CDA NEWS

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From the Editor

This newsletter has been a while in creation because there has been much discussion in the Executive Committee (EXCO) since the wonderful Conference in Manchester in May last year, which culminated in the production of the Manchester Declaration printed in full on Page 4.

You will see below the Address from our new President, Dr Anthony Kravitz, which described his excitement and enthusiasm for the future, if we can get our finances right, and the Valedictory Address from our outgoing President Bill O'Reilly, which presented a positive message about what the CDA had achieved during his presidency.

Sadly – you must then look at our President's later message below, which outlines a very stark scenario, that unless we all pull together to support a number of initiatives, then we are in serious danger of no longer existing.

From the President

Dr. Anthony Kravitz, OBE

President, CDA

This is my first message to you all in 2016, so I would like to wish you a healthy and successful year. You may have thought that the Association has been very quiet since our very successful General Meeting in Manchester, last year – in which case you would be correct.

As you can read in the full report of the meeting, there were two main discussion areas which took place:

- Our chronic lack of finances;
- A new strategy for activity for the CDA.

These two points are inter-related, of course. Our finances have been dwindling for several years, because of a number of different reasons.

Primarily, the removal of core funding for all the Accredited Commonwealth Organisations, by the Commonwealth Foundation (CF) a couple of years ago, which for the CDA amounted to up to £20,000 annually, has been a disaster. There is still a lot of money available from the CF, but this is wrapped up into such conditions that only larger organisations with professional full-time staff and fund-raisers available, can access it.

Half the original funding was for administration, so clearly we have now "cut our costs to the bone" for this. We have limited travel costs to almost zero (meaning officers have self-funded their travel), and increased our use of IT. The British Dental Association (BDA), which provides the secretariat for the CDA, has frozen their charges for many years and now provides its services below cost.

The other half of the CF money was for supporting our activities, providing seed money, which then enabled us to approach external sponsors for additional funding for such as (for example) workshops. Unfortunately, the larger sponsors now appear to focus their support programmes on the FDI – both centrally and

regionally. We have had no interest from them in subsidising the cost of CDA workshops, where the bulk of their funding goes to pay airlines to fly people across the world and hotels to provide their accommodation. It is clear that at a local level there is still sponsorship for local or regional activities – but the CDA is mindful of not interfering with the flow of funds which support our member associations.

The current financial position is that our funds are now so precarious that we are facing the demise of the CDA, unless something changes. This leads me to our new strategy.

For some time I have been concerned that some of the work we have been doing has no defined or measurable outcome. Yes, we have had some notable successes, particularly at health ministers' level and by the production of guidelines and principles documents, following workshops attended by CDA delegates from different regions. We know that many less developed member countries welcomed and used these. But, with the increased use of these ideas by the FDI (copied by the FDI from us on at least one occasion) the relevance of them on a Commonwealth basis became less clear to me.

I have also been concerned that there have been no other measurable outcomes from some of the conferences and congresses we have paid for delegates to attend. It appeared to me that there is a perception by some that the CDA only exists as a "Travel Club" for senior officers of the CDA or some of its member countries. Whilst this is an unfair comment, nevertheless it is thought as such by several.

So, a couple of years ago, I stimulated a process of discussion by the Executive Committee about a new strategy, and this was finalised during the General Meeting – culminating in the Manchester Declaration. You can read this on page 4. At its simplest, this means that all our activity from now onwards – with the single exception of the Biennial General Meetings, will be focussed on workshops regionally based, with a heavy use of IT (webinars and other use of the internet) to support the training of the individuals who will undertake the activity. The local activity will be designed, coordinated and supervised by the Executive member responsible for the region where the activity is taking place, in cooperation with the regional National Dental Associations (NDAs). The focus will be on the CDA providing something unique, and not necessarily possible by such as the FDI.

We have the support of the organisation "Healthcare Learning" (Smile-on.com) who will provide all the necessary IT infra-structure, at no cost to the CDA except whatever external costs they incur, such as the hiring of A-V equipment, internet charges and suchlike. International speakers' fees and travel costs will be non-existent, as these will all be provided from a central base (not necessarily in the UK).

Currently we are working on three projects which fit into the relevant strategy. These will be based on Kenya and East Africa; Nigeria and Ghana; and SE Asia (administered by Sri Lanka). Several members of the Executive are currently (at the time of writing) working on a very complex bid document, which is likely to come to over 60 pages, once it is co-ordinated by Prof Samarawickrama, our Executive Secretary. The focus is on training personnel – not necessarily dental – to provide oral hygiene and preventive measures in outlying regions of less developed countries, as outreach. Those trained will provide advice and instruction to the populations who cannot get this elsewhere; the trained will also provide training for other potential workers.

We have had one meeting with officials of the English Department of Health (DoH) in relation to our strategy and the funding for it. We knew, even before we attended, that they would be unable to provide funding, but the goal was to get their support for an approach to the UK Department for International Development (DfID) which has billions of pounds available for relevant projects in less developed countries. I have known the English Minister of State for Health for over 30 years, and he has promised me a meeting during which I can outline our

plans; but his officials must have our project document well in advance of that meeting. In fact, we did have one such meeting set for last November, but I called it off, as I felt that our document was incomplete.

If he feels, on the advice of his officials, that our plans are sustainable, he will approach his colleague in charge of DfID to recommend acceptance of our bid for money.

I believe that if we are offered substantial funding by DfID, this will attract other external sponsorship for the CDA, which can underpin our work further on. I remain optimistic about all this.

However, any reader of this message who has had dealings with government departments – at least in the larger countries – will know that beaurocrats work exceedingly slowly! I envisage that even if my colleagues complete their work in the next couple of weeks or so, it will be at least the autumn before we learn about any available funding, and 2017 before we receive any of it.

So, where does this leave us for 2016? Shortly we will be sending out subscription requests to all our member countries. We hope that all current members will pay their subscription, despite the lack of CDA activity during the year. With the full subscription money we should be able to struggle through – just - until 2017.

The implications are that we spend no money for travel or conferences, but concentrate on keeping the CDA going. We were invited by the Malaysian Dental Association to put on a "CDA Day" at their Annual Meeting this July, and they have offered very generous financial support to us for attendance of delegates. Unfortunately, we have had to decline as there would be some financial commitment for us – and even a small commitment might cause our money to run out completely before the end of 2016.

Likewise, we are only accepting other invitations that do not commit any CDA funds being spent.

That brings you up to date where we are. We continue to hold regular Executive meetings, by email – so these incur no cost to us. These may be held a little less frequently later in 2016, whilst we await funding decisions.

"The current financial position is that our funds are now so precarious that we are facing the demise of the CDA, unless something changes.

Finally, we have accepted an invitation from the Indian Dental Association to hold our next Biennial General Meeting there, in Mumbai, in October 2017. Let's hope that we are in a position to attend.

In the meantime, I encourage the NDAs to organise regional or national activities and "keep the flag flying". It is encouraging that some NDAs are already doing this.

Anthony Kravitz

The Manchester Declaration

There is a report later of the CDA's Biennial General Meeting in May 2015 and this was followed Wednesday May 6th by a full-day conference and workshop on the topic: "***Support for Vulnerable Patients and Their Carers***". Speakers included members from all regions of the Commonwealth. At the conclusion of the workshop, the participants agreed a statement of outcome related to this topic - "**The Manchester Declaration**". This followed on from the successful conferences in Cape Town, Johannesburg, Colombo and Accra, the latter producing the Accra Declaration. The Association continued to consider issues relating to oral care for vulnerable people and support for those who care for them.

At the workshop, the CDA confirmed an absolute requirement to ensure equality of access to oral healthcare, coupled with a need to understand the importance of values, culture, beliefs and ethnicity on the delivery of oral healthcare. Vulnerable people have the same rights to the same access and the same high- quality services as all other people and the right to self-determination and freedom from discrimination.

The meeting heard a series of presentations from eminent speakers, including those related to the different CDA regions and then held a workshop covering the following three areas, relating to the Conference title of '*Support for Vulnerable Patients and their Carers*'.

- The concept of vulnerability
- Support for those with learning disabilities and their carers
- Strategies for the oral healthcare of those in residential accommodation and their carers

The Conference then called on policy makers, healthcare professionals and all those involved in caring for vulnerable people to:

1. Promote the need for better access to oral healthcare services for all vulnerable people, ensuring that those responsible understand the links between poor oral health and general health.
2. Understand the effects of an increasing older population with a consequently increasing percentage of those becoming vulnerable over time.
3. Understand and work towards mitigating the risk factors of those with learning disabilities and learning difficulties.
4. Understand and publicise the professional duty of care and the need to be aware of, prevent and report abuse.
5. Support individuals who are vulnerable for whatever reason.
6. Promote the concept of a health passport for vulnerable people.
7. Promote the need for a holistic and multi-disciplinary approach to address the complex health needs of vulnerable people.
8. Work to remove or minimise the barriers to providing oral care for vulnerable people, including ensuring that the cultural and local leaders, elders and family traditions are mobilised.
9. Promote the documenting of the best interests process for those with limited capacity, and the use of oral health assessment forms and oral care plans.
10. Provide, promote and utilise education and training materials and opportunities to help Commonwealth nations improve the oral healthcare of their vulnerable people.
11. Promote the concept of health professionals learning and working together for carers and vulnerable people, noting that carers can be the key people in this process.
12. Acknowledge that the differences between people are valuable and enriching and promote the need for high quality culturally responsive care for vulnerable people.

Malaysian Dental Association
Activities from May 2015 – Dec 2015

Dr. Leong Kei Joe
Honorary Publication Secretary of Malaysian Dental Association

May 2015 marked another new page in the history of the Malaysia Dental Association (MDA). The 72nd MDA Annual General Meeting was held in Penang on May 31st. Dr John Ting Sii Ong was officially installed as the President of the MDA during the Malaysian International Dental Exhibition and Conference 2015, which was held in Kuala Lumpur in June 2015 (see below).

The Western part (consisting of MDA Northern Zone and MDA Southern Zone) and Eastern part (MDA Eastern Zone) of Malaysia are uniquely united by the South China Sea. Hence, MDA sees activities such as CSR projects and conferences being organised by its members on both side of the country. Early in the month of May 2015, Malaysian Dental Association Eastern Zone (representing the states of Sabah and Sarawak) organised the Oral Health Awareness Campaign at Sibu, Sarawak.

MDA Council Installation, with President Dr John Ting 8th from the left

Opening ceremony of the 3rd Sibu Oral Health Awareness Campaign 2015

A nationwide oral health awareness campaign was organised by MDA in collaboration with GSK. The MDA-GSK "Nation of Healthy Smiles" Campaign was held at Kuala Lumpur on the 29th October 2015 and was officially launched by the Principal Director of Oral Health Services, Ministry Of Health Malaysia. The objective of the campaign was to help Malaysians care for their oral health to better enjoy life, and achieve its vision of elevating oral health standards amongst Malaysians. Also, it is to reinforce the importance of practising good oral hygiene so that society can smile confidently and be at social best. MDA had actively participated in this campaign and the roles and responsibilities of MDA among others were to organise:

1. Nationwide Free Dental Check-up at private dental practitioners' clinic.
2. Mobile Dental Clinics in public areas for oral health screening.

Dr Chow Kai Foo, MDA President Elect, with Stacy Wallace, General Manager of GSK, at the media launch of MDA-GSK "Nation of Healthy Smiles" Campaign

The Malaysian International Dental Exhibition and Conference (MIDEC) 2015, MDA's annual mid-year event, was held at the Kuala Lumpur Convention Centre from June 10th to 15th and attracted over 2,500 dental practitioners, allied dental health personnel and representatives from the dental trade industry. This event was graced by the Honourable Minister of Health of Malaysia, Datuk Seri Dr S Subramaniam.

Apart from the main scientific program, there were other symposia that ran concurrently, namely the Medico-Legal Symposium, Endodontics Symposium, Allied Dental Health Symposium and Cleft Symposium.

MIDEC 2015 Opening Ceremony and the launching of the MDA Mobile Apps. Organising Chair, Dr Shalini Kanagasalingam (2nd from left), and the Minister of Health Malaysia, Datuk Seri Dr S Subramaniam (3rd from left)

In conjunction with this conference, a cleft carnival was also organised as MDA's Corporate Social Responsibility (CSR) project. This was held at Kota Kinabalu, Sabah, in collaboration with Cleft Lip and Palate Association Malaysia. Among the activities that took placed at this CSR were free cleft surgery and public forum. Dr Leong Kei Joe, MDA Honorary Publication

Dr Leong Kei Joe, MDA Honorary Publication Secretary (front row, 4th from left) and staff from the Department of Paediatric Dentistry, Sabah Women and Children Hospital, who were involved in the Kota Kinabalu Cleft Carnival held in conjunction with MIDEC 2015

After MIDEC 2015, a further dental congress being was organised by the MDA in October 2015, in the eastern part of Malaysia, in Sabah. The MDA Eastern Zone organised the 3rd Sabah Dental Congress 2015 in Kota Kinabalu, on October 10th and 11th. The theme for this event was "Dentistry Beyond ABC" and was officiated by the Minister of Tourism, Culture and Environment, Sabah, Y.B. Datuk Seri Panglima Haji Masidi Manjun.

Participants busy at the 3rd Sabah Dental Congress 2015 workshop

In the international arena, the MDA has also added another “feather to its cap”. At the FDI in Bangkok, in September 2015, the delegation from MDA, headed by the council members, was actively involved in the passing of the following policy statement of FDI World Dental Federation:

“The new dentist should be able to carry out any kind of dental practice without harm to patients using modern, appropriate, effective and currently accepted methods of treatment.”

The passing of this statement clearly protects the professional rights of the dentist to practise any kind of dental practice which translates into a continuing hunger and eagerness to develop a lifelong learning ethos towards continuing professional development. For the public, it will mean easier access to every form of dental treatment and therefore, reasonable and affordable price. In the FDI AWDC 2014 in New Delhi, the statement from Malaysia pertaining to prevention of early childhood caries was adopted in the FDI Policy Statement "Perinatal and Infant Oral Health":-

"There should be a concerted, integrated effort of parents, schools, health ministries and other stakeholders to decrease the intake of sugar in all its forms."

Guest of Honour, Y.B. Datuk Seri Panglima Haji Masidi Manjun (left) and Dr Abd Rashid Hassan, Chairman of the MDA Eastern Zone (right) sharing a lighter moment, at the informal dinner.

Following this effort of Malaysia, the FDI AWDC September 2015 in Bangkok organised a World Oral Health Forum on **"New WHO Guideline on Sugar Intake for Adults and Children"**. The new guideline for sugar intake for adults and children is that the energy contribution of free sugar in all its forms should be reduced from the current 15-20% to 5% or less of total energy needs. The rest should come from proteins and fats.

The MDA Council members with FDI President, Dr TC Wong

CDA Biennial General Meeting on Tuesday May 5th 2015 held at the Manchester International Convention Centre UK

At the BGM, Dr Anthony Kravitz OBE, of the United Kingdom, was installed as the 9th President of the Commonwealth Dental Association. Present were delegates from 12 countries of the Commonwealth.

Officers elected at the General Meeting were:

President-elect	Professor Adeyemi Olusile (Nigeria)
Executive Secretary	Professor DYD Samarawickrama (UK/Sri Lanka)
Treasurer	Dr Stuart Geddes (UK)
Immediate Past President	Professor William O'Reilly (Australia)
Vice President for South East Asia	Dr Suresh Shanmuganathan (Sri Lanka)
Vice President for Europe	Dr Russ Ladwa (UK)
Vice President for East, Central and Southern Africa	Dr Susan Maina (Kenya);
Vice President for West Africa	Dr Gilbert Ankrah (Ghana)
Vice President for the Caribbean and Canada	Dr Ricardo Crawford (Bahamas)
Vice President for Australasia	Dr David Crum (New Zealand
News Editor	Professor Stephen Lambert-Humble (UK)

Presidential Address by Dr Anthony Kravitz OBE

"Whilst we have been active during the time since our last General Meeting, we have been very quiet about this. Many do not know what we have been doing. Some thought that we had disappeared.

"I believe that it is incumbent, indeed a moral duty, on the larger national dental associations of the Commonwealth to take an active part in the CDA and, through our organisation, reach out to our colleagues in the countries with only a limited number of dental professionals, to give help in their endeavours for their populations.

"Our current strategy to do this was developed in the last couple of years. We have moved into a position where we focus on themes particular to the Commonwealth and we spend our limited resources on using internet communication to convey our messages at meetings, rather than paying airlines vast sums to send people across continents. But, so far, we have barely promoted it. So, I intend that we will become "loud". Indeed, we will need to shout, because whilst it may be true that many of our member associations have progressed such that they need our services less, it cannot be denied that there are many others who could look to us for support in the coming years, especially because they are very small".

Valedictory Address

Immediate Past President Asst Professor William James Anthony O'Reilly

"Just two and a half years ago I had the honour of being appointed as President of the Commonwealth Dental Association. Much has happened in that time."

Bill went on to pay tribute to Dr Sonny Prince Akpabio OBE, the CDA's Founder President, who died peacefully after a long Illness, in November 2014. He is survived by his wife and children. He told the meeting that Dr Akpabio had graduated from the University College London, in 1956. He was awarded the Gibbs Travelling Scholarship in 1964, to undertake a three-month epidemiological study in Kenya, Tanzania, Uganda, Nigeria and Ghana. In 1970, he attained an MDS (London) Degree.

He went on "*In 1996 he was awarded the Order of the British Empire (OBE) by Her Majesty The Queen, for services rendered to medicine and dentistry internationally. In 1999, he was awarded the Roll of Distinction in the British Dental Association for outstanding services to UK dentistry."*

He added "*Dr Akpabio had a distinguished career and it is with great sadness that we note his passing. I am indebted to Professor Stephen Lambert-Humble MBE for providing these details*."

Bill then described activities in which he took part during his Presidency: "*In Capetown 2012, a workshop was held and the CDA theme was Oral Health and Oral Disability in the Elderly. A webinar was delivered from London, facilitated by the CDA's Strategic Partner, "Healthcare Learning: Smile-On*.

"In November 2013, a workshop was held in Johannesburg, South Africa on Oral Health Care for the Elderly. It was chaired by Dr Susan Maina from Kenya who is also the CDA Regional Vice-President for Central, East and Southern Africa. I had the privilege to attend another workshop in Accra, Ghana in February 2014, which was also on the same theme - my nominated workshop theme for the time of my Presidency. I was fortunate to attend a Combined CDA/FDI Workshop in Colombo, in which a range of speakers brought to life matters of great import to the oral health of the Commonwealth countries."

He explained that the CDA Executive were very busy attending various organisations, including attendance at the annual Commonwealth Day celebrations in London, UK. *" I had the great fortune to attend a church service at Westminster Abbey, with Her Majesty The Queen, which was followed by a reception with Her Majesty The Queen and Prince Philip – both of whom spoke to me".*

He also thanked Dr Anthony Kravitz OBE for representing the CDA at The Bahamas Dental Association meeting held in November 2014, where he made a presentation on the theme of '*Fitness to Practise'*.

He said "*A highlight for me was in 2013 with the presentations to Mr David Campion, Andrew Quayle, Dr Sam Thorpe and Dr Mike Knowles, who were recipients of awards for their outstanding*

support for the Commonwealth Dental Association over many years".

He continued "*Your Association is also continuing to strive to look at ways to deliver education services to the disparate Commonwealth of Nations and active attempts to utilise webinars. The Commonwealth Dental Association is grateful to Mr Noam Tamir, at Smile-On, for his continuing support to the CDA. Mr Tamir is an extraordinary man and I am truly indebted for all that he and his staff have done.*

"*I also note that over the years of my tenure in the Commonwealth Dental Association we have had extraordinary support from Manchester Unity Friendly Society in Australia, as well as the National Australia Bank in Australia, and more recently, the recurrent funding of BUPA Dental Corporation who have kindly supported the activities of the CDA. I am grateful for their support. Also of note is the support that you, members of the Commonwealth Dental Association, as well as Ulrike Matthesius, Anthony Kravitz, Professor Samarawickrama and my Regional Vice-Presidents have extended to me over this time.*

He finished by saying: ***"Thank you. I wish you fair winds and following seas, and a robust future for the Commonwealth Dental Association."***

Executive Meetings

We hold ExCo meetings every three months; these are by email and we have a timed agenda, to keep discussions focused. However, we have one face-to- face meeting after each General Meeting, giving the opportunity for members to meet and get to know each other.

Naturally, we took the opportunity of the Manchester BGM and workshop to hold an ExCo meeting the day after the workshop. This is the group photograph of those who were able to stay to attend this:

From left (to right): Ricardo Crawford (Bahamas), Stephen Lambert-Humble (UK), Adeyemi Olusile (Nigeria), Suresh Shanmuganathan (Sri Lanka), Anthony Kravitz (UK), Bill O'Reilly (Australia), Susan Maina (Kenya), "Prof Sam" Samarawickrama (UK/Sri Lanka) and Gilbert Ankrah (Ghana)

Missing from the photograph: Stuart Geddes (UK), Russ Ladwa (UK) and David Crum (New Zealand)

SUPPORT FOR VULNERABLE PATIENTS AND THEIR CARERS - THE NIGERIAN PERSPECTIVE: PROVIDING SUPPORT AMID WARS AND DISEASES

Professor Adeyemi Olusile, CDA Vice President, West African Region – presentation to the CDA Workshop in Manchester, May 2015

This presentation will attempt to outline the differences between peaceful and challenging political times in Nigeria and the practical impact on oral health; it will also consider efforts of the professional in delivering oral health care services in such times.

Nigeria is the eighth most populous country in the world, the most populous in Africa. The United Nations estimated that the population in 2009 was 154,729,000, distributed as 51.7% rural and 48.3% urban, and with a population density of 167.5 people per square kilo meter. The economy of Nigeria is one of the fastest growing in the world.

Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. However, because Nigeria operates a mixed economy, private oral healthcare is difficult, if possible at all. The result is high morbidity and mortality. Cleft of the lips and palates in the adult is a common occurrence.

Considerable efforts are being made by the dental professionals to incorporate improved oral healthcare services with the ongoing reforms in the health services. Nigeria has adopted a Strategy of Health for All, through primary health care. There is a new oral health policy, the thrust of which is to take oral healthcare to all the 774 local government areas in the country, the implementation of this is awaiting the President's assertion.

Realising that national capacity and resources are not sufficient to ensure availability and access of essential oral healthcare to the population especially in the deprived communities, the Nigerian Dental Association has embarked on oral health awareness program across the nation.

The NDA is providing oral health education to the population through the electronic and print media, attempts are being made to make inroads to the rural areas, but unless this gets to the most remote of these areas and it is continuous and sustained for some time it will not yield expected result. Sponsorship for such campaign is huge and difficult to get.

BOKO HARAM

Although the Boko Haram, a radical Islamic group from the northeastern Nigeria had been in existence since 2002, it became more visible since 2009 when it launched its violent campaign to wrest power from the government and foist an Islamic State under the supreme law of Sharia. Boko Haram – which translates in English, roughly, as 'western education is sinful' – preys on the perverted belief that the opportunities western education brings are sinful. Anybody that practises a semblance of western culture is a target.

Since 2009, an estimated over 10,000 have been killed, and about two million Internally Displaced Persons (IDP) have been rendered homeless by the terrorist group. There are 18 of such camps in Maiduguri, the capital of Borno State. One of these 18 camps is at the Government College, Maiduguri, a 10 minutes' drive to the Teaching Hospital that houses a dental hospital where dentists and dental students practice. This camp was recently visited by some staff of the Faculty

of Dentistry and some Dental Students.

The aims of the visit included:

- To create oral health awareness among the internally displaced persons
- Assess persons with dental treatment needs for the purpose of training dental students in clinical practice.

The 18,009 displaced persons in this camp were given oral health talk by a Resident Dentist and mouth brushing demonstration done by a Dental Hygienist.

None of these 18,009 persons, some of who are over 60 years old, have ever been to a dentist! The 175 among them that were in need of treatment were taken to the teaching providers of health, who play a visible role in healthcare delivery. The federal government's role is mostly limited to coordinating the affairs of the university teaching hospitals and federal medical centres, while the state governments manage the various general hospitals and the local governments focus on primary health centres, (which are regulated by the National Primary Health Care Directorate Agency and the Ministry of Local Government). The total expenditure on health care as % of GDP is 4.6, while the percentage of federal government expenditure on health care is about 1.5%.

Considering the issues of oral health in the West African region and in Nigeria, the vulnerable people are those living in the rural areas, especially the poor among them. In this region, there is generally low awareness of oral health; this, couple with ignorance and lack of access to oral health care services make the prevalence of oral diseases to be high, this is more so among the poor living in the rural areas.

As properly put by Margaret Chan, the WHO Director General, "the world has never possessed such a sophisticated arsenal of interventions and technologies for curing diseases and prolonging life; yet the gap in health outcomes continue to widen". This is demonstrated very well in Nigeria. While the city people may have access to the best of oral health care facilities, the rural settlers do not even realise that they have an ailment and when they know they do not know where to go for treatment, because there are no oral health facilities nearby.

There are about 5,000 practising dentists in Nigeria, serving a population of 160 million, that is one dentist to 32,000 people, whereas it is about one dentist to 2,000 people in industrialized countries.

Out of the 5,000 dentists in Nigeria, about 3,000 are in the south western part of the country with a population of about 48 million but in the north-east, with a population of about 20 million, there are less than 100 Dentists! Virtually all these 100 Dentists practise in the cities and big town, but none in the rural areas, where 70% of the populace live. In these rural areas, there are no oral healthcare services; over 99% of the adults there have never been to a dentist because there is none in their locality.

Some people may need to undertake a 100 kilometre journey to get to the nearest oral healthcare facility. Such a trip may cost about 3,000 naira (£10) and when added to the charges for treatment - a simple tooth restoration or extraction costs 1500 naira (£5) - the total cost will be about £15. About half of this is what it costs an average family in this group to feed for a week! So, when faced with this choice, oral health is sacrificed for food for the family. The minimum wage is about £60 a month.

Fortunately, because of the nature of the local diet, the incidence of dental caries in these rural communities is very low but when it occurs, it remains mostly untreated. Periodontal disease is very rampant being prevalent in more than 60% of adults. Teeth with deep periodontal pockets are a common occurrence among these people, but they live with it.

Nigeria has its fair share of global orofacial cancers but, because of poverty, ignorance and lack of access, presentation from the rural dwellers is usually so late that treatment is in-hospital for restorations and extractions.

The visits had good military protection, treatment in the hospital was free and transportation to and from the hospital was also free!

In essence the Boko Haram insurgency has brought some good fortune to some of the vulnerable people of north-east, they having been forced from their villages to the capital of the state, those that needed dental treatment among them had it done, free. Hopefully, this exercise will be repeated in each of the other camps in the state.

Also too, when the activities of the terrorists have been checked and the camps become fairly stable, a comprehensive primary oral health promotion program as recommended by Ogunbodede et al can be organised among the IDP in the camps.

Among the Liberian Refugees in Ghana in the late 1990s, because they were far away from the cause of their displacement, there was some assurance of safety and because the camp was fairly well organized, the Refugees in Buduburam, Ghana had an oral health program established within the camp.

The displaced peoples' camps in the north eastern Nigeria are quite different from most of others in the world because safety could not be assured, consequently, organisations and groups that would ordinarily have gone to assist the IDP are not there. Even, the government is basically concerned about feeding the IDP and providing them shelter

To support these vulnerable people in their environment, dental professionals are cajoling the government to implement the new oral health policy. This will include the establishment of oral health clinic at the primary health centre in each locality, and is within 20 kilometres of everybody in the area.

Dental professionals have appointed Dental Ambassadors among government dignitaries; the Senate President is one of them. The motive is that these Ambassadors will plead the case of oral healthcare at appropriate times.

The Nigerian Dental Association is attempting to make inroads to these rural areas, but unless this gets to the most remote of these areas and it is continuous and sustained for some time, it will not yield expected result.

Past President of the CDA, Victor Eastmond of Barbados, is pictured receiving the Gold Crown of Merit, from the Governor General of Barbados, on behalf of HM The Queen, recently.

On the occasion, he wore his CDA Past-President's badge

Feature Article 1 (Nigeria)

THE PREVALENCE AND PATTERN OF DECIDUOUS MOLAR HYPOMINERALIZATION AND MOLAR-INCISOR HYPOMINERALIZATION IN CHILDREN FROM A SUBURBAN POPULATION IN NIGERIA

Oluwaseyi Dada Temilola, Morenike Oluwatoyin Folayan, Titus Oyedele (Nigeria)
BMC Oral Health2015 15:73

An important paper for the field of dentistry in Nigeria, as we clearly establish that deciduous molar hypomineralisation (DMH) and molar-incisor hypomineralisation (MIH) are significant risk factors for caries in the study population. Learning to identify and promptly manage these lesions is important.

The article is also accessible at:
http://www.biomedcentral.com/1472-6831/15/73

Abstract

Background:Molar Incisor Hypomineralisation (MIH) and Deciduous Molar Hypomineralisation (DMH) have significant impact on the quality of life of affected individuals. The objective of the study was to determine the prevalence, pattern and clinical presentation of MIH and DMH in children resident in Ile-Ife, Nigeria, and their association with sex and socioeconomic status of the children.

Methods

Information on age, sex and socioeconomic status was collected from 563 children aged 3 to 5 years and 8 to 10 years using a structured questionnaire through a household survey. Clinical examination was conducted to assess for the presence of DMH and MIH. The prevalence of DMH and MIH were determined. Tests of association between sex, socio-economic status, prevalence, and pattern of presentation of both DMH and MIH were conducted using Pearson's Chi-squared test Fisher's exact test.

Results

Fifteen (4.6 %) of the 327 children aged 3 to 5 years and 23 (9.7 %) of the 237 children aged 8 to 10 years had DMH and MIH respectively. There were no significant association between DMH, sex ($p = 0.49$) and socioeconomic status ($p = 0.32$). There were also no significant association between MIH, sex ($p = 0.31$) and socioeconomic status ($p = 0.41$). MIH/DMH co-morbidity was observed in eight (34.8 %) of the 23 children with MIH. The mandible and maxilla were affected equally. Antimere was not observed.

Conclusions

The prevalence of DMH and the prevalence of MIH in the study population were high. DMH and MIH were not associated with sex and socioeconomic status. There was no specific pattern identified in the presentation of DMH and MIH. The prevalence of DMH/MIH co-morbidity is also high. Patients with DMH should be screened for MIH.

Feature Article 2 (Tanzania)

The Buhangija School/ Centre

Article provided by Mr Andrew Quayle, Quayle Dental

The Buhangija centre in Tanzania has 39 children with blindness, 62 children with hearing impairment, 236 people with Albinism. 72 of the above are registered and attending English Medium Schools outside the center at the moment. The centre has 14 care takers for all the children, 4 cooks and a total of 3 teachers.

Oral health activities undertaken

1.Oral Hygiene Education and Tooth brushing demonstration
2. Free Dental check up and (OHI) to all children, teachers, other staff (the cooks)
3. Treatment of Oral Diseases and conditions, e.g extractions, simple 1 visit GIC restorations, Scaling
4. Incentives e.g. Tooth brushes, tooth pastes and T-Shirts given to all the children, teachers and other staff at the centre.

Positive experiences and lessons learned

1. Logistics excellent, thanks to **Quayle Dental** (MediDent) for sponsorship of meals and accommodation
2. Maximum cooperation from all the Administrative officials, RAS, RMO, District Educational Director (DED), The Council Director, and the District Medical Officer (DMO).
3. Maximum cooperation from the Buhangija Centre
4. Good coverage from media

Achievements / Output of the activity

- 317 Dental Check-ups and OHI conducted on all children and staff at Buhangija Centre
- **119 (37%)** had at least one carious tooth, **130 people (41%)** had periodontal conditions, **3 children (1%)** had dental trauma, **22 children (7%)** had different forms malocclusion, **46 children (14%)** had dental fluorosis. **96 (30.3%)** chil- dren received treatment, either through restoration of the cavities using Glass Ionomer Cement (ART approach), and /or by extraction(s) of the grossly carious teeth, under LA.
- Raised oral health awareness among the children, care givers and teachers through OHE/OHI
- Tooth brushing demonstration was done to all children, care givers and teachers at the Centre
- De-worming tablets obtained for the children living at the Centre.
- Managed to solicit for a nurse and a clinical officer to be stationed at the Buhangija Centre with an immediate effect from the **19th of March, 2015**.

Challenges

1. Communication with the children who could not hear / see
2. Gathering information regarding ages and Identity (names) of the children; Teachers, and care givers tried their best to assist whenever the team needed.
3. Children with blindness could not comprehend fully the OHI given

4. Shortage of Materials and equipments, e.g. Shortage of Intermediate Restorative Material (IRM) or Temporary Filling (TF), Topical Anaesthesia, Mouth mirrors and scalers
5. Facilities to support provision of Oral health care to the children
6. Lack of any sort of medical personnel within the centre, in case of any emergency.

Recommendations

1. We strongly advise for these centers to be visited regularly by various health professional teams (Rural Health Management Teams - RHMTs and Council Health Management Teams -CHMTs)
2. Set a plan to have a health officer based at the centre.
3. Training and education for the care givers to be able to assist the children with special needs, basic oral health hygiene.
4. The Tanzanian Dental Association (TDA) needs to plan and get more necessary instruments for basic examination and scaling, and treatment.
5. To plan to visit these centers regularly and set sufficient time for such oral health activities/camps.

Oral health education OHE sessions

Tooth brushing and OHE sessions

Tooth brushing practice sessions

Treatment of oral diseases and conditions

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