The Commonwealth Dental Association

# CDA BULLETIN

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

## THE CDA PRESIDENT WRITES

Esteemed Colleagues, the CDA organised several activities during the latter part of 2005 as did the National Dental Assoc-iations in the various regions of the Commonwealth.

The most historic event on the calendar was the Pacific Regional Meeting – the first CDA event to be held in the region jointly organised by the CDA and the Fiji Dental Association, at the end of November 2005.

*Dr L K Gandhi with the Honourable Solomone Naivalu (Minister of Health, Fiji)*

In the Caribbean Region, the Bahamas Dental Association held a symposium (10-12 November 2005) on HIV/AIDS for dental health professionals as a follow-up to the CDA/ Caribbean HIV/AIDS workshop in Montreal, which provided participants from the Caribbean Region with valuable information in training members of the dental team. Dr Joyous Pickstock (CDA Vice-President for the Caribbean Region) has informed us that more HIV/AIDS workshops in the region are planned.

In the West African Region a joint Continuing Dental Education Programme was held (5-6 October 2005) by the FDI World Dental Federation and the Nigerian Dental Association. Dr Kofo Savage (CDA Vice-President for the West African Region) was one of the organisers and, with Professor Martin Hobdell, represented the CDA.

The success of the symposium *'Global Health – Networking for Better Outcomes'* at the Commonwealth People's Forum in Malta (22 November 2005), jointly organised by the CDA, the Commonwealth Nurses Federation (CNF), the Commonwealth Pharmaceu-tical Asso-ciation (CPA) and the Commonwealth HIV/AIDS Action Group/Para55, was largely due to efforts made by the health associations in Malta to advertise the symposium.

We have recently received the good news from the Commonwealth Foundation that they have approved our grant applications for 2006-2007 for which we are very grateful. This will enable the CDA to pursue its projects in the coming year *'The Oral Health Workforce in the Common-wealth'* and *'Tobacco Cessation - Developing a Programme for Disadvantaged Populations'*. The CDA is very grateful to the Commonwealth Foundation for its support, to the Common-wealth Secretariat for supporting our projects, for the sponsorship received from other organisations and the CDA Friends for their contributions.

Thank you.

*Dr L K Gandhi*

## EDITORIAL

### Ethical Recruitment of Health Workers and Migration

***Prof DYD Samarawickrama***
*Co-Editor, CDA Bulletin*

The twin issues of ethical recruitment of health care workers and migration have been very much in the news recently. CDA, at its meeting in Montreal last year, endorsed the *Declaration on Ethical International Recruitment of Dental Professionals* displaying its advanced thinking and action on this matter. It is in line with the resolution passed at the World Dental Development Forum recently. These issues were also raised at a meeting hosted by the Commonwealth Secretariat in London on 28 February this year. It will be the main topic for discussion at the Commonwealth Health Ministers' Meeting to be held in Geneva in May 2006. The CDA Triennial Meeting to be held in Sri Lanka in December 2006 has Oral Health Workforce in the Common-wealth on the agenda for discussion.

The migration of highly skilled professionals from less developed to developed countries is not a new

*continued over/.....*

phenomenon. This global migration is commonly referred to as 'brain drain'. It has been recognised internationally since the 1960s. This migration has had particularly serious ramifications in sub-Saharan Africa, where it severely limits the provision of the most basic of health services. The Director-General of the World Health Organization has said that brain drain from Africa is severely limiting the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress towards the Millennium Development Goals.

Some argue that skilled health personnel could be seen as an *'exportable'* asset for the less developed countries, generating remittance incomes for the countries of origin of the workers. For example, the Central Banks of many less developed countries regularly publish such remittance income received from their nationals including health care workers employed abroad. Such remittances by migrant workers are a large source of foreign exchange for these countries, often overtaking income derived from more traditional exports such as agricultural produce. However, such remittances are not directly re-invested in developing human resources including the health care workers.

One of the countries that has a large number of health workers trained overseas is the UK. The UK Department of Health has stated that it *"does not actively recruit from any country that does not wish to be recruited from"*, following the publication of a Save the Children report criticising the *'brain drain'* of medical staff from poorer countries to the UK. It also has a long list of countries from which no recruitment is made. However, the Department of Health has admitted that if health care workers were determined to migrate to the UK they could not legally be denied the opportunity to do so.

How can this issue be tackled? There is no easy answer. A sensible and an effective approach to tackle this problem is on the basis of a partnership between the developed and the less developed countries. For a start, the developed countries need to be self sufficient in training their workforce rather than dependent on overseas recruitment. The less developed countries also need to increase their pool of health care workers. This aspect is referred to in the Report of the Pacific Region Meeting published in this Bulletin *(p.7)*. The less developed countries also need to address the basic issues that lead to the migration of workers overseas in the first place. An often cited reason for such migration is monetary gain, but this is not the only reason. There are related issues of governance, work place issues, political interference in the management of services, lack of professional advancement etc. These sap the morale of the workers for a start. The National Dental Associations as civil society organisations are in a prominent position to influence their respective governments to solve some of the root causes.

The CDA, as a federation of National Dental Associations, is well placed to play a leading role in the development of ethical, but pragmatic approaches in dealing with this issue contribute to the formulation of international co-operative strategies, to address health problems like HIV/AIDS arising from migration of health personnel.

The Montreal Declaration is only the beginning.

## CONTENTS



## ACKNOWLEDGEMENTS

The CDA thanks the Commonwealth Foundation for their support and funding. Also the Commonwealth Secretariat for their support given to CDA's projects.

The CDA thanks Dentsply for their support and sponsorship of this edition of the CDA Bulletin.

The CDA is very grateful for the continued support of Quayle Dental Manufacturing (Export) Ltd, Dr Michael Knowles and, also, the Friends of CDA.

Editor: Professor Martin Hobdell

Co-Editor:
Professor DYD Samarawickrama

Designed by: Julia Campion

Printed by:
Prontaprint Notting Hill, London, UK

Published by:
Commonwealth Dental Association
London, UK

## ELECTION OF CDA OFFICERS

***Elections for CDA Officers will take place on 2nd December 2006 in Sri Lanka, during the CDA 5th Triennial Meeting. The nomination form, together with role requirements for officers, will be in the next issue of the CDA Bulletin (due during June 2006), on the CDA website and will be sent to National Dental Associations.***

# WRITING ORAL HEALTH POLICY
## A Manual for Oral Health Managers in the WHO African Region

***Reviewed by: Professor Aubrey Sheiham***
*University College London*

***AFR/ORH/05.1 (41 pages) Copies from WHO http://afro.who.int/oralhealth/publications.html***
***World Health Organization, Regional Office for Africa, Brazzaville 2005***

A major barrier to improving oral health is the uncommonness of using well-developed evidence based policies. This shortcoming is particularly serious and verges on the unethical when one considers the consequences in terms of human suffering and costs. Oral diseases are major public health problems in Africa. They are highly prevalent and some of them, such as cancers and oral HIV, are very serious. What is more, they are very expensive to treat. The expense of treatment plus the impacts of oral diseases on the quality of people's lives marks oral disease out as an important public health problem. Yet, despite the importance of having a strategy, most countries in Africa have not adapted and applied the *WHO Regional Committee for Africa Regional Oral Health Strategy*.

Dental planners have no excuse for not developing evidence based oral health policy because more than any other aspect of health, dental epidemiology has provided them with information on features of dental caries. For example, for each mean level of DMFT they can plan how many new cavities and the types and sites of cavities that are likely to occur in a cohort of children for each DMFT, because dental caries follow tracklines. Knowing the DMF at one age, say 12 years, predicts the levels at 15 and 18 years. They can predict the percentage of 'cavity-free' children at different levels of caries, the frequency distribution of DMFT, the mean caries at a later age, the mean DMFs by sites - occlusal, buccal, lingual, proximal, the rate of progression of caries through enamel and the time after eruption that caries is initiated. The latter information allows one to decide the recall intervals.

This manual sets out to assist oral health managers at all levels to develop an oral health strategy. Using a systematic approach, the manual takes readers through the stages required to formulate a strategy including getting politicians and general planers interested in having a policv, and consulting key decision makers and the community in the planning process. The manual has many impressive aspects. It builds on the philosophy of the Africa Regional Oral Health Strategy, provides a sound basis for a framework for evidence based oral health policy and outlines the contents of a national oral health policy. These Sections are complemented with a number of very helpful worksheets and flowcharts. The worksheets provide planners with tables which have suggestions for intervention strategies for different levels of disease and pain, under conditions with low, medium or low levels of resources. A central tenet of the inter-ventions is that they are based on sound evidence and acceptable treatment goals. Goals that are linked to national targets.

An important feature of the manual is its practicality. That is evidenced by Worksheet 9 that gives an example of a national oral health policy.

The manual emphasises integration of oral into general policy because the new public health is no longer oriented to single diseases. A number of chronic diseases such as heart disease, cancer, strokes, accidents and oral diseases have risk factors in common and many risk factors are relevant to more than one chronic disease. Therefore a Common Risk/Health Factor Approach (CRHFA) is indicated, one that tackles risk factors such as diet, poor hygiene and smoking by all health workers. The key concept underlying the integrated common risk approach is that promoting general health by controlling a small number of risk factors may have a major impact on a large number of diseases at a lower cost than disease specific approaches. Coordinating the work done by various specialist groups and organisations may make savings.

There are two important shortcomings in the manual. The first is that no details are given on how to assess treatment needs using contemporary methods. The default appears to be the use of the normative needs approach suggested by the WHO. The sole use of the traditional approach has limitations. Apart from conceptual shortcomings, the approach usually results in high and unrealistic estimates of workforce needs and resources. Moreover it fails to take into account the way people really feel and therefore does not correspond to broader concepts of health and perceived needs. To overcome those shortcomings, broader socio-dental methods of assessing dental treatment needs are now available and should be recommended. The second shortcoming is that with the development of the internet and online facilities the authors should have extended their useful list of links to include recommended key publications on current concepts of prevention/promotion, needs assessment and current concepts on the life history of the principal oral diseases. Many oral health managers need such information for planning.

# SO WHERE DOES YOUR MONEY GO?

***Dr Anthony S Kravitz*** OBE BDS MFGDP(UK) MPhil
*CDA Treasurer*

As Treasurer of the CDA I am often asked what happens to the funds so generously donated by so many individuals and organisations – and not least the dental associations which pay subscriptions each year.

Of course we do present annual accounts but these only reach a wider audience at each triennial meeting – and even then only a small proportion of donors attend these anyway. We could of course publish the accounts in full in the Bulletin each year but, until now, this has not been thought to be very useful.

So, I am taking this opportunity of an additional journal during 2006 – made possible by sponsorship from a commercial company – to give an overview of our finances, from where our funding derives and how we spend it.

Our financial year is July 1st to June 30th, which does cause some confusion as our subscription year is the calendar year. For reasons beyond the scope of this article it is difficult to reconcile these. So, my monthly internal budgetary analysis does have to take cognisance of subscription income arriving in the second half of our year, as our Administrator sends out the annual subscription renewal reminders about Christmas time.

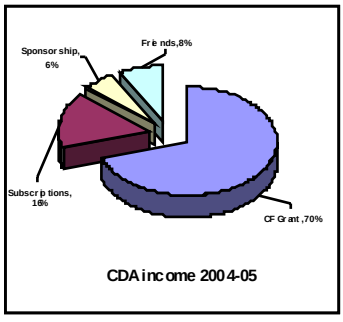



*Fig 1: CDA Income*
*July 1st 2004 to June 30th 2005*

Looking at our income for last year *(Fig 1)* you will see that this late arrival of our subscription income does not cause big cash flow problems, as this income only forms a small part of our overall gross income.

Indeed, all the donations, subscriptions and sponsorship income – whilst very welcome - were less than one third of our total income of around £30,000 in 2004-05. The bulk of our expenditure was being financed by grants from the Commonwealth Foundation (CF) *(see p.10)*[1].

In 2005, the CDA Executive was very concerned about this reliance on grants from a government funded organisation and determined to do something about it. Indeed, during the year the Foundation suggested to the CDA that although they would continue (if possible) to provide similar funding to us each year, we must organise for this to produce a smaller proportion of our total turnover.

At this point I need to discuss briefly our expenditure. The grants from the CF are not just flat amounts but are related to two sorts of activity – administration of the CDA and travel and hotels for meetings or workshops which have defined outcomes for Commonwealth people – dentists and their patients.

Once a year we have to bid for funds from the CF using a standard formula. For subsidy for meetings or workshops we have needed to advise the CF what the event is about, who will be attending (and why) and what we want to achieve from it. For the last few years we have been successful in obtaining the maximum funding available for both administration and events (£10,000 each) and this is paid to us in two tranches during the year.

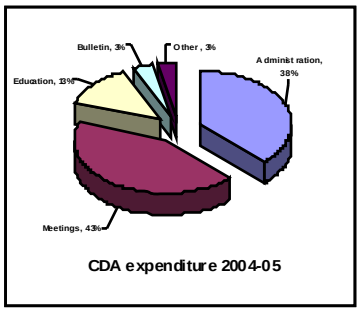



*Fig 2: CDA Expenditure*
*July 1st 2004 to June 30th 2005*

In 2004-05 the administration grant virtually fully covered our administrative expenses, including the cost of our part-time administrator.

However, being so reliant on CF grants for our activities would necessarily curtail these somewhat. The £10,000 pa we are currently receiving for the activity grant is very welcome but we use it only as a subsidy towards the cost of workshops. It does not pay for CDA delegates' subsistence (they have to pay for their own meals) and we cannot normally use it for room costs or receptions for local dignitaries. We also cannot use the grant for political purposes, for example to pay our costs towards attendance at the annual meeting of the Commonwealth Health Ministers in Geneva (where we have observer status – which gives us the entry to lobby individual ministers on a face-to-face basis).

Thus, we also go for sponsorship from commercial companies. Fortunately, this is now increasing and with this increased funding we will be able to undertake more activity and satisfy the request from the CF for their grant to be a smaller proportion of the whole. You will note that the recent editions of the Bulletin have carried advertising and we are looking to extend this into a permanent feature.

We have pruned our expenditure wherever possible. We now use electronic methods for all but one of our Executive meetings, which are held several times a year,

during two-week periods, using Email. We have refined its use since we started two years ago and all members deem it very successful. We only meet 'face to face' at events that most of us are attending anyway – such as the FDI Congress. We are also using electronic distribution of our Bulletin more extensively, cutting down printing and postage costs. And, we are working more with partners – such as the FDI or other Commonwealth organisations, to share costs.

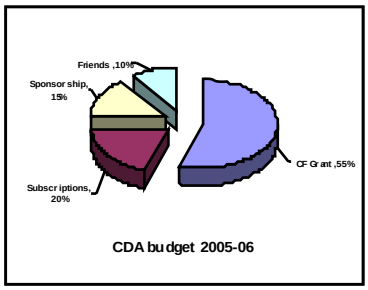



*Fig 3: CDA Budgeted Income July 1st 2005 to June 30th 2006*

So, for 2005-06, I set a differently balanced budget for income, with a larger turnover in real terms, which I am optimistic will be achieved and help us once again to balance our books *(Fig 3)*.

If we are able to attract more sponsors we will be able to increase our activities during 2007 – for which we already have a queue of requests for funding.

## CSO Consultation

Prof D Y D Samarawickrama and Julia Campion represented the CDA at the Civil Society Organisation Consultation, organised by the Commonwealth Secretariat, on 28 February 2006 in London. The health-related CSOs attending each gave a presentation on the activities of their organisation. The remainder of the agenda related to the Commonwealth Health Ministers' Meeting and the issue of health care workers.

# DENTAL DIGEST
## Abstracts of Articles from Other Journals

### Recall intervals for oral health in primary care patients

***Beirne P, Forgie A, Clarkson JE & Worthington HV***

Cochrane Database of Systematic Reviews Issue No. 2 Article No. CD 004346 2005

In selecting studies for review, only those meeting the following criteria were selected:

1. Randomised clinical trials.

2. The subjects were children and adults attending for check-ups in a primary care setting.

3. Reasons for attendance were either due to recall for examination only, recall for examination with scale and polish, recall for clinical examination and preventive advice, recall for clinical examination, scale and polish and preventive advice or patient attending due to symptoms.

In the end, only one RCT of poor quality was included in this review.

There was insufficient evidence from this study to draw any conclusions regarding the potential benefits and harmful effects of altering recall interval between dental check-ups.

The practice of encouraging patients to attend for dental check-ups at six-monthly intervals is not based on evidence.

* * * * * * * * *

### Effectiveness of mechanical non-surgical pocket therapy

***Susan JE***

Periodontol 37 48 – 71 92005)

A study of twelve reviews provided conclusive support that mechanical non-surgical pocket therapy (MNSPT) is effective in treating periodontal diseases.

There were several other significant findings:
1. MNPT reduces inflammation and pocket depth and increases attachment level.

2. The greater the initial pocket depth, greater the reduction.

3. There is no difference in efficacy between engine driven and hand instruments in single rooted teeth.

4. There is no other therapy that can replace MNSPT.

* * * * * * * * *

### Tobacco smoking and oral clefts: a meta analysis

***Little J, Cardy A and Munger RG***

Bulletin World Health Organization No 82, pp 213 – 218 (2004)

Fifteen case control and nine cohort studies were included in this meta-analysis. Statistically significant associations were found between maternal smoking and cleft lip with or without cleft palate and between maternal smoking and cleft palate. The effect was observed for both isolated and multiple clefts. There was evidence of a modest dose-response effect for cleft lip with or without palate, but the evidence was not clear for cleft palate.

* * * * * * * * *

### Determining the optimum obturation length: a meta - analysis of literature

***Schaeffer MA, White RR and Walton RE***

J Endod 31 271 -274 (2005)

Four studies were included in this meta-analysis. Obturation 0 – 1 mm short of the apex was better than obturation 1–3 mm short of the apex. Both were superior to obturation beyond the apex. The success rate of obturating to within 1 mm of the apex was 28.9 % better than obturating beyond the apex. The former was also 5.9 % better than obturating to within 1 – 3 mm from the apex. Thus the results demonstrate that obturating materials extruding beyond the radiographic apex resulted in a poorer prognosis.

# WORKSHOP ON HIV/AIDS - ANTIGUA 2005

**Dr Victor Eastmond**

*Editor, Postgraduate Dentist Caribbean; Co-Chairman, Caribbean Dental Programme*

On 22nd October 2005, the Chancellor of the University of the West Indies, Sir George Alleyne, conferred honorary degrees on six distinguished persons. One of them was the Executive Director of the United Nations Programme on HIV/AIDS Commission, Dr Peter Piot. This Belgian doctor co-discovered the Ebola virus in Zaire and is one of the signatories of the Pan Caribbean Partnership against HIV/AIDS. The Chancellor spoke at length of the need to reduce the stigma of the disease if progress is to be made in its treatment and reduction.

In my view, the dental profession has, so far, not displayed any proactive role in the treatment of the pandemic and it is imperative that the immense potential of the profession to make a difference be recognised, especially since the first signs and symptoms are seen in the oral cavity. I must also question why oral care professionals are not appointed to national HIV/AIDS committees within my region. A lot of questions were addressed at the workshop on 11th and 12th April 2005 and continued at the FDI World Dental Congress in Montreal. The Oral Health Director of the Pan American Health Organisation / World Health Organisation (PAHO/WHO) participated in both of these meetings and spoke at length of the need for participation by oral health care providers.

The outcome of the initial workshop is now referred to as *'The Antigua Summit Resolutions 2005'* and was derived from the deliberations by dental professionals from sixteen countries: Antigua and Barbuda, Barbados, British Virgin Islands, Canada, Commonwealth of Dominica, Grenada, Guyana, Ireland, Jamaica, Mexico, Montserrat, Puerto Rico, St Lucia, Trinidad and Tobago, United Kingdom, and the USA. Representatives came from the University of the West Indies Dental School; Pan American Health Organisation (PAHO); the Caribbean HIV/AIDS Regional Training (CHART), The Caribbean Dental Program Ltd., the Organization for Safety and Asepsis Procedures (OSAP), the University of Alabama at Birmingham School of Dentistry; the University of Illinois at Chicago and the President of the Caribbean Atlantic Regional Dental Association (CARDA). The entire report can be viewed at www.caribbeandentalprogram.com

The report emphasises that health is a pre-requisite for good governance, social stability, and sustainable development especially since the burden of disease from poor oral health remains high in certain populations due to inequity of care, changing pattern of oral disease, and insufficient data on overall oral health status. Oral health is an integral part of general health and therefore requires full integration into national primary care delivery services in order to advance national health development and foster social protection between and within countries. It is now necessary that major oral health advancements made within the Commonwealth, with special reference to the Caribbean, which has the second highest incidence of the pandemic, be maintained and protected via strong partnerships, sustainable infrastructure and effective public policies that encourage and support a cohesive working relationship within our diverse and scattered Caribbean communities. Unless the Caribbean work as a unified federation and focus on achieving their goals together at reduced cost, the successes may not be realised as a practical goal.

Some of the Resolutions from the *'Antigua Summit'* include a need for:

1. Continual training and education of oral health providers in identification of the illness, treatment modalities and counselling on a regular basis to respond to HIV/AIDS initiatives thereby reducing the stigma associated with the illness.
2. Developing more effective case management and referral systems through integration of providers, activists, multidisciplinary approaches and service settings.
3. Emphasising evaluation and evidence based approaches to programme management, resource allocation and decision-making.

In conclusion, this proposal is but an idea to get the oral health care professionals involved in diagnosis, treatment and counselling of HIV/AIDS. The oral health care providers' impact on HIV/AIDS case detection will be reflected by evidence of programmes and resources data especially when using a saliva test such as *'OraSure'*.

The expected result with the participation of the dental team is to diminish/lessen the stigma of HIV/AIDS. However, when reviewing the old adage that *"facts, when combined with ideas constitute the greatest force in the world"*, I feel that this idea is an area where members of the dental profession can make an immense impact.

# PLANNING FOR ORAL HEALTH IN THE PACIFIC REGION

***Dr Temalesi King*** *(CDA Vice-President - Pacific Region)*
***Dr Anthony S Kravitz*** *(CDA Treasurer)*

A meeting of commonwealth countries in Suva, Fiji was the highlight in the oral health calendar in the Pacific region for 2005. Representatives from 10 national dental associations in the region met to discuss mounting oral health problems. Countries represented were Fiji, Australia, Samoa, Tonga, Solomon Islands, Papua New Guinea, Vanuatu, Cook Islands, Kiribati and Tuvalu. The vision of collaborating within the region and with international counterparts stemmed from the realisation that small island nations cannot make a strong impact individually. This is especially true of countries such as Tuvalu, Kiribati, Tokelau and Niue, where only one dentist may be delivering oral healthcare. Collaborative action, therefore requires pooling information, assessing community needs, linking with appropriate stakeholders in setting priorities and implementing intervention strategies.

Opening the meeting the Minister of Health of Fiji, the Honourable Solomone Naivalu, recognised past work and continued action to alleviate health burdens in Pacific Island countries. He acknowledged the interrelationship between oral and general health and that an integrated approach was an efficient way of achieving better outcomes especially in situations with variable and unpredictable resources. The important role of the dental associations in improving oral health was acknowledged.

In his keynote address the President of the CDA, Dr L K Gandhi, emphasised the importance of collaboration with viable partners and establishing solid networks with other coordinating bodies, and associations at international levels for "*Strengthening Regional Cooperation and Integration through Enhanced Engagement with the Civil Society in the Pacific Region*". The draft constitution for the Pacific Region would provide a working paper and should foster the development and implementation of innovative oral health plans and programmess for oral health professionals in the region.

Professor Sitaleki Finau, the Head of the School of Public Health in Fiji highlighted several attempts in the past to unite dental personnel in the region, but these have been unsuccessful. Regardless of the need to collaborate, the lack of willingness and commitment from dentists who were either too busy, lacked leadership skills or few in number hindered the initiation and progress of past plans. He emphasised the need to nurture the values and beliefs of the social and cultural groups in the region, for it would play an important role in the configuration and function of the organisation. In this regard a balance between the western core values, which he said focused more on economic capital by creating personal wealth, and the Pacific core values of individual well-being, embracing social capital through good relationship and strong communities should be reached.

**The role of dental auxiliaries**

Dr Anthony Kravitz, in his role as an Honorary Research Fellow at Cardiff Dental School (Wales) presented a paper outlining his recent research on the use of dental auxiliaries, their value and attitudes towards them. His research had covered the countries of the European Economic Area in general and Belgium, Finland, Greece and the UK together with Canada and New Zealand in particular. He had only been able to cover developed countries.

He explained the history of the introduction of dental auxiliaries. Dental assistants were known centuries ago – but hygienists started in the USA at the beginning of the 20th century and the precursor to therapists, the Dental Nurses/Dressers in New Zealand and the UK, at the end of the First World War. Illegal denturists were around in the 1800s but the first legitimate versions were in Canada and Finland from the 1960s onwards.

Dr Kravitz went on to describe the training, legislation and demographics of the studied countries. Even now, few countries permit auxiliaries to diagnose dental disease. He had examined possible reasons for the introduction of dental auxiliaries into countries but could find little relationship between the various factors which may lead to the introduction of these workers. However, there was a weak association between health-care systems and the use of therapists in particular. He also explained his findings about the attitudes towards auxiliaries in the individual countries, especially in relation to those with few or no dental auxiliaries.

He concluded by suggesting that although most stake-holders believed that dental auxiliaries provided high quality care, there was little evidence to confirm this. Also, it was felt by most that dental auxiliaries provided cost effective care – but again there had been little recent research which confirmed this.

**The Oral Health Climate in the Region**

An appreciation of the environmental and economic impact and agendas surround-ing dental association members in their professional work were the topics of group discussions at the meeting. Common themes affecting the region pointed to a stronger team approach of dentists and dental auxiliaries. Key issues common in many Pacific Islands, as identified at the meeting, were as follows:

*Communications*

It was agreed that the use of computers in communication and data collection is proving to be a basic necessity. However, their use is not yet widespread across the region. The need for a website was identified - the Australian Dental Association (ADA) agreed to incorporate information from the region in its website for access to members. It was also agreed that there was a need for a Pacific Dental Journal or a Newsletter. It was decided that co-ordination between member countries on oral health issues should commence as soon as possible.

*Training*

For more than 100 years health personnel in the region were trained at the Fiji School of Medicine; dentists were trained alongside medical personnel. Except for Fiji, the other Pacific Islands trained dental auxiliaries on the job, as apprentices.

It was agreed that there was an urgent need to develop the capacity of the oral health workforce to meet the needs of the region. Continuing education was essential, to provide staff with the skills to deliver high quality service to consumers. To prevent disruption in the delivery of oral care and concurrently retain the workforce, a short-term solution of attachment to other dental institutions, and a twinning programme were recommended. In the long term, postgraduate training in oral epidemiology and orthodontics are needed in the region.

*Dr Temalesi King*
*(CDA Vice-President, Pacific Region)*

*Workforce*

Whether an acceptable standard of oral health is achieved largely depends on the human resources available to deliver oral care. Planning plays an important role in forecasting the supply and demand of various cadres of oral health workers. Major issues causing the lack of ability of the current workforce to respond to the need of the region were identified.

It was agreed that there was a need to convince Health Ministers in the region train more cadres of dental personnel to meet the backlog of treatment needs, in order to raise oral care to an acceptable level. Commitment from funding agencies must be strengthened, to foster greater investment in health. The reality of marketing oral health needs to be addressed.

*Dental Equipment and Materials*

A centrally planned govern-ment health service, funded by general taxation, or donations, provides the bulk of health care in the region. The recurrent expenditure on oral health needs to increase as a proportion of total health expenditure. The changing face of demands and expectations for more advanced preventive, diagnostic and therapeutic services inevitably calls for sophisticated equipment and dental materials.

It was agreed that collaboration with the dental industry with a view to assisting island countries to acquire affordable dental equip-ment and materials would greatly enhance the delivery of oral care without compromising science and quality. Training in dental equipment maintenance that serves the region is urgently required.

**Meeting Outcomes**

It was agreed to formalise the liaison between dental associations through the establishment of a Regional Organisation of the CDA. Discussions on formalising a constitution would continue. Plans were formulated to make oral health more visible in the Pacific region and strategies to involve the dental associations and the dental trade to contribute to improved oral health of the populations were devised.

**Future Directions for the CDA Pacific Region**

It is clear that national dental associations in the region are small and some may still be fragmented. The majority of dentists work under their respective Ministries of Health, and association activities are carried out in conjunction with the ministry and the dental industry. The CDA will strive to assist small island nations to initiate and strengthen their dental associations. Key issues from the group discussions provided a roadmap and terms of reference for the newly elected CDA Pacific Region executives. The issues identified at the meeting matched the core aims and activities of the CDA.

The meeting ended with agreement for the executive

to meet regularly using electronic means and for an (annual) follow-up general meeting in Nadi, Fiji in 2006. The CDA Pacific Region will also bid to host the CDA Triennial Meeting in 2009.

The CDA meeting was followed by 3 days of continuing education sessions, organised by the Fiji Dental Association.

**The following were elected as the CDA Pacific Region Executives**

| | |
|---|---|
| President | Dr Temalesi King *(Fiji)* |
| President-Elect | Dr William O'Reilly *(Australia)* |
| Vice-President | Dr Amanaki Fakakovi *(Tonga)* |
| Secretary | Dr Cedric Alependava *(Solomon Islands)* |
| Treasurer | Dr Sina Ioapo *(Samoa)* |
| Committee members | Dr Emily Wesley *(Papua New Guinea)* |
| | Dr Ilaitia Lewenilovo *(Fiji)* |

# THE NINTH COMMONWEALTH LECTURE

## The Future Role of the Commonwealth: A Bridge Between an Emerging Three-Speed World

***James Wolfensohn***
*Former World Bank President*

The former President of the World Bank, James Wolfensohn delivered the Ninth Commonwealth Lecture in London on Thursday 2 March 2006.

Mr Wolfensohn outlined how sweeping changes to the global economy over the next 40 years would produce three distinct but interconnected spheres of varying levels of wealth and development. This would present the Commonwealth with new opportunities but also added challenges.

Developed high income countries will form the first tier. They will continue to be some of the wealthiest countries on the planet but may slowly lose their economic dominance to the second group of countries which would include Brazil, China, India and Russia. This second tier will be home to almost half of humanity and could become the new centre of economic power. The third tier will be made up of those countries held back by political social, and institutional factors. These countries will struggle with widespread poverty but will remain an integral part of the global economy and world social order.

Mr Wolfensohn explored the role that the Commonwealth, which has members in all three tiers, can play using its strengths and influence in the areas of trade, development and governance, to restore more balance and equity in the world.

The Commonwealth Lecture is delivered annually and is sponsored by the Commonwealth Foundation in collaboration with the Commonwealth Secretariat, the Royal Commonwealth Society, the Royal Over-Seas League, the Cambridge Commonwealth Trust, the Institute of Commonwealth Studies and the Commonwealth Parliamentary Association.

# THE CDA BULLETIN

### Readers' Comments

*"I did receive the Bulletin - well done - the electronic version is a 'meatier' production than the printed version, I felt".*

*"Thanks for the Bulletin which I found enlightening, I will forward it to my colleagues to view".*

*"I have downloaded and printed a copy of the Bulletin. Once again it's a first class piece of work".*

*"The best ever".*

*"An excellent issue of the CDA Bulletin".*

**We like to receive your comments and the kind of news and articles you would like to see printed in the CDA Bulletin.**

**If you have any news or articles you would like to have printed please send them to the CDA Administrator, who will forward them to the Editors to be considered for inclusion in the publication Contributions, preferably by email, to:**

***Julia Campion***
***CDA Administrator***
***13 Rodney House***
***Pembridge Crescent***
***London W11 3DY, UK***
***JuliaCampion@cdauk.com***

# WHO ARE THEY AND WHAT DO THEY DO?

## Commonwealth Foundation

The Commonwealth Foundation is an intergovernmental organisation founded by Commonwealth governments in 1965. It is resourced by and reporting to Commonwealth governments and guided by Commonwealth values and priorities. Their mandate is to strengthen civil society in the achievement of Commonwealth priorities, particularly those related to democracy and good governance, respect for human rights and gender equality, poverty eradication and sustainable, people-centred development, and to promote arts and culture.

At the heart of civil society are organisations of citizens that come together voluntarily to pursue those interests, values and purposes usually termed the 'common good'. Civil society organisations are diverse and include non-governmental organisations, community grown labour unions, professional associations, faith-based organisations and parts of the media and academia. The Foundation is committed to promoting a viable and vibrant civil society that plays an effective and sustained role in development and democracy in the Commonwealth. This forms the main part of the Foundation's work.
www.commonwealthfoundation.com

* * * * * * * * *

## Commonwealth Secretariat

The Commonwealth Secretariat, established in 1965 is the main intergovernmental agency of the Commonwealth, facilitating consultation and co-operation among member governments and countries. The Commonwealth Secretariat is headed by the Commonwealth Secretary General and is located at Marlborough House in London. Its sister inter-governmental organisations are the Commonwealth Foundation (also based at Marlborough House) and the Commonwealth of Learning (Vancouver, Canada).

The work of the Secretariat is guided by the decisions of Heads of Government and governing bodies. It responds to global developments and the needs of member countries and its activities are results-oriented. The Commonwealth Secretariat's Strategic Plan and work programme is directed by the mandates set by Commonwealth Heads of Government, who meet every two years.
www.thecommonwealth.org

* * * * * * * * *

## The Commonwealth of Learning

Open and Distance Learning for Development: the Commonwealth of Learning is an intergovernmental organisation created by the Commonwealth Heads of Government to encourage the development and sharing of open learning/distance education knowledge, resources and technologies. COL is helping developing nations improve access to quality education and training.
www.col.org

* * * * * * * * *

## The Royal Commonwealth Society

Founded in 1868, the Royal Commonwealth Society (RCS) is an international Non-Governmental Organisation (NGO) working to promote an understanding of the nature and working of the Commonwealth, and of the factors which shape the lives of the peoples and the policies of its governments. The RCS is supported by a worldwide membership of over 10,000, with self-governing branches, honorary representatives and affiliated organisations in 39 countries and territories. The international headquarters are in London.
www.rcsint.org

# DENTAL BOOKS AND JOURNALS FOR TANZANIA

***Julia Campion***
*CDA Administrator*

The Commonwealth Dental Association is very grateful to Andrew Quayle for initiating a scheme whereby dental books and journals are sent to the new Dental School at Muhimbili University in Tanzania.

We received a very good response to a notice we recently placed in the British Dental Journal requesting donations of dental books and journals. These are transported, at no cost to CDA, by the UK-based Quayle Dental Manufacturing Company as part of their consignments of dental equipment to Tanzania. The CDA would like to thank the donors for their excellent response.

This is an ongoing scheme and if anyone in the UK has dental books or journals which they would like to donate to the dental school at Muhimbili University in Tanzania please contact me:
JuliaCampion@cdauk.com
Tel: 020 7229 3931

## Partnership Reception

A Partnership Reception was hosted by The Rt Hon Don McKinnon *(Commonwealth Secretary-General)*, Professor Guido de Marco *(Chairman, Commonwealth Foundation)* and Dr Mark Collins *(Director, Commonwealth Foundation)* on 1st March 2006. The reception was to celebrate the work of the Commonwealth Foundation and to share in their plans for the future in its programmes:

- *Sustainable Devlopment*
- *Governance and Democracy*
- *Culture and Diversity*

Julia Campion represented the CDA at this event.

# CONTINUING EDUCATION IN COUNTRIES MANAGED BY DENTSPLY EXPORT DIVISION

***Penny Hardaker***
*Marketing & Training Director, Dentsply*

**Dentsply** has always been committed to Continuing Education and has been involved in this for many years, working with opinion leaders throughout the world to bring state of the art dentistry to a wider audience. This commitment to education is for professionals in all disciplines of dentistry and extends from students to highly qualified dental personnel. The importance of this is clearly illustrated within the *Dentsply UK Export Division* which manages countries from South Africa to Pakistan and from Cyprus to Yemen, covering a vast geographical region of diverse languages and cultures.

*Dentsply CED Symposium*

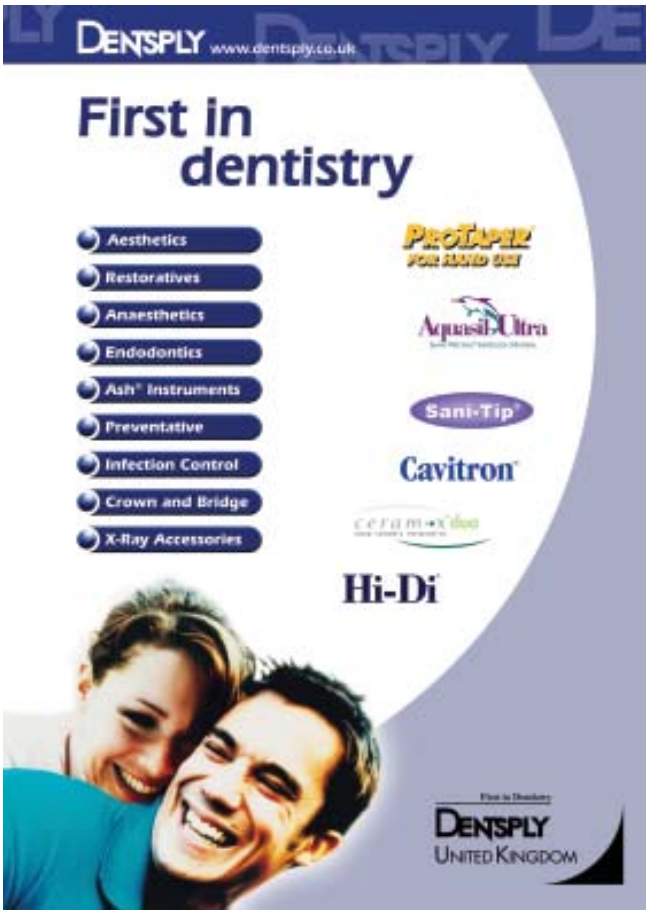
During the past two years the *Dentsply UK Export Division* has been actively involved in promoting Continuing Education programmes in their region and these programmes have been attended by over 6,000 dental professionals from more than 40 countries.

In addition to their support of local dental associations with lectures and hands-on sessions the division also developed the concept of the Centre of Excellence which consists of a programme of lectures and hands-on sessions, conducted by international speakers, delivered to innovative dental professionals from a variety of countries. As well as being able to learn about the latest techniques, and how to solve clinical problems, delegates also have the opportunity to consult with opinion leaders and other professionals in a relaxed environment. *Dentsply* have now held three of these meetings in Dubai and Cape Town and plans are being made for the next symposium to be held in 2007.

Satellite Centre of Excellence meetings are also held in individual countries to bring together local and international opinion leaders to an audience who may not always be able to travel to international congres-ses. In 2006 satellite meetings will be held in Pakistan, Israel and Saudi Arabia.

To complement the local and international meetings and activities *Dentsply Export Division* also publish a twice annual journal - *'Dynamics'* - which contains clinical articles written by dental professionals and international opinion leaders. This journal is distributed free of charge to 10,000 surgeries throughout the region.

The provision of Continuing Education is an important part of the work of the Export Division and they are justifiably proud of the high standard of this promoted by their team, many of whom are themselves dentists. If you would like to receive further information on any of the forthcoming meetings and events please contact:
Penny.Hardaker@dentsply-gb.com
or
Sarah.Halleday@dentsply-gb.com




# DENTSPLY Ash Instruments has got all angles covered

For more than 180 years, DENTSPLY Ash® Instruments has manufactured high quality dental instruments in the UK, and have distributed them worldwide. This tradition is still proudly adhered to today and is clearly witnessed in the unique craftsmanship of its products.

**Flexichange™ - Its time to change:**

- Silicone handled instruments with a comfortable non-slip grip may aid the reduction of Carpal Tunnel Syndrome
- A comprehensive range available – over 70 periodontal and restorative therapy instruments are available
- Interchangeable tips allow for the customisation of instruments and the replacement of worn tips
- There are a range of handle colour available in the range, which allows for easy identification

**Ceramicolor® - Innovation with style:**

- Hard wearing white ceramic handle offers an equally durable aesthetic option
- 6 colour coded handles for easy identification
- Ergonomically designed octagonal shape enhances control, grip and long-term comfort
- Handles can be individually branded with the dental practice name or logo
- All Ceramicolor® Instruments have interchangeable tips offering long term economy

**Lustra® - Setting the standard:**

- These slim handled instruments set the Ash® standard for quality dental instruments
- Manufactured from stainless steel, these instruments are highly resistant to corrosion
- Comprehensive range of Periodontal and Restorative patterns to meet all clinical needs

For more information on the Ash® product range, please contact your local DENTSPLY subsidiary or dental wholesaler regarding supply in your location.