The Commonwealth Dental Association

CDA BULLETIN
and Proceedings of the CDA 4th Triennial Meeting

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

MESSAGE FROM THE CDA PRESIDENT

Dr L K Gandhi

Esteemed CDA Colleagues,

I have great pleasure in writing, as the recently elected President of the Commonwealth Dental Association, in this spring issue of our *CDA Bulletin* prepared by the Administration of the new CDA Executive, I have every confidence that the contents will be carefully read by all. The articles in this issue are intended to act as clarification of what the Commonwealth Dental Association stands for. This special issue of the CDA Bulletin includes the Report and Proceedings of the CDA 4th Triennial Meeting held in Nairobi, 13-14 December 2003. Our sincere gratitude goes out to the editors, Professor Martin Hobdell and Dr D Y D Samarawickrama. The Administration has done a super job of compiling this Bulletin and our appreciation should be directed towards to them.

This is the first CDA Bulletin in the new triennium. It will continue to be published twice a year and I request all individuals from all parts of the Commonwealth to contribute towards the Commonwealth Dental Asso-ciation's Bulletin. Particularly concerning the latest developments in the six Regions of the Commonwealth, this would be of interest to all readers around the world. This should also act as a guide to the basic principles that govern the Association in terms of the manifesto-cum-constitution laid down.

It is undeniable that London is the centre of all Commonwealth Activities and that our Head Office should continue to be located there.

CDA Executives should meet representatives of National Dental Associations and report back on such meetings.

The CDA has had the honour and privilege of a series of eminent personalities as their past Office Bearers, who have undeniably projected this august body to the forefront of Oral Health Care in all member countries, particularly the developing regions. We have to diligently pursue these objectives in the future.

While it is true that all oral cancers are not always life threatening, they are, nevertheless, serious public health hazards. This is due to their high prevalence and consequent impact on the individual as well as society at large, in terms of pain, discomfort, social and functional limitations and the ultimate effect on the quality of life.

I earnestly request all my colleagues and fellow office bearers to help and assist me in the next few years to keep up the high tradition of this office. It will, of course, require considerable creative input from all, coupled with a lot of organisation to project a Seminar and/or Congress on *Oral Cancer*. This will undeniably compel us to seek substantial assistance and help and raise adequate funds to launch this project on an International basis with Africa and India, as well as other developing member countries of the CDA.

I thank you all for patiently reading this message.

God bless you all!

EDITORIAL

Professor Martin Hobdell
Editor

This time of year in the northern hemisphere is, for many, the end of the school year and for some the very end of school and the start of a new way of life, while in the southern hemisphere people are coming into winter and the end is not yet in sight. The seasons are always changing within each hemisphere and between hemispheres – change is ever present. The theme of this edition of the *CDA Bulletin,* might also be seen as change, for it records many changes and reflects the growing maturity of the CDA as it enters its eleventh year with growing confidence and a sense of purpose.

The proceedings of the Nairobi Triennial meeting reflect change as they record the new Officers of the Association with Dr Gandhi taking over as President and Dr Sam Thorpe becoming Honorary Executive Secretary and the new regional representatives (*page 32*).

Dr Sam Thorpe reports on historic changes in oral health priorities and policies that were discussed at a meeting held in April in Nairobi, at which many African Commonwealth countries were present to discuss improving oral health in the Region with Ministers of Health and other senior government representatives and the World Health Organization (*page 4*).

The African report is complemented by a report from Dr Temalesi King on Oral Health in the Pacific Region (*page 7*).

Other news comes from the Commonwealth Health Ministers' meeting in Geneva prior to the World Health Assembly (*page 4*).

continued on page 2

Julia Campion reports on the changing form of presentation of the *CDA Bulletin* itself that was agreed upon at the Nairobi Triennial Meeting (*page 2*).

We are delighted that the newly elected CDA Treasurer, Dr Anthony Kravitz, has recently been installed as the President of the British Dental Association (*page 3*).

Sadly we also record the untimely death of Dr Norman Whitehouse, a founding member of CDA and former Secretary. We extend our sincere condolences to his family (*page 3*).

IN THIS ISSUE

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CDA BULLETIN
Change of Format

Julia Campion
CDA Administrator

As mentioned in the editorial, the form of presentation of the *CDA Bulletin* is changing. This is due to the increase in electronic communication and the high postal charges incurred in mailing copies at home and overseas.

As many will know, the *CDA Bulletin* is currently on the CDA website *www.cdauk.com* as well as being mailed in hard copy format. During the CDA 4th Triennial Meeting in Nairobi it was decided that this issue would be the last one to be sent out in its present form of bulk mailing. For future issues, an email alert notification that the *CDA Bulletin* is on the website will be sent to recipients. This will enable National Dental Associations, in particular, to print copies and distribute them to their members who are unable to access the website, thus ensuring a very much wider distribution of the CDA Bulletin than can be achieved by sending it by airmail from the UK.

There will, however, still be a small number of printed copies which CDA will send to individuals who are not on email.

We would like to receive news and reports from the regions, for publication in the CDA Bulletin please send them to me by email to:
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To receive an email alert notification that the CDA Bulletin is on the website, please send your name and email address, also the name of your organisation (if applicable), by email to : JuliaCampion@cdauk.com

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NEW PRESIDENT OF THE BRITISH DENTAL ASSOCIATION

Congratulations to Anthony Kravitz who was installed as the BDA President on 6 May 2004 at the Presidential Meeting during the British Dental Association's Annual Conference in Bournemouth, UK. Anthony Kravitz is the current Treasurer of the Commonwealth Dental Association and is a former Chair of the General Dental Services and Auxiliaries Committees of the BDA. He has also just published a book - the *EU Manual of Dental Practice 2004*.

Dr Ralph Davies (left)
Dr Anthony S Kravitz OBE (right)

IN MEMORIAM

Professor Norman Whitehouse

Dr S Prince Akpabio *OBE OFR*
Emeritus CDA Founder President

The Commonwealth Dental Association (CDA) and friends and colleagues from the international dental community lost, very sadly, a most distinguished friend and colleague in the death of Professor Norman Whitehouse on 10 October 2003. Norman had been ill for some time but very few, except those very close to him, knew of his illness. His illness and death took many of us, even those in the CDA circle, by surprise.

Norman had a long and distinguished career in dentistry, and made some very significant contributions to the dental profession at the Commonwealth, national and international levels. During his professional life, he worked hard and with great success, not only to further the interests of the profession in the United Kingdom, particularly in Wales which was always closest to his heart, but also in the European Union, the Commonwealth developing countries, which he loved greatly, and third world countries in which he helped to establish and initiate a proper university dental education system.

As the Chief Executive of the British Dental Association (BDA), Norman played an extremely important part in the formation of the now very active Commonwealth Dental Association, working very closely with such Commonwealth dental colleagues as Dr S Prince Akpabio, Professor A K Adatia, Dr George Gillespie (*United Kingdom*) and Dato Dr A Ratnanesan (*Malaysia*). In May 1990, it was Norman Whitehouse, with the agreement and support of the British Dental Association which provided the excellent facilities of the BDA headquarters in Wimpole Street, who chaired the first 2-day Commonwealth Oral Health Initiative Conference in London jointly with Dr S Prince Akpabio. It was at this first Commonwealth Oral Health Initiative Conference, assisted and supported by the Commonwealth Foundation and attended by 44 Dental Surgeons from 31 Commonwealth countries, that the historic decision to form a Commonwealth Dental Association was taken unanimously. That unanimous decision was put into effect in Kuala Lumpur, Malaysia, on 25 April 1991. The Commonwealth Dental Association owes much to the late Professor Norman Whitehouse, as he was elected the first Honorary Secretary of the Commonwealth Dental Association in 1991. Norman served that office with great distinction.

Inaugural Meeting of the CDA
25 April 1991, Kuala Lumpur, Malaysia
(left to right) Dr S P Akpabio,
Prof N Whitehouse, Prof A K Adatia,
Dr G Gillespie

Norman Whitehouse never forgot his links with Wales, and returned there as Chief Administrative Dental Officer and Director of Dental Public Health in 1993. In 1993, he was also appointed as Dean of the Dental School and Professor of Dental Public Health at the University of Wales College of Medicine. In holding these joint appointments, Norman showed that there could be a useful link between dental education and the provision of dental care to the community. He fully justified these joint appointments.

Norman Whitehouse retired in 1999, and then became Chairman of the Trustees of the Borrow Milk Foundation. Through this work, he did much to help the children of northern Peru. I am sure that the new dental school in Trujillo, Peru, will still remember him as some of us in the CDA still do.

Notwithstanding all his strenuous international activities, Norman remained very much a committed family man, and was given full support by Barbara, his charming wife, and his family till the end. The CDA has lost a good friend.

FDI/WHO PLANNING CONFERENCE FOR ORAL HEALTH IN THE AFRICAN REGION

Dr Sam Thorpe OR
CDA Executive Secretary

Introduction

The FDI/WHO Planning Conference for Oral Health in the African Region took place at the Safari Park Hotel in Nairobi, Kenya from 14-16 April 2004.

Participants included Health Ministers, Directors of Service, Responsible Officers for Health Budgets within the Ministries of Finance, Chief Dental Officers, Representatives of National Dental Associations, Academia and the dental industry.

Partner organisations present at the Conference were; African Regional Organization (ARO), Commonwealth Dental Association (CDA), Groupement de Associations Dentaires Francophone (GADEF), World Medical Association (WMA), Aide Odontologique Internationale (AOI), International Association for Dental Research (IADR) and Organization for Safety and Asepsis Procedures in Dentistry (OSAP).

CDA was represented by its Executive Secretary, Dr Sam Thorpe. He presented a paper during the session on *Framework and Partnerships*, and was the Moderator on the third day of the Conference.

Opening and Closing

The Conference was officially opened by the Honourable Vice-President of Kenya, and closed by the Permanent Secretary of the Ministry of Health, Kenya.

Also present at the Conference were Dr H R Yoon (*President of FDI World Dental Federation*) Dr E.M Samba (*Regional Director of WHO/AFRO*) Honourable Charity Ngilu (*Minister of Health Kenya*) Dr B Piccard of Foundation Winds of Hope, who delivered the Keynote Lecture, and Dr T J Ocholla (*Chairman of Kenya Dental Association*).

Aims, Objectives and Method of Work

The Aims and Objectives of the Conference were:

- Get commitment of political leaders by sensitising them on the link between general and oral health as well as the existing inequalities;
- Increase the number of functioning national oral health strategies by training technical government officers and providing examples of innovative ways of financing;
- Develop and strengthen public-private partnerships to improve oral health and oral health services;
- Agree on recommendations resulting from the meeting.

The Method of Work included presentations and discussions at plenary sessions, and working group sessions.

Main Outcomes

At the final session of the second day, Participants approved the *Nairobi Declaration on Oral Health in Africa*, by popular acclaim. The Declaration emphasised the following:

- Develop oral health policies for African countries;
- Address the environmental and lifestyle determinants of oral diseases, such as tobacco/alcohol, fluoride, nutrition, causes of facial trauma and others;
- Actively pursue health promotion/disease prevention strategies;
- Integrate oral health strategies within broader general health policies and programmes;
- Improve access to essential oral health care for the communities.

The following Action Plan was also adopted on the final day of the Conference:

- Assure wide distribution of the Conference Report to all stakeholders;
- Wide distribution of the *Nairobi Declaration*;
- Exploration of alternative ways of financing – encourage research;
- Further promotion of lifestyle changes (particularly tobacco and diet), by dissemination of papers and information;
- Shaping of experiences of different training programmes, human resources, primary health care and access problems;
- Guidance on infection control
- Setting up of appropriate and sustained data collection
- Survey of existing oral health policies – development and distribution of templates for oral health policies.

Conclusion

The final report of the Conference is being prepared by the organisers and will soon be circulated to all participants.

COMMONWEALTH HEALTH MINISTERS MEETING

Julia Campion
CDA Administrator

Dr L K Gandhi (*CDA President*) represented the CDA on the Commonwealth Advisory Committee for Health (CACH), in Geneva on 15 May 2004. CACH is a committee which advises the Commonwealth Secretariat, through the Health Secrtion of their Social Transformation Programmes Division, on matters of public health concern and interest to the Commonwealth. The Committee is a great help as the Health Section is small in number and the issues relating to health and development are many, varied and in many cases complex. The Committee's role is critical since the annual Commonwealth Health Ministers Meeting (CHMM) held each May in Geneva, prior to the World Health Assembly, is now the sole forum at which both review of on-

going health activities and discussion with agreement on future activities will occur.

Dr Gandhi also attended the Commonwealth Health Ministers Meeting (CHMM), the following day (16 May 2004), the agenda comprised:

1 *Opening*
2 *Maternal Mortality - Delivering Key Messages*
3 *Roundtables - Exploring the issues on Maternal Health*
- ♦ *Political Will*
- ♦ *Strengthening the National Health Information System*
- ♦ *Socio-cultural barriers to women's health*

4 *Director-General, WHO*
5 *Secretariat's Action on Commonwealth Health Priorities*
6 *HIV/AIDS*
7 *Report of CACH*
8 *Any Other Business*

During the afternoon session, Dr Jong-Wook Lee (Director-General, World Health Organization) addressed the Commonwealth Health Ministers and took questions.

BUILDING A COMMONWEALTH OF FREEDOM

Commonwealth Day

Julia Campion
CDA Administrator

"*Twenty-seven years ago, Commonwealth Heads of Government designated the second Monday in March as Commonwealth Day. A consideration much in their minds was that it would be term time rather than holidays for schools all over the Commonwealth, thus making it easier for young people in particular to learn about and mark the day together.*

Today, Commonwealth Day is celebrated across the member countries of the Commonwealth, and in other parts of the world where Commonwealth citizens gather together."

In London, UK, on Monday 8 March *An Observance for Commonwealth Day 2004* was held at Westminster Abbey in the presence of Her Majesty The Queen, Head of the Commonwealth, His Royal Highness The Duke of Edinburgh and His Royal Highness The Prince of Wales. The Dean of Westminster gave the Welcome and Introduction with a special welcome to Archbishop Emeritus Desmond Tutu from South Africa. The congregation, from all parts of the Commonwealth made the six Affirmations, led by the Dean:

- ♦ *We affirm that every person - of whatever colour, class or creed - possesses unique worth and dignity*.
- ♦ *We affirm our respect for the world and pledge that we will be its stewards by caring for every part of it*.
- ♦ *We affirm our belief in justice for everyone and peace between peoples and nations*.
- ♦ *We affirm our faith and love as the foundation of all human relationships*.
- ♦ *We affirm that we each belong to our own nation and to the whole human family: to the service of both we pledge ourselves*.
- ♦ *We affirm that every national and people may rightly desire freedom; and that it is in seeking freedom for others that we find our own freedom*.

These six affirmations are at the heart of the Observance and rest upon values and principles which sustain the Commonwealth.

A MESSAGE FOR COMMONWEALTH DAY FROM HER MAJESTY THE QUEEN

The lives of many of my generation were profoundly changed by a world war fought in the name of freedom. I have often reflected with pride on the huge contribution made by the peoples of the Commonwealth to that cause of liberty in which millions perished.

In the years following the war, a succession of countries emerging into independence chose to join the Commonwealth as free and equal members. As a result, the Commonwealth became rooted in all parts of the world and developed into the modern organisation we know today.

Democracy, national self-determination, individual liberty and human rights all these are fundamental to that which binds the Commonwealth together.

The importance of these principles was clearly in the minds of Commonwealth leaders during their discussions at last December's summit in Abuja, Nigeria. Living up to principles is never easy. It can involve diffuclt and painful decisions. But the affirmation of those values provides common ground for the Commonealth as a whole to grow stronger.

The Abuja meeting also made the crucial link between democracy and development. Democracy is important to sustained development and underdevelopment can be democracy's greatest threat.

Nowhere is freedom perfectly realised and its enemies are not only those who terrorise and torture. They are also hunger, poverty, disease and ignorance. That is why it is important for the Commonwealth to do all it can to tackle these challenges directly, whether in alleviating poverty or in promoting education and health. It is also essential to strengthen the rule of law, protect democratic freedoms and build strong civil societies.

I firmly believe that if the Commonwealth is to increase its role as a force for good in the world, strengthening democratic freedoms must remain at the heart of its purposes.

Elizabeth R
8 March 2004

THE CDA's VIRTUAL MEETING

Julia Campion
CDA Administrator

The Commonwealth Dental Association held its first *Virtual Executive Meeting*, conducted entirely by email, from 29 March to 8 April 2004.

About a week before the commencement of the meeting, the Agenda and supporting papers were sent out by email. On 29 March the CDA President, Dr L K Gandhi (India), opened the meeting, welcomed the participants and introduced the first item on the agenda.

After a full discussion, by email, of the first item Dr Gandhi summed up and introduced the second item on the agenda. We continued in this way, working systematically through the agenda, until all the items had been debated and decisions reached. We did not email simultaneously because of the time zones and participants' varying commitments to work. We emailed when we could, this worked out very well as everyone debated one item at a time until the next one was introduced.

The meeting was a great success as all the CDA Executives are on email and were able to participate from their respective countries, which included: Bahamas, Fiji, India, Kenya, Nigeria, Sierra Leone, Sri Lanka, UK, USA and Zambia.

At the end of the meeting, the CDA President concluded: "*I take the opportunity of extending to you my sincere appreciation on a very successful Electronic Meeting held by all concerned with excellent suggestions from practically all those present. I must comment that this first attempt of our exchange of ideas through modern media methodology was a grand success, may I extend my heartest contratulations to you all. May this be a prelude to many such success in future. Warm regards to all*".

THE CDA's FIVE-YEAR STRATEGIC PLAN

Dr Sam Thorpe OR
CDA Executive Secretary

One of the major items on the agenda of the CDA's *Virtual Meeting* was to establish the *CDA's Five-Year Strategic Plan* for 2004 to 2009. This was debated at length and an outline for the strategic plan was arrived at.

One of the principal objectives of the CDA is to enhance the importance of oral health among policy makers, as this affects the resources made available for oral health programmes.

Furthermore, the 5-year strategic plan will contribute to the implementation of the *United Nations Millennium Development Goals (MDGs)*. Also, the relationship of CDA with the World Dental Development Committee of the World Dental Federation (FDI) and WHO would be emphasised. To effect meaningful changes, CDA will need to work with these partners as well as collaborate with other Commonwealth Professional Associations to further the cause of oral health.

CDA Mission
To contribute to improved levels of oral health in all Commonwealth countries, by working with others to achieve healthy lifestyles, community development and equitable access to oral health care services.

CDA Vision
The Vision of the CDA is that within the next five years:

- *Partnership with FDI, WHO and other stakeholders and major NGOs would have further developed and strengthened*.
- *Membership of CDA would have increased to include all National Dental Associations of Commonwealth countries*.
- *Active involvement of National Dental Associations which are member associations of CDA in activities directed towards the achievement of the MDGs would have increased*.
- *Contribution to the improvement of oral health in the poorest Commonwealth countries would have increased*.
- *Participation of Commonwealth Chief Dental Officers at FDI and Regiional meetings would have increased*.

The UN Millennium Development Goals and the Five-Year Strategic Plan of CDA
The MDGs in summary consist of:
1. *Eradicate extreme poverty and hunger*.
2. *Achieve universal primary education*.
3. *Promote gender equality and empower women*.
4. *Reduce child mortality*.
5. *Improve maternal health*.
6. *Combat HIV/AIDS, malaria and other diseases*.
7. *Ensure environmental sustainability*.
8. *Develop global partnerships for development*.

Given the mission of CDA , it is clear that some of the MDGs apply more directly to the mission of the CDA than others. For this reason this new CDA strategic plan will concentrate mainly on working towards the achievement of Goals 3 to 8. At the same time it should be emphasised that the CDA strongly supports the achievement of all the MDGs and not just those to which the nature of its work is more directly related; and would encourage its member associations to actively support national efforts to achieve them.

The eradication of extreme poverty and hunger (*Goal 1*) is, for example, directly related to improved health. Also, the achievement of universal primary education (*Goal 2*), will directly assist in the improvement of oral health; as it has been shown in numerous reported studies that parental level of education is related to both the level of oral health of the parent and their children.

A small working party consisting of CDA Executives has drawn up a draft five-year stragegic plan based on the above. The final version will be published on the CDA website.

ORAL HEALTH IN THE PACIFIC REGION
An Overview

Dr Temalesi King DDS MDSc MBA
CDA Vice-President (Pacific Region)

Introduction

There are altogether 12 of the 22 countries in the Pacific region served under Commonwealth with a total population of 7 million. The region is separated into three sub-regions of Melanesia (west), Polynesia (southeast) and Micronesia (north) based on ethnic, linguistic and cultural differences. Spread over 30-million sq m, more than 98% consists of ocean.

This isolation complicates administration, communication, marketing and export, provision of basic health care, education and training. Although globalization may not be so significant more than decade ago, since then, the momentum of change is inevitable. Over the last 30 years changes in diet and lifestyle in the Pacific region has brought about an increase in conditions such as high blood pressure, diabetes, heart disease, drug and alcohol abuse.

Diabetes and Oral Health

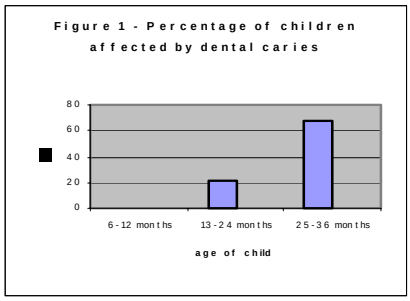
Diabetes Mellitus is a common chronic disease prevalent in almost all the populations in the Pacific Islands. It has brought social and economic challenges to society, public health, clinicians, government and non-governmental organizations. Statistics from Fiji's Ministry of Health reported an increase in the incidence of diabetes from 1983-2000. There were 151.12 per 10,000 people affected in 2000 and an incidence rate of 6.21 per 10,000 people. Registered data from the Vaiola Hospital alone in Tonga, also reported an increase from 33 new cases in 1993 to 114 new cases in 1996. Simmons in 1996 reported that Pacific people have the highest hospitalization rates for Diabetes in Auckland, New Zealand and are expected to have a 120% increase in prevalence by 2026. Periodontal disease is the main reason for extraction of teeth among adults. For older diabetics (>40 years of age) severity of periodontal disease (e.g probing depth of >6mm) increases with longer duration of diabetes. Diabetes increases the risk for periodontal disease because of complications associated such as xerostomia, elevated glucose in the crevicular fluid, alterations in collagen metabolism, and microangin-opathy of the periodontal tissue. The extensive alveolar bone loss in long duration diabetics results in tooth mobility hence food is not chewed properly. Persons with Diabetes who are prepared to live with mobile teeth are handicapped due to limited food selection and altered food digestions. Further, dental treatment for uncontrolled diabetic patients is often delayed.

Oral Cancer

Prevalence of cancer in the mouth has been associated with betel nut chewing and smoking. Chewing of betel nut is a culture in the Solomon Islands, Papua New Guinea, Vanuatu and Nauru. Most chew betel nut (areca nut) with the leaf of the betel vine (piper betel) and powdered lime (calcium hydroxide) - referred to as betel quid. Some chew virtually all hours and mothers may give infants pre-masticated quids. In the daily lives of Solomon Islanders, it is offered and chewed during gatherings to welcome guests, visiting friends, marriages, funerals, and means of reconciliation. Majority of the diagnosed oral cancer patients chews more than five betel quid per day. Lack of screening programs and awareness allows the disease to be undetected in the community during its early stages. It is only reported to the hospitals once it progresses to its late stages, usually beyond treatment. Recommendations to curb the rise in oral cancer lies with health promotion, rehabilitative services, training of personnel for proper diagnosis and care, screening and proper documentation.

Dental caries

The World Health Organization oral health country profile reported the caries prevalence in most countries in the South Pacific. From this data, more than 50% of the DMFT component was of untreated dental decay in 12 year-old children. In young children, the use of sweetened drinks in a bottle and prolonged feeding without cleaning the teeth have been the major cause of "nursing bottle caries". In a survey of children in Fiji, age 6 to 36 months, there was no caries detected in 6 12 months age group. Caries was reported as early as 16 months of age. In 13 24 months age group 21% had dental caries and increased to 67% in children aged 25 36 months old; an increase by approximately three-fold with age.



Oral Health Services

Oral health services are organized through the Ministry of Health in many of our countries in the South Pacific. The general aim of our health care is to deliver quality care that is accessible to everyone in the community. Emphasis on curative care is still the main focus due to the magnitude of oral diseases however; prevention exists in a much smaller scale. Fixed dental clinics and mobile dental services are placed around the country to better serve the people both in the urban and rural areas. Oral health is somehow incorporated into the national

health priorities of each country presenting a stiff competition for that slice of cake (Appendix 1).

Dentists usually work as general practitioners having an overall skill in oral surgery, endodontics, prosthodontics, etc. In addition, dentists have the responsibility of managing dental services and being an overall leader. The greatest challenge is that of training and retaining personnel to accomplish the vision and goals of the dental services. Dental care is greatly assisted by the many dental therapists who are permitted to execute basic functions. For many years, the Fiji School of Medicine trains all undergraduate dental personnel from the region. Commitment to serve the country in many ways suppresses dental personnel to opportunities for postgraduate training mostly to Australia, New Zealand and the United Kingdom. Collaboration between the Universities of Washington, Guam and Hawaii and the Fiji School of Medicine bring health information to the islands via telehealth.

The need to plan is imperative; countries in the South Pacific region are faced with common problems such as migration of dentists, continued dependence on expatriates, re-employment of retired dentists and movement to the private sector. Human resource development is a significant priority for many countries.

With the magnitude of the problems faced in the Pacific Island it is obvious that countries have to strategize because of the meager resources available. Selecting strategies maybe influenced by many criteria such as your goals, orientation of dental services, tackling causes that are common to a number of chronic diseases, social and cultural causes of ill-health, community participation, financial and political background of a country. For many, primary health care approach, health promotion and protection are means of achieving better health outcomes. The impacts of these programs have not been monitored and in many instances sustainability largely depends on availability of funds from Ministries of Health.

Appendix 1
National Health Priorities

Cook Islands
- Human Resource Development
- School Health including Oral Health
- Health and Environment
- MCH and Family Planning
- Immunisation, NCD
- Nutrition and Food Safety
- STD and AIDS
- Adolescent Health and Elderly care
- Occupational Health

Fiji
- Health sector reform, Health information system
- Health promotion and protection
- Protection of environment and prootion of urban health programmes
- Health workforce planning and training
- Prevention and Management of Communicable and Non-Communicable diseases

Kiribati
- Primary Health Care system
- Human Resource development
- Reproductive Health
- Health Promotion, Environmental Health, Nutrition
- Prevention of Communicable and Non-Communicable diseases
- Traditional medicine and Primary Health Care

Nauru
- Primary Health Care to
- Acute respiratory infections
- Diarrhoeal Disease
- Immunisation
- Health Promotion

Niue
- Reduce Non-Communicable diseases, eg:
  Diabetes, Obesity, Hypertension
- Immunisation
- Elderly care
- Healthy environment

Papua New Guinea
- Health Promotion
- Family Health
- Health Protection
- Human Resource Management
- Strengthen district and hospital services
- Improving access to medicines and medical supplies
- Elimination and control of priority diseases

Samoa
- Prevention and Primary Health Care
- Strong leadership and advice to Minister of Health
- Effective and Efficient management of health services
- Access of health services

Solomon Islands
- Primary Health Care Approach
- Access to health services in remote areas
- Reduce morbidity and mortality
- Human Resource Development
- Family Health and Social welfare services
- Health Promotion
- Health Information System and Surveillance
- Cost recovery

Tokelau
- Health management system
- Primary Health Care
- Human Resource Development
- Health Promotion and Protection
- Health of mothers, children, adolescents and elderly
- Diagnostic capacities
- Emergency preparedness

Tonga
- Human Resource Developmen
- Health Promotion and Protection
- Environmental Hazards
- Vector control
- Management of Non-Communicable diseases eg Diabetes
- Nutrition, Family Planning, Immunisation, Cancer
- Mental Health

Tuvalu
- Prevent disease, Promote healthy lifestyles
- Provide high quality health services
- Effective and Efficient Health-Care Delivery
- Retain Health personnel

Vanuatu
- Control Malaria, Diarrohea, Acute Respiratory Infections
- Control Childhood diseases
- Health Promotion
- Health workforce planning
- Improve referral hospitals
- Strengthen TB and eliminate leprosy
- Better health for women and children
- Control of STD/HIV
- Promote health environment

Oral examination at the beach by dental students in one of the community visits

Dental team travelling to nearby island for oral health services

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Pacific Region

The Fiji National Dental Association is the newest member of the Commonwealth Dental Association, having joined in November 2003.

Dr Temalesi King (*Fiji*) was recently elected as the CDA Regional Vice-President for the Pacific Region, during the CDA 4th Triennial Meeting in Nairobi, Kenya. It is the first time for many years that the Commonwealth Dental Association has had a representative from the Pacific Region. We look forward to Dr King working with us and this new link with the Pacific Region.

PREVENTIVE STRATEGIES AGAINST CANCRUM ORIS (NOMA) IN ZAMBIA

Dr Pashane Mtolo
CDA Vice-President
(East, Central & Southern African Region)

Although there are few known cases of Cancrum Oris (Noma) in Zambia, less than a hundred, it is expected that with a national wide survey, more cases could be identified. Currently, hospital records are being used to estimatethe prevalence of noma in Zambia. Considering the horrifying effects of untreated noma which include facial disfigurement, functional impairement and stigma which leads to social outcast, Zambia, with the support of WHO is actively involved in creating community awareness of the disease. A meeting consisting of local experts was called at which local preventive strategies against Noma were developed. These emphasised the need for good nutrition (using available local food), oral hygiene, vaccination against childhood diseases such as measles, early detection, immediate management and referrals for rehabilitative surgery. An overview of Noma was also presented.

The implementers of these preventive straegies were targeted at the health worker and parent/guardian. As a follow-up, the first sensitisation workshop to disseminate the preventive strategies were carried out on 15th March 2004. The participants (90) included health workers, traditional healers ('doctors'), NGOs, parents/guardian, social workers and members from the church. More workshops will take place in other parts of the country.

The preventive strategies will be put into a booklet, 500 copies will be printed. I hope that can be used in the region since we have more or less a similar environment. There will be need to update them from time to time.

CDA Meeting during FDI 2004 New Delhi, India

Saturday
11 September 2004

14.00hrs

Mumtaz Mahal Room
Taj Palace Hotel

The Commonwealth Dental Association is holding a meeting during the FDI 2004 World Dental Congress in New Delhi.

This meeting follows on from the FDI *Oral Cancer* seminar in the morning. There will also be an *Open Forum*.

We look forward to seeing you at our meeting in New Delhi.

NYUMBANI HOME FOR HIV AND ABANDONED CHILDREN

Julia Campion
CDA Administrator

Nyumbani is home to about 100 children whose ages range from newborn to twenty years old. They come from all over Kenya and represent all tribes and ethnicities of Kenya. Children ae referred to Nyumbani through national hospitals and through Nyumbani's own outreach programme. The children's medical status is closely monitored by the Nyumbani laboratory and they receive any necessary treatment from Nyumbani doctors and nurses. Younger children attend school, in the Paul Miki School House, Nyumbani's own school huse. Older children attend school outside Nyumbani, in local schools, where many children have received awards for academic and athletic excellence. Outings, for the purpose of cultural and educational enrichment are regularly organised.

During the CDA 4th Triennial Meeting in Nairobi, representatives from the Commonwealth Dental Association (CDA), the FDI World Dental Federation and Colgate-Palmolive visited tne Nyumbani home and met the Founder, Father Angelo D'Agostino. Father Angelo had joined the Jesuits in 1955 and, previous to Nyumbani, had worked in Washington DC as a surgeon with the US Air Force and then trained as a Psychiatrist and practised and taught in Washington DC. He also worked in China and then in Thailand with Indochinese Refugees. He was then Co-ordinator of the Jesuit Refugee Service in Africa and programmes were established in Sudan, Ethiopia, Zaire and Tanzania. After another spell in the USA he returned to East Africa and

Father Angelo D'Agostino

worked as a Superior of a Retreat House. He also served on the Board of Governors of a large orphanage which was receiving abandoned children who were testing HIV+. It was during this time that he thought there should be a special facility made available for such children because of their needs; there were no such facilities in the country. A programme was embarked on resulting in the opening, on 8 September 1992, of the Nyumbani home for HIV+ abandoned children.

We toured the home with Father Angelo d'Agostino, it employs around 70 staff members and up to 20 volunteers. Visitors from the local community and international volunteers play an important role in supporting the work of the staff. Enriching the lives of the children with donations of toys, maize, juice and by telling them about other countries, cultures and customs. The children's residences are in five cottages with 'Mothers' and 'Uncles' providing daily care as well as fostering a family-like environment. Older children live in their own cottages to enable them to learn how to live independently. There is a team of social workers who help the children with emotional adjustments as well as trying to reunite them with any living family members.

We met some of the children and members of the staff of Nyumbani and, while we were there, Colgate-Palmolive donated some dental products to the home and the CDA and FDI gave a small donation.

It was a moving experience to have visited the Nyumbani home and to see the children happy and cared for..

The CDA / FDI / Colgate-Palmolive visit to the Nyumbani Home

REPORT OF THE PROCEEDINGS OF THE CDA 4th TRIENNIAL MEETING

13-14 December 2003

Safari Park Hotel
Nairobi, Kenya

Preface

Professor Martin Hobdell
Dr D Y D Samarawickrama
Editors

The following pages record the proceedings of the Triennial Meeting which was held in conjunction with the Kenya Dental Association's and the FDI International Dental Federation's Continuing Education Programme. Therefore, the Proceedings record both the business meetings as well as some of the scientific papers presented. We have attempted to summarise the papers in a way of interest to all our Commonwealth colleagues.

The Meeting is a testimony to the dynamic partnership the CDA has with the FDI and National Dental Associations, in this case, with the KDA.

Contents

Introduction

The CDA 4th Triennial Meeting was held from 13 to 14 December 2003 at the Safari Park Hotel, Nairobi, Kenya in collaboration with the Kenya Dental Association's and the FDI World Dental Federation's Continuing Education Programme.

The programme of the meeting is given in Section A.

The Continuing Education Programme was held over two days and addressed by many eminent speakers. Summaries of some of the presentations are given in Section B.

During the CDA General Assembly, reports were received from the Executive Secretary, Treasurer, outgoing President and the Regional Vice-Presidents.
The report of the General Assembly can be found in Section C.

During the Assembly a resolution was adopted conferring the title of Emeritus Founder President on Dr S Prince Akpabio OBE OFR. This resolution can be found in Section D.

The new President Dr L K Gandhi's inaugural address is given in Section E.

The new Executive elected for the next three years is given in Section F.

Acknowledgements

The Commonwealth Dental Association (CDA) would like to thank the following for their support towards this 4th Triennial Meeting: The Commonwealth Foundation, Mr David Parker and GlaxoSmithKline; the FDI World Dental Federation, the Kenya Dental Association (KDA), Mr Michael Knowles and Coca-Cola, Mr Andrew Quayle and Quayle Dental Manufacturing, and the Manager and staff of the Safari Park Hotel, Nairobi.

Section A
THE PROGRAMME

Commonwealth Dental Association
Working for Oral Health in the Commonwealth

CDA 4th Triennial Meeting
In association with the Kenya Dental Association
and the FDI World Dental Federation

CONTINUING PROFESSIONAL EDUCATION PROGRAMME

Safari Park Hotel, Nairobi, Kenya
13-14 December 2003

Saturday 13 December 2003

08.00 – 09.00	Registration	
09.00 – 09.30	Welcome	
	President Kenya Dental Association:	*Dr Tom Ocholla*
	Executive Director FDI:	*Dr J T Barnard*
	President CDA	*Dr Brian Mouatt*
	Guest of Honour - Minister of Health	
09.30 – 10.15	CDA Invitation Lecture - 'Capacity Building in Africa'	
	Professor Raman Bedi, Chief Dental Officer England & Wales	
10.15 – 11.00	Periodontology	
	Professor Jacob Kaimenyi (Kenya)	
11.00 – 11.15	*Break*	
11.15 – 12.45	Medical Emergencies	
	Prof. Jean Morkel (South Africa)	
12.45 – 14.00	*Lunch*	
14.00 - 17.00	**CDA Triennial Open Forum (*open to all*)**	
	FDI and its Partners in Africa	
	Dr J T Barnard	
	Dr Lethoko Tsiu (FDI Councillor for Africa)	
	WDDC - An Update on its Work	
	Dr Brian Mouatt	
	Welcome to Fiji	
	Dr Brian Mouatt & Dr Bernadette Pushpaangaeli	
	Business Items	
	Open Forum	
	Installation of CDA President	
	Dr L K Gandhi	
	Election of Officers	
17.00 - 18.00	*CDA Reception*	

Sunday 14 December 2003

09.00 - 10.00 **Morning Plenary Session 1 Chairman: Dr H Sachdeva**
Infection Control and Risk Management
Dr John Hunt (OSAP, UK)
Dr Brian Mouatt (CDA, UK)

Workshops Room 1

10.15 - 11.15 Dental Infections
Prof Jean Morkel (SA)

11.15 - 11.45 *Break*

11.15 - 12.45 Dental Trauma
Prof Goran Koch (Swden)
12.45 - 14.00 Lunch
14.00 - 15.30 Practice Management
Dr Jennifer De St Georges (USA)

15.30 - 16.00 *Break*

Workshops Room 2

10.15 - 11.15 Practice Management
Dr Jennifer De St Georges (USA)

11.15 - 11.45 *Break*

11.45 - 12.45 Dental Infections
Prof Jean Morkel (SA)

12.45 - 14.00 *Lunch*

14.00 - 15.30 Dental Trauma
Prof Goran Koch (Sweden)
15.30 - 16.00 *Break*

16.00 - 17.00 Dental Trauma
Prof Goran Koch (Sweden)

Round Table Discussion

16.00 - 17.00 Management of the High Risk Patient
Dr Jennifer De St Georges (USA)
Prof Jacob Kaimenyi (Kenya)
Prof Jean Morkel (SA)
Prof Goran Koch (Sweden)
Dr John Hunt (UK)

17.00 - 17.15 Closing Remarks and Certificates

20.00 - 22.00 *Farewell Dinner*

Monday 15 December 2003

08.00 - 10.00 CDA Executive Meeting (new Executive)

Section B
THE CONTINUING EDUCATION PROGRAMME

Excerpt from the address by Dr J T Barnard (FDI Executive Director) at the Opening Ceremony of the FDI/KDA CE Programme

Dr Barnard said that this Continuing Education (CE) programme was the FDI World Dental Federation's (FDI) first attempt in bringing continuing education on a regular basis to dentists of Africa. The scientific programme has been developed in co-operation with the Kenya Dental Association (KDA).

He said that the speakers that would educate and entertain the participants to the congress were top class world-renowned scientists and well experienced presenters. He paid tribute individually to every speaker and thanked them for their support to the FDI and the Kenya Dental Association.

Dr Barnard highlighted some of the FDI's achievements regarding Continuing Education programmes worldwide and said that currently the FDI contributed to a CE programme somewhere in the world on average every third week – a unique and outstanding achievement. He hoped that this event in Nairobi would be the first of many similar programmes in Africa. The FDI is committed to this, not only in Anglophone countries, but also in Francophone Africa.

He congratulated all the dentists and oral health care workers who have registered for the Congress. He said that every dentist has the commitment to keep up to date with developments in the science and practice of dentistry. Through their presence, all in the audience have proven that they are committed to the improvement of their own knowledge and skills and to the ultimate well being of their patients.

He extended his appreciation and thanks to the dental trade and industry for their presence and financial contributions. He also paid tribute and thanked the Local Organising Committee of the KDA under the Chairmanship of Dr Jacob Kaimenyi. A special word of thanks was extended to Dr Habib Benzian, the FDI Development Manager and Ms Jenny Lee of the FDI Nairobi Conference Co-Ordinator, for their exceptional efforts.

The summaries of some of the lectures are given in the following pages.

Capacity building in Africa

Professor Raman Bedi
Chief Dental Officer, England

1. A major health aim for any country is to improve the health of poor people, and underpinning any health strategy are three main considerations:

(i) Creating social, political and physical environments that enable poor people.
(ii) Addressing priority problems of the poorest billion, through strengthening access to services, products and care.
(iii) Supporting investment in strong, efficient and effective health systems.

2. Africa may encounter additional challenges to these goals, such as: economic barriers, greater disparity in gender differences in health, educational differences and the effect of HIV/AIDS.

3. In the context of oral health, the main goals are to improve oral health generally, raise awareness of dental hygiene and facilitate the provision of dental services. The development of these areas together, rather than in isolation, is important for oral health improvements.

4. National Strategic Planning for Oral Health is a management process undertaken within the whole oral health system to develop strategies that will best improve the nation's oral health. Strategic planning provides the means to achieve change across the system - orientated to primary oral health care; oral health stakeholder cohesiveness and focus; and policy and protocol development.

5. The Strategic Planning Process has to include analysis, review, planning, implementation and review. Situational analysis is a written description of the oral health system's internal and external operating environment and the mission statement is developed on the basis of this, and clarifies the aim of the oral health system. The SWOT analysis is a review of the situational analysis and mission statement, to identify the strengths, weaknesses, opportunities and threats. The GAP analysis highlights any discrepancies between the current situation and the mission of the oral health system. Following on from these analyses is the development of the strategic direction. The information from the SWOT and GAP analyses are used to prioritise areas of focus for the strategy, and then potential strategies are identified (a strategy being the broad process required to achieve the system's aim in its current environment).

6. The next step is action planning with objectives, responsibilities, time lines, evaluation methodology and budgets. Stakeholders in Nepal prioritised strategies using a framework that accounted for acceptability; cost effectiveness; equity; implementability / sustainability.

7. Completion of the plan document is organised and written as a draft document, and then the completed strategic plan is distributed throughout the health system.

8. Successful implementation of the strategic plan has a number of different contributory factors. It is of paramount importance to involve people and institutions that will be responsible for implementation at all stages of the planning process. The practicalities of implementation should be considered at all stages of strategic planning. Action planning is necessary for effective strategic planning. Monitoring methods need to be developed, including progress reviews. Implementation responsibilities should be included in job descriptions and personal performance reviews. Implementation is reliant on ongoing political and stakeholder support.

9. Monitoring is needed to document what has been done and who did it, and what the effect of the action was – this therefore includes process monitoring and impact monitoring. The development of Performance Indicators relevant to oral health systems will assist in the monitoring.

10. The work needs to be evaluated, to determine the extent that the strategy is realising the goals of the oral health system. Monitoring and evaluation are essential to Evidence Based Management.

11. There is a clear planning cycle to be followed: planning the strategy and actions, implementing them and then evaluation of the impact. The information received from the evaluation feeds back into the planning process to develop the strategy effectively to ensure that it continues meeting the original goals and aims, and delivering progress.

12. Moving onto the theme of leadership, one of the key determinants of effective leadership is clear vision – knowing what the end goal is and being able to communicate this to others.

13. Who are leaders and why do we need them? Leadership is necessary for action at international, national and local level. Leaders drive initiatives to translate ambitions and targets into concrete improvements in the health and well being of people. Leadership is about setting standards, often (but not always) setting targets, taking responsibility and devolving responsibility to meet targets, and being able to generate interest in the strategic aim. In dentistry, this could include motivating dentists and patients to take an active role in oral health protection.

14. Effective leadership has helped develop oral health strategy in the UK, notably with fluoridation and 'Options for Change'. This year (2003), the Water Bill has had an unopposed third reading to introduce national fluoridation of water. This effectively means that where the local population is in favour, the water companies will increase the concentration of fluoride in their water as requested by Strategic Health Authorities. The timeline for implementation is summer 2004. Options for Change is about the modernisation of NHS Dentistry in the UK. This should see more flexibility in the system with increased access for patients, varied service provision and increased career options for dentists.

15. Maintaining the strategic focus is about ensuring that resources and time are devoted in the areas they are most needed. What proportion of time do you think should be spent on mission / objectives / strategy / or tactics?

16. Leaders need to manage the link between communication and business performance. The four critical factors are:

(i) Clarity of purpose –a clear purpose that is shared by all the leaders, and the employees understand the purpose of the business and their role in achieving it.
(ii) Effective interfaces – trusting face-to-face relationships between leaders and employees, managers and direct reports, employees within working teams and supply chains, and the business and its customers.
(iii) Effective information sharing – the systems and networks should enable managers and employees to have the right information at the right time to do their job, share opinions and discuss ideas, and circulate best practice and learn from each other
(iv) Leader communication – a leader's behaviour needs to be consistent with what they are saying (both formally and informally) and leaders should be role models of good communication.

17. There are five take home messages for leadership:

1) Be enthusiastic
2) Keep the initiative
3) Keep in with the outs – i.e. be inclusive
4) Build good teams
5) Don't get caught between the dog and the wall.

Infection Control

Dr John Hunt OBE FFGDP (UK) BDS (OSAP UK)
Dr Brian Mouatt CBE BDS MGDP RCS FFGDP (UK) (MPS)

The presentations, which were complementary, focussed on the current received wisdom in the field of cross infection control in dentistry. The new challenges of Methicillin Resistant *Staphylococcus Aureus* (MRSA) and Severe Acute Respiratory Syndrome (SARS) were described and placed in context. There was an examination of the threat of Transmissible Spongiform Encephalopathies (TSE) in dental practice and their relation to the various types of Creutzfeldt-Jacob Disease (CJD) currently known. The effect of migration of prions internally and externally to the central nervous system were critically assessed as it was noted that abnormal prions (PvP) had been found in lymphatic tissues, particularly and tonsil and lingual tonsil, the trigeminal ganglion and less certainly in dental pulp tissue. The aetiology of sporadic, acquired, varieant and familial CJD was discussed. The older challenges of TB, HIV/AIDS and Hepatitis B and C were then given detailed examination in the context of assessment risk and mode of transmission in dentistry.

Advice on the precautions and preventive regimes for practical clinical practice was then proposed, including protective clothing and equipment, instrument handling, cleaning, decontamination, sterilisation and storage. The dangers of poor clinical practice and low quality technique were vividly illustrated by a showing of the OSAP video '*If Saliva Were Red*'.

The practical difficulties in clinical situations encountered and solutions to them were discussed and specialised techniques recommended.

The seminar then went on to consider the risk management aspects of cross infection control by looking at the clinician's legal, ethical and professional responsibilities. The common law duty of care was discussed in respect of its interaction with health relation laws and regulations. The serious consequences of failing to act to protect patients were described and it was explained that patient safety was an integral part of the quality of care. The profession has a duty to work as a team to maintain public confidence in the profession. Details of how colleagues, staff and third parties in the community needed to be safeguarded. It was suggested that each practice should have a written cross infection policy. The importance of training and immunisation in this policy were emphasised. The importance of the recording of the immunological status of healthcare workers was made clear since, particularly with Hepatitis B, some individuals failed to sero-convert after vaccination. The problem of infected carriers in the clinical field was considered.

The seminar concluded with recommended key risk management considerations and a review of cleaning, decontamination, sterilisation and storage procedures emphasising the importance of attention to detail. Finally, the practitioner's note in ensuring safe protection of patient, staff, community and public were re-emphasised.

Dental Traumatology and Caries Prevention

Professor Goran Koch (Sweden)

Dental Traumatology

The majority of dental traumatic injuries happen in childhood. The trauma can result in simple situations such as infractions, enamel-dentin fractures, and slight luxations as well as complicated fractures and avulsion. A correct clinical management of these injuries will be of vital importance for the result and survival of the tooth. The lecture will present guidelines for clinical examination, diagnosis of the injuries, and the immediate (acute) treatment as well as for the follow-up and expected long-term prognosis. Special reference will be made concerning treatment of the exposed pulp in fractured young permanent teeth, root fractures, and splinting times. Recommendations for the treatment of complications such as pulp necrosis, root restorations, anchylosis, and obliterations will be given. The presentation will be based on a large number of clinical cases.

Caries Prevention - How and When

In most countries caries in children is a great health problem, both for the individual and the society. In principal caries development can be controlled by effective and structured preventive measures and interceptive caries treatment. The lecture will discuss methods how to control caries in different age groups as well as the management of carious lesions of different severity. Treatment recommendations will be given for individuals in different age groups and with different caries activity with special reference to the high caries active individual.

Open Forum

Panel: John Hunt (JH), Brian Mouatt (BM), Jean Mickel (JM), Goran Koch (GK), Jennifer St Georges (JStG)

The following points were made:

- Infection control is only part of risk management. There are many risks facing dentists. Anyone practising without professional indemnity is taking an enormous risk. (BM)
  Ideally, the work surfaces should be disinfected after every patient. There are many proprietary agents available. One needs to seek local advice regarding which agent to use.
  OSAP is in the process of developing disinfection and infection control in rural and deprived areas. (JH)

- There are two types of CJD. Variant CJD crosses species barriers e.g. from cattle to humans. There is also a genetically transmitted CJD. Some have got CJD following brain surgery. Dura mater implants can be infected with CJD. It is known that those who have received growth hormones e.g. pituitary extracts) can get CJD. (BM)
  Deaths due to prion diseases e.g. CJD are small in number so far, amounting to about 50. However, we cannot predict the true figure due to the long incubation period. The risk of getting prion diseases seems to be low. (JH)

- Infections should not be treated with antibiotics only. Local measures should also be used. There is too much abuse of antibiotics. Use antibiotics with discretion with a look to the future. It is important to have a protocol for antibiotic usage. An Infection control group consisting of a dentist, bacteriologist and a pharmacist can develop the protocol. (JM)

- Antibiotic resistance is a growing problem. Dental associations need to work with other organisations to enact legislation so the there is no easy access to antibiotics. (BM)

- How to get paid for the provision of professional services seems to be a recurring theme. In the USA, many went into group practices, as there were many fringe benefits. However, recent studies have shown that dentists practising solo take home more money. (JStG)

- Calcium hydroxide is the dressing material used in endodontics. However, it is an agent capable of drying out dental hard tissues e.g. dentine. Studies in New Zealand have shown that sheep teeth treated many times with calcium hydroxide tended to fracture easily. Therefore, calcium hydroxide should be used with caution, avoiding too frequent changes of root canal dressings. (GK)

- Obliterated canals do not contribute to tooth death with orthodontic treatment. External resorption results mainly from excessive orthodontic forces. (GK)

- Water fluoridation has been shown to be beneficial according to studies in Scandinavia. However, there were so many topical F agents in Scandinavia, it was considered not necessary to have water fluoridation as well. Moth rinsing programmes started in Sweden in 1968. Mouth rinsing with 0.2% F is equivalent to brushing with F containing toothpaste. Therefore, some of these programmes have not been cost-effective. Nevertheless, controlled mouth rinsing with f has been re-introduced in Sweden among ‘at risk’ populations. (GK)

- Affordable water fluoridation programmes are a concern. Therefore, affordable F toothpastes are the way to go where there is no pipe borne water. Therefore, FDI is trying to get the manufacturers to produce affordable F toothpaste. (BM)

- FDI Continuing Education Programme: FDI works through a number of committees and commissions with the aim of improving oral health through out the world. Annual World Dental congress provides a vast opportunity for continuing education. However, a large number of dentists cannot attend the world Dental Congress. Therefore, these regional continuing education programmes were launched. The first such programme was held in Singapore, paid for by the Singaporean Chinese. Next was South America. The East European programme was launched in 2002. The intention was to hold these with a combination of local and external speakers. The FDI Commission on Continuing education was instrumental for these. (GK)

- World Developing Countries Programme: This was set up to offer something tangible to world community. It has been operating for the last 5 years. Several pilot projects have been undertaken:

    - Smile in Schools – Namibia
    - Affordable toothpaste – Namibia
    - Infra-structure rebuilding programme – Rwanda

- World Development Fund has begun raising funds for the FDI foundation. (BM)

It was clear from participants' reaction that the exercise had been interesting, valuable and a worthwhile contribution to Continuing Professional Development Programmes.

Section C
REPORT OF THE GENERAL ASSEMBLY OF THE CDA 4th TRIENNIAL MEETING

Saturday 13 December 2003 at 14.00hrs, Safari Park Hotel, Nairobi, Kenya

Present:	Dr Brian Mouatt CBE	(*CDA President) (Chair*)	(BM)
	Dr S Prince Akpabio OBE OFR	(*CDA Executive Secretary*)	(SPA)
	Dr L K Gandhi	(*CDA President-Elect*)	(LKG)
	Dr John Hunt OBE	(*CDA Treasurer*)	(JH)
	Prof Jacob Kaimenyi	(*CDA Adviser*)	(JK)
	Dr Joyous Pickstock	(*CDA Regional Vice-President, Caribbean*)	(JP)
In attendance:	Mrs Julia Campion	(*CDA Administrator*)	(JC)
	Prof Martin Hobdell	(*Editor, CDA News*)	(MH)
	Dr D Y D Samarawickrama	(*Co-Editor, CDA News*)	(DYDS)

Dr J T Barnard (*FDI*); Prof Raman Bedi (*UK*); Dr Habib Benzian (*FDI*); Dr Hilary Cooray (*Sri Lanka*); Ms Katy Kabenge (*Uganda*); Prof Jacob Kaimenyi (*Kenya*); Dr Lennie Kyomuhangi (*Uganda*); Prof B Lembariti (*Tanzania*); Dr Clement Luhanga (*Botswana*); Dr Happiness Mabuza (*Swaziland*); Dr H J Mosha (*Tanzania*); Dr Bernadette Pushpaangaeli (*Fiji*); Mr Andrew Quayle (*UK*); Dato' Dr A Ratnanesan (*Malaysia*); Dr Kofo Savage (*Nigeria*) Dr Sam Thorpe OR (*Sierra Leone*); Dr L Tsiu (*South Africa*); Dr Robyn Watson (*New Zealand*)

Apologies:	Dr Neil Campbell	(*South Africa*)
	Dr Victor Eastmond	(*CDA Immediate Past-President*)
	Dr Temalesi King	(*Fiji*)
	Dr Anthony Kravitz OBE	(*UK*)
	Dr T Thurairatnam	(*CDA Regional Vice-President, S E Asia*)

Dr Brian Mouatt welcomed those present and thanked them for coming to the meeting. He said we were delighted to be holding the CDA 4th Triennial Meeting in Nairobi in conjunction with Kenya Dental Association and the FDI World Dental Federation's *Continuing Education Programme*.

Dr Brian Mouatt asked for those present to observe one minute's silence in memory of Professor Norman Whitehouse who died on 10 October 2003. Professor Norman Whitehouse was on the Organising Committee of the Oral Health Initiative Meeting in London (1990) to discuss the formation of the CDA and was Hon CDA Secretary 1991-1994.

1. Chief Dental Officer for Swaziland
BM welcomed Dr Happiness Mabuza (CDO Swaziland) who then gave a short presentation on Oral Health in Swaziland. On thanking Dr Mabuza BM said CDA would write to the Minister of Health for Swaziland.

2. FDI and Its Partners in Africa
Dr Brian Mouatt welcomed Dr J T Barnard (Executive Director, FDI World Dental Federation) who gave a short presentation on FDI and *Its Partners in Africa*. Dr Barnard thanked the CDA for having given him the opportunity to talk at their triennial meeting and wished Dr Gandhi good luck. He thanked Dr Barnard and said that since Dr Barnard had taken over the role of Executive Director of the FDI he, together with Dr Habib Benzian (Development Manager, FDI), had brought new life to the FDI
Dr Brian Mouatt then welcomed Dr Lethoko Tsiu (FDI Councillor for Africa) who gave a short presentation on the *FDI Council for Africa*. BM thanked Dr Tsiu for his work on the Council.

3. World Dental Development Committee
Dr Brian Mouatt gave a short presentation about the *World Dental Development Committee* and an update of its work.

4. Welcome to Fiji
Dr Brian Mouatt welcomed Dr Bernadette Pushpaangaeli (President, Fiji Dental Association) and said that it was the first time for many years that CDA had a representative from the Pacific Region attending their triennial meeting. Dr Pushpaangaeli gave a short presentation. He thanked Dr Pushpaangaeli for her contribution to the meeting.

5. CDA President's Report
Dr Brian Mouatt reported that a document giving a brief outline of each of CDA's Activities during the past triennium (2000–2003) had been tabled at the meeting. He stated that:

- The Canadian Dental Association had joined the CDA in April 2002.
- The *Commonwealth Oral Health Statement*, initiated by the CDA at the 3rd Triennial Meeting in New Delhi in January 2000, was unanimously approved and adopted by the Commonwealth Health Ministers at their Pre-WHA Meeting in Geneva on 13 May 2001.
- The CDA issued an important statement on *Sugar and Dental Disease* in response to the WHO consultation on Nutrition and Chronic Disease.

He stated that the above can be used as tools to bring CDA to the attention of Ministers of Health.
Dr Brian Mouatt stated that communications had improved because of IT.
CDA had sent books and CAL programmes to the National Dental Associations and Dental Faculties in Commonwealth countries.
He extended a welcome to Dr Robyn Watson (President, New Zealand Dental Hygienist's Association) and thanked her for attending the meeting.
He thanked the CDA Executives for their support during his term office and said that his future lies with links with the World Dental Development Committee (WDDC) and the CDA.

6. CDA Resolution

Dr Brian Mouatt read the Resolution: "*The General Assembly wishes to acknowledge the long and distinguished service given so freely to the Commonwealth Dental Association by Dr Sonny Prince Akpabio, from its inauguration, where he was elected as the first CDA President, through his subsequent roles, to the present time. It therefore wishes to make this appreciation by conferring upon him the title 'Emeritus Founder President' and hereby so resolves. Furthermore it is the wish of the General Assembly that Dr Akpabio be asked to continue his work with the Commonwealth Foundation and Commonwealth Secretariat in London on behalf of the CDA in pursuance of its objectives/goals. Proposed unanimously by the CDA Executive Committee 12 December 2003".*
Dr Brian Mouatt thanked Dr Sonny Prince Akpabio for his work over many years and presented him with a certificate honouring him with the title *Emeritus Founder President*.
Dr S P Akpabio said that the CDA was formed in 1990 at an Oral Health Initiative in London and was launched in Malaysia in 1991 and that he was very grateful to Dato' Dr Ratnanesan and the Malaysian Dental Association for hosting the inaugural meeting.
He thanked Dr Brian Mouatt and all those present at the meeting for their support and Julia Campion (CDA Administrator). He said it was a great pleasure to work with the CDA.
Dato' Dr A Ratnanesan warmly thanked Dr S Prince Akpabio for his contribution to the CDA. Dr Ratnanesan also recognised the yeoman role of the late Dr Norman Whitehouse (then Executive Director of the BDA) who was the Founder Executive Secretary and, also, Dr Brian Mouatt who had taken the CDA to even greater heights.

7. CDA 5-Year Plan

It was suggested that the CDA 5-Year Plan should incorporate working together with WDDC and the FDI. A strategic plan and way of working together to be discussed by the CDA New Executive.

8. CDA Treasurer's Report

Dr John Hunt reported that:

- Each year application has to be made to the Commonwealth Foundation for Core Grant funding, which is used for the general running of the CDA.
- Core Grant funding will only be considered by the Commonwealth Foundation if applications for funding for specific Activities are submitted at the same time.
- A survey was carried out, on behalf of The Commonwealth Foundation, by Stephen Matlin (former Director of the Human Resource Development Division, comprising the Departments of Education and Health, in the Commonwealth Secretariat). A *Study Report and Draft Policy* was produced, on the findings of the survey, and circulated in November 2003, asking for responses from NGOs by 16 January 2004. According to the Report, it seems that the CDA will fall into the category of NGOs still requiring funding by the Commonwealth Foundation. This would be discussed at the Meeting of the CDA New Executives on Monday 15 December 2003.
- *CDA Standing Orders/Handbook* should be produced giving guidelines on CDA procedures. For example: correspondence written on behalf of CDA should go through the CDA Secretariat; CDA logo not to be used without permission. There would be further discussion at the Meeting of the CDA New Executives on Monday 15 December 2003.

9. CDA Bulletin

Prof Martin Hobdell (Editor) and Dr D Y D Samarawickrama (Co-Editor) said that they write and also collect articles for the CDA Bulletin, which is produced twice a year (Autumn and Spring) and Julia Campion (CDA Administrator) puts it together and gets it printed. They stated that they receive few articles for publication and more are needed. Printing and postage of the CDA Bulletin is expensive and it was suggested that it should be electronic and on the CDA website and an email alert sent out to inform people when it is available on the

website. Copies could then be printed from the website for local distribution, thus enabling a wider circulation. It was suggested that the next issue of the CDA Bulletin would incorporate the Report and Proceedings of the CDA 4th Triennial Meeting and it would be the last edition in hard copy.

10. CDA/FDI/Unilever Computer Project

Dr Lethoko Tsiu reported that he had received a computer and it has been a great help to him with IT. He stated that there are still many Africans that require computers.

Dr Brian Mouatt said that it was a very successful project. He stated that Unilever had been restructured and that the contact CDA had there had retired. CDA were able to get one computer from the Cordent Trust, it was sent to the Dental Training Centre in Zambia. He said the Computer Project is still on CDA's agenda.

11. CDA Constitution

The amendments to the CDA Constitution, which had been previously circulated, were agreed and accepted.

12. CDA Triennial Meetings

The following offers of hosting future CDA Triennial Meetings had been received:

- Year 2006 – Sri Lanka National Dental Association.
- Year 2009 – Malaysian Dental Association.

13. Open Forum

- Dr J T Barnard stated that Dato' Dr A Ratnanesan had played a major role in making this *Continuing Professional Education* meeting in Africa possible, and thanked him for his work.
- Dr Joyous Pickstock, on behalf of the Caribbean Regional Dental Association (CARDA|) and the Bahamas Dental Association, thanked Dr Brian Mouatt for his work during his term of office and, also, Dr S Prince Akpabio for all the work he had done during the last 12 years. She reported that the 12th Biennial Meeting of CARDA will be held 7-11 July 2004 in Miami, Florida and we extend an invitation to all to attend.
- Ms Katy Kabenge stated that she liked the CDA's *Adopt-a-Dentist* scheme and hoped that it would continue.
- Dr H J Mosha suggested that there should be pilot projects with WDDC. Dr Brian Mouatt said that pilot projects should have government backing and sustainability. Aid organisations now exchange information because FDI put that altogether. Aid organisations programmes are ongoing.
- Dr Lethoko Tsiu reported that AFRO now has a website.
- Dr Brian Mouatt said that communication between CDA and GADEF (Groupement des Associations Dentaires Francophones (the French-speaking CDA)) had only just started, FDI could help.
- Dr L K Gandhi reported that Computer Studies is compulsory in Secondary Schools in India. India is leading the world in IT.
- Dr Lethoko Tsiu said that Dr Neil Campbell had been elected to Communications of FDI, he is also Vice-President of the African Regional Organisation (ARO). Dr Neil Campbell had withdrawn his candidature for the CDA Election of Officers.

14. Election of Officers

The election, by ballot, of the CDA Officers for the next triennium (2003-2006) took place, Mr Andrew Quayle was the Returning Officer.

15. Installation of CDA President

Dr L K Gandhi was installed as CDA President for the next triennium (2003-2006).

16. CDA New Executive (2003-2006)

CDA President	Dr L K Gandhi (*India*)
CDA Executive Secretary	Dr Sam Thorpe OR (*Sierra Leone*)
CDA Treasurer	Dr Anthony S Kravitz OBE (*UK*)
CDA President-Elect	Prof Jacob Kaimenyi (*Kenya*)
CDA Immediate Past-President	Dr Brian Mouatt CBE (*UK*)

CDA Regional Vice-Presidents:

Europe	Dr John Hunt OBE (*UK*)
South East Asia	Dr Hilary Cooray (*Sri Lanka*)
Pacific/Australasia	Dr Temalesi King (*Fiji*)
Canada/Caribbean	Dr Joyous Pickstock (*Bahamas*)
West Africa	Dr Kofo Savage (*Nigeria*)
East, Central & Southern Africa	Dr Pashane Mtolo (*Zambia*)

The following were appointed to support the Executives:

CDA Administrator	Julia Campion (*UK*)
Editor, CDA Bulletin	Dr Martin Hobdell (*UK*)
Co-Editor, CDA Bulletin	Dr D Y D Samarawickrama (*UK*)

The FDI and Its Partners in Africa

Dr J T Barnard (FDI Executive Director)

Mr President, Dr Mouatt, President-elect Dr Gandhi, colleagues and friends

Thank you for the invitation to address this auspicious meeting. I have been asked to say a few words on the topic of '*The FDI and its partners in Africa*'.

I had a 'very nice' speech prepared, but after listening to the presentations by Dr Raman Bedi and others this morning during the plenary session of the FDI - Kenya Dental Association continuing education congress, I have decided to change my presentation and to speak frankly and from the heart.

I will stick my neck out and state that the FDI have few if any real partners in Africa. We certainly have many and highly valued stakeholders such as the CDA, African Regional Organisation, FDI Member Associations, WHO, IADR, GADEF, Dental Aid Organisations and others. This may sound semantic, but according to Dr Raman Bedi, a partner is someone or a group with a common sense of purpose and a common vision and, very importantly, there should be active collaboration between the partners.

From comments and remarks that I have heard from some individuals, I fear that we still have some way to go to achieve a true collaboration among all the stakeholders. I will explain why I came to this conclusion, but firstly I have to highlight a few of the key aspects of what the FDI has done and achieved in the field of development over recent years:

1. Development

- **2000**
  The FDI organises the first meeting and discussion forum for Dental Aid Organisations.
  The FDI Fund finds its feet after a difficult start.
- **2001**
  The FDI Fund approves its first grants for projects – two in Africa, one in India and one global.
  The FDI adopts a new strategic plan and establishes the World Dental Development Committee. World-renowned experts are appointed to serve on the Committee.
- **2002**
  A Development Manager is appointed at FDI Head Office.
  The FDI Fund changes its name to FDI World Dental Development Fund. Further grants are approved by the Fund for projects in South America and Africa.
- **2003**
  The ground breaking Development Workshop is held in Thoiry near the FDI's Head Office and is attended by more than 80 delegates from more than 30 countries. The adoption of the Ferney-Voltaire Declaration by the participants set the basis for the reduction of inequalities and inequities in the deprived communities and will coerce governments and planners to ensure that oral health is a priority and an integral part of general and total health. The project is funded mainly by a grant from the FDI's Charity, World Dental Education.
- **2004**
  The Planning Conference for Oral Health in the African Region that is being organised by the FDI and co-sponsored by the WHO, is planned to take place in April 2004 in Nairobi. This event has already captured the imagination of governments and stakeholders. The key funder for this event is again the FDI.

2. Education

- Continuing education programmes are a high priority for the FDI. Regular CE programmes are already well established in Asia-Pacific, Eastern Europe and Latin America. Africa is also coming into the loop and the programme currently underway in the adjacent Conference Centre is the FDI's first involvement in a CE programme in Africa. Record-breaking numbers of dentists have already registered. The costs for the programme are again carried by the FDI and sponsorships obtained by the FDI and the KDA.
- Currently the FDI organises on average one CE programme every three weeks in a developing country somewhere in the world, in collaboration with our member associations in those countries. A monumental achievement! For the CE programmes in Asia-Pacific, we are indebted to the World Dental Education Singapore for their contributions.

3. Other Areas

- **World Dental Partners**
  This FDI company, through business deals with sugar free chewing gum manufacturers, have donated to Member Associations of the FDI, more than $350,000 since 1999. All indications are that this initiative will develop even further in the near future. The result of these FDI activities is that some of the FDI's Member Associations receive more from the FDI in hard cash than they pay for their membership dues! This is specifically the case for smaller associations in the developing world. The total profit of this FDI company is donated every year to the FDI Charity World Dental Education to be used for educational and development work.

- **FDI Foundation**
  One of the proposals that were made as part of the current evaluation of Governance in the FDI is that a Foundation be established, mainly for development purposes, but also to support delegates from the least developed countries and others to attend the annual World Dental Parliament meetings. As a true global organisation we need all our Member Associations to attend and participate in the FDI General Assembly – the proposed Foundation will have this as an objective.

- **Fund Raising**
  The FDI Council has approved substantial funding to develop a strategy for fund raising. The first stage has been completed successfully. The result that we aim for is to have a professional fundraiser on the permanent staff of the FDI in order to manage and coordinate this important venture. The funds raised will be used for educational, development and scientific purposes.

- **General**
  There is a host of other activities that the FDI is involved in that make a real difference to oral health worldwide. The FDI has had meaningful achievements - a look at the contents of the 2003 Annual Report will give an indication of the very wide scope of these accomplishments.

With this very superficial overview of some of the FDI's recent achievements in the field of development as background, I would like to return to the issue of true partnership. Looking at the outstanding achievements and progress in the field of development, the provision of financial support and guidance to FDI member associations and the plans well underway to do even more for developing countries, I wonder on what grounds do a few influential individuals maintain their old rhetoric that the FDI is a Federation only for rich associations. This is simply not true. Constructive criticism is always welcome but constant negativity mainly from the same small number of people does not contribute.

We require more real partnerships, we need to break away from old clichés, we have to collaborate in the true sense of the word and be committed to the same high ideals. The FDI is willing and keen to have all the colleagues and groups mentioned at the outset as our partners and to work together in the pursuance of our mutual objectives.

Thank you again Mr President for the opportunity to participate in your meeting. I wish you and the President-elect, Dr Gandhi, and the CDA every success for the future.

Reports from the Regions and States

Fiji

Dr Bernadette Pushpaangaeli (President, Fiji Dental Association)

Greetings from the Fiji Dental Association and the Fiji School of Medicine! It is indeed an honour to be present here and for the first time have a representation from the Pacific and especially Fiji to the CDA meeting.

The Fiji Dental Association had a new team come on board on October 18, 2003. Within a month our secretary Associate Professor Zac Morse came in first contact with the CDA. Since then Julia, through her highly efficient arrangements and co-ordination, made it possible for a Pacific presence at this meeting. Thanks to the President, Brian Mouatt, and Julia Campion for the assistance that made it possible for me to attend. It is also timely that we are the latest National Dental Association to join and just in time to nominate Dr. Temalesi King for the post of Regional Vice-President for the Pacific Region at this meeting.

I though I would touch on certain key aspects to bring you news from the FDA and the happenings of the region. There is a lot to talk about but I will make it brief as per our schedule.

First, some news from the Fiji Dental Association (FDA). The new exclusive officers have been at task since coming into office trying to forge links and ties and with local, regional international bodies and personnel to foster collaboration, communication and initiate partnerships in order to assist in improving the status of oral health of communities in Fiji and also in an endeavour to support personal and professional development of dental personnel.

One of our aims is to improve communication among the members and also non-members through networking and information technology so that resources are easily and more readily made available through less expensive means. We intend to do this through an association website so that members have ready access to continuous education and other useful resources.

Education

The School of Oral Health, Fiji School of Medicine trains dental personnel for the various Pacific Island countries. In 1993 a five-year multi-entry/exit partially problem based learning dental curriculum was instated for a Bachelor of Dental Surgery. This was initiated in order to meet the needs of the PICs and to graduate dentists who would be able to perform under the conditions they are faced with the Pacific. Particular emphasis is placed on community dentistry and public health skills, research skills and the dentists' role as a manager and an advocate for change.

Regional - 2001 Pacific Oral Health Summit

The 2001 Pacific Oral Health Summit - "A Call for Action" was held in Nomea, New Caledonia, 12 to 15 February 2001. It was hosted by the Secretary of the Pacific Community and the Fiji School of Medicine. The following countries were represented by attendance through their Chief Dental Officers: American Samoa, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Republic of Marshall Islands, Nauru, Niue, Commonwealth of the North Mariana Islands, Republic of Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

The goal of the Summit was to establish a regional initiative for sustainable development in oral health and to raise awareness among Pacific Island Countries and Territories regarding the severity and consequences of oral disease for the population.

The Actions taken at this meeting were:
a) Establishment of the Pacific Advisory Board on Oral Health
b) Resolutions were adopted for the development of a Regional Framework for promotion of Oral Health in the Pacific

Fiji is scheduled to host the 2004 IADR Australasian Division meeting for the first time.

I look forward to our new membership with the CDA and the existing opportunities that it promises for us in Fiji and the Pacific.

A special thanks to the current FDA executive committee (Associate Professor Zac Morse, Dr. Seema Lal, Dr. Leenu Raju, Dr. Anare Sailo, Dr. Jeremaia Koroi and D. Prakashni Singh) for their efforts that have resulted in a great milestone.

Thank you.

Swaziland

Oral health services in Swaziland - Background

There are just over 1 million people in Swaziland and they are served by a total of fourteen dental surgeons; only seven of these are in the public service. There are thirty-eight dental hygienists and one dental therapist.

The bulk of the oral health services in Swaziland are in the towns, where the facilities are frequently of the high standard technically, are costly to operate and are staffed by highly trained professionals (the dentists). Most work in their own private dental clinics (70%); patients pay very high fees for dental treatment at these clinics.

For the majority of the population access into these dental clinics is difficult. These are also public oral health services in Swaziland run by the Government.

The majority of the services rendered are curative based and emergency oriented type of treatment.

The latest oral health epidemiological survey was done in 1994. The DMFT was 0.91 but there is an indication that it is now higher than 0.91, because already in 1994 the:

- DMFT for the urban areas was 2.73. There was a backlog of untreated caries
- Periodontal disease was affecting most of the population; in fact, only 2.2 had sound periodontium
- Oral manifestations of HIV infection and AIDS are in line with what is referred to in the literature. In a hospital-based survey done in May 2000 - over 80% of the parents presented with oral conditions, others included oral ulcerations, oral heavy leukoplakia and Kaposi's sarcoma. These manifestations are on the increase making oral health services overwhelmed.
- Maxillo-facial trauma has increased in Swaziland due to interpersonal violence and road traffic accidents. Complicated maxillo-facial complex fractures are referred to the Republic of South Africa for management as there is no oral maxillo-facial specialist in the country - also there is one specialist who visits the country once every month to operate on patients.

There is one dentist training as an oral-maxillo-facial specialist in the Republic of South Africa currently. There is no dental school in Swaziland.

Dentists are mainly trained in neighbour countries (e.g. The Republic of South Africa, Zimbabwe, Kenya and very few of them were trained outside the continent.

Dental hygienists were trained in the country at the Swaziland Institute of Health and Services, which has now become a Faculty of Health Services of the University of Swaziland.

Dental Hygienists were trained to do preventative treatment and oral health education as well as extractions. They were not trained to do restorative treatment. However, there are negotiations are taking place currently with the University of Swaziland to implement the training of dental therapists. This cadre would provide restorative (fillings) care.

There are very few mobile school dental services set up to serve the needs of the rural community. These are generally ineffective partly because of the poor road network into some of our rural areas and the unavailability of reliable transport for the oral health services.

These have been problems also due to the fact that we were relying on the donations of free toothbrushes and other brands by the Colgate Palmolive Company to the schools. Moreover, for xxx RDI and its xxx in Africa sense of vision a person a company based in Boksburg in the Republic of South Africa.

School health committees have been started in some schools and money for toothbrushes have been collected together with school fees but put into a separate bank account. This arrangement helps to sustain this project. The project is divided into three components:

1 ***Oral Health Education***

The children are taught about the different oral diseases, their causes and how they could be prevented and treated. This includes a session on diet counselling mainly on the proper foods that are needed by the body and the xxx foods.

2. ***Demonstration of tooth brushing technique***
This is introduced to the children so that they could get used to the idea of cleaning their teeth in childhood, so that they could maintain it in adulthood. This is a way of making sure that dental plaque that is the greatest enemy of the teeth gets removed from the teeth.

We also encourage the use of the traditional methods of cleaning teeth like the traditional chewing sticks.

3. ***Treatment component***
We believe that it is important to have a treatment project running side by side with the preventive project. This is because; most of the time when we go to the schools we find that there are children who need emergency care, for example, tooth extractions. For the children who need restorative work, they are referred to the dental clinic closest to their school.

The Colgate Palmolive Company in the Republic of South Africa has been approached to assist in the launch of the "Bright Smiles, Bright Future" Project in our primary schools. They have promised to start with twenty primary schools.

Presently, we are also working with the Swaziland Sugar Association, which is providing some toothbrushes that have been used to start the preventive project in some of the schools. Sugar producing companies have been requested to assist in making oral health services accessible to their workers, they are providing transport for the oral health workers, one company has also provided the logistic support for this project (e.g. providing local anaesthetics and dental instruments).

Swaziland has declared the second week of August as National Oral Health Awareness Week. During this week oral health personnel raise the awareness of the general population through the distribution of leaflets, pamphlets and posters on oral health. They also do interviews through the mass media. This increases the demand for the service especially for restorative treatment.

Two National Oral Health Epidemiological Surveys have been undertaken to assess the oral disease patterns in Swaziland in 1989 and 1994.

The results of the 1989 survey led to the formulation of the National Oral Health Policy and Plan.

The mean DMFT of 0.91 places Swaziland as a country with a low prevalence of dental caries and the disease levels fall below the lower limit determined by the World Health Organisation. However, in view of the fact that dental caries has been seen to increase with urbanisation and industrialisation, every effort is made to ensure that this prevalence rate does not increase.

The Ministry of Health and Social Welfare is working together, with the University of Swaziland to finalise the training programme of dental therapists. They believe that this cadre will meet the treatment and prevention needs of especially the rural population. With only seven dental officers in the public service it is not possible to cover the whole country. It is hoped that the dental therapists will serve the rural, peripheral and underserved communities. This is where 77% of the population resides. Oral Health Services will (therefore) then be accessible to all population groups of the country.

Section D
RESOLUTION ON DR AKPABIO

Resolution conferring the title *Emeritus Founder President* on Dr S Prince Akpabio OBE OFR

"This General Assembly wishes to acknowledge the long and distinguished service given so freely to the Commonwealth Dental Association by Dr Sonny Prince Akpabio, from its inauguration, where he was elected as the first CDA President, through his subsequent roles, to the present time.

It therefore wishes to mark this appreciation by conferring upon him the title "Emeritus Founder President" and hereby so resolves.

Furthermore it is the wish of the General Assembly that Dr Akpabio be asked to continue his work with the Commonwealth Foundation and Commonwealth Secretariat in London on behalf of the CDA in pursuance of its objectives/goals."

Proposed and adopted unanimously by the CDA Executive Committee 12 December 2003.

Dr Brian Mouatt (left) and Dr L K Gandhi (right) congratulating Dr S Prince Akpabio

Section E
DR L K GANDHI'S INAUGURAL ADDRESS

My Friends, Colleagues, Associates, Ladies and Gentlemen

My respects, good wishes and greetings go out to all Officers, Members, Friends of the CDA and the FDI.

At the very outset let me extend to you all, my deep appreciation and humble thanks for the honour you have bestowed on me in installing me as the President of this August Body of the Commonwealth Dental Association.

My sincere thanks also go out to the President and Members of the Kenya Dental Association for the wonderful hospitality and excellent arrangements made for our stay here in Nairobi on the occasion of this important get together of eminent personalities from the International Dental Fraternity.

Dr Brian Mouatt (left) congratulating Dr L K Gandhi (right) on his inauguration as CDA President

The Commonwealth embraces fifty-four countries from all regions of the world. It was their respective Governments, who decided to interact with each other and establish a Registered Governmental Forum and this was legally ratified in the year 1965. The Commonwealth was then established with Headquarters at Marlborough House. London with the basic and primary object of, among other things, to motivate,

- Good Governance and Democracy
- Sustaining Economy & Social Development
- The Rule of Law, Human Rights & Gender Equality
- Health for all citizens in the Commonwealth

The Commonwealth Dental Association was then set up as an exclusive International Non-Government Association on the 24th of April 1991, as result of a decision taken at a meeting of the representatives of the Commonwealth National Dental Associations, with the initiative to better the lot of all people in Oral Health.

The primary objective of the Commonwealth Dental Association is the exchange of information, experience and expertise between member countries, on all aspects of their work, particularly in the promotion of oral health strategies with appropriate technology applicable to all regions. This sharing of knowledge emphasised the need to train and develop adequate Auxiliary, Oral Health Manpower for the delivery of cost effective programmes of preventive oral health care, particularly in the rural areas in developing countries of Asia, Africa and other developing regions.

Special attention was devoted to the updating of continuing education programmes in dental health education and the application of the latest technologies in distance learning, for all dental surgeons and

other related oral health personnel, actively involved in the promotion of oral health, within all member countries.

Members of the CDA actively participate with WHO and Health Ministers of the Commonwealth Countries, insofar as is consistent with the Association's Consultative and Observer Status with these bodies. Regular meetings and seminars as well as conferences are held, as may be incidental to the promotion of Oral Health, in member countries.

A meeting of the General Assembly of the CDA is held every three years, preferably in one of the member countries and, today, it is a pleasure indeed for all of us to have gathered here in Nairobi to celebrate this 4th Triennial Meeting in association with the Kenya Dental Association and the FDI World Dental Federation.

At the last "3rd Triennial CDA Meeting" held in January 2000 at New Delhi" the Theme of the Congress was,

'*Equity and Excellence in the New Millennium*'

The existing barriers of the access of promotion of Oral Health in rural India as well as in other member countries, were both related to service provisions as well as social issues and these important subjects were discussed in depth, of the methods, ways and means of adopting suitable and appropriate programmes with emphasis on the prevention and curative aspect of oral health for all in the new millennium.

The paramount objective was to arrive at a legitimate and appropriate programme on "Oral Health for All" which could be suitably promoted and projected at the grass roots level in all developing member countries, so as to benefit all sections of society, irrespective of cast, creed, religion or gender, with special emphasis on children of the deprived sections of society.

A special project on the Prevention of Oral Cancer has also been projected on the priority list of programmes of our Association, as the prevalence of Oral Cancer, is around forty percent of all cancers in India. This translates into hundreds of thousands of oral cancer patients in our country. The single greatest risk factor is undeniably 'Tobacco'.

This must be the case in all other developing country of Africa and other backward regions and the importance of countering the incidence of this dreaded aliment cannot be over-rated.

While all oral cancers are not always life threatening, they are nevertheless serious public health hazards due to their high prevalence and consequent impact on the individual as well as society at large, in term of pain, discomfort, social and functional limitations and the ultimate effect on the quality of life.

The Commonwealth Dental Association has had the honour and privilege of a series of eminent personalities as their past Officers Bearers, who have undeniably projected this august body to the forefront of Oral Health Care in all member countries, particularly the developing regions, and we have to diligently pursue these objectives in the future as well.

I earnestly request all my colleagues and fellow office bearers to help and assist me in the next few years to keep up the high tradition of this office. It will of-course require considerable creative in-puts from us all, coupled with a lot of organisational arrangements to project a Seminar and/or Congress on *Oral Cancer*. This will undeniably compel us to seek substantial assistance and help and raise adequate funds to launch this project on an International basis with Africa, India as well as other developing member countries of the Commonwealth Dental Association.

Friends & Colleagues, in conclusion, I take this opportunity of announcing that during the middle of September next year, there will be an exclusive International Annual Congress of the FDI, at New Delhi India. Your new CDA President also happens to be the Chairman of this FDI Local Organising Committee at New Delhi. As Dr J T Barnard, the Executive Director of FDI and, of-course, the chief functionary of this outstanding International event is here today, we both extend to each one of you a very hearty welcome and assure you of an unforgettable Congress in the lush green tropical metropolis of New Delhi, India. Please make sure to mark this down in your engagement diary.

I thank you for all your patient hearing. God Bless You All.

Section F
THE NEW CDA EXECUTIVE FOR THE TRIENNIUM 2003-2006

President	Dr L K Gandhi (*India*)
Executive Secretary	Dr Sam Thorpe OR (*Sierra Leone*)
Treasurer	Dr Anthony S Kravitz OBE (*UK*)
President-Elect	Prof Jacob Kaimenyi (*Kenya*)
Immediate Past-President	Dr Brian Mouatt CBE (*UK*)

Regional Vice-Presidents:

Europe	Dr John Hunt OBE (*UK*)
South East Asia	Dr Hilary Cooray (*Sri Lanka*)
Pacific/Australasia	Dr Temalesi King (*Fiji*)
Canada/Caribbean	Dr Joyous Pickstock (*Bahamas*)
West Africa	Dr Kofo Savage (*Nigeria*)
East, Central & Southern Africa	Dr Pashane Mtolo (*Zambia*)

The following were appointed to support the Executives:

CDA Administrator	Julia Campion (*UK*)
Editor, CDA Bulletin	Prof Martin Hobdell (*UK*)
Co-Editor, CDA Bulletin	Dr D Y D Samarawickrama (*UK*)

Front row (left to right) Dr Kofo Savage, Dr Sam Thorpe, Dr L K Gandhi Dr S P Akpabio, Dr D Y D Samarawickrama, Julia Campion
Back row (left to right) Dr John Hunt, Dr Brian Mouatt, Prof Jacob Kaimenyi, Dr Joyous Pickstock, Dr Bernadette Pushpaangaeli