



Commonwealth Dental Association

Working for Oral Health in the Commonwealth



restoring smiles • changing lives

**REPORT OF THE COMMONWEALTH DENTAL
ASSOCIATION – BRIDGE2AID
WORKSHOP
ON
ORAL URGENT TREATMENT
(IN PARTNERSHIP WITH TANZANIA DENTAL ASSOCIATION)**

**MWANZA, TANZANIA
FEBRUARY 24-26, 2009**

Authors - Mark Topley & Dr Ian Wilson (BDS)



**Commonwealth
Foundation**

THE COMMONWEALTH DENTAL ASSOCIATION ACKNOWLEDGES THE FINANCIAL
SUPPORT PROVIDED BY THE COMMONWEALTH FOUNDATION FOR THIS
WORKSHOP, WITHOUT WHICH IT COULD NOT HAVE TAKEN PLACE

REPORT ON CDA WORKSHOP ON ORAL URGENT TREATMENT

FEBRUARY 24TH-26TH 2009

MWANZA, TANZANIA

1. OPENING

Dr Ian Wilson, Chief Executive of Bridge2Aid (B2A) opened the workshop and thanked delegates not only for their attendance but also their commitment to the delivery of oral health services in their professional lives. It was hoped that the conference would be an opportunity to build friendships, share experience and develop a better understanding of problems that dental health care professionals face in different countries. Each attendee brought different experience and whilst there was acceptance that there is no perfect model to address the issue of provision of emergency oral health services, through sharing different needs and delivering a supportive environment in which we can learn, it was hoped that we could develop a model that would better support the communities in pain and help make a difference.

Bridge2Aid acknowledged the cooperation of the Tanzanian Dental Association, the co-hosts of the workshop and especially the generous hospitality of Dr Mmasi, the Regional Medical Officer for Mwanza. Dr Mmasi in turn thanked Ian and the team at B2A for organising the workshop and was delighted to welcome the attendees to Mwanza as it was a fitting venue for the discussion given the location of the current Dental Volunteer Programme (DVP). He expressed hopes that the conference would be a supportive opportunity to exchange skills and knowledge so that we can learn from each other. Dr Mmasi wished the workshop success and health for the duration.

2. PRESENTATIONS AND DISCUSSIONS

2.1. Prevalence of Oral Pain and Barriers to Use of Emergency Oral Care Among Adult Tanzanians

Prof Emil Kikwilu (Dean of Dental Faculty, Muhimbili University, Dar es Salaam) presented 'Prevalence of oral pain and barriers to use of emergency oral care among adult Tanzanians.'

He highlighted the main findings of the study he undertook with colleagues, Joyce Rose Masalu, Febronia Kokulengya Kahabuka and Ahadieli Raphael Senkoro.

a. Background

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

b. Methods

Questionnaire data were collected from 1,759 adult respondents aged 18 years and above. The study area covered six urban and eight rural study clusters, which had been selected using the WHO Pathfinder methodology. Chi-square tests and logistic regression analyses were performed to identify associations.

c. Results

Forty two percent of the respondents had utilized the oral health care facilities sometimes in their lifetime. About 59% of the respondents revealed that they had suffered from oral pain and/or discomfort within the twelve months that preceded the study, but only 26.5% of these had sought treatment from oral health care facilities. The reasons for not seeking emergency care were: lack of money to pay for treatment (27.9%); self medication (17.6%); respondents thinking that pain would disappear with time (15.7%); and lack of money to pay for transport to the dental clinic (15.0%). Older adults were more likely to report that they had experienced oral pain during the last 12 months than the younger adults.

d. Discussion

There are many incidences of people who have dental pain – more than 58% of the surveyed population had oral pain within the preceding 12 months. Of these, only 25% had sought assistance from a recognised practitioner.

The principal reasons for not seeking help in rural areas were distance from a health centre and the cost of transport. The older people faced the greatest difficulties.

Choices of where to practice by the qualified has left the rural areas short of practitioners.

The recommendation of the study was to move towards the provision of emergency oral health care in rural facilities.

There was recognition that dental professionals who have undergone several years of training were concentrated in cities. This was due to the availability of paid work and the location of health facilities that provide Oral Health Care. The high cost of dental care equipment and facilities means that these centres are concentrated in cities. Also, dental professionals were unwilling to work in rural locations because of the aspiration to a certain standard of living. In urban areas, options of treatment were actually a barrier – patients are able to put off treatment until another time.

However, since 75% of the population live in rural areas, the provision of safe emergency dental treatment is crucial if the rural community are to be relieved of dental pain. The study called for the training of health care personnel already based in rural locations as a means of widening access to emergency dental care or Oral Urgent Treatment (OUT), a component of the WHO Basic Package of Oral Care (BPOC).

Since 1989, the Tanzanian government response has been to successfully train Clinical Officers (Previous Rural Medical aids) in OUT as part of their 3 year diploma. However lack of resources, lack of awareness in the community and cost sharing being just some of the barriers that stop rural communities accessing such care. (Moshi Ntabaye Oral urgent treatment: Experiences from Tanzania)

e. Conclusion

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

f. Overview of PhD Theory

Professor Kikwilu then moved to an overview of his PhD: 'Appropriate management of dental caries in Tanzania.'

His aims were to assess barriers to the management of dental caries in Tanzania and to identify ways of improving it.

Rural area communities have more numerous barriers to seeking oral care – up to 10 factors have been looked at and the conclusion is that more input is needed from the Government to promote the provision of oral care in the rural communities.

Some of the findings being that there was a low financial capability of the oral health care system to equip, run and maintain the dental clinics for effective conventional restorative care for treating dental caries throughout the country for easy accessibility by all Tanzanians.

Also there was a lack of a systematic way of educating the communities on the management of dental caries at individual, community and dental clinic levels. Ineffective monitoring systems were present for quality control in oral health care in the existing dental clinics to ensure patient satisfaction.

Rural areas were seen to be accepting the care faster than urban. What does that mean for replicable nature? The financial barrier is still a huge consideration for this communities accessing oral care. Most rural Tanzanians cannot afford a number of the treatment and that is a systemic government issue, not a regional one.

The rural population is willing and therefore intervention is welcome.

2.2. The Bridge2Aid Clinical Officer Training Programme & Dental Volunteer Programme

a. Background

Ian Wilson began by explaining his background in working in developing nations, beginning in the mid-nineties with short term visits to various parts of Africa where the work concentrated on treating high numbers of patients within a short period of time, but not training local personnel to deliver services after the volunteer team had left.

Ian believes that dentists in the UK have a responsibility to train and resource their colleagues across the world. Bridge2Aid aims amongst other things to provide an opportunity for the professions in the UK to deliver that in a way

that contributes to sustainability. At the heart of the Bridge2Aid ethos and objectives is a desire to work in a way that builds capacity into the local health systems. Hope Dental Centre, a commercial clinic set up and run by Bridge2Aid, both provides dental services to the local community and generates a profit, 100% of which is donated to Bridge2Aid to help fund its programmes.

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

Greater exposure to carbonated drinks and inappropriate levels of fluoride in toothpastes sold in developing countries are also contributing to a decline in oral health.

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

b. Basic package of Oral Care (BPOC, WHO Collaborating Centre, Nijmegen)

Ian described the WHO approach to solving the problem of providing oral health care in developing nations – the BPOC, which has four components:

- Oral Urgent Treatment (OUT)
- Affordable Fluoride Toothpaste (AFT)
- Atraumatic Restorative Treatment (ART)
- Oral Health Promotion (OHP)

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

c. Why is there a need for OUT?

In rural areas, in non-developing countries, the incidence of caries is increasing according to recent studies. The impact of untreated decay and

infection can be devastating – people simply cannot work when they are in pain and that has a high social and financial impact.

In response to a need for training in OUT for personnel based in rural areas, Bridge2Aid's desire was to create a programme which would harness the goodwill of the dental profession in the west in a way that would contribute to the provision of safe pain relief in a sustainable way.

Ian pointed out a number of examples of where volunteering can be inappropriate, typically where volunteers see themselves as the solution to another's problems without sufficient knowledge, understanding or respect for the situation within a community. In these situations volunteers can feel they have the right to tell people what the problems are and then deal with those problems on their own terms. Bridge2Aid's approach is strongly integrated with government strategy, and the planning and execution of their programme has been a partnership with national, regional and local government officials.

d. So what should NGOs do?

NGOs can contribute positively if they chose appropriate intervention. There is a huge need for training in OUT and the people best placed to deliver OUT in Tanzania are clinical officers because of their proximity to 75% of the population.

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

(Dr. Habib Benzian FDI)

e. The Bridge2Aid Dental Volunteer Programme

Mark Topley explained the key components of the Bridge2Aid programme, which was first piloted in 2004, and since then has trained over 80 clinical officers. The key aspects of the programme are:

- Training in OUT for frontline healthcare personnel – Clinical Officers (COs)
- High quality 1:1 training ratio
- Contributes to an existing primary health care system (PHC)
- Replicable
- Highly Effective
- Grounded in locally based NGO

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

There are three phases to the programme:

1 – *Intensive Phase* – which involves a team of Volunteers/trainers (possible to use any team of ex-pat or national trainers) training several COs at one time in a rural health centre for a two week period.

2 – *Supported District Phase* – the Bridge2Aid team supports the district with expertise and some logistics to deliver their own small scale training

3 – *Independent Phase* – Ongoing training is fully absorbed into the local government planning and budget.

Phase 1 – Intensive Phase

This began in 2005 with one district, and now includes 4 across the region. There are three aspects.

The first is theory training (3-4 days), which is delivered by the District Dental Officer at the District Hospital. The second is practical training (6 days) which involves the CO working 1:1 with a UK volunteer dentist, a local dental therapist or the District Dental Officer. A free clinic at a rural health centre is publicised and the team travels with all the necessary equipment to deliver treatment and training. Equipment is deliberately kept simple and appropriate to what the COs will be using after training. The training is based rurally because a large number of patients are required for the CO to gain enough experience during the 6 days. They typically will extract 50-100 teeth during this time, and the programme dictates how much they are permitted to do on each day, rising from observation, history taking and diagnosis on the first day, to extraction under supervision on the last. The training syllabus is based upon the CO dental training syllabus for Tanzania and '*Basic oral emergency care by auxiliaries for under-served populations*' by Dr Jacques Baart, Dr Jurgen Bosgra and Prof Wim van Palenstein Helderma, an FDI publication.

Clinics are very popular, with typically 100-250 patients arriving for treatment each day. The rural environment is important for patient numbers, but also to train in conditions which the COs will experience post training. The instrumentation used follows FDI guidelines in '*Basic oral emergency care by auxiliaries for under-served populations*'. B2A have added an upper premolar after recommendation from our trainers and consultation with the FDI.

Everything is focussed on simplicity – the COs are trained to do the basics well and refer the rest. The programme aims to help them to learn their limitations as well as skills.

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

Assessment of competence takes place throughout the training programme. There is ongoing assessment throughout the 6 days of key competencies which are signed off as they are achieved in the COs learning record. The decision to pass or defer is based on this and is a training team decision as each one of them will have worked with each CO during the course. After reaching a consensus around the stated criteria, a decision is made. If the CO passes then they are allocated an instrument kit and steriliser, again the kits and steriliser are based on FDI guidelines. During training a 23g hypodermic syringe & vial of local anaesthetic are used. These items are available locally or through the government supply chain, another crucial contributor to ongoing success.

Since 2005 91% of COs have been successful at their first training course. 100% of those that are sent for further training are successful after a second programme.

After training, supervision is provided by the existing health care management structure in the form of the District Dental Officer (DDO). The DDO will visit the CO who has been successfully trained within 1 month of training, and then twice more during the first quarter to carry out a supervision visit. These visits are provided within the Primary Health Management Team visits, which are a normal part of the district's plan. The DDO completes a monitoring form which involves the observation of 18 different aspects of practise, as well as a written section.

f. Evidence base

In a comparison of 2005 when training started and the last six months of 2006 - after B2A had 20 trained clinical officers in place - they saw a significant drop in the number of patients being seen at the district hospital compared with the previous year. At the same time there was a four fold increase in the total number of patients treated in the district. The vast majority of these (876) were treated successfully in the rural health facilities (showing that people are

not having to travel for basic extractions). The District Dental Officer reported a 50% increase in the number of conservative treatments he was able to provide due to extra time released. In summary, the training led directly to a large increase in access to care at a local level, a relief of pressure on centralised resources and the release of time to the DDO for advanced procedures and supervision.

After training the supervision & monitoring aspect is very important. Over the past 4 years Bridge2Aid have collected the data and met regularly with the DDOs to discuss the progress of the COs. In November 2008, after consultation with our clinical advisory team and the districts we introduced a new system which standardises the reporting from supervisory visits, and expect to have the data from the first group in March 2009.

Over the past 4 years B2A have gathered a great deal in the way of anecdotal evidence. Mark Topley said that there would be an opportunity to discuss this face to face with the District Dental Officers Samuel Kalongoji (Magu) and John Nyorobi (Misungwi) that afternoon.

In summary:

- The trained COs are safe – there are no reports of referral after failed extractions.
- The COs do refer. In some cases they even attend the district hospital so they can observe and learn from the procedure.
- There is a large need for the service, some COs are treating up to 300 patients per year.
- The community response is very positive, with village elders all stating that the service provided is good. The next step for us is a more evidence based survey which will take place later this year.

After the intensive Phase 1, Phases 2 & 3 follow, and these will start this year. Phases 2 & 3 will address the issue of ensuring that training is sustained within the existing PHC system.

To this end discussions have led to the conclusion that it will be possible for a district that has been involved in Phase 1 to run its own training.

Firstly, the numbers will be lower. B2A estimate that between 5 and 10 personnel per year will require training to incorporate new staff. This should be manageable, whereas the task of training typically 50 in a district is beyond the resources available.

In Phase 2 the aim is to support the district in creating the logistical systems, expertise, funding pathways and equipment to operate their own training programmes in Phase 3. This will involve in-house training organised at a health centre for 1-3 COs, with the trainers being district staff (DDO, therapist, experienced COs). Theory training could be centralised, perhaps in Mwanza and combined with other districts. Bridge2Aid provides the loan of instruments and equipment (at a time when a DVP programme is not happening), manuals and assessment documents and continues to issue instrument kits and sterilizers after training, which will only be necessary for COs being deployed to new locations where no kit exists.

The aim of Phase 3 is that training is fully integrated into Health Planning. Bridge2Aid will help to procure a set of instruments to support training, or perhaps loan a basic set of equipment on an ongoing basis.

For monitoring, the DDO maintains records of the performance of trained staff, and submits an annual report as normal to the District Council which is copied to Bridge2Aid.

After 4 years, B2A are looking to the future and considering whether the model can be developed for use elsewhere. The first obvious place is elsewhere within Tanzania, then perhaps to other nations.

The keys to success will be:

- Local grounding - People with local knowledge, infrastructure and relationships who can host/organise training with external consultancy/training.
- Skilled Trainers – can be volunteers or if a good network of indigenous trainers exists then that is equally good if not better.
- 1:1 aspect – crucial for successful training. The ratio is key to a successful programme of both theory and dextrous practical skills. In our experience, many COs have been trained and have tools but it might have been years since practical experience.
- Intensive – within a 2 week period to increase skill sufficiently.
- Supervision – managed by the local health management system.
- Phased – with a progression from close support and high logistical input to an independent self sustaining training cycle.

These principles run alongside the key issue for a primary health care plan being:

Accessibility	Accessibility to essential health services with no financial or geographical barriers.
Appropriate Technology	Technology used and approaches of care should be based on health needs, and appropriately adapted to the community's social, economic and cultural development.
Community Participation	Communities should be encouraged to participate in planning and making decisions about their own health care.
Prevention and Health Promotion	Health systems should focus on helping people stay well instead of treating them when they become ill.
Intersectoral Collaboration	Professionals from various sectors, including the health sector, work independently with community members to promote the health of the community.

3. VISIT TO VIEW PRACTICAL TRAINING IN ACTION AT KOROMIJE HEALTH CENTRE

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

4. DISCUSSION OF THE ISSUES RAISED AND THE B2A TRAINING PROGRAMME

The session began with reflections from Professor Emil Kikwilu to stimulate thoughts about the provision of emergency care. A summary of his comments follows;

Dentistry has evolved in terms of legislation while at the same time being a market that its professionals feel needs to be protected. Governments accept some of that protection for good reasons, to ensure that people are attended by trained people who are responsible for what they do.

Dentists should serve all of Tanzania, but in practice this doesn't happen. Individuals have worked hard to qualify as dental professionals and want a standard of life that cannot be delivered in the environment in rural areas. 'I' is a stronger concept than 'you'. Professionals have never managed to serve the population in the way they were prescribed to serve. The question is therefore of moral obligation. How much suffering will we allow in our population?

We have recovery programmes in Tanzania in which every sector has to address the need to deliver a better life. In health, that means reducing suffering to enable them to be productive. How long can the dental profession say that only they can support the population when they don't go to the rural areas where there is 75% of the need?

We need to find a viable solution. It is not that dentists suddenly should move to rural areas because they simply won't do that. But neither should we be allowed to control access to the solution. Dental professionals have the right to work and do their job, but we also have a responsibility to the people who need treatment. How can we best meet that need? We cannot let our countrymen suffer. This is the concept of primary health care.

The Basic Package of Oral Care is a staged concept. Firstly, it is about the relief of pain, and then about the prevention of pain or intervention. This latter stage is about health information so people can make informed decisions about the danger of sugar etc. It is education to allow for rational decisions. We need to assist our communities to make better and easier choices and this supports the pathway to the end of oral disease. It is also about making the solution affordable as well as appropriate and available. You cannot just tell them to get toothpaste, you have to ensure there is the right and affordable product available.

The Basic Package of Oral Care does not exclude the dentist. There is a place for them of course but in a different place and time to what we are

discussing here. The provision of OUT to rural communities will not involve the dentist, but neither should we stand in the way of that provision by appropriately trained personnel.

5. WORKING GROUPS

The workshop then divided into groups to discuss a number of questions.

5.1. What are the barriers for communities to access Urgent Oral Treatment?

The groups responded with the following:

- Affordability – the high fees required for equipment, and transport into rural areas were highlighted as a problem. Some countries adopt a cost sharing model where the patient pays a registration fee and the treatment is free. Others have a free system, and some operate a full payment system where patients pay for consultation, medication etc.
- Accessibility – Several people highlighted that distance from a facility where trained help is available is a problem. This is not the case in every country, e.g. Sri Lanka has an average of 5-10km to a facility, in Uganda the distance is more like 50km. The groups observed that the B2A programme is applicable where local rural community needs define the need for OUT, but that there is no blanket problem so no blanket solution. They also commented that in order to deliver a model like the B2A programme, it must be contextualised for each country and so each National Dental Association and government must discuss the application. There might be very different solutions needed.
- Indirect cost was highlighted as a barrier, particularly waiting time (for the qualified person to arrive or return, as well as travel time to and from the facility).
- Lack of knowledge among the population as to who should look after their dental needs.
- Availability of appropriately trained personnel. Cases were cited of people travelling many kilometres to a facility and the dentist was not there or did not have the right materials etc.
- Legislative control of the profession. Dentists frequently prevent others from carrying out pain relief by obstructing legislation at a national level.

For example in Nigeria, dentists oppose and legislate against allowing non-dentists to provide care. In the south of Nigeria, there are lots of oral health care facilities based in urban areas and the population have access to facilities close by. In the north, the situation is very different with one therapist to 1 or 2 million of population and 150km distance to a practitioner.

- Gender – females need to be accompanied to the oral health facility in some countries.
- Poverty, political stability and political will were also noted as barriers but time did not allow us to discuss such large issues.

5.2. Where in your health care system does OUT fit?

The groups felt OUT could be incorporated at all levels. Dentists tend to work at a tertiary level, but can get frustrated or weighed down with simple, repetitive pain relieving work, and so it was felt there was a place for suitably trained personnel to deliver OUT in tertiary facilities, as well as at the district health centre and rural dispensary levels.

5.3. Is an OUT training course needed where you are?

- Some felt that it should be a tiered programme, it was acknowledged that you need to consider the principles of PUFA – pain, ulcer, fissure and abscesses. This being another approach to ensure that rural communities are able to access primary health care to address their felt needs.
- Early treatment is a step up in terms of training, and health personnel trained in OUT should be given experience once the first round of training is complete. The main work is the need to alleviate the pain, then look at the rest.
- It was pointed out that patients are most susceptible to education when they are in the dental chair. Western model needs to be reversed. Relieving pain is the priority. Primary prevention comes last. Rehabilitate first, then screen early and educate. You need to manage the disease and pain first as that already exists. Dental disease needs to be reduced as a priority in communities.
- The question of using volunteers is one aspect to be addressed. The main question for some is how to make it sustainable. Can you rely on Western volunteers 100% or can this work alongside a network of indigenous dental professionals as the source of trainers? This highlights the issue of

ensuring that in any OUT programme we are also including the principle of training the future trainers.

- Another point made was that you need an education programme to go along side the programme or else you focus on curative issues rather than prevention.

6. RECOMMENDATIONS

The session began with a short presentation by Dr Felician Gombo, representative of the President of the Tanzanian Dental Association (TDA).

“On behalf of the dental profession, TDA congratulates the Commonwealth Dental Association (CDA) and Bridge2Aid in partnership with the TDA for organising the event. Thanks to sponsors and organisers. We hope and believe this has opened doors to other workshops in all CDA countries. It has been a creative, useful workshop which in turn has widened our view and understanding of the problems that we and our colleagues face as we deliver basic oral care in our own environments.

The TDA heartily thanks Bridge2Aid for complementing the efforts of our government and the dental profession as they try to help us build the profession in Tanzania. TDA had concerns at the beginning of this workshop, but by the end of yesterday, our concerns have been clarified and addressed. It is requested that CDA and Bridge2Aid along with all other stakeholders work with us to make strong recommendations to the decision making powers to promote the profession.”

The workshop recognises that:

1. The magnitude of the current level of untreated oral disease is enormous
2. The joint FDI (World Dental Federation)/WHO global goals for Oral Health for the year 2020 clearly defines reduction in the ‘D’ component as the primary goal.
3. The prevalence of dental pain is high in all groups of populations.
4. Barriers to oral health care seeking behaviours exist and these need to also be addressed.
5. It is not possible under present constraints to address this issue adequately because of lack of resources in terms of finance and manpower.
6. The dental profession needs to accept that other health care personnel will have to be involved in order to control the present disease burden.

7. BPOC in all its four components has to be developed in cohesion with all dental associations.
8. BPOC has been advocated as a practical and effective oral care package for developing countries.
9. OUT is recognised to be focussed on alleviation of pain.
10. OUT may be the most appropriate opening component for implementation of the whole package.
11. A local needs assessment and agreement with the National Dental Association are a compulsory requirement to start this programme in any country.

The workshop recommends:

1. Formation of a global task force for elimination/alleviation of dental pain. This task force will:
 - a. Prepare formal/structured processes to follow when implementing BPOC.
 - b. Define standard operating procedures for all components of BPOC.
 - c. Document a uniform programme for training, implementation, monitoring and evaluation to assess the use and benefit of the programme.
 - d. Establish a focus group within the task force to disseminate information on BOPC in scientific journals and periodicals.
2. FDI, CDA, WHO, Commonwealth Foundation should be approached to fund the formation of this task force.
3. Establishment of a steering committee made up of all attending delegates of the workshop with secretariat being Bridge2Aid and Professor Emile Kikwilu as chairman to follow up formation of the global task force.

7. CLOSING

Professor Ayyaz Ali Khan gave a vote of thanks and quote,

“We have had a few conversions here. Making a living out of our technical skills, it takes courage to agree with the finding of the workshops. Thanks to CDA for bringing us together. Thanks to B2A in terms of response times and helping deliver a very useful experience. You have given us a direction and go back with a passion and will that this programme needs to go ahead and deliver relief.”

PARTICIPANTS AND SPEAKERS

Participants

Dr Upul Dissanayake	Sri Lanka
Dr Charles Mugisha Rwenyonyi	Uganda
Dr Tom Ocholla	Kenya
Dr Kelebalwe Lekau-Tacheba	Botswana
Dr Femi Orebanjo	Nigeria
Professor Ayyaz Ali Khan	Pakistan
Dr Naresha Samarasekara	Sri Lanka
Dr. Gombo M. Felician	Tanzania (President's representative)
Dr. Cosmas F. Mango	Tanzania
Dr. Kajiur Mhando	Tanzania
Dr. Emilton Ndanshau	Tanzania

Speakers

Professor Emil Kikwilu	Dean of Dental Faculty, Muhumbili University, Dar es Salaam
Dr Ian Wilson (BDS)	Chief Executive & Dental Director, Bridge2Aid, Mwanza
Mr Mark Topley	General Director, Bridge2Aid, Mwanza