The Commonwealth Dental Association

CDA BULLETIN

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

THE CDA PRESIDENT WRITES

Esteemed CDA Colleagues, Greetings of the Season to all of you. Welcome to this issue of the CDA Bulletin that keeps us updated with all the ongoing activities and progress we achieve in various fields.

Dr L K Gandhi
at the Pacific Regional Meeting

The Pacific Regional Meeting was held from 25 to 30 November 2005 in FIJI, at which CDA was represented by me and Dr Anthony Kravitz. The importance of this meeting was emphasised by the presence of the Minister of Health and other dignitaries.

The meeting, jointly organised by the Fiji Dental Association (FDA) and CDA will have a far reaching impact on the future development of oral health care in the region, especially keeping in view its vision, aims and objectives and its activities in the past three years, as well as its role in revitalising the process of development in partnership with CDA, the local bodies and other associations.

The Constitution for the Pacific Region, once finalised, will set the framework for activating the Pacific Forum Secretariat, which will be the main body for coordinating all matters to ensure that the Millennium Development Goals (MDG's) are achieved.

The CDA's Five Year Plan and strategies will go a long way in forming a fruitful alliance in every sphere of activities and key priorities to ensure progress and set a new milestone of achievement.

With the support of all our colleagues, CDA should be able to overcome all obstacles and establish itself as one of the dynamic organisations in the world, in furthering the cause of the less developed countries to improve oral health care and prevent diseases like HIV/AIDS.

I am sorry that I missed the opportunity to chair the last electronic meeting held from 1-12 May 2005 as I was away touring India on some other specific cause. My heartfelt congratulations and thanks go to Dr Brian Mouatt for his wonderful work in conducting the meeting.

Let us look forward to "*Creating Smiles and Happy Faces*" across the World.

Thank you all.

Dr L K Gandhi

EDITORIAL

Prof Martin Hobdell

At this time of year in both hemispheres be it summer or winter, it is natural that people review the successes and failures of the past year and draw-up a balance sheet of what has happened.

For the World in general it has been a hard year: the tsunami, which hit the shores of many Commonwealth countries was but the start of what was to become a year notable for several gigantic natural disasters – the hurricanes that hit many of the Caribbean islands, as well as the USA, and the terrible earthquake that devastated the mountainous regions of Pakistan and India were but later episodes of a very difficult year for much of the Commonwealth.

One of the problems in all this is that although dramatic events like these natural disasters seem to demand an urgent humanitarian response by organisations such as the CDA, there is relatively little that can be done in the first phase, because we are not equipped to send in teams of relief workers capable of search and rescue operations. Ours should be to focus on the sustained restoration and development of services once the immediate situation has been dealt with.

The report given at the FDI World Dental Congress by the Malaysian Armed Services team who were sent to Aceh Province in Indonesia, immediately following the tsunami,

continued over/.....

WORKING SMARTER – achieving more with less effort

You may have heard of the 80/20 rule, sometimes also described as the Pareto Principle. Vilfredo Pareto was an Italian economist who was studying the distribution of wealth in Victorian England. He found that 80% of the country's wealth was in the hands of just 20% of the people. And the more he looked, the more he became convinced not just that most things in life were subject to an inherent imbalance or skew, but also that there was a level of predictability in that imbalance. Pareto did not subscribe to the theory of *"all things being equal….."* and nor would he be persuaded by the concept of *"level playing fields".*

50 years later, a Professor of Philosophy at Harvard University in the US (George Zipf) described his "principle of least effort". In short his message was that by focusing your attention, energy and resources on the important stuff in life you could make a much bigger difference in a fraction of the time and using a fraction of the resources, than if you were to treat all things as being equally important. They are not.

Around that same time, Joseph Duran was a Russian-born engineer who was working in industry. In manufacturing processes, he discovered that 80% of any quality improvement you were trying to make, could be found in just 20% of the processes involved. In short, if you know where to look you can make a bigger impact with relatively little effort. In contrast, if you are looking in the wrong place, you can waste 80% of your time, energy and resources.

In some parts of the world, dentists are aware of the growing need to reduce the risk of complaints and litigation, as well as the desirability of keeping their patients happy and satisfied. In other parts of the world the challenge is one of making the best use of limited resources, targeting them in order to make the biggest possible difference. Dentists will also be aware of which procedures are occupying most of their time. Wouldn't it be great, then, if someone could capture all the really important things you need to know about what goes wrong in periodontics, or oral surgery, in orthodontics, or treating children, or crown and bridgework, or whatever, and provide you with a checklist of what you need to think about, what needs to be on your record card, what you need to explain or discuss with patients, and so on. Then by focusing on those few things you could eliminate 80% of your risk.

Well, it has happened. DPL's series of risk management **modules** now covers 36 topics, and they are available in printed form, or on CD as you prefer. A new variation is DPL's risk management **bundles** which group together several modules, clinical audit exercises, and other material on a specific subject, which have proved to be highly popular with dental team members all over the world. Visit www.dentalprotection.org or refer to the details provided alongside this article.

Editorial continued:

underlined the limited roll for oral health service personnel in immediate post-disaster situations. They ended up providing much needed emergency dental services for the deprived people of the area. The lack of dental services was, however, something that long pre-dated the tsunami.

Beside these natural disasters the continuing toll that HIV/AIDS, TB and malaria, for example, bring to the lives of millions of people have become dimmed and been lost to many. In this age of 'breaking news headlines' it is in such on-going tragedies that organisations like the CDA can play an important role. The reports of the joint meeting in Malta *(pp 6-8)* in which the CDA took a leading role and the HIV/AIDS meeting *(pp9-10)* held jointly with Caribbean countries at the FDI World Dental Federation meeting in Montreal are two examples of such continuing activities.

Meetings are, however one thing, what happens on the ground is another and it is here that we can really make a difference. The newly instituted FDI Continuing Education Programme in Africa, with which the CDA is fully collaborating will bring to local practitioners up-to-date information and hands on training in important clinical techniques. The summaries of information given at the Montreal meeting given on pages 12-13 will help practitioners check that they are up-to-date in, for example, their use of infection control measures *(see pp 13-16)*.

This coming year will see further developments of the CDA Bulletin. It will continue to be produced and distributed largely on-line as this is most economical and efficient, but as always a few hard copies will also be printed and distributed to sponsors and potential sponsors and others with specific interests in the CDA. It will this coming year be appearing three times, in February, June and October.

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New contact details?

If you have any change in your contact details please let the CDA Administrator know so that the database can be kept up-to-date. Email addresses are most important as the CDA's main mode of contact is electronic. Send new contact details to:

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The CDA thanks Dental Protection and Smile-On for their support and sponsorship of this edition of the CDA Bulletin.

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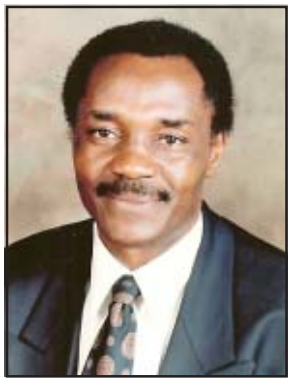
DR GEORGE R OWINO - THE PASSING OF AN ICON

Prof Jacob T Kaimenyi
CDA President-Elect

It is with sadness that I announce the death of the late Dr George Owino on 4th October 2005.

'George', as he was properly known was a member of several dental professional bodies. George was a team player and a great leader. He was one time a Secretary of the Kenya Dental Association (KDA) and eventually became its Chairman. He was a founding member of the CDA and it was during his chairmanship of the KDA that the CDA, in conjunction with the World Health Organiz-ation, organised an international conference on dental care in the African Region in 1993.

George started the popular *National Dental Health Action Month* in Kenya, several decades ago, with a few dentists who saw the need to take dental care to the underprivileged Kenyans. Through these National Dental Action months, the dental profession became extremely popular compared with the bigger professions. This was primarily because many Kenyans, at that time and even today, saw the dental profession as being sensitive to serving the dental needs of Kenyans, especially at rural level where access to modern dental care is insufficient or totally lacking. Again, through the National Dental Health Action Month, George started, regularised and popularised international dental conferences.



Dr George Owino

It will be remembered, vividly, it was during his tenure when the debate on whether to use fluoridated toothpastes in Kenya or not was very alive. True to his character, George invited world authorities on the use of fluorides to Kenya, to discuss and give expert opinion on this important topic. George founded the Kenya *South Africa Dental Alliance*, whose main objective was to enc0urage interaction amongst dentists in South Africa and Kenya. Beyond being an active participant in Kenyan professional matters, George was the Vice-President of the FDI African Region.

George was clearly a pioneer and a founder of several things in Kenya. No wonder an international colleague was overheard saying, "*if you don't know George Owino then you don't know dentistry in Kenya*".

Many will remember him for the innumerable press conferences he held in the spirit of promoting better dental health in Kenya. He was the first Chairman of a committee that started lobbying and planning for a *National Oral Health Policy*, which I eventually took over and we finally drafted one recently.

Ladies and Gentleman, because of the afore-mentioned attributes, it has been suggested that, as his professional colleagues, we should go out of our way to ensure that George is remembered vividly by future generations. Towards this end, there was a proposal to set up a *George Owino Memorial Lecture*. The other interesting proposal by Dr Jandu is to rename the National Health Action Month as *Dr Owino Dental Health Action Month*. In my strong considered opinion, these proposals should be implemented at the earliest.

Finally, Ladies and Gentleman, you will agree with me that we have, indeed, lost a husband, a father, a relative, a great teacher, a friend, a dependable colleague, a motivator, a role model and a pacifier.

George, farewell, until we meet again and may God rest your soul in eternal peace.

Amen

CDA's Distance Learning Initiative

As part of their Distance Learning Initiative the CDA sent the Organization for Safety & Asepsis Procedure (OSAP) CD and training manual '*If Saliva Were Red*' to Commonwealth countries. This very positive feedback was received from the Malawi College of Health Sciences:

> *"The programme is useful. It is used for teaching students. It is used by both lecturers and students. Much infection control is done in Malawi but infection control specifically for dental practice is not done. With support from organisations the college is ready to orient all dental practitioners on infection control using the very statement - 'If Saliva Were Red'."*

CONTINUING EDUCATION PROGRAMME IN WEST AFRICA

Dr Kofo Savage
CDA Regional Vice-President (West Africa)

A joint Continuing Dental Education Programme of the Nigerian Dental Association and the FDI World Dental Federation took place at the Ladi Kwali Hall, Sheraton Hotels & Tower, Abuja, 5-6 October 2005. It was the first of its kind in West Africa.

(left to right) Lesotho Tsiu Kofo Savage, Martin Hobdell Foluso Babasola, Jean Morkel

The Commonwealth Dental Association (CDA) was represented by Professor Martin Hobdell and Dr Kovo Savage.

The African Regional Organisation (ARO) meeting (previously scheduled for 7 October) took place at the same venue on 6 October 2005.

Two guest lecturers, Professor Martin Hobdell and Professor Jean Morkel were fully sponsored by the FDI World Dental Federation. These two lecturers spoke on the theme, *Common Oral Infections, Infection Control and HIV/AIDS in Dental Practice*.

Professor Hobdell has an impressive history of appointments in the US, South Africa, Mozambique and the United Kingdom. He is currently a Visiting Professor at the Department of Epidemiology and Public Health at University College, London, as well as a Visiting Professor at the University of Dublin, School of Dental Science, Trinity College in Ireland.

Professor Jean Morkel is currently Professor and Academic Head and Chair of the Department of Macillofacial & Oral Surgery and Division of Anaesthetiology at the Faculty of Dentistry, University of the Western Cape in Cape Town. He is dually qualified in both medicine and dentistry.

A lecture entitled *The Current Uncontrolled Migration of Training Health Workers Internationally* was given by Dr Sonny Prince Akpabio who is currently an honorary Senior Research Fellow at the Oral Health Section of the University of London, UK.

The Continuing Education Programme was well attended with participants from more than half of the 36 states of the Federation, including the Federal Capital Territory (FCT). Participants also included Dental Surgeons from the Republic of Benin and South Africa.

Delegates at the Continuing Education Programme

Videos and CDs were given to participants on the proceedings of the programme. Incentives from oral health exhibitors were also given.

Certificates of participation, duly signed by the guest lecturers, National President and the Chairman of the NDA Continuing Education Programme were distributed.

The Nigerian Dental Association thanks the FDI World Dental Federation for this unique programme and hopes for its continuity.

BAHAMAS DENTAL ASSOCIATION CONFERENCE

Dr Joyous Pickstock
CDA Regional Vice-President (Caribbean)

The HIV/AIDS Workshop for Oral Health Personnel in The Caribbean, sponsored by The Commonwealth Dental Association was a great success. The workshop was held in Montreal during the FDI 2005 congress. The workshop provided participant from the region valuable information useful in training other members of the dental team.

The Bahamas Dental Association held its 2005 Dental Conference in Nassau, Bahamas 10-12 November 2005, under the theme: '*Raising the Bar in Dentistry: 2005 and Beyond*'. New legislation regarding mandatory Continued Dental Education was introduced with specific requirements for 2 credit hours of HIV/AIDS education within a 2 year period.

As a follow-up to the Montreal workshop and part of the conference, a half-day HIV/AIDS symposium was held for dental health professionals. In attendance were over sixty participants including Dentists, Dental Hygienists, Technicians, Assistants and Office Managers. Professor S. Prabhu, Professor of Oral Medicine at The University of the West Indies School of Dentistry, Trinidad was the Guest presenter. The main topics for the workshop included: '*Oral Manifestations of HIV/AIDS and its Pathogenesis*'.

More Workshops on the topic of HIV/AIDS have been planned throughout the region to sensitise all oral Health professionals on the dreaded disease which is rampant throughout the Caribbean.

The Bahamas Conference also honoured 17 members of the Profession who have provided 25 or more years of service to the Bahamian community.

THE CDA IN MALTA

Dr John M G Hunt *OBE FFGDP(UK) BDS*
CDA Regional Vice-President (Europe)

Every two years the Commonwealth holds a Heads of Government Meeting and this year it was the turn of Malta to be the host country. Since 1997 the Commonwealth Foundation has organised a range of activities under the banner of The Commonwealth People's Forum immediately preceding these biennial meetings with the aim of providing opportunities for networking and interaction among civil society organisations in the host country and in the Commonwealth.

Delegates at the CDA/CNF/CPA/Para55 Symposium

For the meeting in Malta the Commonwealth Dental Association (CDA), the Commonwealth Nurses Federation (CNF), the Commonwealth Pharmaceutical Association (CPA) and the Commonwealth HIV/AIDS Action Group/Para55 combined to organise a prestigious symposium '*Global Health – Networking for Better Outcomes*'. This was designed to reflect the overall theme of 'Networking Commonwealth People' and addressed two key health issues; HIV/AIDS and the Migration of Health Workers.

An informal dinner was held on the evening before the Symposium at which we entertained not only the four speakers but also the Deputy Secretary-General of the Commonwealth Secretariat, Winston Cox; the Director of the Commonwealth Foundation, Mark Collins; Ann Keeling also from the Commonwealth Secretariat and the High Commissioner for Malta in the UK. Also with us were the Presidents or representatives from the Commonwealth and Malta healthcare organisations.

The next day we were joined for the Symposium in the historic Cotoner Room of the Malta Conference Centre by many local doctors, dentists, pharmacists and nurses. As we sat in the somewhat austere surroundings it was interesting to reflect that as long ago as 1574 this room formed part of the Holy Infirmary (Sacra infirmeria) of the Order of St John and probably housed many of the sick and wounded of the time.

Under the Chairmanship of John Hunt (CDA Vice-President), the proceedings began with Mr Winston Cox, Deputy Secretary-General of the Commonwealth Secretariat, giving an inspiring welcome address to the large number of delegates. Then it was the turn of the first keynote speaker, Dr Alice Welbourn. Alice has carried out research in rural Kenya and worked in East, Southern and West Africa. She was diagnosed HIV positive some 13 years ago and since then has written training packages now used in communities across Africa, Latin America and Asia. Married with two teenage children she was, until recently, the International Chair of Women Living with AIDS/HIV.

In a very moving address she reminded us that around 40 million people were living with HIV at the end of 2004 of whom about two-thirds are Commonwealth citizens. UNAIDS has identified marriage as a risk factor for women in Africa and in sub-Saharan Africa 76% of the young people with HIV are girls. Young women are especially vulnerable, through physical factors, through their lack of education, and their poor social, legal and economic status in society. Many are subject to violence, abuse, and exploitation – all of which increase their risk of HIV infection. By the end of 2003 there were at least 15 million AIDS orphans who are vulnerable to poverty, exploitation and themselves becoming infected with the virus. They are often forced to leave the education system and head a family.

She estimated that only 1 million of the 6 million people who need treatment have yet been able to access it and women, particularly, face huge treatment access issues.

Winston Cox
(seated L to R) John Hunt
Richard Scheffer, Alice Welbourn

Research shows that for many health conditions treatment access is harder for women and HIV is no exception. Moreover, HIV increases risks of TB co-infection, from which many with HIV also die. Unless women are kept alive, their children too will be orphaned, exacerbating the crisis yet further. Governments were urged to provide access to treatment and care for all people living with HIV/AIDS including anti-retroviral drugs

and home-based care and support.

The second speaker was Dr Richard Scheffer who chairs the Advocacy Committee of the UK Forum for Hospice and Palliative Car Worldwide. Richard is a consultant in palliative medicine in the UK and the medical director of a hospice in Devon. He trained in South Africa and is involved in the development of Integrated Community Home Based Care Programmes in Port Shepstone, RSA and other sites. He and his advocacy committee are committed to raising the awareness of governments to the importance of palliative care especially in patients with HIV/AIDS.

Richard described various models of care that are currently in use in various parts of the world. He demonstrated the value of appropriate palliative care to the patient, to the family and to the wider community and urged that all Governments develop practical policies for the care of the terminally ill. Such policies should form part of that Government's health strategy.

The afternoon session was devoted to the very contentious issue of 'Migration of Health Workers' and we first heard from the President of the Commonwealth Medical Association, Professor Agyeman Badu Akosa.

Agyeman Badu Akosa

He is the Director-General of the Ghana Health Services and Professor of Pathology at the Ghana Medical School. Previously he was a Consultant Histopathologist at Whipps Cross Hospital in London; a post which he resigned to return to his native country.

In graphic detail Professor Akosa told us about the difficulties that Ghana and other developing countries have in retaining qualified medical and nursing staff. Over the past 30 years Ghana has trained, at enormous cost, about 30 doctors each year but so many of them leave to take up posts in the USA, Canada, UK and South Africa that the number of doctors has increased only a little during this period. And, to aggravate the problem the country's population has doubled.

Trained nurses are leaving at an even greater rate and a similar problem is developing with other healthcare professions such as pharmacists, radiographers and laboratory technicians joining the brain drain. This is having a devastating effect on countries where HIV/AIDS and other diseases are presenting even greater challenges to the healthcare providers.

Professor Akosa argued that governments of 'recipient' countries as well as 'donor' countries must work together to develop ways of managing this flow. The developing countries must look at innovative ways of encouraging staff to remain at home perhaps by helping with housing or improving the general working environment. The host countries, who benefit from not having to fund the education of the immigrant professional, should consider how best they can assist by entering into bilateral or multilateral agreements on staff movements.

The last speaker was Dr Richard Cooper, a Professor of Medicine from Philadelphia, USA, who is now primarily interested in healthcare workforce policy. He is at the forefront of developing medical manpower models and has demonstrated that there will be a significant shortfall in many categories of healthcare workers in the USA during the next twenty years or so. He dramatically illustrated the size of the problem by telling us that by the year 2020 there is likely to be a shortfall of around 200,000 doctors in the United States alone.

Richard Cooper

This shortfall would be similar to the total 'production' of doctors in the less well developed countries of the Commonwealth. Because of this shortfall, and because the rewards in the USA are so much higher, the migration from these less well developed countries will continue in ever increasing numbers unless drastic action is taken very soon.

He told us that there are even some immigrants to the US who have received a medical training in their home country but as their qualifications are not accepted in the US, they are content to work as nurses. Dr Cooper was critical of the US Government for not providing sufficient training for the country's own requirements and urged action by governments to manage these migration issues.

The morning and afternoon sessions were followed by lively debate amongst the 180 attendees at the Symposium chaired by Dr Grace Allen-Young, the President of the Commonwealth Pharmaceutical Association.

The outcome of the Symposium was to deliver a communiqué to the Commonwealth Secretariat which, hopefully, would be

incorporated into the final communiqué from the People's Forum to Heads of Governments and Foreign Ministers. In the event most of what we urged was included in this document and the relevant paragraphs are printed on page 8.

So our job was done. The many months of planning by Julia Campion (CDA), Betty Falconbridge (CPA), Mike Stubbings (CNF) and Frank Davis (HIV/AIDS Action Group) had paid off and demonstrated the sense in working together with other organisations for a common purpose.

This effort, and the financial support and assistance of the Commonwealth Foundation, combined to deliver a powerful message to Commonwealth Governments. Let's hope they take notice.

Excerpt from the Communiqué of the Commonwealth People's Forum

We *[the members of civil society and the representatives of peoples' organisations in the Commonwealth at the Commonwealth Peoples' Forum, from 20 to 25 November 2005, in Malta]* call on Commonwealth governments to consider the following key recommendations, which emerged from the 14 national civil society consultations, the discussions of the '*Committee of the Whole*', the e-consultation and the deliberations of the Commonwealth People's Forum in Malta, to:

19. Ensure the human right to health care for all, devoting adequate resources to ensure universal, free and sustained quality access to treatment for all those infected by and affected by HIV/AIDS, especially women, children and older persons, and immediately substantially scale up international support for the treatment as well as prevention of HIV/AIDS;

20. Create opportunities for young people to discuss issues of health and sexuality, and empower them to assist in all areas of health education, including HIV/AIDS;

21. Take the necessary legal, social, educational and cultural steps to stop stigmatisation and discrimination against people infected by and affected by HIV/AIDS;

22. Remove from trade and intellectual property agreements any obstacles to access, supply and distribution of affordable quality generic drugs;

23. Advance agreement among Commonwealth governments on migration of health and education workers with the objectives of meeting national needs and self-sufficiency.

The CDA were pleased to welcome members of the Dental Association of Malta (DAM) to the joint health symposium 'Global Health - Networking for Better Outcomes' in Valletta on 22 November 2005.
(L to R) Dr Martha Vella (President DAM), Dr Alfred Magri Demajo (President FAPB), Prof Hector Galea, Dr Audrey Camilleri (International Liaison DAM), Dr Jeffrey Pullicino Orlando MP.

Don McKinnon (Commonwealth Secretary-General) *(centre)* ***with*** *(L to R)* ***Frank Davis (Para55), Julia Campion (CDA), Carolyn Bell (CPA), Michael Stubbings (CNF) on World AIDS Day (1.12.2005). After presenting the Executive Summary of their joint health symposium 'Global Health - Networking for Better Outcomes' to the Commonwealth Secretary-General.***

REPORT OF THE CDA MEETING IN MONTREAL

RECENT CDA ACTIVITIES

Dr Sam Thorpe *OR*
CDA Executive Secretary

Introduction

The annual FDI World Dental Congress, held in a different country each year, attracts many delegates from the dental profession from all over the world, including the Commonwealth countries. It is for this reason that the Commonwealth Dental Association has, in recent years, held a meeting during this congress. This year, during the FDI Congress in Montreal, was no exception. On 27 August 2005, in the morning, the CDA held an *HIV/AIDS Seminar for the Caribbean Region*. The afternoon session was devoted to a *CDA Open Meeting* which included feedback on the HIV/AIDS Seminar.

The purpose of the seminar for oral health personnel was to heighten the awareness of HIV and AIDS related issues in the Caribbean Region, with the aim to disseminate the latest research, especially in relation to the oral manifestations of AIDS and HIV. The objectives being to train a group of oral health personnel who would be able to teach and train others in the areas of oral manifestations and universal precautionary measures. Also, to foster collaboration and communication throughout the Caribbean among oral health personnel. The presentations are reported in this issue of the CDA Bulletin.

In addition to the CDA Executives participants attended from Anguilla, Australia, Bahamas, Barbados, Canada, Dominica Fiji, Ghana, Grenada, Jamaica, Malaysia, Nigeria, Singapore, Sri Lanka, St Croix, Swaziland, UK, USA and, also, representatives from the FDI World Dental Federation and the British Dental Association.

Opening

Dr L. K. Gandhi (CDA President) opened the meeting by welcoming those present to Montreal. He reported that the CDA/Caribbean HIV/AIDS Seminar which took place that morning had been very successful. He indicated that there would be an opportunity for feedback on the Seminar during the CDA meeting.

Dr Sam Thorpe

Executive Secretary's Report

Dr Sam Thorpe (CDA Executive Secretary) said that his report covered the period September 2004 to August 2005. He highlighted the significant events during the period, which included the following:

♦Preparation and adoption of the CDA Funding Strategy for 2005/2006 to 2009/2010 which provides the guidelines CDA intends to follow in order to increase the income of the Association

♦*Virtual* meetings of the CDA Executive Committee conducted by e-mail in November 2004 and in February, May and July 2005, at which all CDA Executive members in different countries of the Commonwealth had taken part, and at no cost to the Association. Some major decisions resulting from the meetings were:

- Organisation of a Pacific Regional Meeting;
- Organisation of a CDA/Caribbean Regional Seminar on HIV/AIDS;
- Purchase and distribution by CDA of a Distance Learning Package for Oral Health Workers;
- Participation of CDA at the Commonwealth Health NGOs Seminar during the Commonwealth Heads Of Government Meeting (CHOGM) 2005 in Malta, in collaboration with three other Commonwealth health organisations;
- Development of a research project involving the use of a simple intervention that would engage the oral health profession in the struggle against the main cause of oral cancer (and other cancers) namely tobacco.

♦Participation of CDA at the Commonwealth Health Ministers Meeting in Geneva on 15 May 2005. This meeting organised by the Commonwealth Secretariat is held annually in Geneva the day before the World Health Assembly begins. The activities of CDA during the period March 2004 to February 2005 feature prominently in the Report – 'Activities on Health Priorities 2004/2005' distributed by the Commonwealth Secretariat at the meeting;

♦Meeting of the CDA Administrator and the Executive Secretary with Dr Mark Collins the new Director of the Commonwealth Foundation, on 12 August 2005. The purpose of the meeting was for the CDA Executive Secretary to meet

and establish contact and a working relationship with Dr Collins and discuss the membership, structure, funding and activities of the CDA;

♦He stated that since April this year, he has been residing in the UK, and this has greatly facilitated interaction with the CDA Administrator and other members of the Executive Committee. He emphasised that in his capacity as CDA Executive Secretary, he will be working closely with the Commonwealth Foundation and the Commonwealth Secretariat on all matters concerning the CDA. and will endeavour to attend all their meetings to which the CDA are invited, or at least ensure valid CDA representation when unable to do so;

♦The re-entry of the Australian Dental Association into the CDA.

Treasurer's Report

Dr Anthony Kravitz (CDA Treasurer) circulated the Audited Accounts (01 July 2004 to 30 June 2005) and the CDA subscription table. He indicated that the CDA income is made up as follows:

- 70% from the Commonwealth Foundation – grants for core and programme funding have to be applied for annually;
- 16% from National Dental Association subscriptions;
- 8% from CDA Friends;
- 6% from sponsorships.

He said that the CDA continually chases subscriptions and that the rate is set at CDA triennial meetings. He emphasised the aim of CDA to improve communication with National Dental Associations. He added that there is a void in income from the trade; consequently while in Montreal, he had held discussions on this issue with trade representatives. He promised to follow up on this.

Other Significant Outcomes

The significant outcomes of the other agenda items for the meeting included the following:

♦ The CDA Bulletin will continue in the current electronic version and will contain articles of information about/for dentists;

♦The Australian Dental Association (ADA) was welcomed back to the CDA after an eight-year absence. Dr William O'Reilly President of ADA said they were looking forward to contributing meaningfully to the CDA;

♦ The following update on the FDI World Dental Development Health Promotion Committee (WDDHPC) was provided by the Chairman of the Committee, Dr Brian Mouatt:

- The source of computers supplied to Commonwealth countries in the first demonstration project was no longer available. Since they were used computers maintenance was difficult and expensive. It is now cheaper for computers to be bought locally;
- Following the Oral Health Conference in Nairobi (April 2004), 10 African countries had asked WDDHPC for help on an oral health policy. Also, there is increased access to fluoride as Colgate are establishing new factories in Africa;
- Countries are encouraged to submit projects for funding to the FDI *Live, Learn and Laugh* programme which is sponsored by Unilever.

♦ The CDA will endorse the principles of '*The London Declaration on Ethical International Recruitment of Dental Professionals*';

♦ CDA 5th Triennial Meeting will take place in Colombo, Sri Lanka from 1-3 December 2006, and the theme will be *Yesterday, Today and Tomorrow*. The programme will include lectures, symposia, free communications, poster presentations and a trade exhibition;

♦ In connection with the CDA/ Caribbean HIV/AIDS Seminar, CDA will publish in the CDA Bulletin or in a letter to National Dental Associations, all the best websites on cross infection including the websites of UNAIDS, UNFEMME and OSAP. A small CDA group will undertake a study on the inclusion of an oral health component in health education programmes on HIV/ AIDS in schools, intended to be used by Commonwealth National Dental Associations;

♦ On the issue of oral cancer, CDA will work towards undertaking a research project that will involve training local people in National Dental Associations on techniques for training other dentists in tobacco cessation;

♦ Since Dr Kofo Savage and Prof Martin Hobdell were organising an Oral Health Conference in Abuja, Nigeria from 5-6 October 2005, both of them will be the official CDA representatives at the conference;

♦ The Pacific Regional Meeting will take place in Fiji from 25-30 November 2005.

Conclusion

Dr Gandhi thanked participants for attending the meeting, and declared it closed at 5pm. He then invited them to join the CDA at an informal reception that followed.

The CDA 5th Triennial Meeting

Theme:

YesterdaY todaY tomorrow

1-3 December 2006

Colombo Sri Lanka

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UNAIDS - FACTS and FIGURES

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Chair FDI World Dental Development & Health Promotion Committee

Global summary of the HIV and AIDS epidemic: December 2003

Number of people living with HIV in 2003

Total	37.8 million (34.6–42.3 million)
Adults	5.7 million (32.7–39.8 million)
Children under 15 yrs	2.1 million (1.9–2.5 million)

People newly infected with HIV in 2003

Total	4.8 million (4.2–6.3 million)
Adults	4.1 million (3.6–5.6 million)
Children under 15 yrs	630 000 (570 000–740 000)

AIDS deaths in 2003

Total	2.9 million (2.6–3.3 million)
Adults	4 million (2.2–2.7 million)
Children under 15 yrs	490 000(440 000–580 000)

Global estimates for adults and children

People living with HIV	37.8 million (34.6–42.3 million)
New HIV infections in 2003	4.8 million (4.2–6.3 million)
Deaths due to AIDS in 2003	2.9 million(2.6–3.3 million)

Adults and children estimated to be living with HIV

Sub-Saharan Africa	25.0 million
South & South East Asia	6.5 million
Latin America	1.6 million
Eastern Europe & Central Asia	1.3 million
North America	1.0 million
East Asia	900,000
Western Europe	580,000
North Africa & Middle East	480,000
Oceania	32,000
Caribbean	430,000
Total	**37.8 million (34.6 – 42.3)**

Estimated number of adults and children newly infected with HIV

Sub-Saharan Africa	3.0 million
South & South East Asia	850,000
Latin America	200,000
Eastern Europe & Central Asia	360,000
North America	44,000
East Asia	200,000
Western Europe	20,000
North Africa & Middle East	75,000
Oceania	5,000
Caribbean	52,000
Total	**2.1 million (1.9 – 2.5)**

Estimated adult and child deaths from AIDS

Sub-Saharan Africa	2.2 million
South & South East Asia	460,000
Latin America	84,000
Eastern Europe & Central Asia	49,000
North America	16,000
East Asia	44,000
Western Europe	6000
North Africa & Middle East	2,400
Oceania	700
Caribbean	35,000
Total	**2.9 million (2.6 – 3.3)**

Children (<15 years) estimated to be living with HIV

Sub-Saharan Africa	1.9 million
South & South East Asia	160,000
Latin America	25,000
Eastern Europe & Central Asia	8,100
North America	11,000
East Asia	7,700
Western Europe	6,200
North Africa & Middle East	21,000
Oceania	600
Caribbean	22,000
Total	**2.1 million (1.9 – 2.5)**

Estimated deaths in children (<15 years) from AIDS per year

Sub-Saharan Africa	440,000
South & South East Asia	34,000
Latin America	5600
Eastern Europe & Central Asia	900
North America	< 100
East Asia	2,000
Western Europe	< 100
North Africa & Middle East	5,000
Oceania	< 200
Caribbean	5,200
Total	**490,000 (440,000 – 580,000)**

Estimated number of children (<15 years) newly infected with HIV per year

Sub-Saharan Africa	550,000
South & South East Asia	8,400
Latin America	6,400
Eastern Europe & Central Asia	1,500
North America	< 100
East Asia	3,000
Western Europe	< 100
North Africa & Middle East	21,000
Oceania	600
Caribbean	22,000
Total	**630,000 (570,000 – 740,000)**

About 14 000 new HIV infections a day

- More than 95% are in low and middle income countries
- Almost 2000 are in children under 15 years of age
- About 12 000 are in persons aged 15 to 49 years, of whom:
  - almost 50% are women
  - about 50% are 15–24 year olds

Global HIV and AIDS estimates Children (<15 years)

Children living with HIV	2.1 million (1.9 – 2.5)
New HIV infections in 2003	630,000 (570,000 – 740,000)
Deaths due to AIDS in 2003	490,000 (440,000 – 580,000)

Caribbean Update 2005

- The epidemic is well established
- It is spreading
- Prevalence between 1.4% - 4.0 %
- Up to 140,000 new cases
- Up to 59,000 AIDS-related deaths
- 2.9% women – 1.2% men affected

Impact

- Economies dependant on tourism
- There is high unemployment
- Vulnerable to socio-economic disturbances
- Caribbean economies down 6% (World Bank)
  - lost workers & unemployment
  - cost of health care & reduced savings

Access to Care

- Mixed picture : Bahamas → Jamaica
- Pan-Caribbean Partnership against AIDS
  - agreement with pharmaceutical companies for access
- Cuba - care across the continuum

AIDS Issues

The focus: The common worldwide problems of the poor

Treatment

- 1 million on Anti-retroviral treatment (ART)
- The majority in affluent countries
- 3% in Sub-Saharan Africa
- Botswana – women use services more than men
- Worldwide – 1% of women have access to treatment

Care-giving

- Care-giving reduces earning opportunities
- Care-giving is a female role
- Female headed households – widows
- Larger family groups - orphans

Education

- IF all children had a complete primary education:
- 7 million less cases in 10 years (700,000 / year)
- Better educated girls delay first sexual experience
- Better educated girls insist on condom use
- 40% of countries have no AIDS information in schools

Violence fuels the epidemic

- Beaten / dominated women 2X more infected
- In D R Congo – 60% militia HIV+
- In Rwanda of 1125 survivors of rape 70% HIV+
- Zimbabwe – six girls raped daily
- Uganda, 60% women in Internal Displaced Camps HIV+

Women's Rights

- Child marriage is a positive risk factor
- Worldwide 82 million girls marry before 18
- 90% Widows in Uganda have property disputes
- 88% widows unable to meet their household needs
- HIV+ women are cast out or returned without dowry
- Only 32% widows in Bangladesh get their inheritance

Higher HIV+ prevalence in young women?

- There is increasing disparity between HIV+ prevalence between young women and young men.:
  Glynn JR et al AIDS 15 S 4 S51-S60 A study in Kenya and Zambia)
- Women - 6X higher in 15-19 year old women -WHY?
- Marry younger
- Men have more partners
- Women often have older partners
- Susceptability higher due to higher incidence of Herpes Simplex type 2 infections

The lessons

PREVENTION
KNOWLEDGE
BEHAVIOUR

Our partners

- **FDI World Dental Federation**
- **National Dental Associations**
- **World Dental Development**
- **WHO**
- **OSAP**
- **UNAIDS**
- **UNIFEM**

What can we do?

- **Get involved with colleagues**
- **Show interest in public health issues**
- **Be safe practitioners**
- **Educate the young**

CROSS INFECTION IN DENTISTRY

Eve Cuny *MS (University of the Pacific)*
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Standard Precautions

- Synthesise major features of Universal Precautions and Body Substance Isolation
- Precautions
  - Applies to all patients regardless of diagnosis or infection status
  - Includes blood and all body fluids except sweat (includes saliva in all settings)
- May be supplemented by special isolation precautions for diseases transmitted by contact, droplet or airborne routes

Elements of Standard Precautions

- Hand-washing
- Use of gloves, masks, eye protection, and gowns
- Patient-care equipment
- Environmental control
- Injury prevention

Modes of Transmission

- Direct contact with blood and body fluids
- Indirect contact with contaminated instruments or surfaces
- Contact of mucosa of the eyes, nose or mouth with droplets or spatter
- Inhalation of airborne microorganisms

Benefits of Infection Control Training

- Occupational safety
- Patient safety
- Environmental safety
- Reduction in discriminatory practices
- Access to care for infected patients

Occupational Safety

- Exposure prevention
- Environmental control
- Immunizations
- Post exposure management
- Protective attire
- Basic asepsis (hand washing)

Immunisation Program

- Recommended vaccinations
- Hepatitis B
- Measles/Mumps/Rubella
- Varicella
- Diphtheria/Tetanus
- Polio
- Influenza
- Others depending on disease prevalence in the area

Personal Protective Attire

- Eye protection
- Gloves
- Masks
- Overcoats (cliinical)

Hand Hygiene / Hand washing

- Hands are the most common mode of disease transmission
- Reduce spread of antimicrobial resistance
- Prevent infections in healthcare settings
- Efficacy of Hand Hygiene
- Preparations in Killing
- Bacteria

Efficacy of Hand Washing

***Good*:** Plain Soap

***Better*:** Antimicrobial soap

***Best*:** Alcohol-based hand rub

Hand Hygiene / Antisepsis for Routine Dental Procedures			
	Soaps & Water	**Antimicrobial Soap & Water**	**Alcohol-based hand rub alone**
If hands are visibly soiled with blood, body fluids or proteinaceous material	Yes	Yes	No
If hands are not visibly soiled	Yes	Yes	Yes

Types of Occupational Exposures to Blood

- Percutaneous injury
- Mucous membrane exposure
- Non-intact (broken) skin exposure
- Bites

Risk of Infection after Needle stick

Source	Risk
HBV	6.0-30.0% 1/3
HCV	1.8%
HIV	0.3% 1/300

Elements of an Effective Post-exposure Management Program

- Clear policies/procedures
- Education of health care personnel (HCP)
- Rapid access to
  - Clinical care
  - Post-exposure prophylaxis (PEP)
  - Testing of source patients/HCP

Elements of Post-exposure Management

- Wound management
- Exposure reporting
- Assessment of infection risk
- Type and severity of exposure
- Blood-borne infection status of source person

Assessment of Infection Risk

- Type of exposure
- Type and amount of body substance
- Source evaluation
- Susceptibility of the Exposed person

OraQuick Rapid HIV-1 Test

- Results in 20 minutes
- Uses finger stick blood
- High sensitivity (99.6%) and specificity (100%)
- More cost-effective for post-exposure management (e.g. no unnecessary PEP use)
- Can use outside traditional settings
- OraQuick using oral mucosa
- Issues related to scope of practice for dentists

OraQuick Rapid HIV-1 Test

1. Collect
2. Mix
3. Read

Patient Safety

- Instrument sterilisation
- Disposable needles
- Protective attire
- Immunisations

Scottish Intercollegiate Guidelines Network (SIGN)

- WHO group on safe injections
- Includes discussion of safe disposal of needles and sharps
- Did not initially include dentistry
- FDI and OSAP collaborating to provide information to the group

Transmission of HIV from Infected Dentists to Patients

- Only one documented case of HIV transmission from an infected dentist to patients
- No transmissions documented in the investigation of 63 HIV-infected healthcare personnel (including 33 dentists or dental students)
- Test results from more than 22,000 Patients

Selected Diseases Requiring Work Restrictions	
Conjunctivitis	Until no discharge
Diarrheal disease	Until symptoms stop
Herpes simplex	Until lesions heal
Measles/rubella	About 1 week
Pertussis	5 days after antibiotics
Strep Group A	24 hours after antibiotics
Varicella	Until lesions crust
Viral respiratory illness	Until symptoms resolve
Shingles/zoster	Cover lesions/crusted

Environmental Safety

- Medical waste disposal
- Sharps
- Blood-contaminated disposable products

Management of Medical Waste Collection

- Storage
- Disposal
  - Incineration
  - Sterilization
  - Destruction

Worker Training

- Relevant
- Clinically oriented
- Evidence-based or based on strong theoretical rationale
- Appropriate for workers with broad range of background and experience
- Reinforced regularly

Organization for Safety and Asepsis Procedures (OSAP)

- Membership organisation
- US-based with global membership and activities
- Foundation
- Education, training, support
- **WWW.OSAP.ORG**

Training Tools

- Infection Control In Practice
- Published 8 times per year
  - Inside Each Issue
    - Compliance Corner
    - Glossary & Calendar
    - Putting It All together
    - Charts & Checklists
    - Practice Tips and Q&A

Traveller's Information

- Traveller's Guide to Safe Dental Care
- Patient-oriented

OSAP's Mission

To promote science-based policies and practices for infection control, health, and safety in dental healthcare settings worldwide.

OSAP Humanitarian Efforts

- Guide for Safety and Infection Control for Oral Healthcare Missions
- Discussion and tools for planning and execution of safe dental care in locations with limited resources

OSAP 'Frequently Asked Questions'

- What is the estimated risk for contracting HIV through a percutaneous exposure?
- Prospective hospital-based studies indicate that the estimated risk for HIV infection after percutaneous exposure to HIV-infected blood is approximately 0.3%(1). To date, there are no confirmed occupationally acquired cases of HIV in dentistry.

Infection Control Education

- 1/2- and 1-day seminars around the country
- 4-day intermediate level course
- 3-day advanced symposium on new information, regulatory issues, products and techniques

Further information:

Online Resources for Infection Control and Safety in Dentistry
www.cdc.gov/oralhealth/infectioncontrol

ORAL MANIFESTATIONS OF HIV DISEASE: Implications to the Dental Profession

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Introduction

Since 1981 when the first cases of HIV were recognised in USA several important oral manifestations of HIV disease have been described. While many of these lesions relate to immunosuppression or diseases affecting the immune system some oral conditions are thought to be unique to HIV infection. Some reports suggest that in a significant number of subjects the suspicion of HIV infection could be based on the initial observation of an oral mucosal lesion or lesions acting as surrogate markers of HIV disease. Since the mouth is easily accessed for clinical examination an oral lesion may serve as a diagnostic tool indicating that the patient has HIV, especially in developing countries. Furthermore development of some oral conditions trigger decision making concerning treatment and chemoprophylaxis and sometimes act as a predictor of disease progression to AIDS. Importantly the initial appearance of any HIV-associated oral lesion is correlated with seroconversion. Over 30 oral lesions and conditions are known to be associated with HIV infection. EEC clearing house classification[1] grouped these oral lesions associated with HIV infection into three categories based on their reported cumulative frequency. In many Western countries while the frequency distributions of these markers of HIV are now altered by highly active antiretroviral therapy (HAART) the EEC classification may still be valid for many developing countries where HAART is practically unavailable for economic reasons. The clinical and diagnostic aspects of some oral lesions strongly associated with HIV infection are featured here.

Oral Candidosis

While various opportunistic fungal infections can present as complications of HIV, candidosis is by far the commonest fungal infection encountered in the oral cavity. Oral candidosis may be pseudomembranous (thrush) or erythematous type. Up to about 90% of HIV-infected patients develop one or more episodes of candidiasis at some stage during disease progression.

The most commonly reported type of candidiasis is the pseudomembraneous variety (thrush), which consists of loosely adherent, creamy yellowish-white plaques that can be scrapped off to reveal a raw (erythematous) surface. Occasionally, drop-like appearances (confluent white papules), which are sometimes interconnected are noted. The most common oral sites affected are buccal and labial mucosa, dorsal tongue and palate. The erythematous type, characterised by a red appearance, is commonly located on the palate and the dorsum of tongue. Because the tongue and palate are in constant contact, both sites eventually will show the same reddish lesion characteristic for erythematous candidiasis with varying degrees of redness. Erythematous candidiasis of the tongue is often associated with papillary atrophy leading to a bald area. Erythematous candidiasis may also appear as large macules (spotty lesions) of the buccal mucosae. Candida associated angular chelitis may co-exist in the same patient. In angular chelitis a spectrum of clinical changes are noted from very mild fissuring and reddening, whitish crusting to frank ulceration and suppuration of the corners of the mouth. These lesions are often bilateral.

Confirmation of diagnosis of oral candidosis is based on a smear test (stained with periodic acid Schiff for the presence of hyphae), demonstration of candida species in culture or by establishing the colony count in whole mouth saliva or an oral rinse sample.

Erythematous candidosis is known to precede the development of pseudomembranous type and indeed recent studies have associated pseudomembranous type with later HIV disease compared to erythematous type[2]. While earlier conducted longitudinal studies have suggested that both forms of candidiasis carry a similar prognosis for progression to AIDS in HIV disease, it now appears that the two forms do not carry the same prognostic significance.

Conventional topical antifungal treatment is recommended, but if oral lesions are persistent systemic fluconazole may be indicated. Either type of candidiasis is more likely to occur at low CD4+ counts and prophylaxis of oral candidosis has been recommended for patients whose CD4 count is below 200/mm^3.

The progression of immunesuppression due to infection with HIV is mirrored by an increase in the severity and prevalence of oral candidosis. The development of oral candidosis occurs at a lower incidence in subjects receiving anti-retroviral therapy compared to untreated controls. In some published studies thrush is a significant predictor of the development of pneumocystis carini pneumonia (PCP). Development of recurrent mucosal candidiasis should trigger the recommendation of anti-retroviral therapy in all cases. Three male

cohort studies from San Francisco reported that subjects with oral candidiasis at initial presentation developed AIDS more rapidly than those with normal oral mucosal findings.[3]

Hairy Leukoplakia

Originally regarded as pathognomic of HIV disease these are adherent white patches/plaques on the lateral margins of the tongue, occurring in most cases bilaterally. The surface texture is often corrugated with fine finger-like projections that have a hairy appearance. From the lateral margins these white patches may extend to the ventral surface of the tongue where the lesions are usually flat. Hairy leukoplakia is often symptomless. It is now known that lesions clinically similar to hairy leukoplakia may be present in other immuno-suppressive conditions such as transplant recipients or rarely in those using corticosteroid inhalers[4]. Other oral white lesions that need to be considered in the differential diagnosis of hairy leukoplakia include frictional keratosis and tobacco-associated keratosis (leukoplakia). Hairy leukoplakia has some unique histo-pathological features and, therefore, the diagnosis can be confirmed by taking an oral biopsy. The lesion is character-ised by the presence of replicating Epstein Barr virus in the superficial layers of the epithelium which is clearly implicated in the aetiology of the condition. Other histo-pathologic features include keratin projections, acanthosis and parakeratosis, ballooning of prickle cells giving the appearance of koilocytosis, little or no inflammation in the lamina propria despite the fact that superficial layers of the epithelium often display invading hyphae of *Candida.* Keratoses of the lateral tongue that clinically and histologically resemble hairy leukoplakia but lacks evidence of EBV DNA within superficial keratinocytes are sometimes encountered in clinical practice. Furthermore, these lesions are detected in subjects who are not recognised to be at risk of HIV infection and the term pseudo-hairy leukoplakia has been coined for these oral lesions mimicking hairy leukoplakia.[5]

In a consecutive sample of 456 HIV patients attending several London hospitals during 1992/ 93 the most common oral lesion noted was hairy leukoplakia.[5] Hairy leukoplakia is seen in about 25 percent of HIV-infected persons but great geographic variations are noted. The lesion is also known to be significantly less common in females compared to men at comparable stages of the disease. Hairy leukoplakia is considered as a predictor for development of AIDS; in earlier studies three-quarters of HIV seropositive patients with hairy leukoplakia were reported to develop AIDS in 2-3 years without therapy. Oral hairy leukoplakia has no known premalignant potential.

Gingival and Periodontal Conditions

Linear Gigival Erythema

A distinctive band shaped erythema usually 1-3 mm in width affecting the marginal gingival and interdental papillae is noted in about one third of patients with HIV. This fiery band-like appearance is referred to as linear gingival erythema. In the early stages of development of this lesion erythema may be limited to the marginal gingival adjacent to few anterior teeth or few interdental papillae and therefore give a punctuate appearance rather than a linear distribution. Although gingival inflammation is common in mouths with heavy accumul-ation of plaques this distribution of erythema is rarely encountered in non-HIV-infected persons. Patients may report bleeding on brushing and rarely spontaneous bleeding is observed from the erythe-matous sites. Improvement of oral hygiene always does not result in resolution of this type of gingivitis seen in HIV. Some workers have isolated Candida albicans from the gingival crevice in linear gingival erythema. As this site is rarely colonised by candida an etiological association has been suggested.[7]

Acute Necrotising Ulcerative Gingivitis (ANUG)

Minor Necrotic and ulcerative areas on one or more interdental papillae clinically similar to what has previously being described in the dental literature as acute necrotizing ulcerative gingivitis (ANUG) is reported in HIV disease. The features consist of pain, ulceration, bleeding on brushing or probing and cater formation at the interdental papillae. The extent of ulceration is variable in some cases spreading to attached soft tissues leading to mucosal ulceration.

Necrotising Gingivitis and Periodontitis

Complete necrotic destruction of the interdental papillae or attached gingivae is some quadrants of the mouth is noted leading to exposed bone. The lesion is rapidly progressive and causes severe pain due to marked gingival recession. When almost all of the papillary structure is necrotic the underlying crestal bone may sequestrate and it would be possible to lift out small pieces of alveolar bone from such sites. This is an extension of necrotic gingivitis to necrotic periodon-titis. Tooth mobility may result. Although this kind of gingival/ periodontal tissue loss is not unique to HIV disease rapid progression of the disease leading to bone sequestration is distinctive in HIV disease[8]. In some reported studies there is a clear association between severity of immune-depletion and severity and extent of periodontal breakdown and its rate of progression, others have failed to demonstrate this association.[2] Periodontal status does not seem to be particularly helpful in predicting the progression of AIDS[9].

Oral Neoplasms

Kaposi's Sarcoma

Whilst classical Kaposi's sarcoma (KS) is noted in older men and the disease affects lower extremities, KS seen in HIV disease mostly affects men

around 30 years of age and the upper extremities commonly involving face and mouth. The hard and/or soft palate, the gingival and midline of the tongue are the most frequently affected oral sites. The frequency of oral KS varies in populations; these lesions are rarely encountered in Indian subjects while the prevalence is variable in Africa and observed to be associated with the latitude. Two morphological types of KS are recognised; well defined red or purple flat/ macular spots or nodular exophytic overgrowths. KS lesions are often multifocal. The flat lesions may represent the initial presentation that may progress to overt outgrowths with superficial ulceration. KS needs to be differentiated from bacillary epitheloid angio-matosis and if patient's HIV status is unknown a biopsy is indicated. Kaposi's sarcoma in association with HIV infection is an AIDS-defining condition.

Oral squamous cell carcinoma has been reported in HIV seropositive patients but it is not yet clear whether there is an increased risk of developing oral cancer in HIV disease.[10]

Less Common Oral Lesions

The deep mycoses are uncommon infections but oral manifestations of conditions such as histoplasmosis and cryptococcosis are increasingly seen in HIV and AIDS.[11] Other less common oral lesions and conditions include herpes gingivostomatitis, herpes zoster, salivary gland enlargement and dry mouth associated with to lymphocytic infiltrates, purpura and bleeding from oral cavity, hyper-pigmentation, condyloma acuminatum, atypical recurrent oral ulceration, and nerological disturbances. Chronic parotitis is often observed in children with HIV.[12]

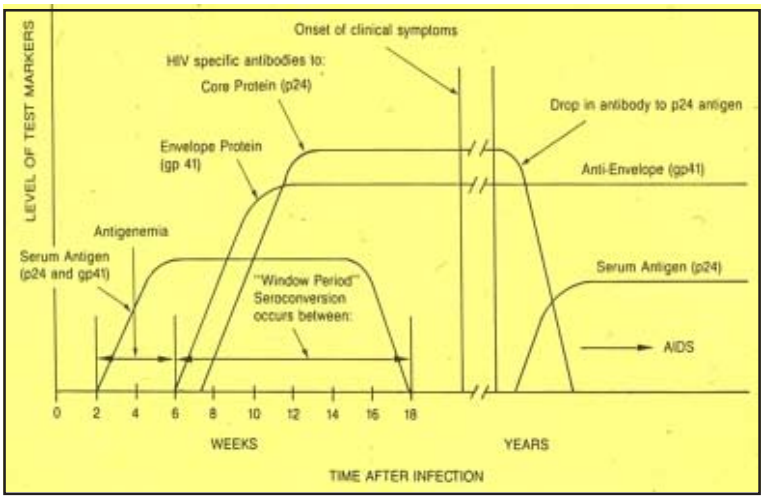

Fig 1

Non-Hodgkin's Lymphoma

Common presentation of non-Hodgkin's lymphoma in HIV disease is a firm non tender rubbery mass appearing at extra nodal sites involving any part of the oral cavity particularly the mandibular gingivae and sulcus, the palate and the fauces. The lesions are rapidly progressive and may lead to surface ulceration. Definitive diagnosis is by biopsy or fine needle aspiration. Biopsy often shows B-cell variety.

HIV Detection, Transmission and Infection

Human Immunodeficiency virus (HIV 1 and HIV 2) contains several so-called core proteins and an envelope that carries a protein, p24, which is particularly antigenic *(Fig 1)*. Antibodies to p24 forms the basis of most serological testing or called the HIV test. HIV transmission is mainly by hetrosexual intercourse during unprotected sex with infected individuals, particularly in Asia and Africa, and increasingly in the Western world, though men who have sex with men are particularly vulnerable in North America and Europe. HIV is transmitted by contaminated needles and syringes, causing a high prevalence of the disease in intravenous drug users. The disease is also transmitted via infected blood or blood products. Mother to baby transmission accounts for a high prevalence of HIV disease in children in Africa.

After primary infection with HIV, acute viraemia results in widespread dissemination of the virus and seroconversion occurs within 6-18 weeks *(Fig 1)*. At the time of clinical seroconversion an illness resembling glandular fever could manifest as the first sign of the disease. Many infected individuals however, remain asymptomatic for months after seroconversion. HIV damage to CD4 lymphocytes results in lymphopenia and eventually a reduction in CD 4 cell counts, and a fall in CD4:CD8 ratio leading to a profound defect in cell-mediated immune activity *(Fig 2)*. This clinically manifests with fungal, bacterial and viral opportunistic infections. In the absence of appropriate therapy AIDS develops in a high proportion of patients over a period of time. A CD4 count less than 200 per cubic millimeter of blood and associated illnesses define AIDS.

Treatment

There is no effective treatment for the underlying immune dysfunction but drugs that target retroviruses are available. Treatment with a combination of the retroviral drugs is termed highly active antiretroviral therapy (HAART). These drugs help to reduce the viral load and significantly improve the CD4 count, and significantly impede the progress of the disease. Clinical, immunological and viral time course of HIV infection during successful combination therapy is shown in Fig 3. Drug resist-ance, however, is not

uncommon. Only 10% of the world's poorer countries have access to these drugs. With the advent of HAART the prevalence of oral candidosis, hairy leukoplakia and HIV-associated periodontal diseases have decreased in North American and European adults.[13-15] Antiretroviral treatments may result in several adverse side effects in the oral cavity. These include, erythema multiforme, oral ulcers, xerostomia, taste alteration, perioral paraesthesia, oral hyperpigmentation, chelitis and facial lipodystrophy.[16] A significant rise of human papilloma virus (HPV) associated benign oral lesions including condylomas (warts) is reported in patients on HAART therapy.[17] Basic and inexpensive oral and dental care protocols for underserved communities, applicable also to many Commonwealth countries, are discussed by Coogan et al.[18]

Conclusions

The vast majority of HIV-infected persons are asymptomatic in the early stages of the disease and most do not know they are HIV-positive. Oral lesions are common in all stages of HIV infection. These may interfere with oral function and could have a significant impact on oral health related quality of life. The appearance of an oral lesion frequently is the first indicator of progression to symptomatic disease. An increased knowledge of the oral signs and symptoms reported here may assist in raising the threshold for early diagnosis of HIV. A diagnostic Atlas of oral lesions[19] would provide clinical calibration for clinicians with special interest on the subject. Oral health services and oral health professionals can contribute effectively to the early diagnosis, prevention and management of this disease.[20] The Phuket Declaration (2004)[21] highlights many oral health policy and research issues that are of relevance to the dental associations to strengthen their efforts for the effective control of HIV disease.

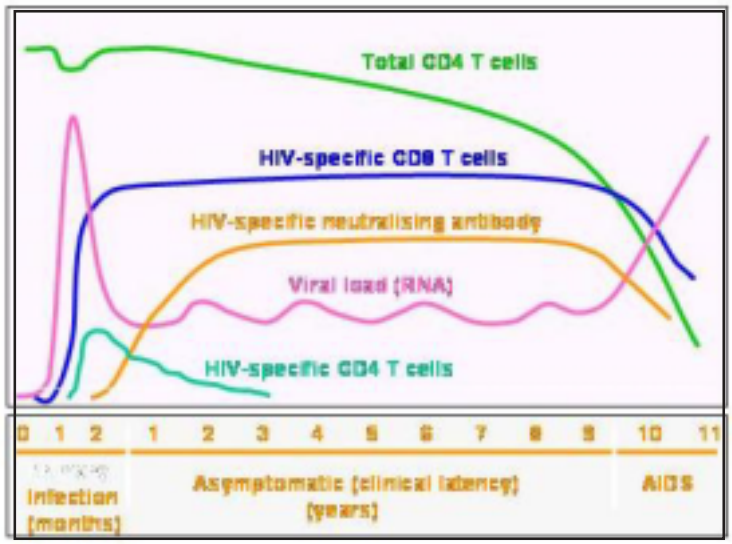

Fig 2 Clinical, virological and immunological time course of HIV infection

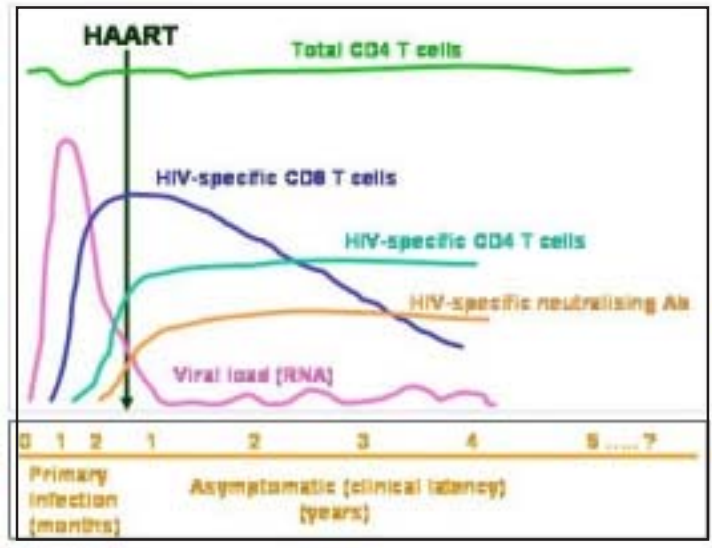

Fig 3 Clinical, virological and immunological time course of HIV infection during successful combination therapy

Based on a lecture delivered at the Workshop of the Commonwealth Dental Association held in Montreal, Canada, August 2005

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This Declaration was endorsed by the CDA at its meeting in Montreal on 27 August 2005

RESOLUTION

The World Dental Development Forum at Montreal urge the FDI Council to adopt an Ethical Recruitment and Workforce Migration policy.

To this end the forum agreed the following draft declaration:

DECLARATION ON ETHICAL INTERNATIONAL RECRUITMENT OF DENTAL PROFESSIONALS

Each country should assess its dental workforce needs and ensure it trains sufficient numbers to meet those needs, and the right of individuals to obtain dental care, however,

♦ We recognise the basic human right to migrate for economic or personal development reasons

♦ Welcoming staff from abroad enables the transfer of experience and sharing of ideas, which can be extremely valuable.

♦ However, it is essential that international recruitment fills its proper place and is not done to the detriment of countries experiencing their own staffing difficulties. To this end, the 57th World Health Assembly recognised the place of government to government agreements in helping to manage migration, and to consider independent monitoring of these agreements.

♦ Targeted international recruitment of dentists and other healthcare professionals can only be a short-term solution to domestic shortages. It is no replacement for robust workforce planning and high standards of human resource management practices.

♦ The actions of recruiters and employers are paramount in ensuring the success of human resource strategies and should include:

- Fair pay
- Good terms and conditions of employment
- Career development opportunities
- Healthy and safe working environments
- Induction programme and long term support

♦ Staff legally recruited from abroad should be protected by the employment law of the recruiting country in exactly the same way as all other employee nationals.

♦ Staff legally recruited from abroad should have the same support and access to further education and training and continuing professional development as all nationals.

August 2005

Key Skills with Smile on

Smile On offers dental professionals complete learning solutions through a comprehensive suite of educational products suitable for every branch of dentistry. In association with leading academic institutions, it offers an integrated approach to education combining seminar and hands-on experiences with highly engaging, easily accessible, interactive computer based learning modules.

In particular, Smile On offers a CD ROM based education programme, *Key Skills in Primary Care*, which covers a significant spectrum of practice issues, invaluable to all dental practices. Launched in July 2005 in association with the Faculty of General Dental Practice UK (FDGP), the programme offers a commonsense approach to clinical governance issues relevant to all members of the dental team.

The package provides a flexible education and accreditation tool, and can be used by the whole dental team, Primary Care Trusts (PCTs) and other dental health care delivery organisations as a quality assurance mechanism. The interactive programme adopts a scenario-based learning methodology, including clips of real life situation, quizzes to test knowledge and study tips for the user. It also provides a quality benchmark for commissioners of dental services and features advice from the Department of Health on confirming generalist skills for dentists with a special interest.

Developed with the assistance of subject matter specialists, the programme covers seven major areas in which the establishment of good practice is considered essential, and these are:

- Record keeping
- Infection control
- Legislation/good practice guidelines
- Medical emergencies
- Radiography
- Risk management and communication
- Team training

The CD ROM learning approach is structured and well thought out, offering an approach to learning which ensures flexibility and self paced learning, important to allow all staff to digest information thoroughly at their own speed.

Completion of the Key Skill Programme demonstrates that the practice complies with the seven areas essential to good clinical governance and ensures legislation and good practice guidelines are adhered to. It is also an invaluable way to ensure essential learning for the whole dental team, providing important knowledge for all staff, and especially for dentists working towards the MFGDP (UK) examination. Completion of the *Key Skills in Primary Care* will also give participants a certificate of completion, which includes seven hours of verifiable Continuing Professional Development (CPD).

There is a wide range of positions within the dental profession that will benefit enormously from undertaking the programme, including dentists, overseas dentists, vocational dental practitioners, medical emergencies, Therapist and Hygienists, dental nurses, practice managers and receptionists and any other professionals complementary to dentistry. By inviting staff to complete the programme, dentists will be ensuring that the highest level of professionalism is maintained within their practices.

With an understanding of the dental industry, clinical language and learning in a clinical environment. Smile On has over 15,000 registered members and is proud to be the foremost provider of integrated learning to the UK dental profession.

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