Commonwealth Dental Association

Working for Oral Health in the Commonwealth

CDA BULLETIN

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

From the Editor

In this troubled world, there are many challenges to be overcome to get on with one's share of work. Although individuals as well as organisations are faced with these challenges, the latter's efforts are compounded by the very fact that these are dependent on constituent members and partners to deliver the outcomes on the organisations' behalf. Therefore, it is heartening to report in this issue of the Bulletin a number of activities that have been completed by our partners.

Kenya Dental Association has undertaken a project to identify and manage the oral health needs of children residing at children's homes and special schools. It is heartening to note that 80% of children reported an improvement in oral health at the conclusion of the project. What is more, treatment approaches have not been complex at all, requiring only modest resources.

The Symposium on Migration of Health Workers, often termed the "Brain Drain", held in New Delhi, discussed underlying issues and strategies to manage this effectively.

Iain Corran considers a very important issue affecting dentists wishing to work in a less developed country as a volunteer: the need to be registered with the local national dental council, as well as possessing indemnity cover. He also raises issues affecting dental students seeking elective placements abroad, especially with charitable organizations and NGO's.

A joint Workshop on Oral Urgent Treatment held in partnership with the Tanzanian Dental Association and Bridge2Aid at Mwanza, Tanzania, was funded by the Commonwealth Foundation. It shows what can be achieved when organizations work together for a common purpose.

In order to keep up with rapid advances in dentistry, it is necessary to engage in continuing Professional Development, CPD. The report on how CDP is managed in Kenya will be of interest to other national dental associations.

CDA participated in the Commonwealth Health Ministers Meeting in Geneva. This provided an opportunity for the CDA representatives to interact with many Ministers and senior health officials. Several important issues were discussed.

The Financial report by the Treasurer of the CDA, Dr. Anthony Kravitz, highlights the dwindling resources at the Association's disposal. Raising funds for the CDA has always been difficult. The current recession affecting the world economy has compounded the problem.

Finally, the CDA Triennial Meeting is to be held in Singapore on 5th September 2009, during this year's meeting of the FDI, The World Dental Federation. We look forward to welcoming many of you to this meeting.

Thus it can be seen that despite many challenges facing us, the CDA and its partners are striving to get on with their share of work to improve oral health of the people in their countries.

DYD Samarawickrama

Message from the President

Prof Jacob Kaimenyi

Greetings to all members of the dental fraternity in the Commonwealth!

May I take this opportunity to sincerely thank everyone of goodwill who has given me tremendous support during my term of presidency. As you are aware, my presidency comes to an end during the forthcoming 6th Triennial Meeting of CDA, which will be held on 5th September 2009, in Singapore.

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In an effort to meet its aims and objectives, the Association has continued to promote oral health care strategies, including the application of appropriate technology, facilitating continuing dental education programmes, participating actively in the work of Commonwealth ministers in so far as is consistent with the Association's consultative and observer status, editing and publishing a regular Bulletin and holding regular meetings and conferences.

However, there are two areas which we need to address, namely; assisting member countries to establish dental associations where such do not exist, and providing technical cooperation and advice to member associations of countries within the Commonwealth. Mine is to appeal to you all to be sensitive to participating in those activities which will make CDA a vibrant and relevant association. Towards this end, we welcome your views, from time to time, on whether the Association is meeting its aims and objectives or not. For example, we would like to find out whether we are meeting the Millennium Development Goals or not. Indeed, this will be part of the agenda during the Triennial Meeting.

Once again, as I have done in the recent past, I kindly appeal to the regional Vice-Presidents to promote the aims and objectives of the Association. Indeed if all submitted quarterly reports of the activities within their regions, then we would be able to appreciate and share information on best dental practices from different regions of the Commonwealth.

Since members' contributions are central to improving the performance of any Association, mine is to also request those who will be in attendance during the FDI meeting in Singapore in September 2009, to attend the General Meeting as well as the workshop on "Challenges of Infection Control in a Rural Setting", which will be taking place during the meeting.

KENYA PROJECT REPORT (Children)

Reaching Out To Needy Children With Oral Health Education And Intervention In Kenya

Dr. Susan Maina *- Project Leader*
Senior Lecturer, University of Nairobi School of Dental Sciences
Sponsored by FDI World Dental Federation/Unilever Partnership

Introduction

The FDI World Dental Federation formed a partnership with UnileverOral Care in 2005 to promote oral health globally under the theme LIVE, LEARN, LAUGH.(LLL). The ultimate mission of the Live Learn Laugh Programme is to improve oral health globally. Presently, Partnership is funding 40 oral health development programmes in 37 countries worldwide.

FDI World Dental Federation

The FDI World Dental Federation represents approximately 200 national dental associations and specialist groups. Its vision is, "leading the world to optimal oral health, acknowledging, general health does not exist without oral health". Their vision is brought to life through the global voice for oral health, and delivering excellence in oral health policy and promotion; continuing professional education; and access to care.

The Kenya Dental Association initiated the project, "**Reaching Out To The Needy Children with Oral Health Education and Intervention**", which was approved and sponsored by FDI/Unilever Global LLL Partnership. This project was motivated by "The Nairobi Declaration on Oral health in Africa," which in itself was conceived following the first FDI/ WHO planning conference for Oral Health in Africa, which took place in 2004 in Nairobi, Kenya. This declaration affirmed our commitment to oral health as a basic human right and the need for sustained oral health data in order to pursue promotion of lifestyle to benefit the communities and to support affordable prevention strategies. It is also important to acknowledge the fact that Oral Health forms an integral part of the general health of an individual.

However, marginalized groups have been known to have poor access to health care services including oral health care. Children with disabilities, orphaned by HIV/AIDS, abandoned, former street children or those whose parents are imprisoned are a part of these marginalized groups.

The purpose of this project was therefore to improve the oral health status of children at childrens' homes and special schools, through oral health education, diet education and counselling and to offer dental treatment for the needy cases, with a long term goal of imparting knowledge on preventive measures of the two common oral diseases, mainly: dental caries and periodontal disease.

The project was started in earnest with a launch on the 5th of August, 2006 at Mama Ngina Children Home in Nairobi with the following specific **objectives**:

- To identify oral health treatment needs of children in different homes in the eight Provinces in Kenya,
- To provide oral health education and diet counseling to the needy children and their caretakers,
- To provide intervention per the treatment needs,
- To provide continuous oral health education through monitoring of oral hygiene and diet.

Project Sites	Descriptions	Ages
Mama Ngina Children Home (Nairobi)	Hosts, orphans, abandoned and disadvantaged childrenabandoned and disadvantaged children	up to 18 years
Rescue Dada Home (Nairobi)	Deals with the rehabilitation of street and abused children of all ages	up to 18 years
Rehema PEFA Home (Nairobi)	Hosts children who are abandoned, abused, children of imprisoned mothers, orphans, those living with HIV/AIDS and children with mental and physical disabilities	up to18 years
Emmanuel Feeding Center (Nairobi)	Hosts children from Kayole Soweto slums	3-18 years
Wamunyu Home (Eastern)	Hosts mentally handicapped children	3-15 years
Machakos Special School (Eastern)	for the physically handicapped. This a day mixed school that hosts children	6-15 years
Nest Home in Limuru (Central)	Home hosts children of imprisoned mothers and re-integrates those in conflict with the law	
Mudzini Children's Center (Coast Kilifi-Kikambala).	This home hosts orphaned, abandoned and mistreated girls only	2-18 years
Good Life Children's Home (Coast-Mtepeni in Mtwapa)	Hosts orphaned, abandoned and vulnerable children	2–18 years
Green Olive Children's Home (Coast, Mtwapa)	Hosts orphaned and abandoned children	2-18 years
TWAAYF Children's Home (Total War Against AIDS Youth Foundation) Coast. Likoni)	Hosts orphaned, abandoned and vulnerable children. Also acts as a rehabilitation center for minors who have engaged in drugs at an early age	2 -18 years
Grandsons of Abraham. (Coast Kilifi Kikambala)	This is a boys' orphanage, which hosts children	4-18 years
Jambo Jipya Children's Home (Coast)	Hosts boys who are Orphans, abandoned and/or abused	10-18 years
Kikambala Community (Coast Kikambala)	Children with special needs	3-10 years

Table showing details of the Project Sites

Target group

Children aged 3-18yrs, living in children's homes and special schools who were abandoned, abused, children of imprisoned mothers, orphans and those living with HIV/AIDS; children with mental and physical disabilities andrecognized groups of marginalized children living in slums with special needs.

Project sites

The project has so far reached 1,055 children in 12 homes, one special school, a poor community and a feeding centre in a slum. These sites are in four provinces in Kenya namely; Coast, Eastern, Central and Nairobi. The Table above show details of each site.

Materials and Methods

A questionnaire was used to collect each child's personal details. Data on basic oral health; oral hygiene habits, brushing with fluoridated toothpastes and the frequency of intake of sugary diet was recorded. Intra oral examination was done. Dental caries and periodontal status were recorded on data collection form. Each child's treatment needs were determined and a treatment plan was formulated .

Oral health education was taught to all the children in small groups using designed poster with messages on brushing twice daily with a fluoridated toothpaste, good diet verses sugary diet and the need to visit a dentist. The caretakers and matrons were separately also taught on good oral hygiene principles and practices and the effect of sugary diet.

Toothbrushes and toothpastes were provided and marked for each child. Brushing with fluoridated toothpaste was demonstrated and each child was requested to brush as demonstrated. The caretakers and matrons ensured that all children brushed their teeth at least twice a day after breakfast and after dinner, except for children in Emmanuel feeding center, where tooth brushing was done after lunch, since that was the only time the children were fed. In this center the children were also provided with toothpaste and brushes to take home and requested to brush after dinner, with the help of their parents/guardians who had been allowed to sit in during the oral hygiene instruction sessions. Toothbrush holders were designed and delivered to the homes, marked to correspond to each child toothbrush identification number.

The home administrators were requested to reduce the provision of sugary diet to the children after being informed of the detrimental effects of sugary diet. Posters with oral health instructions on brushing and diet were placed in strategic positions, classes, dormitories, bathrooms doors and dinning room so as to act as a reminder to the children.

Treatment Needs of the Children

All the 1055 children required oral health education, oral hygiene instruction and diet and counseling. 100% of the children needed oral prophylaxis and scaling. Details of other treatment needs are presented in Table 1 on the next page.

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Treatment Needs	*Children*
Prophylaxis/Scaling	1055
Filling	590
Extraction	230
Pulpotomy/Root canal treatment	30
Interceptive orthodontics	14
Crowning	8
Tongue tie treatment	1

Table1. Shows the treatment of the children screened.

Treatment

Over 90% of the treatment was provided on site using the Kenya Dental Association dental caravan and the other was done at the School of Dental Sciences, University of Nairobi. The Table 2, shows the treatment provided to the children.

Treatment	*No*
Baseline screening and examination	1055
Oral hygiene instructions	1055
Diet analysis and counseling	1055
Radiographic examination	
Orthopantogram	14
Bilateral Bite wings	19
Intraoral Periapical	30
Impressions	14
FMS/Prophylaxis	820
Extractions	230
Intercept Orthodontics	14
Surgical	3
Pulpotomy and root canal treatment	30
Filings	590

Table 2. Shows the treatment given to the children in all the homes.

Results

100% of the children needed oral health education and diet counseling due to the poor oral hygiene status and high caries diet. Most homes (70%) gave the children biscuits twice weekly and brushed only occasionally. The homes in Nairobi had a higher caries incidence as compared to those in Mombasa/Kilifi. This was attributed to the high and frequent consumption of sugary items mainly biscuits which are donations to these homes. The children in homes in Mombasa/Kilifi, had poorer oral health status with a lot of plaque and calculus compared to those in homes in Nairobi and all of them required either oral prophylaxis or full mouth scaling and polishing. This was thought to be due lack of toothbrushes, poor oral hygiene practices and oral health awareness on basic principles of maintaining good oral health, which is an integral part of general health. Majority of the children reported lack of knowledge in maintaining their teeth and only brushed occasionally and most of them had never visited a dentist. 590 fillings were done and 77.7% of children had oral prophylaxis or scaling and polishing done.

Project impact

- Improvement of oral hygiene status of the children by 80%,
- Reduction of sugary diet (50%),
- Reduction of pain by 80% for those offered treatment and
- Reduction of oral disease burden by 50% of the children treated.

Sustainability

It is hoped that sustainability will be achieved by the homes, Ministry of Health (Kenya) and the Kenya Dental Association.

Challenges

The project budget was to cater for a small population but the need to offer oral health education and intervention is enormous. The long-term sustainability of this project presents a main challenge. It is hoped that other organizations can partner with the Kenya Dental Association and form initiatives like this one to help the needy children in Kenya and globally.

Conclusions and Recommendations

- Dental caries and gingivitis were the commonest oral diseases among the children seen.
- Children in Mombasa/Kilifi homes had more periodontal disease as compared to those in other homes who had higher caries incidence. This was associated with oral hygiene awareness and sugary diet.
- Oral health status of these children was improved by 80%. Therefore, there is a need for similar projects in other parts of the country.
- It is recommended that all oral health policy makers emphasize on preventive measures of the two main oral diseases especially among children at an early age.

Acknowledgements

- Unilever and FDI, for sponsoring and disseminating information and training on project implementation
- Administrators and matrons on project sites
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- KDA for planning, implementation of the project and for providing its members to carry out the project namely; Dr Linus Ndegwa, Dr. Avni Shah, Dr.Gichagi and Dr. Y. Sakina. They were assisted by Mr. Makhanu-Dental Technician, Tabitha Nyahe-Dental assistant and Esther Mwendwa-KDA secretary.

REPORT ON COMMONWEALTH ASIA SYMPOSIUM ON MIGRATION OF HEALTH WORKERS

New Delhi, India 17-18 November 2008

Datin Dr. Norain Abu Talib - *Principal Director of Oral Health Malaysia*

Introduction

Recent trends in the international migration of health workers have resulted in many issues of concern regarding health care workers. The Commonwealth Foundation in collaboration with Commonwealth Secretariat and the Commonwealth Medical Association (CMA) convened a two-day symposium on the migration of health care workers, with particular focus on the Commonwealth code of practice for the international recruitment of Health Workers. This symposium was particularly aimed at all members of the Commonwealth professional bodies. Eight Asian Commonwealth countries i.e. India, Sri Lanka, Singapore, Pakistan, Malaysia Bangladesh, the Maldives and Brunei participated in the 2 day symposium.

The objectives were to share experiences of good practice among countries and to address challenges on managing health workers migration. Strategies to manage issues on migration at national, regional and international levels were identified raised and discussed.

The Symposium

The Commonwealth Code of Practice was a multilateral agreement adopted in 2003 by all Asian members of the Commonwealth health professional bodies towards enabling effective advocacy to address health workers shortage. It is not legally binding but the document offers recommended workable solutions to address the issues pertaining to migration of health care workers. At the same time, it is the responsibilities of governments to work collaboratively and identify effective strategies to retain health workers.

The healthcare sector is labour intensive and there are issues in ensuring equal distribution of manpower between urban and rural areas. In the symposium it was highlighted that 17 Commonwealth countries are facing critical shortage of health care workers and the global shortage is around 4.3 million. There is a need to address the imbalance between the pull and push factors, as well as the unethical practice in recruiting health care workers. Issues within the Code must be made known to those concerned and contractual requirement must be clear to all those who wish to migrate.

International recruitment of dental professionals

1.Recruitment of dental professionals abroad seems to have some impact on the distribution of manpower in both the source and recipient countries.

2. From the professional viewpoint, migration is necessary to enable the transfer of expertise and sharing of knowledge and skills.

3. There is also room for personnel and professional development besides the monetary gain.

4. However, to safeguard countries from experiencing a shortage of dental professionals, in the future migration should only be an interim short term measure and must be on a government to government agreement.

5. In the world of globalisation and liberalisation, countries should welcome dental practitioners with expertise in specialty and niche areas.

6. There is also concern for quality and safety of patients and thus dental professionals must possess a qualification that is registerable with the competent authority and possess a valid practicing certificate.

7. Practitioners must also practice in compliance to the current domestic regulations of each country. The code of professional conduct must be adhered to.

Recommendations

The following resolutions were proposed to be adopted at the Health Ministers Meeting in Geneva in 2009:

1. To encourage all national associations to play supportive roles in dissemination of relevant information for health care workers migration.

2. Research on migration of healthcare workers will be addressed jointly by Commonwealth Foundation and Commonwealth Secretariat.

3. The Commonwealth Code of Practice for the international recruitment of health workers introduced in 2003 was the first policy document. All member countries are required to ensure compliance to the Commonwealth Code of Practice for migrant workers.

4. Each country must assess its own workforce need and that each government must have a social responsibility towards health and improve retention of healthcare workers.

5. There must be a mechanism in place to improve data exchanges between recipient and source countries.

6. Strategic alliances between countries must be strengthened to manage the problem.

NO EXCUSES FOR DOUBLE STANDARD

Ensuring Appropriate Professional Registration When Working Outside The UK

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Ian Corran

It Started with a Phone Call

Recently I received a call from a CDF Colleague, who was imminently departing the UK to undertake voluntary dental work in an African (Commonwealth) country, The colleague had confirmed with his indemnity organisation that his indemnity covered him whilst undertaking this work. The Dental Indemnity organisation asked the CDF Dentist whether he had complied with any Professional Registration requirements with the Dental Council of the country he was going to work in.

Our colleague had a dilemma. I knew from my own experience when I had worked as a dental volunteer at a Hospital in Zambia over 20 years ago, and subsequently for a Christian UK Based NGO/Charity in Tanzania, I had ensured I had indemnity cover, but did not consider applying for temporary registration with the Dental Councils in Zambia or Tanzania.

Twenty years later, professional regulation has developed and is more comprehensive than two decades ago. Dental Professionalism in 2008 is more than just paying the annual retention fee (ARF) whether you are a Dentist, Dental Therapist, Dental Hygienist or Dental Nurse. There is the widening scope of the requirements set out in the General Dental Council's ethical framework *Standards Guidance* Documents that have to be complied with.

No excuse for Double Standards

Should a dentist from an African Country wish to work in the United Kingdom, they would be required to have full or temporary registration with the UK General Dental Council,

Why should it be any different if we wished to go and undertake dental work, voluntary or paid, in any other country in the world?

There is still a requirement to ensure we are appropriately registered with the governing Dental Council in that country and comply with their regulatory requirements.

Advice from the Commonwealth Dental Association (CDA)

In the circumstances I contacted the Administrator of the CDA, Ulrike Matthesius who provided the following advice;

"Those dentists should always be registered in the country where they are practising, even if they are volunteering. There may be arrangements between charities and regulators that could help facilitate this registration. If the country registers and regulates dentists, then all practising dentists should comply with the country's requirements and the sending organisation should liaise to this effect with the relevant regulator."

This guidance is quite clear and unambiguous.

On the Commonwealth Dental Association Website www.cdauk.com, you can access a *Survey of the Dental Workforce in Commonwealth Countries (2007)*. This provides details of regulatory authority for dental workers in each Commonwealth country.

An Exemplar: *Bridge2Aid*

I subsequently discussed this matter with Ian Wilson, the CEO of *Bridge2Aid*.

Ian explained that *Bridge2Aid*, ensure that all dentists working for the charity comply with all necessary legal requirements to work as a dentist in Tanzania.

Ian is registered with the Tanzanian Dental Council (as well as the UK GDC) and has the necessary professional indemnity to undertake dental work at Hope Clinic in Mwanza and outreach dental work.

For those UK dentists who go out to Mwanza to work on the Dental Volunteer Programme (DVP), *Bridge2Aid* arranges Temporary Registration with the TDC. This involves an administrative fee, and requires certified copies of a dentists' current GDC Annual Practising Certificate, Current Indemnity Certificate, and a letter of good standing.

It would be hoped that all other charities and NGO's who provide dental care in developing countries, follow *Bridge2Aid*'s example and ensure that the necessary Dental Council Registration is in place before undertaking any dental work outside the jurisdiction of their GDC UK registration.

FDI Guidelines for Dental Volunteers (2005)

The World Dental Federation (FDI) have produced a guideline for dental volunteers.

http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Ethics/Guidelines_dental_volunteers.pdf

This one page statement includes:

"Volunteers should conform to the legal requirements for the practice of dentistry in the selected jurisdiction and including the required qualifications,

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diplomas and professional liability insurance"

Further, the FDI have published a policy statement on the illegal practice of dentistry which can be found at:

http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Illegal Dental Practice/Illegal dental practice.pdf

Paragraph 3 states *"The FDI recommends that the appropriate Governmental agencies of all countries, legally regulate the practice of dentistry, based on the principles of self regulation and competent authority"*

Further at paragraph 5:

"The FDI recommends the competent authorities in each country – to control the practice of dentistry within the established legal framework"

Whilst this is only a policy statement from the FDI, it states their unequivocal position, and is clear in its intent.

Dental Student Electives

This raises the question in relation to Dental Students undertaking electives in developing countries.

Currently dental students are not registered with the GDC in this country, so are unable to secure temporary registration to undertake dental work in any other country in the world [1].

The UK GDC does not allow dental students from another jurisdiction to practise in this country, unless it is part of a recognised training course, say at a UK dental school, as part of their training.

Likewise it would not be ethical or legal for a dental student to go to a developing country and undertake dental work, as they would not be registered with the Dental Council of that country, unless formal arrangements are in place to ensure appropriate supervision and approval by that regulator.

It is one thing for a dental student to observe dental treatment being undertaken in a developing country, and possibly act as a dental nurse - if they could demonstrate the necessary competencies, but to actually undertake dental procedures, which in the UK they would undertake in a supervised training environment, is an entirely different matter.

I have been informed by a colleague who chairs the *Central Committee for Dental Academic Staff* (CCDAS) that all UK electives are highly regulated and always undertaken in agreement with a local dental school, going through the appropriate channels, with appropriate insurance and academic teaching arrangements.

However, this only relates to student electives in dental schools outside the UK, and makes no reference to NGO's or Healthcare Charities, who provide Dental Care in Developing Countries, and who accept dental students for electives.

It would be appropriate that UK Dental Schools organising Dental Student electives with UK based NGO's or Charities in Developing Countries, undertake a vetting procedure of the NGO / charity against a relevant checklist. It would follow that a dental student would not be allowed to undertake dental procedures they were not trained for or allowed to work unsupervised whilst on an elective in a Developing Country with a NGO or Charity.

Other Legal Requirements

There may be additional legal requirements that have to be met when undertaking dental (or non-dental) work in a Developing Country. These may include the necessity for a visa, and/or a work permit.

In Conclusion

Whilst writing this article I received an email from the Colleague who phoned me initially. It posed the following question:

"I would like your advice regarding the registration issue and if you think there is any way round it that is legal should I wish to provide my dental skills and knowledge in a Developing Country in the future."

The dental need in these countries is still so great, which I feel leaves me in a personal dilemma.

This brings me back to my initial premise, that there cannot be double standards, whatever the level of need, if the dental work being undertaken is by way of an arranged elective visit, as apposed to an acute natural disaster i.e. a Tsunami [2], then compliance with the legal rules of that country has to be observed.

It is a difficult dilemma but we should not compromise. Besides, would this risk our personal GDC Registration by undertaking an illegal act, even if outwith the GDC's jurisdiction?

I am sure you may have your own personal views on this issue. I hope that it will raise awareness of this matter, and that there is no excuse for not complying with the legal framework that exists in any country outwith the UK, where you are seeking to undertake dental work, both in regards to professional registration, professional indemnity, and any entry and working requirements.

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CDA Administrator

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Peter Swiss
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Ross Hobson
Chair, CCDAS

Footnotes

[1]. Unless they hold an existing non UK dental qualification which is recognised by that countries dental council but not by the GDC.

[2]. Where there can be exceptions made to the acute short-term medical care provision, as opposed to an established healthcare provider i.e. a Charity or NGO working in a developing country.

KDA REPORT ON CONTINUOUS PROFESSIONAL DEVELOPMENT OF KENYAN DENTISTS

Dr Melvin D'lima - *KDA Chair of CPD and Scientific Committee*

Introduction

KDA has been involved in CPD provision to its members from the time of its inception in 1978. For many decades this has been industry driven and financed. Generally, Dentists were passive attendants at several lectures, symposia and conferences.

Dentists had to leave the country to undergo hands on training that would assist them acquire new skills.

This small cadre acquired skills in diverse practices like Advanced Restorative Dentistry, Orthodontics and Implantology.

A smaller number were privileged to acquire a post graduate dental specialty education outside the country, largely on financial scholarships provided by friendly nations.

Many of these specialists were employed at the Dental School, University of Nairobi and continued the CPD lecture tradition set by KDA founding Fathers in a town and gown collaborative effort.

This provided a useful medium for introduction to new materials and methods but the outcome of these CPD activities was not measurable.

However, in 2005, CPD was written into the statute books when the Medical Practitioners and Dentists Act, Cap 254 of the Laws of Kenya was amended to require any Dentist seeking renewal of his/her practicing licence to show documentary evidence of having undergone CPD in the preceding year.

The MP&DB now has prescribed log books which must be filled and turned in by each practitioner.

There are 3 levels of CPD activities and one is expected to demonstrate evidence of having participated in at least 2 levels, the highest level being the pursuit of full time post graduate diploma or degree studies.

KDA is a registered CPD provider and as such, has appointed a CPD Committee to oversee provision of CPD to the dental fraternity. This Committee is an organ of the National and Branch Councils. All CPD activities at branch level are peer reviewed and approved at National level.

Policy

1. KDA run CPD activities at Level 1 will be held at least once a month in each branch. These will take the form of lectures with a practical take home message to General Dental Practitioners and specialists alike. An attendance fee will be payable for these activities.

2. KDA will partner with Private CPD providers and/or industry to provide Level 2 hands on experiential training in diverse fields. KDA will levy a fee for this partnership.

3. KDA will hold an Annual Scientific Conference at which limited opportunities for Level 2 Hands on courses will be provided at a separate registration fee.

4. KDA Branches will be provided one CPD speaker per year per branch from National H/Q.

5. KDA will progressively increase its capacity to provide affordable, accessible and appropriate Level 1 and Level 2 CPD activities across its branch network.

Achievements in 2008

1. An orthodontic one day lecture series by an Orthodontist from Sydney, Australia.

2. Level 1 lectures throughout each of the 4 KDA Branches at least once every two months.

3. Annual Scientific Conference in conjunction with IADR (ESA Division) in October 2008

4. Hands on courses for 15 Dentists in each of the following disciplines: Endodontics and Cosmetic Dentistry during the Scientific Conference. (The theoretical basis for these courses had been laid during the conference plenary sessions)

5. A one day orthodontic hands on course for 13 Dentists conducted by an Orthodontist from University of Michigan, Ann Arbor, USA.

6. Replication and modification of the KDA model of CPD in Addis Ababa, Ethiopia and Lagos, Nigeria.

Challenges in 2008

1. Sub-optimal uptake of CPD by Dentists because of a long established culture of free CPDs facilitated by industry.

2. Prohibitive costs of organizing Level 2 CPD activities.

Way forward 2009

KDA wishes to enhance the operationalisation of its KDA CPD strategy and increase the scope and extent of its CPD activities.

To date a 4 day Orthodontic hands on course was held in Feb 2009 for 16 Dentists including 2 from Rwanda and 1 from Nigeria.

KDA celebrates its close working relationship with the Medical Practitioners and Dentists Board, private CPD providers and other stakeholders in this exciting field.

Nairobi
11 Feb 2009

Report on CDA Workshop on Oral Urgent Treatment In Partnership with the Tanzanian Dental Association

MWANZA, TANZANIA FEBRUARY 24 -26 FEBRUARY 2009

Mark Topley & Ian Wilson BDS

Introduction

Dr Ian Wilson, Chief Executive of *Bridge2Aid (B2A)* opened the workshop and thanked delegates from seven Commonwealth countries not only for their attendance but also their commitment to the delivery of oral health services in their professional lives.

It was hoped that the conference would be an opportunity to build friendships, share experience and develop a better understanding of problems that dental health care professionals face in different countries.

Each attendee brought different experience and whilst there was acceptance that there is no perfect model to address the issue of provision of emergency oral health services, through sharing different needs and delivering a supportive environment in which we can learn, it was hoped that we could develop a model that would better support the communities in pain and help make a difference.

Presentation by Professor Emil Kikwilu Dean of the Dental Faculty Muhimbili Univeristy Dar es Salaam

"PREVALENCE OF ORAL PAIN AND BARRIERS TO USE OF EMERGENCY ORAL CARE AMONG ADULT TANZANIANS"

Oral pain has been the major cause of the attendances in the dental clinics in Tanzania. Some patients postpone seeing the dentist for as long as two to five days. This study determines the prevalence of oral pain and barriers to use of emergency oral care in Tanzania.

The conclusions from the study by Professor Kikwilu and his colleagues were that; Oral pain and discomfort were prevalent among adult Tanzanians. Oral pain and discomfort were equally relevant in rural and urban areas. Only a quarter of those who experienced oral pain or discomfort sought emergency oral care from oral health care facilities. Self medication was used as an alternative to using oral care facilities mainly by rural residents. The more prevalent barriers to seeking treatment existed in rural areas. The rural population showed the same need for treatment as those living in urban areas. Some claim that people living in rural areas will not go for treatment. However a three-year study cited by Prof Kikwilu showed that rural areas are very positive towards the provision. Establishing oral care facilities in rural areas is recommended.

The Bridge2Aid Clinical Officer Training Programme & Dental Volunteer Programme

At the heart of the *Bridge2Aid* ethos and objectives is a desire to work in a way that builds capacity into the local health systems. Ian Wilson believes that dentists in the UK have a responsibility to train and resource their colleagues across the world. *Bridge2Aid* aims amongst other things to provide an opportunity for the professions in the UK to deliver that in a way that contributes to sustainability.

The typical Oral Health problems as observed in developing nations were outlined, and the fact that more working hours are lost in oral health related diseases each year than from HIV, TB and malaria combined (Wim van Palenstein Helderman, Habib Benzian).

At the government level, challenges faced include a lack of infrastructure, funding and trained manpower. There are Primary Health Care Facilities available in all areas, but not the training to deliver the Basic Package of Oral Care (BPOC). The primary need in oral health facilities was for emergency extraction, and this was borne out by Professor Kikwilu's study – 97% of treatment by oral health professionals was to relieve pain. Relief of pain and infection is the number one perceived need by rural communities.

Ian Wilson described the WHO approach to solving the problem of providing oral health care in developing nations – the BPOC, which has four components: Oral Urgent Treatment (OUT), Affordable Fluoride Toothpaste (AFT), Atraumatic Restorative Treatment (ART), Oral Health Promotion (OHP).

Bridge2Aid's role in Tanzania has concentrated on training in OUT for rurally based clinical officers to provide OUT to their communities. These clinical officers are medically trained in basic procedures for 3 years, and then posted to rural health centres and dispensaries. There is a dental component to the clinical officer's original training programme. However this training seems to be a challenge to implement after qualification.

"NGOs and their volunteers can be important contributors to the aim of provision of oral health if they choose appropriate interventions and activities. The ultimate goal of NGOs should be to make a contribution towards training of local health workers who can continue with the care after the departure of the volunteers." (Dr. Habib Benzian FDI)

Ian Wilson pointed out a number of examples of where volunteering can be inappropriate,. Bridge2Aid's approach is strongly integrated with government strategy, and the planning and execution of their

Continued on page 10

programme has been a partnership with national, regional and local government officials.

The Bridge2Aid Dental Volunteer Programme

Mark Topley explained that the *Bridge2Aid* programme, commenced in 2004, and subsequently has trained over 80 clinical officers. The key aspects of the programme are: Training in OUT for frontline healthcare personnel – Clinical Officers (COs) , High quality 1:1 training ratio, Contributes to an existing primary health care system (PHC), Replicable, Highly Effective, Grounded in locally based NGO

The training programme is designed to be a complete training package to take the district (typically 300-400,000 people) to sustainability in the provision of OUT by training their entire COs in OUT. Government and local community leadership ownership from the beginning is crucial if the training is to survive – their involvement from the beginning has been key to the success of the *Bridge2Aid* programme.

The training syllabus is based upon the *'CO dental training syllabus for Tanzania',* and *'Basic oral emergency care by auxiliaries for under-served populations'* an FDI publication. Everything is focussed on simplicity – the COs are trained to do the basics well and refer the rest. The programme aims to help them to learn their limitations as well as skills.

Cross infection control training is vital, and B2A gives a non-electric sterilizer that works on a kerosene stove and is available locally. Volunteer nurses in a separate room to the training do instrument sterilisation procedures on site. The COs are fully trained in the cleaning, sterilisation and care of their instruments. The guidelines followed for training are those laid out in *'Infection control for the delivery of basic oral emergency care'* by Robert Yee (FDI).

Assessment of competence takes place throughout the training programme. When the CO completes their training they are allocated an instrument kit and steriliser, based on FDI guidelines. During training a 23g hypodermic syringe & vial of local anaesthetic are used. These items are available locally or through the government supply chain.

After training, supervision is provided by the existing health care management structure in the form of the District Dental Officer (DDO).

Practical benefit: From 2005, when training commenced, and the end of 2006 – when 20 trained clinical officers were in place - a significant drop in the number of patients being seen at the district hospital compared with the previous year was noted . The training led directly to a large increase in access to care at a local level, a relief of pressure on centralised resources and the release of time to the DDO for advanced procedures and supervision.

Conclusions

The trained COs are safe. The COs do refer appropriately. There is a marked demand for the service. The community response is very encouraging; with village elders stating the service provided is good.

Visit to View Practical Training in Action at Koromije Health Centre

One of the core objectives of the workshop was the practical viewing of the OUT training of COs performed by dental volunteers from the UK. This site visit took place with the delegates split into 3 groups with each group having the opportunity to view and discuss patient management, cross-infection control procedures and the clinical delivery of the OUT training. At the end of the visit B2A the delegates had the opportunity to discuss issues that were raised during the visitations.

The subsequent workshop

Barriers for communities to access Urgent Oral Treatment?

The groups identified the following:

Affordability: the high fees required for equipment, and transport in rural areas.

Accessibility: The distance from a facility where trained help is available is a problem. The groups observed that the B2A programme is applicable where local rural community needs define the demand for OUT

Availability of appropriately trained personnel. Cases were cited of people travelling many kilometres to a facility and the dentist was not there or did not have the right materials etc.

Legislative control of the profession. It was recognised that the governing dental council of each country has responsibility for the registration of dental healthcare workers, and that it is important that all training programmes are approved and validated by the respective dental council.

Gender: females need to be accompanied to the oral health facility in some countries.

Poverty: political stability and political will; were also noted as barriers

Is an OUT training course needed where you are?

Relieving pain is the priority. Rehabilitate first, then screen early and educate. You need to manage the disease and pain first as that already exists. Dental disease needs to be reduced as a priority in communities.

A main issue is how to make it sustainable. This recognises in OUT programmes there is a component for training future trainers.

It was recognised an education programme is required in conjunction with the programme or the focus on curative issues precludes preventive measures.

Recommendations

1. Formation of a global task force for elimination/alleviation of dental pain. This task force will:

a. Prepare formal/structured processes to follow when implementing BPOC.

Continued on page 11

b. Define standard operating procedures for all components of BPOC.

c. Document a uniform programme for training, implementation, monitoring and evaluation to assess the use and benefit of the programme.

d. Establish a focus group within the task force to disseminate information on BOPC in scientific journals and periodicals.

2. FDI, CDA, WHO, Commonwealth Foundation should be approached to fund the formation of this task force.

3. Establishment of a steering committee made up of all attending delegates of the workshop with secretariat being *Bridge2Aid* and Professor Emile Kikwilu as chairman to follow up formation of the global task force.

Closing Ceremony

Professor Ayyaz Ali Khan gave a vote of thanks.

Acknowledgements

The Commonwealth Dental Association acknowledges the financial support provided by the Commonwealth Foundation for this workshop without which it could not have taken place.

CDA WEBSITE

The CDA website provides a facility for the dissemination of information to all the Commonwealth Dental Associations and includes access to the former Newsletters and subsequent Bulletins.

It also contains articles of relevance to CDA including also a Who's Who of the current Executive Committee and, importantly, contact information for CDA and its officers.

Whereas, previously, CDA had a large number of Newsletters and Bulletins printed and posted to Commonwealth Associations, the cost of printing and distributing has been saved by only making the Bulletin available on the web, apart from a very limited number of copies that are printed and posted and some which are directly E-mailed to CDA Associations.

The printing costs saved are now used to further CDA's other objectives and compensate for the increasing difficulty of attracting support grants in the current financial climate.

The CDA Executive wishes to remind Associations that the CDA website is being used for information and announcements so they should make a point of visiting it from time to time. If they wish to be notified by E-mail of any new information put on to the website then they should send CDA the E-mail address of the person to be notified. The E-mail should be sent to:

webmaster@cdauk.com

The CDA website address is:

www.cdauk.com

CONTACT INFORMATION

CDA now uses electronic information as its primary means for communication so it is important that it has an up to date record of E-mail addresses. People do occasionally change their E-mail address so please keep us up to date with yours.

ACKNOWLEDGEMENTS

CDA thanks the Commonwealth Foundation for their funding and support. CDA also thanks the Commonwealth Secretariat for their support and encouragement.

The CDA is very grateful for the continued support of Dr Michael Knowles and other sponsors and Corporate and Individual Friends of CDA.

Dental Digest

Using transparency of assessment criteria with self-assessment to improve student performance in a dental practical skills examination.

The authors were teachers and examiners of the Dental Clinical Skills Module at their Dental School. They were concerned with the low pass rate (45%) at the first attempt, in the practical skills examination. Therefore, the authors attempted to increase the pass rate by improving the transparency of the assessment criteria used at the examination. Throughout the course, the students were taught in exactly the same way by the same teachers using the same equi0pent as was done the previous year (2006). However, they introduced one difference: The students were given a self assessment sheet to mark their work using detailed and clear criteria which were fully discussed with the students. The students were advised to use these sheets during their practicals to assess their own work in the weeks prior to the examination. At the examination, there was a 55% pass rate, a 10% increase compared to the year before. Even allowing for the differences in the two cohorts, this was a marked improvement.

During feedback after the examination, students stated that seeing the marking criteria in advance of the test was helpful. The self-assessments had also helped them to better prepare for the test.

***Good J & Dysart L**: The Higher Education Academy Subject Centre for Medicine, Dentistry & Veterinary Medicine; Pages 4 & 5 Summer 2009 ISSN 1740-8768*

OBITUARY

Professor John Lowry CBE

It was a typical cold and wet January day in London when 500 of us descended on St Clement Danes Church, in the Strand, to pay our respects at the memorial service for one of the giants of British and Commonwealth Dentistry – Professor John Lowry CBE, who died on September 29th 2008, after a very short illness.

John graduated from Manchester Dental School in 1963 at the age of 21. He subsequently qualified in medicine in 1970. He went on to gain many other qualifications, awards and honours over the years – including the FDSRCS and FRCS.

He was appointed CBE by HM The Queen in 2003.

His contributions to healthcare were recognised by other Fellowships - of the Royal College of Anaesthetists and the Faculties of General Dental Practice and the Royal College of Surgeons of Edinburgh.

He became consultant oral and maxillofacial surgeon in Bolton in 1976 and developed an outstanding clinical service linked with Burnley, Bury and Blackburn, towns in Lancashire.

All through his career he was committed to postgraduate education and during recent years was appointed Professor of Surgery in the University of Central Lancashire. However, he was most well known in dentistry through his work in the Faculty of Dental Surgery of the Royal College of Surgeons of England where he played a leading role, culminating in being elected Dean in 2001. In this role he travelled extensively in the Commonwealth, being a popular speaker in many countries. He proved an effective leader and ambassador of his profession.

He was President of the British Association of Oral and Maxillofacial Surgeons in 2001 and was Secretary-General to the European Association for Cranio-Maxillofacial Surgery for the ten years until his untimely death.

John was appointed chairman of the main government Advisory Committee on dentistry in 2000 and so helped develop policy in a number of key areas within dentistry. He held a key role in the development of clinical guidelines in a number of areas, including anaesthesia and sedation in dentistry and the management of third molars.

John was a stalwart within the BDA serving as President of the Hospitals Group and also as chairman of the Association's Committee for Hospital Dental Services. He was also for a time President of his regional branch of the BDA and chaired its council. He was awarded the Tomes' Medal by the Association.

Notwithstanding all this hard work for his profession, indeed for patients, John was also well known for his fitness regime. Whatever the day was to bring, wherever he was in the world, John could be found - first thing every morning - pounding the streets in his running shirt, shorts and shoes for his hour's exercise.

He is survived by his wife Valerie, daughter Michelle (also a dentist) son Johnny, and young grandsons Lawson and Louis. We extend our deepest sympathy.

Anthony Kravitz

COMMONWEALTH HEALTH MINISTERS MEETING
Geneva, Switzerland - 17th May 2009

Dr Sam Thorpe OOR
Executive Secretary

Introduction

Commonwealth Health Ministers held their annual meeting at the Crowne Plaza Hotel, Geneva, Switzerland on Sunday 17 May 2009, the eve of the 62nd World Health Assembly (WHA). The meeting was organized by the Commonwealth Secretariat and had as its theme *'Climate Change and Health'*, in response to member states request made in 2008 and in implementation of the Lake Victoria Commonwealth Climate Change Action Plan of 2007. The Action Plan calls for the use of Commonwealth networks to strengthen the consideration of the human and economic aspects of climate change.

The meeting was chaired by Senator the Hon. Jan McLucas, Parliamentary Secretary to the Minister for Health and Ageing in Australia. It had representatives from 43 Commonwealth member states, the Cook Islands, partners representing bilateral and multilateral organisations, and national and regional civil society organisations working in health.

The Commonwealth Dental Association (CDA) was represented by Dr Hilary Cooray (President- Elect) and Dr Sam Thorpe (Executive Secretary).

Opening

The Deputy Commonwealth Secretary-General Mr Ransford Smith, called the meeting to order. He welcomed all delegates and then introduced the Commonwealth Secretary-General H E Mr Kamalesh Sharma. In his opening remarks, Mr Sharma warmly welcomed the Ministers and other participants and highlighted the scale of health challenges in the Commonwealth and the leadership by WHO regarding A(H1N1) influenza.

Presentations

The keynote address was delivered by Professor Sir Andrew Haines, Director, London School of Hygiene and Tropical Medicine on the subject *'Climate Change: A Threat to Health and Development'*. This was followed by a presentation by Professor Tony McMichael, Professor of Epidemiology, Australian National University, on the subject *'Climate Change: Risks to Human Health and Wellbeing'*. There was a very lively discussion after both presentations.

Dr Michael Ryan, Director, Epidemic and Pandemic Responses, WHO, then presented a technical briefing on *'Novel Influenza A(H1N1) (Swine Flu)'*.

Dr Sheila Campbell-Forrester, Chief Medical Officer, Ministry of Health Jamaica, presented the report of the meeting of the Commonwealth Advisory Committee on Health (CACH) which had taken place the day before, 16 May 2009 at the same venue.

Technical Panels

During the technical panels session, there were four groups each with a speaker, a discussant and a moderator. The following topics were discussed:

- Group 1: *'Conducting Vulnerability Assessments of Climate Change Health Risks'*;
- Group 2: *'Implementing Adaptation Strategies and Implementation Challenges'*;
- Group 3: *'Achieving Health Co-benefits in Reducing Greenhouse Gas Emissions'*;
- Group 4: *'The Global Framework on Climate Change and Health'.*

Dr Hilary Cooray participated in Group 4 and Dr Sam Thorpe in Group 2.

The group reports with key recommendations were presented in plenary after the lunch break.

Dialogue With WHO Director-General

In her introductory remarks on *'Climate Change and its Impact on Health'*, Dr Margaret Chan, Director-General of WHO, stated that climate change is the greatest global health threat of the century. She noted that public health security can only be achieved by strengthening health systems in an equitable way. Human resources capacity will also need to be strengthened if the Millennium Development Goals are to be achieved. This was followed by a lively session of questions and comments from Ministers.

Launch Of Commonwealth Health Professions Alliance (CHPA)

Ms Jill Iliffe, Executive Secretary of the Commonwealth Nurses Federation, briefly introduced the CHPA, after which Ms Susie Kong, President of the Commonwealth Nurses Federation, presented the report of the *Climate Change and Health Survey* of health professionals in Commonwealth countries carried out by the CHPA. The survey report contains important messages for Commonwealth health ministers from their health professional workforce on global warming and climate change. Dr Caroline Pontefract, Director, Social Transformation Programmes Division of the Commonwealth Secretariat then proceeded to officially launch the Commonwealth Health Professions Alliance.

The CHPA which was formed recently, is an alliance of Commonwealth professional associations and currently consists of:

- Commonwealth Association for Health and Disability
- Commonwealth Association for Paediatric Gastroenterology and Nutrition
- Commonwealth Dental Association

Continued on page 14

- Commonwealth HIV and AIDS Action Group
- Commonwealth Medical Association
- Commonwealth Nurses Federation
- Commonwealth Pharmacists Association.

Members of the CHPA are of the opinion that by working together they can more efficiently and effectively represent and support health professionals in Commonwealth countries and promote high standards of care and equity in access to care for Commonwealth peoples.

Statement To The Heads Of Government Meeting (CHOGM)

At their meeting in Port of Spain, Trinidad and Tobago in November 2009, Commonwealth Heads of Government are urged by CHMM to:

• Use the Copenhagen Climate Change Conference in December 2009 to forge strong post-2012 International Climate Change arrangements that will support the smallest, poorest and most vulnerable states, including small island states, in underpinning effective mitigation and adaptation to reduce the potential health impacts of climate change on health and development;

• Support the leadership role of Health Ministers in conducting robust assessments of climate change health risks, to enable countries to prepare adaptation strategies;

• Meet new and existing funding commitments to support the development, implementation and monitoring of health and climate change adaptation plans;

• Support health system strengthening and increase funding for health emergency preparedness systems as a means of reducing the economic and social costs of expected long term crises, as well as pandemic outbreaks;

• Ensure that health sector concerns are given greater consideration in the planning and implementation of national and regional climate change responses.

Any Other Business

The Ministers agreed that the theme for CHMM 2010 will be: *'Status of Health in the Commonwealth'*.

It was also agreed that the Chairperson for CHMM 2010 will be the Minister of Health, Bahamas.

Conclusion

The Ministers and other delegates participated actively in the discussions, and the meeting was a success. As usual, the participation of CDA at the meeting provided an opportunity for its representatives to interact with many Ministers and senior health officials to raise awareness and stress the importance of oral health care in the minds of decision makers.

After the day's proceedings, the Commonwealth Health Ministers and other delegates attended a Reception hosted by the Commonwealth Secretary-General, H E Mr Kamalesh Sharma.

The CDA President-Elect Dr. Hillary Cooray with the Minister of Health of Sri Lanka and other members of the Sri Lankan delegation at the Geneva meeting.

CDA Financial Report - July 2009

The figures below show the Income and Expenditure for the last three years and should be read with the article on Finance on page 15

	2006-07	2007-08	2008-09
INCOME			
CF core grant	£10,000	£9,160	£6,000
CF activity grant	£10,000	£7,500	£8,000
Subscriptions	£6,408	£6,640	£6,559
CDA Friends	£1,300	£1,200	£415
Sponsorship	£9,903	£4,257	£0
Advertising	£1,000	£1,500	£1,500
Bank interest	£0	£487	£200
Sub-Totals	**£38,611**	**£30,744**	**£22,674**
EXPENDITURE			
Conferences & Workshops	£17,007	£15,800	£14,620
Administrator	£9,732	£5,779	£5,800
Office, computer and website	£930	£910	£60
CDA Bulletin	£614	£659	£115
Subscription to FDI	£245	£295	£372
Auditor	£999	£1,439	£1,150
Miscellaneous	£910	£298	£0
Sub-Totals	**£30,437**	**£25,180**	**£22,117**
Balance	**£8,174**	**£5,564**	**£557**

CDA Administration Arrangements

General Matters:
For queries of a general nature, and membership please contact the CDA Administrator:
Ms Ulrike Matthesius at:
Administrator@cdauk.com

CDA Secretary Matters:
Please Contact the Executive Secretary Dr Sam Thorpe at:
Sam.Thorpe@cdauk.com

Financial Matters:
For subscriptions, invoices and other financial matters, contact the CDA Treasurer
Dr Anthony Kravitz at:
Anthony.Kravitz@cdauk.com

Communications:
For website and Contacts Database updates, contact:
Mr David Campion at:
David.Campion@cdauk.com

CDA FINANCIAL REPORT - JULY 2009

Dr Anthony S Kravitz OBE - *CDA Treasurer*

Dr Anthony Kravitz

Once again income is considerably down on last year's, because sponsorship funds have all but dried up. The positive signs I reported last year did not come to fruition. Added to this, two of our biggest national association subscribers have not yet paid their 2009 dues. This means that the outturn is that our income is about £9,000 less than we budgeted for and now only just half of what it was at the time of our last Triennial Meeting, just under 3 years ago.

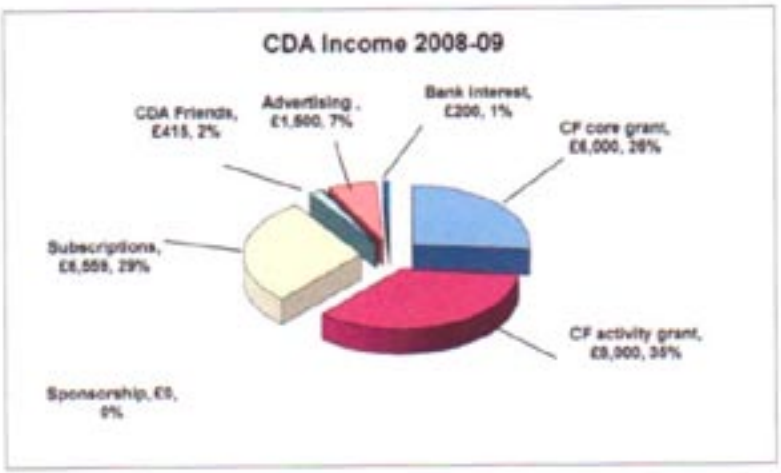
Our main sponsor – the Commonwealth Foundation – has continued to press us to raise a higher proportion of our annual income than hitherto from subscriptions, so this outturn is very disappointing. It is already adversely affecting us, with core sponsorship from the Foundation being reduced (as we were warned it would be); it is now considerably less than our costs.

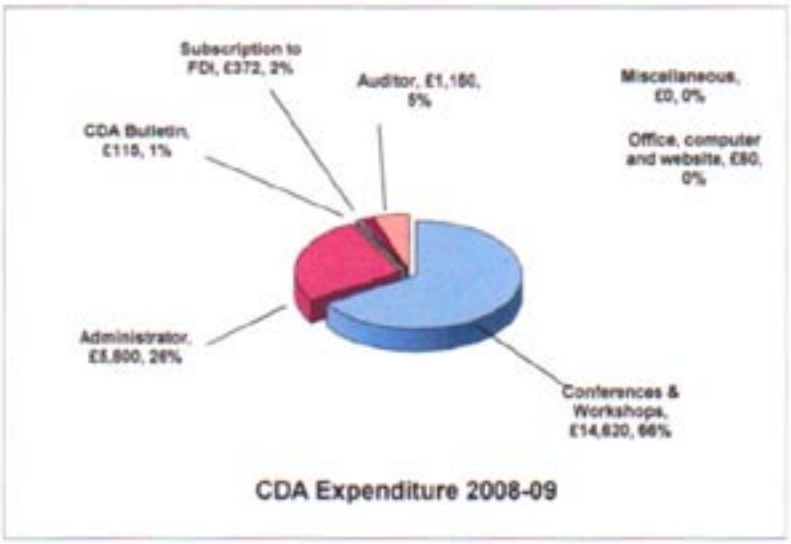
One of the major calls on our expenses is administration costs. Ulrike Matthesius of the British Dental Association carries out our day to day administration, for which the BDA charges us a flat rate. To date this has been a very reasonable amount, probably less than their actual costs so our administration is also running at about half of what it was 3 years ago.

Our main expense now is activity – the reason (after all) why we exist. Our workshop in Mwanza in February consumed about 60% of our costs for the year and the Annual Health Ministers' Meeting (CHMM) about another 7% (we have cut the annual cost of our attendance for this by half, also). The reception at CHMM, which we formerly hosted using sponsorship monies, has now been taken over by the Commonwealth Secretary-General. We have persuaded the (former) sponsor to apply the funds instead to supporting dentists from less developed countries to attend our Triennial Meeting.

Again, summing up, our expenses outturn looks like being about £7,000 down on budget. So, taking income and expenses into account, we look like having a small budgetary surplus, which represents a reasonable result based on our turnover.

However, I am not complacent. Next year's grants from the Commonwealth Foundation – whilst still very generous – will not cover our planned expenditure. We will have a shortfall for our administration funding, which will need to be raised from general funds; and, the cost of our Triennial Meeting in Singapore means that I have had to set a budget for 2009-10 with a deficit of over £4,000 – which will mean a big depletion of our reserves.





See the breakdown of the Income & Expenditure in the Table on page 14 that was used to create these graphs

CDA TRIENNIAL MEETING

The 6th Triennial Meeting of the
Commonwealth Dental Association
will be held at the
Suntec International Conference Centre, Singapore
on
5th September 2009
during the
Annual World Dental Congress
of the
FDI World Dental Federation.

The morning session will be devoted to a Workshop on:

'**The Challenges of Infection Control in a Rural Dental Practice**'

The programme for the workshop will include presentations by the following speakers:

Associate Professor Robert Yee (Singapore):
"**Improving Infection Control in Resource Limited Settings**"

Associate Professor Sanjay Joshi (India):
"**Ways of Training and Monitoring for Infection Control in Rural/Urban Settings**"

Dr Christopher Vincent (Malaysia):
"**Update in Infection Control Practice and Antibiotic Prophylaxis in Dentistry**"

The presentations will be followed by a working group session and end with a plenary debate and adoption of recommendations.

The afternoon session will be the CDA Business Meeting and will include the following:

Report by the President
Report by the Executive Secretary
Report by the Treasurer
Report by the Vice-Presidents
Debate on the Future of the CDA
Constitutional Amendments
Open Forum on "Millennium Development Goals"
Election of Officers
Presentation of CDA Awards

The day will end with a Reception and the CDA Ceremonial Inauguration.

As many national dental associations as possible are invited to send delegates to the Triennial Meeting especially as many members will be in Singapore attending the FDI Congress.

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