrs Annette King, Minister of Health of New Zealand, was attended by 104 delegates from 32 countries (23 of them led by Ministers). The Secretariat's team was led by Rt Hon Mr Don McKinnon, Commonwealth Secretary-General.



(courtesy Commonwealth Secretariat (left to right)  
Dr B Wint, Hon Dr F Songane, Hon Mrs A King,  
Rt Hon D McKinnon, Dr C P Thakur

There were 21 Accredited Observers from Commonwealth Health Professional Associations and NGOs. There was a parallel symposium and trade fair organised by Kensington Publications Ltd (KPL). A 2-day forum of 41 Commonwealth Health NGOs was held in Christchurch prior to the Ministerial Meeting. Its Report was presented to the Health Ministers at a plenary session. The NGOs would like to thank the Hon Mrs Annette King and the other Commonwealth Health Ministers for having made this possible.

The following are some of the important health issues which the 13CHMM discussed:

- ◆ Improving information on health systems .
- ◆ Health promotion interventions
- ◆ Health Ministers expressed satisfaction with the work of the Secretariat, with very limited resources.

**HIV/AIDS** - The Ministers expressed strong appreciation for the work of the Secretariat's Health Department, and also that of the Para55 Group, on HIV/AIDS.

**Impact of Globalisation on Health** - The Ministers identified *poverty* as the main obstacle to development.

**Depletion of Human Resources** - The current international problem of *poaching* of trained health personnel, such as Doctors, Dentists, Pharmacists,

Nurses, Midwives and Teachers, by more wealthy countries has become a major international problem. The Commonwealth must work hard to regulate and control this very difficult problem.

**Cost of Drugs** - Despite the availability of drugs to combat many diseases such as Malaria, HIV/AIDS, Tuberculosis, etc, many Commonwealth developing countries are unable to make these drugs available to their population due to their high cost.. Ministers advocated some positive action.

**Commonwealth Working Group on Traditional and Complementary Health Systems** - Ministers noted the generous offer of the Government of Malaysia to provide substantial *initial* funding for the establishment of an information hub for Traditional and Complementary Medicines. The Secretariat should prepare a detailed proposal, to be presented at the Pre-WHA Meeting in May 2002 in Geneva.

### Report of the Pan-Commonwealth NGO Consultation Workshop

Representatives of the 41 Pan-Commonwealth NGOs held their 2-day Consultation Workshop at the University of Christchurch, New Zealand, on 23-24 November 2001 to consider key health issues that the Commonwealth faces within the context of 'Priority Setting in Health'. Their Report emphasised the following health issues:

- ◆ Inequity in health care.
  - ◆ Globalisation – its effect on health.
  - ◆ Mental Health – Depression.
  - ◆ HIV/AIDS and reproductive health.
- The NGO Workshop Report was submitted to the Commonwealth Health Ministers at one of their Plenary Sessions and was warmly applauded.

### Conclusions and Recommendations

#### Globalisation and Health Care

The Commonwealth should develop structured positive responses to globalisation and address:

- ◆ Poverty.
- ◆ Access to Medicine.
- ◆ The burden of disease including HIV/AIDS.
- ◆ Support each other through initiatives which promote health.

#### Financial Resources

◆ Commonwealth countries should carefully assess what percentage of their national budget should be allocated to the health sector. The Abuja Declaration recommended 15% for African countries and 0.7% GDP as

assistance from developed countries.

- ◆ The Commonwealth Secretariat should encourage financial agencies to accelerate debt cancellation.

#### Human Resources

- ◆ The Commonwealth Secretariat should encourage and support programmes to increase the training and retention of *health care workers*.
- ◆ The Commonwealth Secretariat should assist countries to facilitate training health workforce in *multi-skills*.
- ◆ The Secretariat should prepare a companion volume to the *code*, which will address the planning, training, recruitment and retention of health care workers.

#### HIV/AIDS

- ◆ The Commonwealth Secretariat should seek expeditious access to the UN Global Fund for health.
- ◆ Implement a multi-sectorial approach to HIV/AIDS, targeting young people and women.
- ◆ Prevent mother-to-child transmission of HIV/AIDS.
- ◆ Commonwealth countries should share best practices in HIV/AIDS and



promote regional programmes and collaborations.

(left to right) Dr S P Akpabio, Hon Mrs A King

The 13CHMM was very successful and well organised and due credit must be given to the Hon Mrs Annette King and her organising team and, also to the Rt Hon Mr Don McKinnon and the Secretariat's Health Department. The 13CHMM addressed important, difficult and pressing health problems efficiently, with practical recommendations.

Finally, on behalf of the Commonwealth Dental Association (CDA), the writer would like to thank the Hon Mrs Annette King and the people of New Zealand for the very warm welcome and generous hospitality that we all enjoyed in Christchurch. I should also particularly like to thank the Commonwealth Foundation for having sponsored me to attend and participate in this very unique Commonwealth Health Ministers' Meeting in Christchurch, New Zealand.

## HIV/AIDS WORKING FOR CHANGE IN THE COMMUNITY

*Richard D Bebermeyer*  
Associate Professor, University of Texas  
Health Science Center, Houston, Dental Branch

In the last edition, information on HIV/AIDS and Oral Health was presented, including a discussion of the epidemiology and common HIV-related oral infections and their treatments. HIV/AIDS remains perhaps the most serious problem facing dentists and oral health workers in the Commonwealth. As professionals, we meet this clinical, moral and ethical challenge as best we can.

### HIV Transmission

The transmission of HIV remains the primary concern for those who treat infected patients. HIV is not transmitted by casual contact. However, HIV is documented to be passed by:

- (1) engaging in sexual intercourse with an HIV-infected person;
- (2) using needles contaminated with this virus;
- (3) having parenteral, mucous membrane or non-intact skin contact with HIV-infected blood;
- (4) receiving transfusions of HIV-infected blood; and
- (5) perinatal transmission from mother to child around the time of birth and breast feeding.

While progression to the terminal phase (AIDS) may be rapid, in many infected individuals the immunosuppression is a slow process, taking many years. It should be remembered that at all stages of HIV infection, even during long asymptomatic periods, HIV is being produced and shed by HIV-infected patients, and those individuals are potentially infectious. If you do identify someone infected with HIV, respect that person's privacy and maintain confidentiality about the infection. Those with HIV want to be treated just like anyone else.

There is no available vaccine to protect people from HIV infection.

Although medications are available to some, there is no real cure for HIV. This means that the only certain way to avoid AIDS is to prevent infection in the first place. Altering behavior patterns through education is essential in controlling the spread of HIV.

### Treatment

Appreciating and understanding the care and support needs of persons living with HIV and AIDS are essential in order to develop relevant and adequate care responses. The needs of persons living with HIV and AIDS go beyond clinical care and treatment. Their needs also include social support, psychological support, emotional support, protection against discrimination and stigma, and social support for their orphans left behind after the patients die. Persons living with HIV and AIDS also need the right to protection in employment, to confidentiality, and to health care including access to new treatments.

Access to care and support contributes to the prevention of HIV infection. Care provision offers an opportunity to discuss with the patient and significant others how they might prevent further spread of the infection. It offers the opportunity to support them in their choices to do so; e.g., by seeking interventions that reduce mother to child transmission of HIV, by enabling them to increase their safety as sexual partners through safer sex and condom use, and through use of anti-retroviral therapy.

Palliative care includes not only the management of physical symptoms - such as pain, cough, skin rashes, fever and diarrhea - but also deals with depression, suicidal thoughts, and other psychological problems. It also includes spiritual support and bereavement counseling, and being sensitive to patients and their environments.

### Patient Education and Health Promotion

Unintentional weight loss of more

than 10% (wasting syndrome) is an AIDS-defining disease, a sign of declining immunocompetency, and a leading cause of death. Therefore, good nutrition to maintain weight is critically important. To prevent wasting and nutritional deficiencies, the person living with HIV/AIDS will need nutritional assessment, nutritional counseling and education which includes food safety, and the development of a plan to prevent weight and muscle mass loss. With some drugs, dietary changes are also needed to prevent side effects and specific symptoms. In some cases, provision of nutritional supplements may be useful to prevent or treat wasting. Urging a high-calorie consumption in addition to maintaining an appetite will contribute to both quality and length of life. However, the basic cause of wasting is related to poorly understood factors involving both absorption of nutrients and metabolism. Optimal oral health to prevent infection and pain becomes a substantial factor in eating. Oral hygiene instruction and maintenance of a healthy mouth are essential to weight maintenance and overall health.

### HIV/AIDS Prevention and Care

Improving patient access to HIV/AIDS care and support requires that health workers fight stigma and discriminatory attitudes. All people who are close to the patients such as health professionals, relatives and friends should have supportive attitudes towards persons living with HIV and AIDS and should fight stigma or discrimination against persons living with HIV and AIDS. Stigma and discrimination constitute obstacles to care, and may jeopardize access, openness, adherence to treatment and the overall quality of care.

Drug addiction, when present, can greatly complicate the clinical management of HIV infection. Continued HIV drug use might put others at risk of becoming infected, in particular when needles are shared or when drug users resort to sex

work to finance their habit. For both the individual patient and society, it is therefore important that support services take into account the management of drug addiction in HIV infected clients. Care provision should be an opportunity to explain and recommend to the patients, particularly vulnerable groups (e.g youth, sex workers, mobile and migrant groups, intravenous drug users, those with multiple sex partners) cost-effective HIV prevention methods that could be used to protect themselves and those around them.

Social and legal supports are also part of HIV/AIDS care. Community involvement and household assistance to mitigate the impact of HIV/AIDS are examples of social support. Providing food support, volunteers for daily duties, orphan support, peer support, welfare services, and legal support are also part of social support and should be part of a comprehensive care program.

### Helping People with HIV/AIDS in Your Community

As a dental professional or health worker, you can make a great difference in the well being of both the person with AIDS and his or her family. Take a special interest in them and help them find ways to get the care and companionship they need.

### Care During the Final Days

During the final days of their illness, most people with AIDS prefer to be at home with their families. Both the sick person and the family need a lot of special care and help during this time. This includes care for medical problems, as well as help with social and legal issues. You can support the family if you organize volunteers in the community to:

- ◆ provide food and cook meals.
- ◆ help with daily household chores.
- ◆ look after babies and children whose parents are sick and dying, or who may have already died.
- ◆ help with funeral arrangements.

It may also help to ask other family members, friends, community members, or a religious leader to visit the family and the person who is dying. This will assist the sick person to die with dignity, and the family to cope with losing a loved one.

### Working to Prevent HIV/AIDS In Your Community

As a dental worker and health leader, you can have a great impact on your community's health and well-being. Through teaching and talking about HIV/AIDS, you can play a very important role in your community to help prevent the spread of the disease. Treating people with HIV infection is important, but preventing its spread in the community is an even greater challenge. You can help if you:

(1) learn as much as you can about HIV/AIDS, how it is spread, and how to prevent it.

(2) set an example in your community by treating everyone with respect, including people who have HIV/AIDS. Support them, their partners, and families.

(3) give advice to the people you treat, especially those most at risk of getting infected, such as young people, sex workers, families on the move, drug users who share needles, and anyone having sex with more than one faithful partner.

(4) fight for improvements in the social and legal services available for people with AIDS, and against the conditions that lead to the spread of AIDS and not against people who have AIDS.

(5) teach people how to prevent HIV from spreading by practicing safer sex. Explain that safer sex means to:

- ◆ have sex with only one partner who has sex only with you.
- ◆ always use condoms during sex, and help women learn how to ask men to use them.
- ◆ have sex in ways that do not get your partner's body fluids into your body.
- ◆ think of other ways to have pleasure, such as touching genitals with the hands, and rubbing or mas-

saging different parts of the body. not have sex with many different partners, or have sex with someone who does.

- ◆ not have sex with someone who shares drug injection needles.

Most people with HIV/AIDS live in countries where there is not enough food to eat, not enough work, or where there are wars. Many times people are forced to move away from their families. This can make them feel very lonely, so that traditions often break down and sex with new partners is common. Fight to end discrimination against those infected with HIV/AIDS. Discrimination is an obstacle to care. It may stop people coming for treatment, and it may stop people learning how to prevent the spread of infection.

In summary, we are challenged to meet the needs of all our patients as best we can. In addition to clinical treatment needs, we are challenged to work for change in our communities through education and health promotion.

*Note: The author is grateful to the UNAIDS and WHO websites for their information, from which parts of this article are derived.*

#### Useful References:

- <http://www.hivdent.org>
- <http://www.aegis.com>
- <http://www.UNAIDS.org>
- <http://www.ama-assn.org/special/hiv/treatment/updates/oral.htm>
- [http://www.WHO.int/HIV\\_AIDS/](http://www.WHO.int/HIV_AIDS/)

Just published:  
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## CELEBRATING DIVERSITY

Each year the Queen issues a special message for the occasion of Commonwealth Day, with a focus on that year's particular theme. The theme for 2002 is 'Celebrating Diversity'. Commonwealth Day was celebrated on 11 March this year and the message is reproduced below.

"Over the last fifty years the Commonwealth has undergone a remarkable transformation from an association defined by its history into the modern, multicultural organisation we know today. Across those years, it has been the privilege of many of us to witness that evolution; to see at first hand the contribution made by the Commonwealth's leaders, as evident in Australia last week; and to share in the enthusiasm and warmth of its peoples.

Today the Commonwealth is a meeting place for North and South, East and West. It is built on diversity - which is why this year's theme 'Celebrating Diversity' goes to the heart of the association.

Politically, the Commonwealth sees its diversity as a strength. That was certainly true of its invaluable contribution to the ending of *Apartheid* in South Africa. The practical assistance it was able to offer in such crucial areas reflects the kaleidoscope of its membership and its expertise. As a result, the Commonwealth was able to work with all the different communities of what is now proudly called 'the rainbow nation'. Bridging social and political divides has also been a feature of the Commonwealth's continuing work in seeking to encourage democracy, good governance, the rule of law, and respect for human rights.

In all this, we recognise that promoting diversity is not just tolerating difference. Living together as neighbours needs more than that. The true celebration of diversity involves reaching out, recognising and embracing difference, and in so doing enriching our lives. It

requires respect for others and a readiness to learn from them; recognising that we have duties as well as rights; and seeking to leave the world a better place than the one we inherited.

As each of the last fifty years has passed, so too has our appreciation of the contribution made by the Commonwealth, an association of peoples as much as it is of governments, bound together by ideals as well as interests. If the Commonwealth is to remain a force for good, we must ensure that those ideals are carried forward by the millions of young people across the world who are its future - so that they too can celebrate and build on the diversity of this unique organisation.

## DENTAL DIGEST

Abstracts of articles from other journals

### Plasma cell gingivitis apparently related to the use of khat: report of a case

P Marker & A Krogdahl  
*Brit Dent J* (2002) 192 311-313

Chewing the leaves of the khat plant is a centuries-old habit in the countries of East Africa and the Arabian Peninsula. It is similar to the chewing of betel nut common in south East Asia. Khat has three main alkaloids: chatinone, norpseudoephedrine and norephidrine. Chatinone has a pronounced effect on the central nervous system and all three have peripheral effects. Chatinone liberates catecholamines from the pre-sympathetic nerve endings and this is probably the reason why khat leaves are popular. Khat is supposed to have the following effects: euphoria, anorexia, insomnia, hyperactivity, excitation, hyperthermia, increased respiration, mydriasis, arrhythmias, hypertension and constipation. The first of these effects is the one sought by those addicted to the habit. Khat also has tannic acid, which is thought to be responsible for the stomatitis and gastrointestinal side effects.

A case of gingivo-stomatitis diag-

nosed as plasma cell gingivitis has been reported for the first time.

The patient was a 30-year-old Somalian who has been referred due to gingivitis-like changes in the left mandibular gingiva. The condition has not responded to the usual periodontal treatment and has been present for two months. Clinical examination has revealed pronounced changes in the left side of the mandibular gingiva together with similar changes in parts of the maxillary area. Both marginal and alveolar gingivae were red and swollen. Similar changes could also be seen in the sulcus and cheek mucosa in the same area. There were fibrin-covered ulcerations and desquamation of the epithelium. Radiographic examination has revealed marked destruction of the bone in the affected area. The general health of the patient was good. He was not taking any medicines.

The histological examination revealed infiltration of polyclonal plasma cells without signs of fungus, tuberculosis or malignancy. It was concluded that the changes were compatible with an allergic-like reaction.

\* \* \* \* \*

### Smoking in adolescence as a predictor of early loss of periodontal attachment

R Hashim, WM Thomson et al  
*Community Dent Oral Epidem*(2001)29 130 135

Tobacco smoking is a well-recognised risk factor for periodontitis. The sample for this study carried out in New Zealand consisted of 1019 survivors of a representative cohort of 1037 children born in a hospital. Their health data had been collected from age 3. Of these, 914 were examined at age 26 yrs. for attachment loss at 3 sites in all the teeth in two quadrants. CPITN data available from two incisors and four first molars at ages 15 and 18 ruled out any juvenile periodontitis.

In 220 who had never smoked, a mean of 0.45% sites had attachment loss of 4+mm. In 694 who had smoked at 15, 18, 21 or 26 years, a mean of 1.24% sites had attachment loss of 4+mm. In 304

**DENTAL DIGEST**  
Abstracts of articles from  
other journals

who had smoked at 21 and 26 years, a mean of 1.58% sites and in 128 who had smoked at all 4 ages, 2.23% sites had attachment loss of 4+ mm. Prevalence of subjects with such sites was 33.6% in the last group. In contrast, the prevalence of such sites in all 914 was 19.4%.

After adjusting for gender and local dental factors, those who smoked at all four ages were 2.8 times as likely to have one or more sites with attachment loss of 4+mm.

\* \* \* \* \*

**Squamous Cell Carcinoma presenting as a Peritonsillar Abscess**

*S B Holmes, K Vora & P S G Hardae  
Brit. J Oral & Maxillofacial Surgeons 2001, 39:46-48*

This paper presents two case reports of this unusual presentation of squamous cell carcinoma. One case is of a 57 year old lady and the other a 31 year old man. Both reported with fever and symptoms of peritonsillar abscess. Peritonsillar abscess is a complication of tonsillitis in which infection has spread deep to the tonsillar capsule and superior constrictor muscle. Physical signs include medial displacement of the tonsil, with oedema and displacement of the uvula. Trismus and offensive halitosis are cardinal features. Initial management is drainage at presentation, although pus may be difficult to locate. Because of a recurrence rate of between 10%-15% the medium to long-term management is interval tonsillectomy done around 6 weeks after drainage. These case reports underscore the need to send all excised tissue for histopathological diagnosis.

\* \* \* \* \*

**Management of the deep carious lesion and the vital pulp dentine complex**

*D Ricketts Brit Dent J (2001) 191 606 – 610*

This paper describes the relationship between the carious process and pulp-dentine complex reactions.

At the advancing front of the dentine lesion, demineralisation precedes bacterial infection. The permeability of dentine, which resists this inward diffusion, changes with age. There is a fine balance between the speed of the advance and the rate at which pulp-dentine defences can be laid down. These defences require a healthy pulp. If the advancing front is 1.0 mm from the pulp then no significant disturbance occurs. However, once within 0.5mm of the pulp, more pathological changes occur within the pulp.

The direct pulp cap has questionable prognosis where a carious exposure is concerned. Teeth with a history of pain will have an area of necrosis within the pulp chamber and for many this will extend into the root canal. These teeth should be endodontically treated.

It was once thought that only pinpoint exposures could be capped. However, recent research would suggest that the size of the exposure has no bearing on the clinical outcome. It has been suggested that deep carious lesions can be opened up and 1-3mm of exposed pulp removed. This reduces the possibility of introducing dentine chips into the pulp and enables good contact between pulp and the capping agent. Dentine chips pushed into pulp can cause severe inflammation leading to pulp necrosis.

Calcium hydroxide remains the material of choice. However, a new material, mineral trioxide aggregate MTA, has been investigated. It has a composition broadly similar to Portland cement but with additives. MTA promotes more dentine bridge formation.

The success rate of direct pulp cap is difficult to establish. Teeth with carious exposures appear to fare less well than those with traumatic exposures. In a retrospective study of 123 direct pulp caps on carious exposures, only 37% were clearly successful after 5 years. After 10 years, 80% had failed.

Some argue that it is over-judicious

removal of carious dentine that leads to pulp exposure. In a majority of cases this can be avoided if a stepwise approach is adopted. In this, caries is removed over two separate appointments 6-12 months apart. At the first appointment, access to caries is gained and periphery made caries free. Soft, wet and pale coloured dentine is left pulpally, cavity lined with calcium hydroxide and restored with glass ionomer cement for 6-12 months. At the second visit, further excavation is made with less risk of pulp exposure.

The success of this technique depends on the integrity of the restoration and its seal. Regular recall would be essential. Following sealing caries into the tooth, the carious dentine becomes dry, harder and darker in colour. As a result, there is shrinkage of the tissue leading to a void beneath the restoration. These two factors support the second stage of the stepwise excavation. It seems that the interval between first and second excavations is not critical and could be left for longer than 6-12 months.

The thought of leaving heavily infected carious dentine for 6-12 months would seem contrary to teaching in dental schools. However, teeth that have been treated with the stepwise excavation do not show any signs or symptoms of pulpitis.

Thus the use of a more conservative technique in a young patient with deep caries could eliminate the need for conventional direct pulp cap. In those cases where this is still required, stepwise excavation should result in a minimally inflamed pulp, superior tertiary dentine formation, less bacterial load and a more predictable pulp cap. Calcium hydroxide may be superseded by MTA.

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